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CO-EVOLUTION OF POLICY SECTORS: HEALTH CARE AND PUBLIC HEALTH IN FIVE COUNTRIES

Trein Philipp

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UNIL | Université de Lausanne

Faculté des sciences
sociales et politiques

INSTITUT D'ÉTUDES POLITIQUES HISTORIQUES ET
INTERNATIONALES (IEPHI)

Co-evolution of Policy Sectors: Health Care and Public Health in five Countries

THÈSE DE DOCTORAT

presentée á la

Faculté de sciences sociales et politiques
de l'Université de Lausanne

pour l'obtention du grade de
Docteur en science politique

par

Philipp Trein

Directeur de thèse
Prof. Dr. Dietmar Braun

Jury
Prof. Dr. Jean-Philippe Leresche
Prof. Dr. Daniel Kübler
Prof. Dr. Stéphane Nahrath
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Faculté des sciences sociales et politiques

IMPRIMATUR

Le Conseil de la Faculté des sciences sociales et politiques de l'Université de Lausanne, sur proposition d'un jury formé des professeurs

- Dietmar BRAUN, directeur de thèse, Professeur à l'Université de Lausanne
- Stéphane NAHRATH, Professeur à l'Université de Lausanne
- Yannis PAPADOPOULOS, Professeur à l'Université de Lausanne
- Daniel KÜBLER Professeur à l'Université de Zürich

autorise, sans se prononcer sur les opinions du candidat, l'impression de la thèse de Monsieur Josef Philipp TREIN, intitulée :

« Co-evolution of policy sectors : Health care and public health in five countries »

Lausanne, le 3 août 2015

Le Doyen de la Faculté

Professeur
Jean-Philippe Leresche

Résumé

Cette thèse analyse la co-évolution de deux secteurs dans la politique de la santé: santé publique (public health) et soins aux malades (health care). En d'autres termes, la relation entre les dimensions curative et préventive de la politique de la santé et leur développement dans la durée. Une telle recherche est nécessaire car les problèmes de la santé sont complexes et ont besoin de solutions coordonnées. De plus, les dépenses de la santé ont augmenté sans arrt durant les dernières décennies. Un moyen de réduire une future augmentation des dépenses pourrait consister en davantage d'investissement dans des mesures préventives. En relation avec cette idée, ma recherche analyse les politiques de la santé publique et les soins aux malades de cinq pays: Allemagne, Angleterre, Australie, États-Unis et Suisse. En m'appuyant sur la littérature secondaire, des statistiques descriptives et des entretiens avec des experts et des politiciens, j'analyse la relation entre les deux secteurs depuis la fin du dix-neuvième siècle. En particulier, je me focalise sur la relation des deux champs sur trois niveaux: institutions, acteurs et politiques. Mes résultats montrent les similitudes et les différences d'évolution entre les cinq pays. D'un côté, lorsque la profession médicale est politiquement active et que le pays consiste en une fédération centralisée ou en un gouvernement unitaire, les deux secteurs sont intégrés au niveau institutionnel, ralliant les professions et groupes d'intérêt des deux secteurs la cause commune dans une activité politique. Par contre, dans tous les pays, les deux secteurs ont co-évolué vers une complémentarité malgré de la politisation des professions et la centralisation du gouvernement. Ces résultats sont intéressants pour la science politique en général car ils soulignent l'importance des professions pour le développement institutionnel et proposent un cadre pour l'analyse de la co-évolution des politiques publiques en général.

Abstract

This Ph.D. thesis analyzes the co-evolution of the health care and the public health sectors. In other words, the relation between preventive and curative health policy and its evolution over time. Such research is necessary, because current health problems are complex and might need coordinated solutions. What is more, health expenditures have increased continuously in the last decades. One way to slow down further increase in health spending could be to invest more in preventative health policies. Therefore, I am connecting individual health care and public health into a common analysis, taking Australia, Germany, Switzerland, the UK and the U.S. as examples. Based on secondary literature, descriptive statistics and interviews with experts and policymakers, I am analyzing how the two sectors' relations co-evolved between the late nineteenth and the early twenty-first century. Specifically, I am researching how health care and public health were related on the levels of institutions, actors and policies. My results show that there are differences and similarities in the co-evolution of policy sectors between these countries. On the one hand, when the medical profession was politically active and the country a centralized federation or a unitary state, there was institutional integration and common political advocacy of the sectors' interest groups and professions. On the other hand, in all countries, both sectors co-evolved towards complementarity, irrespectively of the politicization of professions and centralization of government. These findings are interesting for the political science literature at large, because they underline the importance of professions for institutional development and propose an analytical framework for analyzing the co-evolution of policy sectors in general.

To Thenia

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Acronyms

ACoSH Action Council on Smoking and Health, Australia

AHA Area Health Authority, UK

AHV Alters- und Hinterlassenenversicherung, Switzerland

AMA American Medical Association

AMA Australian Medical Association

ASH Action on Smoking and Health

AAAS American Association for the Advancement of Science

AUS Australia

BMA British Medical Association

CACR Centre Anti-Cancéreux Romand

CDP Cantonal Directors of Public Health, Switzerland

CG Central Government

CHP Community Health Program, Australia

CME Coordinated Market Economy

CW Commonwealth of Australia

DHA District Health Authority, UK

DHHS United States Department of Health and Human Services

DRG Diagnosis Related Groups

EHI Etatist Health Insurance

FAZ Frankfurter Allgemeine Sonntagszeitung

FCTC Framework Convention on Tobacco Control

FDR Federal Democratic Republic of Germany

FSA Federal Security Agency, USA

GB Great Britain

GDR German Democratic Republic

JPCSS Joint Parliamentary Committee of Social Security, Australia

HC Health Care

HTA Health Technology Assessment

LME Liberal Market Economy

LTC Long Term Care

MOH Medical Officer of Health, UK

NHI National Health Insurance

NHMRC National Health and Medical Research Council, Australia

NHS National Health Service

NRW North Rhine-Westphalia, Germany

NS National Socialism

NSDAP Nationalsozialistische Deutsche Arbeiterpartei, Germany

NSW New South Wales

NZ New Zealand

IMNA Institute of Medicine of the National Academies, US

PBS Pharmaceutical Benefits Scheme, Australia

PHI Private Health Insurance

PHIAC Private Health Insurance Administration Council, Australia

PHIO Private Health Insurance Ombudsman, Australia

PH Public Health

QUE Queensland

RACP Royal Australian College of Physicians

RACS Royal Australian College of Surgeons

SA Southern Australia

SHI Social Health Insurance

SKI Schweizerisches Krankenhausinstitut, Switzerland

SUVA Schweizerische Unfallversicherungsanstalt, Switzerland

TAS Tasmania

TB Tuberculosis

USPHS United States Public Health Service

VIC Victoria

VoC Varieties of Capitalism

WA Western Australia

WHO World Health Organization

WZB Wissenschaftszentrum Berlin

“L’affiche annonçait ensuite des mesures d’ensemble, parmi lesquelles une dératisation scientifique par injection de gaz toxiques dans les égouts et une surveillance étroite de l’alimentation en eau. Elle recommandait aux habitants la plus extreme propreté et invitait enfin les porteurs de puces à se présenter dans les dispensaires municipaux. D’autre part les familles devaient obligatoirement déclarer les cas diagnostiqués par le médecin et consentir à l’isolement de leurs malades dans les salles spéciales de l’hôpital. Ces salles étaient d’ailleurs équipées pour soigner les malades dans le minimum de temps et avec le maximum de chances de guérison. Quelques articles supplémentaires soumettaient à la désinfection obligatoire la chambre du malade et le véhicule de transport. Pour le reste, on se bornait à recommander aux proches de se soumettre à une surveillance sanitaire.”

(Camus, 1947, 54-55)

Chapter 1

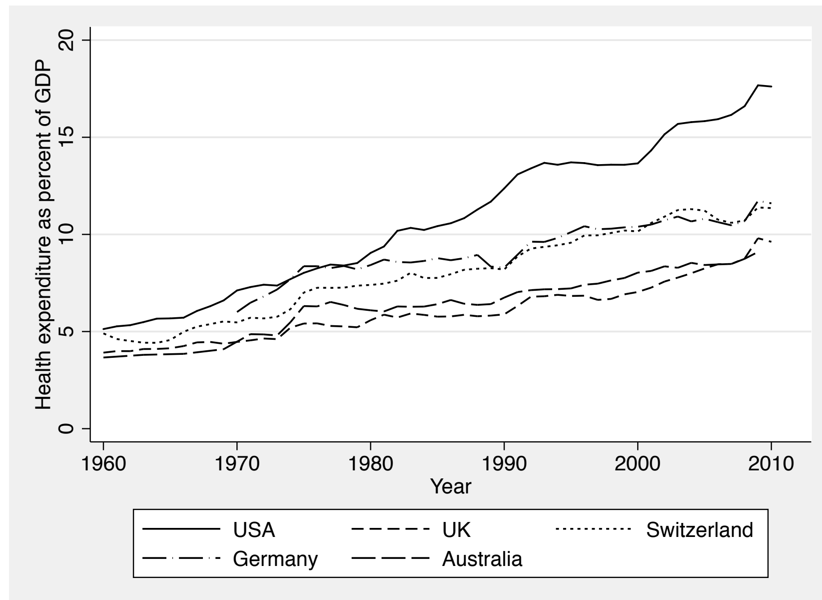
Introduction

The introductory quote from the Albert Camus' *La Peste* refers to a fictive outbreak of a plague in a small North African city under the reign of colonial France and city officials' reactions to the disease. Although this example is entirely fictitious, a similar situation could easily occur today. The Ebola epidemic, which recently hit countries in Western Africa, bluntly shows how this can happen. Other examples are resistant influenza viruses (such as H5N1) and the MERS (Middle East respiratory syndrome) coronavirus, which have become concerns for health policymakers. More generally, reports by the WHO, OECD and UN point to the problems of tuberculosis and antibiotic-resistant bacteria (WHO, 2013*b*; WHO, 2014) and to the importance of preventing noncommunicable diseases (UN General Assembly, 2010; OECD, 2011; WHO, 2013*a*), such as cancer and diabetes. These health problems are complex and mobile. Therefore, in order to deal with them efficiently, health systems have to deal with complex cases of multiple morbidities simultaneously with new threats from resistant viruses and bacteria, which can travel easily in a globalized world.

If we remain for a moment with the fictional example from Camus' book, the measures that the officials take are twofold. One part of the response entails curing those who have already been infected. In addition, the city administration aims to prevent the disease from spreading further. Nowadays, in developed democracies, these strategies individual cures and large-scale prevention are in different policy sectors that operate according to different logic and have distinctive actors and policies (Blank and Burau, 2007; Tulchinsky and Vavravikova, 2009). However, in order to respond to complex health problems, there is a need for coordination and flexibility in each of these sectors, and we need to know how they operate not just independently but also in coordination. The problem is that we do not know much about the relation of health care and public health (understood as policies of prevention that focus on the population), especially regarding different forms of relations and how they have co-evolved.

The coordination of health care and public health is important for another reason. Figure 1.1 shows that health expenditures are consuming an increasing share of the national income, based on the example of five OECD countries. In 1960, each of these nations

Figure 1.1: Evolution of health expenditure



spent around five percent of their GDPs on health (care and prevention). By 2010, this share had doubled, and in the U.S., it had more than tripled. This poses a problem for many countries, as it decreases governments' leverage in other policy areas. What is more, in times of budgetary austerity, it is difficult to avoid cutting or at least capping health expenditures, which can have consequences for health quality. Nowadays, about 98 percent of health expenditures are invested in individual health care, such as physicians' remuneration and payments for treatment, drugs and hospitals. A possible solution to prevent health expenditures from increasing further is to invest more into preventive health, especially regarding risk factors, such as encouraging less smoking and drinking and promoting healthier diets and more exercise. Ideally, these kinds of preventive measures would not be in conflict with individual health care but instead would appear in a coordinated (Chernichovsky and Leibowitz, 2010) manner in order to be efficient and focus on the patients' interests. Again, this leads us to the question of the relation between health care and public health.

A lack of knowledge regarding the relationship between health care and public health ties into a general problem in the political science literature: the question of how two related policy sectors emerge and co-evolve. During the past two decades, the political science literature frequently discussed the impact of historical events and decisions on policymaking and reforms, most prominently outlined by Paul Pierson (Pierson, 2000). On the other hand, Guy Peter referred to the search for the coordination of policy sectors as the "Holy Grail" for policymakers (Peters, 1998, 295). However, neither the political science nor the public administration literature has researched the co-evolution of two policy sectors from a broad and comparative perspective.

Using the example of health care and public health, this thesis undertakes a comparative analysis of two policy sectors that work to solve the same problem according to different principles. In doing so, I analyze how the relations between the two sectors' actors, institutions and policies evolved from the mid-nineteenth century to 2010 in five countries: Australia, Germany, Switzerland, the UK and the U.S. My main argument is that government centralization and professions' political activity are important for how the two sectors co-evolve. This research outlines the role of professions in institutional development and presents a typology to comparatively analyze the coordination of policy sectors. What is more, both are starting points for further research projects.

1.1 Co-evolution in the political science literature

Co-evolution is a concept from biology that refers to the mutual adaptation of two organisms, or their parts, in order to ensure continuing responsiveness between the two (Thompson, 1982; Thompson, 1994), for example between flowers and insects to make sure that the insects receive nutrition and the flowers receive pollination. Recently, social sciences and evolutionary theory have been increasingly connected, which has brought forward a variety of usages of the term *co-evolution*. Evolutionary theory has been used to explain dynamics in many disciplines of the social sciences, including economics (Metcalfe, 1998; Metcalfe and Foster, 2004), geography (Schamp, 2010), psychology (Confer, Easton, Fleischman, Goetz, Lewis, Perilloux and Buss, 2010), sociology and political science (Luhmann, 2000; Miller and Page, 2007; Page, 2010). Political scientists have used evolutionary theory particularly to explain the development of institutions over time, as with regard to vocational training regimes (Thelen, 2004). Sven Steinmo and others went further and explicitly transferred the concepts of evolutionary theory to the analysis of institutional change (John, 2003; Lewis and Steinmo, 2010; Steinmo, 2010; Lustick, 2011).

Other authors in social science used co-evolution more explicitly (Bowles, Choi and Hopfensitz, 2003). For example they referred to co-evolution concerning economic geography and business studies, notably with regard to the co-evolution of firms along with their institutional environment. Thereby, the research has yielded interesting results, for instance about the co-evolution of strategic alliances between firms (Koza and Lewin, 1998) and between firms and their environment (Krug and Hendrischke, 2008; Cantwell, Dunning and Lundan, 2009). Political scientists also have drawn on this concept to analyze the co-evolution of dyads such as capitalism and systems of political representation (Cusack, Iversen and Soskice, 2010), skills and welfare (Trampusch, 2010), and society and the state, all with regard to policy fields (Böhret and Konzendorf, 1997). What is more, sociologists have proposed a general theoretical approach to co-evolutionary systems (Hird, 2010; Hodgson, 2010; Gual and Norgaard, 2010).

Eventually, authors referred to co-evolution in the literature on institutional complementarity (Boyer, 2005; Campbell, 2011). Boyer even put forward a *co-evolutionary hypothesis*, which contends that capitalist systems contain a configuration of technolo-

gies, organizations and institutions that coevolve and are selected according to a fitness criterion and that these systems subsequently evolve by learning and by trial and error. One central characteristic of the outputs are "non-ergodicity, path dependency, possible irreversibility and ex post sub-optimality" (Boyer, 2005, 45).

In this thesis, I refer to co-evolution in the descriptive sense of the above definition. In other words, co-evolution is the relationship between units and their development over time. In the following, I am going to use co-evolution as an analytical starting point for my research on the development of two sectors' relations over time. Theoretically, this is an important problem, as many complex issues, such as health, security and employment, require coordination between, or at least mutual recognition of, different policy sectors.

1.2 Coordination of policy sectors

According to Guy Peters (Peters, 1998), a key problem is that there are many demands for more coordination but few comparative analyses. Scholars of public administration and public policy have extensively discussed the horizontal relations of policy sectors.[1]. In particular, the post-new public management literature accounts for the reintegration and centralization of state power as a reaction to the new public management literature (Christensen and Lægreid, 2002; Hood, 1991; Hood and Peters, 2004; Kaboolian, 1998; Rhodes, 1996), which emphasizes the delegation of policy tasks to independent regulatory (Gilardi, 2008; Maggetti, 2007) and executive agencies (Pollitt, 2006), subnational governments (Heinelt and Kübler, 2004) and international organizations (Hooghe and Marks, 2003). Toward that end, authors have employed a variety of terms, such as holistic government (6, 2013; Dunleavy, Margetts, Bastow and Tinkler, 2006; Mawson and Hall, 2013), joined-up government (6, 2004; Bogdanor, 2005; Office, 1999) and whole of government (Chow, Humphrey and Moll, 2007; Christensen and Lægreid, 2007), in order to analyze central planning processes and interagency collaboration within governments. These concepts overlap to a large degree, in that they all refer to horizontal coordination in government, such as the collaboration between governmental agencies. Regarding the inclusion of actors beyond formal government, especially interest groups such as corporations and NGOs, this literature has coined the terms *horizontal governance* (Fidler, 2004; Kickert, 2001; Murray, Fagan and McCusker, 2009; Phillips, 2004; Termeer, 2009; Yesilkagit and van Thiel, 2012), *holistic governance* (Owen, Moseley and Courtney, 2007), *collaborative governance* (Emerson, Nabatchi and Balogh, 2011), *intra- and inter-policy coordination* (Knoepfel, 1995), *boundary-spanning policy regimes* (Jochim and May, 2010; Laffan and O'Mahony, 2007; May, Jochim and Sapotichne, 2011), and *functional regulatory spaces* (Varone, Nahrath, Aubin and Gerber, 2013).

In terms of theoretical development, two new concepts have been put forward recently. Firstly, boundary-spanning policy regimes required the concept of regimes to describe the relation of policy sectors and to define the issues, ideas, interests and institutions

[1] For more extensive reviews of this literature read (6, 2004; Tosun and Lang, 2013).

that span different policy sectors (Jochim and May, 2010, 311). Secondly, the concept of functional regulatory spaces extended the focus of horizontal governance by adding a vertical perspective and connecting policy sectors, levels of government (federalism) and institutional territories so as to explore "super-wicked" issues (Varone et al., 2013).

Empirically, these authors analyze the connection of sectors, such as domestic security (Jochim and May, 2010; May, Jochim and Sapotichne, 2011), environmental policy (Jordan and Lenschow, 2010; Lenschow, 2002), and water policy, for example, in transboundary river catchments (Varone et al., 2013). Other empirical analyses focus on public health or social policies, notably the problems of food safety (Lie, 2011) and employment, such as the coordination of different labor market instruments (Askim, Fimreite, Moseley and Pedersen, 2011; Champion and Bonoli, 2011). Although some of this literature presents theoretical elements to explain the coordination of policy sectors(Champion and Bonoli, 2011) or provides some empirical material (Askim et al., 2011), one of the weaknesses in the literature is a lack of comparative frameworks to compare the coordination of sectors. To better understand the challenges and processes in the horizontal relationship between sectors, especially from a comparative perspective, more conceptual work is necessary. This thesis's analysis of the co-evolution of policy sectors contributes to solving this problem.

1.3 Historical institutionalism

The second dimension of co-evolution is temporal: the direction of two policy sectors over time. Therefore, this thesis ties into another political science theory, the historical version (Lecours, 2005) of neo-institutionalism (March and Olsen, 1983), which shifted the attention of political scientists back to institutions. Historical institutionalism has been at the heart of the "historical turn" in political science research, which points to the importance of historical origins and developmental pathways in understanding specific forms of change in the study of institutions and policies. Oftentimes, authors point to a volume edited by Sven Steinmo, Kathleen Thelen and Frank Longstreth (Steinmo, Thelen and Longstreth, 1992) as the origin of this renewed importance of historical events and sequences for the study of politics. However, after this work was published, numerous contributions emerged that stressed the importance of historical processes for the study of institutions. As I mentioned in the introduction, four important findings in the literature on historical institutionalism are important to account for:

1. *Contingent events and increasing returns:* The most prominent argument in the historical institutionalist literature refers to contingent events and path dependence. Authors have argued that specific incidents, even if they are seemingly insignificant at the time they occur, can become critical junctures for future institutional development. They might crucially change the direction of a chain of historical events or the onset of a self-enforcing sequence (Mahoney, 2000; Skocpol, 1979). Paul Pierson

has added the concept of increasing returns that maintain institutional equilibria due to positive feedback mechanisms (Pierson, 1994; Pierson, 2000; Pierson, 2004).

2. *Gradual institutional change:* The concept of path dependency has been criticized because authors would often use it in an unspecified way, generally proposing that history matters and focusing too much on stability (Kay, 2005).[2] To be fair, Mahoney had already discussed institutional change in his study on sequences in historical analyses (Mahoney, 2000, 517). More recent works in the historical institutionalist literature have referred to problems of institutional change, especially slow rates of change. This problem had been subject to substantive theoretical contributions that emphasized different forms of institutional change, such as layering and drift, and factors that determine how institutions change (Streeck and Thelen, 2005; Mahoney and Thelen, 2010).[3]

3. *Different types of institutions and countries:* Authors who oppose Pierson and Mahoney insist that, rather than timing and specific events, the specific type of institution matters most for institutional evolution (Steinmo and Watts, 1995; Steinmo, 2010; Thelen, 2004; Thelen, 2014). Specifically, this variation of the historical institutionalist literature emphasizes the importance of differences between institutional models, such as health insurance systems (Steinmo and Watts, 1995), countries (Steinmo, 2010), and varieties of capitalism (Thelen, 2014), to understand different manners of institutional continuity and change (Thelen, 2003).

These theories had a lasting impact on the study of politics and public policy. However, the theoretical contributions to the historical institutionalist literature have not yet fully explored the idea of co-evolution. This is surprising, as this concept could help researchers to understand different coordination problems between sectors. In turn, the analysis of the co-evolution of policy sectors makes an important contribution to the literature on historical institutionalism because it includes a more actor-centered argument than those usually presented in this literature.

1.4 Health care, public health and political science research

My empirical example to analyze the coordination of policy sectors focuses on the health care and public health sectors. In a nutshell, health care sector policies focus on individuals who are already sick. On the contrary, public health sector policies focus on the population and aim to prevent diseases. Globally, speaking, these two sectors provide the same service

[2] Kay suggests that in some cases, an evolutionary approach (John, 2003; Steinmo, 2010) or a punctuated equilibrium model (Baumgartner and Jones, 2002; Baumgartner and Jones, 2009; Kay, 2005) might be more justified.

[3] Rapid institutional changes occur with the emergence of new problems through sudden events, such as crises, but seemingly unimportant elements might become important for institutional change (Mahoney, 2000; Pierson, 2000), as has, for example, the termination of policy programs (Baumgartner and Jones, 2002; Baumgartner and Jones, 2009).

according to different principles. Therefore, coordination between the sectors might be necessary, and conflicts are possible. I am going to discuss the definition and the overlap of the two fields in the next chapter. Now, I will take a look at scientific literature on health care and public health to demonstrate that there is a need for more research on the relation between these two fields.

1.4.1 Health care

The literature on health care is vast. Therefore, I cannot attempt to review the field entirely and discuss its strengths and weaknesses. For the purpose of this project, I am focusing on two points in the literature that are important for my research project. These are the distinction of different health systems and the political influence of the medical profession.

First of all, it is important to note that countries have different health care systems. Health care systems are institutional arrangements to regulate, finance and provide health care. Extensive literature distinguishes between different health care systems, beginning with three ideal system types: national health services, social health insurance, and private health insurance (Field, 1973; Terris, 1978; Frenk and Donabedian, 1987; OECD, 1987; Alber and Bernardi Schenkluhn, 1992; Moran, 1999; Wendt, 2006; Blank and Burau, 2007; Freeman and Rothgang, 2010). More recent contributions regarding health system types stress the convergence of health systems that has occurred due to cost containment reforms implemented since the 1980s. Theoretical considerations (Wendt, Frisina and Rothgang, 2009) and empirical evaluations (Rothgang, 2010) show that health care systems have evolved to mixed system types (Burau and Blank, 2006; Blank and Burau, 2007; Schmid, Cacace, Götze and Rothgang, 2010). A refined classification of health care systems points to five types that can be found in the OECD world. These are: national health services, national health insurance, social health insurance, private health insurance and statist health insurance (Böhm, Schmid, Götze, Landwehr and Rothgang, 2012; Böhm, Schmid, Götze, Landwehr and Rothgang, 2013).

However, the literature on different health care system types has not yet connected these different systems to public health policy. We do not know whether countries that have a national health service give more attention to public health policies than those with private health insurance or statutory health insurance. Some initial research has focused on the effect of health care systems on public health and prevention. These authors have noted that countries with a social health insurance system have problems deciding on public health issues because health governance is in the hands of social insurance, which addresses its members but not the entire population. Therefore, these systems are lacking the infrastructure and responsibilities to facilitate public health policies (Allin, Mossialos, McKee and Holland, 2004). Another problem that social health insurance faces in effectively pursuing public health policies is that contracting systems make it difficult to span several insurance funds or professions. Eventually, competencies concerning population health are very low in the social insurance systems. In order to address these problems,

the state must intervene decisively, as it happened, for instance, in France (McKee and Brand, 2004). Other comparative political science studies completely ignore the public health sector, and if they include it, they focus on the socioeconomic problems of public health (Blank and Burau, 2007) or only mention it briefly (Wendt, 2009).

However, public health and prevention have not been entirely absent from research on health policy. For instance, Braun's analysis on health research emphasizes that there are conflicts between clinical researchers and public health scientists when creating common outputs, especially strategic outputs that could be translated to policymaking (Braun, 1994). In a more recent contribution, Noweski points to the high demand for analysis of public health policies based on political science concepts and theories (Noweski, 2010).

A second important point regarding health care is the power of the medical profession. The standard argument in the literature on public policy and the sociology of professions is that the medical profession is a very powerful and influential actor. Due to its distinctive knowledge and education and its immense influence on life and death, this field has a lot of political influence and faces a conflict between morals (i.e., the interest of the patient or society) and personal economic interests (Döhler, 1993; Freidson, 1970; Freidson, 1986; Freidson, 1990; Hancock, 1999*b*; Lupton and Najman, 1995; Rodwin, 2011; Saks, 1995; Starr, 1982). Ellen Immergut challenged this argument, holding that the political influence of the medical profession is constrained by political institutions (Immergut, 1990; Immergut, 1992*b*). However, we do not know about the influence of the medical profession on public health policymaking. This is an important element, and it will be part of my argument. Since the medical profession is a key actor in health policy, it plays an important role in connecting the two sectors.

1.4.2 Public health

The other policy sector that I am going to analyze is the public health sector. Similar to the health care sector, the research on this sector is vast and impossible to review here. Therefore, I will focus on the key explanations researchers have developed to explain successful public health policymaking. Above all, this research has shown that there are differences in public health policymaking across OECD countries with regard to policy outputs (Allin et al., 2004; Mackenbach, Hu and Looman, 2013; Mackenbach and McKee, 2013*a*; Mackenbach and McKee, 2013*b*) and the process of policymaking in public health (Holland and Mossialos, 1999). These differences have been analyzed for different areas of public health policymaking, such as tobacco control policy (Marmor and Liebermann, 2004; Raw and Joossens, 2010*a*).

To provide explanations for differences with regard to public health policymaking, the literature posits a number of explanatory factors. Firstly, institutions matter. Specifically, in countries without a strong national government, it is much more difficult to pass national public health legislation (Albaek, Green-Pedersen and Nielsen, 2007; Nathanson, 1996; Nathanson, 2007; Oliver, 2006). Secondly, veto points in the political system play an important role. As public health policymaking often faces strong opposition from in-

terest groups (Bero, 2003), countries with many venues for these interest groups have more difficulty passing public health policies (Mayes and Oliver, 2012; Oliver, 2006). Thirdly, political values, national income and government efficiency all lead to better heath policymaking, including in public health. Fourth, substantial political activity by communities, such as members of local health services and health foundations, increases the likelihood that a country will adopt new public health policies (Chapman and Wakefield, 2001; Givel, 2007; Goldman and Grossman, 1988; Mindell, 2001; Princen, 2007). Similarly, strong research activity from these groups improves public health policymaking (Braun, 1994). Fifth, the literature shows that politicians are more inclined to pass public health policies if they have the support of the electorate (Scutchfield, Ireson and Hall, 2004; Pacheco, 2012; Toshkov, 2013). Sixth, internationalization matters because international organizations such as the WHO have, for example, pushed their member states toward transposition of tobacco control policies (WHO, 2000; WHO, 2002; Dodgson, Lee and Drager, 2002; Collin, Lee and Bissell, 2002; Thomas and Weber, 2004; Irvine, Elliott, Wallace and Crombie, 2006; Gostin and Mok, 2009). The EU plays a special role because it has more means for coercion than other organizations such as the WHO. Consequently, EU membership should give an extra push regarding the adoption of public health policies (Duina and Kurzer, 2004; Mossialos, Permanand, Baeten and Hervey, 2010; Greer, 2012).

However, there is a need for more research on public health policy, particularly regarding its relationship to health care. The reasons for this are the following:

1. The literature on public health policymaking often focuses on one public health issue, especially tobacco control policy. Many of the previously mentioned explanations for differences in public health policymaking come from the literature on tobacco control. We know that successful tobacco control policies depend on a series of elements, such as community actions, strong advocacy coalitions that defend anti-smoking policies (Chapman and Wakefield, 2001; Givel, 2007; Mindell, 2001; Princen, 2007), the tobacco industry's influence on politics and medical research (Drope, Bialous and Glantz, 2004; Bornhäuser, 2006; Lopipero and Bero, 2006; Grüning, Gilmore and Mckee, 2006), international conventions on tobacco control (Hammond and Assunta, 2003; Roemer, Taylor and Lariviere, 2005), internationalization of interest group activity (Stillman, 2005; Wipfli, Fujimoto and Valente, 2010), the EU (Gilmore and McKee, 2004; Duina and Kurzer, 2004; Studlar, 2006; Studlar, 2007; Cairney, Studlar and Mamudu, 2012), and a favorable public opinion toward tobacco control (Pacheco, 2012; Toshkov, 2013). However, a broader analysis of public health policy is lacking.

2. The link between health policy institutions and public health policymaking has been poorly explored. As mentioned before, comparative health analyses of health politics and policies mostly focus on how the health care system is institutionalized. The health policy literature distinguishes different systems of health care, such as national health service, social health insurance, and private health insurance (Saltman, 2004;

Burau and Blank, 2006; Blank and Burau, 2007; Wendt, Frisina and Rothgang, 2009; Rothgang, 2010; Schmid et al., 2010). These systems differ with regard to the coordination of regulations, financing and the provision of health care (Wendt, Frisina and Rothgang, 2009; Böhm et al., 2013). Some authors suggest that the way health care is governed affects public health policymaking, as the connection between these policy sectors is formed more easily in some health systems than in others (McKee and Brand, 2004). However, this link has been only briefly examined in systematical empirical research (Allin et al., 2004; McKee and Brand, 2004).

3. The third reason that more research on public health policy is needed comes from the field itself. Recent contributions propose more political science approaches to the analysis of public health policy are needed. The reasons for this are twofold. Firstly, the public health literature takes a too-narrow approach to public policy (Bernier and Clavier, 2011; Clavier and de Leeuw, 2013). Secondly, due to the growing importance of (new) public health since the 1980s, the field has developed toward a separate policy sector, which needs to be explored as such in the political science research (Noweski, 2010).

To sum up, I have shown that this research project is important from both a theoretical and a substantial perspective. Theoretically, the political science literature lacks the tools and insights to draw conclusions about the long-term development of the policy sector coordination. On the one hand, the literature on historical institutionalism has shown little interest in the systematic relationship between policy sectors. On the other hand, the comparative public policy literature lacks a comparative analysis of the coordination between two policy sectors over a long period, which would help us to understand and compare the relationship between two sectors. Substantially, there is a lack of insight into the relationship between health care and public health, notably the connections between actors, institutions and policies in the two fields. However, it is important to research this issue, as current health problems demand more coordinated solutions for complex health problems. What is more, rising health expenditures have become a serious problem and will continue to pose problems because of the aging population. More preventive health policies could be used to reduce morbidity and, consequently, the rise in health expenditures. Similar instruments have been used in other social policy fields in order to get costs under control (Bonoli, 2013).

1.5 The argument in brief

In this thesis project, I analyze the co-evolution of health care and public health. I examine how the two sectors relate to one another and why there are differences between countries. The basic unit of analysis in this thesis is the policy sector, a subpart of the political system that solves certain problems while maintaining a certain autonomy (Howlett, Ramesh and Pearl, 2009). To analyze the differences in the co-evolution of the

two sectors, I develop an argument in two steps:

1. Harkening back to the concept of coupling (Orton and Weick, 1990; Weick, 1976), I propose four forms of coupling to denote different conditions of the relationship between policy sectors. These are tight coupling, loose coupling, de-coupling and non-coupling. Tight coupling entails institutional integration and the responsiveness of interest groups and professions in the two sectors. Institutional integration means that the sectors are organized in the same ministry or administrative unit. Responsiveness is present if professions and interest groups in the two sectors commonly politicize problems and "support" one another, as when doctors publicly support tobacco control policies. Loose coupling, entails institutional separation and the presence of responsiveness. De-coupling includes institutional separation and the absence of responsiveness, and non-coupling refers to the combination of institutional integration and the absence of responsiveness. The level of policy integration between health care and public health depends on the type of coupling. I hypothesize that policy integration is most likely in tightly coupled sectors and least likely if de-coupled sectors.

2. In order to explain differences in the coupling of policy sectors and their evolution over time, I develop three hypotheses, of which the third is subordinate to the first two. My first hypothesis holds that health care and public health are institutionally integrated if government is unified. This can occur through either a centralized federation (Hueglin and Fenna, 2006) or the presence of many veto points (Tsebelis, 2002) at the national level. The second hypothesis states that two sectors show high responsiveness if professionalism in that country is high (Freidson, 1983; Rodwin, 2011; Rueschemeyer, 1973*a*). Strong professionalism means that due to the free market, professions need to aggressively protect their members and businesses, which makes them politically active organizations. Consequently, they protect their own interests, but they might also transport new ideas and innovations from their field into the policy process. On the other hand, weak professionalism implies that markets are protected and therefore that professional organizations are not as politicized. Thus, there will be less responsiveness between the two sectors. Due to professions' tendencies to defend their own interests, I hold that it depends on the context whether high professionalism leads to responsiveness. In the case of health care and public health, this means, for example, that responsiveness between the medical profession and the public health profession is most likely when pressing health problems demand integration of the sectors. On the other hand, in times of budgetary austerity, conflicts should prevail.

1.6 Summary of the research design and the results

In order to empirically analyze this argument, I discuss five comparative case studies. The countries I selected are Australia, Germany, Switzerland, UK and the U.S. I chose these nations according to their differences in professionalism and government unity; other elements, such as the nations' economic development and levels of democracy, are fairly stable. The only difference is that the UK is not a federal state. It serves as a control case, a role that is important for the results, as explained later in the manuscript.

My empirical analysis is a historical account of the development of coupling between the two sectors from the mid-nineteenth century until 2010. I chose this long time period because it allowed me to trace the relationship between the two sectors from the origins of the modern state until today. I based my analysis on secondary literature, official documents (including Internet sources) and interviews. Based on a review of these sources, I recorded instances of institutional reforms, responsiveness between the actors, and policy integration. An example of institutional integration is the creation of a national health service. Responsiveness entails a common advocacy between health care and public health actors, such as the medical profession and health foundations sharing support for tobacco control policy or health promotion. Absence of responsiveness occurs if there are conflicts between the professions. An example of policy integration is a policy that combines prevention and cures, as is seen with respect to cancer.

The results of my analysis confirm my hypothesis regarding the effect of professionalism on policy sectors' responsiveness. In countries where professions were more politically active, the medical profession tended to advocate for public health issues, such as health promotion services, immunization, and tobacco control policy, serving as an important pressure group in these matters. This was especially the case if the issue did not concern the group's original interests, as with the merger of universal health care with a public health service. Responsiveness changed according to the context. In the U.S., and partly in Australia, responsiveness was strong, but only at times when the most prevalent diseases demanded integration of the two sectors. If this was not the case, conflicts and an absence of responsiveness remained. In the UK, the situation was different. There, health care and public health were institutionally integrated in the late nineteenth century. During the late nineteenth and the early twentieth centuries, this led to many conflicts between the medical profession and public health professions, mostly about resources. At the same time, in Australia and the U.S., there were fewer conflicts, but professionalism was roughly as strong as in the UK. Nonetheless, through a learning process, the relationship between the two sectors co-evolved toward greater responsiveness. On the other hand, in Germany and Switzerland, there was no responsiveness because the medical profession was not politicized in the same way as it was in the other countries; rather, it acted like a member of the administration. Consequently, professions in Germany and Switzerland did not play the same role in the coupling of the two sectors as professions did in the other countries.

Based on this information, I have to my hypothesis on unified government. Federalism most impacted the institutional relationship between the two sectors. Two general results are important. Firstly, there has been an overall centralization of health policy, which means that in all countries, the two sectors co-evolved toward institutional integration. However, this process went more slowly in decentralized federations, namely in Switzerland and the U.S., than in Germany, which is a more centralized federation. In Germany, health care and public health were integrated institutionally at a later time. In Australia, which has an even more centralized form of federalism, the two sectors were integrated earlier at the national level due to the advocacy of the health professions, especially doctors.

In addition, my results showed that a number of other elements impacted the relationship between health care and public health. Another key finding is that the two sectors coevolved toward complementarity, independent of the responsiveness between them. Similar to the varieties of capitalism as discussed in the political economy literature, policy sectors emerged randomly and co-evolved to complementarity. In complementarity, two sectors generate policy outputs that complement one another, and they attempt to provide better outcomes than any single sector's instruments can provide. Although my analysis targeted democratic countries, the results of my analysis show that the difference between democratic and autocratic countries had an impact on the integration of the two sectors. During my analysis, I collected information on Germany during Nazi rule in addition to some preliminary findings for the GDR and the USSR. In all these countries, autocratic government accelerated the institutional integration of health care and public health, though this process at times had deadly consequences for parts of the population. In Germany, the connection of the two sectors was part of the Holocaust. Another finding concerns policy learning. I argued that the absence of responsiveness led to less policy integration between the two sectors. However, my results show that in countries with no responsiveness (for example, Germany), there was policy integration between the two sectors. Instead of learning from politicized professions, national policymakers followed the examples set by other governments about integrating health care and public health.

The design and the placement of this analysis are in some ways unusual because it is situated at the intersection of comparative public policy and comparative politics. I use concepts from the public policy literature, such as sectors (Howlett, Ramesh and Pearl, 2009) and their coordination (Peters, 1998), and I apply them to a longitudinal comparative analysis of five countries, which is usually done in the comparative politics literature (Caramani, 2011). This hybrid approach has advantages and shortcomings. The problems are that such an analysis does not have as much detail as is usually found in public policy analyses, which focus on an in-depth understanding of agenda-setting, decision-making and/or implementation processes (Howlett, Ramesh and Pearl, 2009; Knoepfel, Larrue and Varone, 2011; Saetren, 2005). Due to the extended time frame of my analysis, I am not able to provide the same detail, as this study remains at the macro level. In that sense, my research is more like that of comparative politics, particularly the historical institutionalist literature. This caveat needs to be taken into consideration when

interpreting the study's findings.

Nonetheless, this thesis makes some important contributions to the political science literature in general, which I discuss in the following section.

1.7 Lessons from this research for the political science literature

My findings lead to a number of conclusions that go beyond the co-evolution of the health care and public health sectors. My findings are interesting for the political science literature in at least three ways. Firstly, I forge a link between historical institutionalism and professionalism. Secondly, I develop a typology for the coupling of policy sectors. These two elements can easily be transferred to other problems in political science. Thirdly, I contribute to the health policy literature by connecting health care and public health to a common analysis.

1. **Sectorial co-evolution and professional activism:** My argument and my research design are at the intersection of comparative politics and comparative public policy. I propose an argument that has a strong focus on actors, in this case professions, and I connect their behavior to the emergence and evolution of institutions. I propose that, in free markets, professions are politically more active than those in other economic systems. Consequently, they fiercely defend their interests, but they also transport new ideas, such as innovative policies, into the political process; these ideas go beyond the professions' original economic interests, which in this case led to the connection of two policy sectors. On the other hand, in coordinated market economies, professions are not politicized. Therefore, while they defend their interests, they do not inject innovations into the political process. Accordingly, in these countries, other actors, such as political parties and corporatist interest groups, take this role. This insight could be transferred to other professions, including lawyers, accountants and engineers, which all have expert knowledge and could politicize new ideas in novel ways. In other words, in countries with free markets, professions defend their interests and are privileged, but at the same time, they become politically active experts, shaping the development and relationships of political institutions.

2. **The relation of policy sectors in political analysis:** A second general contribution of this thesis to the political science literature concerns the coordination of policy sectors. I propose a typology to compare horizontal relations between policy sectors based on the concept of coupling, following Karl Weick (Orton and Weick, 1990), which I briefly explained before. This typology amends recent analytical contributions regarding connections between policy sectors, such as boundary-spanning policy regimes (Jochim and May, 2010) and functional regulatory spaces (Varone et al., 2013), as it provides a flexible typology that can be used for comparative analyses. The typology can be transferred to analyze the coupling of policy sectors

with regard to problems such as energy, environmental protection, and domestic security. What is more, I apply the idea of co-evolution to comparative public policy analysis and show that sectors, on the one hand, emerged randomly, and on the other hand, coevolved toward complementarity and policy integration.

3. **Connection between health care and public health:** This thesis's third general contribution concerns the literature on health policy. My results are very interesting for the literature on both health care and public health because I connect policies from health care, which focus on sickness, to public health policies, which focus on prevention. This analysis fills a gap, especially in the public health literature, as it suggests a new argument to explain differences in public health policymaking. Apart from the substantive problems concerning the coordination of health policies and investments in additional prevention, this project makes a general conceptual contribution to the health policy literature by connecting these two basic principles of health policy.

1.8 Outline for the thesis

In order to pursue the planned analysis of the co-evolution of the health care and the public health sector in five countries, I will proceed in the following manner. In the next chapter, I will develop my argument concerning the coupling of health care and public health. In particular, I will first define health care and public health as two different policy sectors. Then, I will discuss how both sectors can be coupled by developing different forms of sectorial coupling. The third part of this theoretical chapter is devoted to my argument and discusses why I am expecting differences in sectorial coupling between countries. My argument refers to the importance of contextual elements, namely pressing problems for changes in health policy, due to new diseases.

Chapter three discusses the contextual conditions for the different time periods I am analyzing. Chapter four focuses on the study's research design, case selection, and material used for the analysis in addition to providing the respective empirical expectations for the five countries. In this chapter, I justify my selections of Australia, Germany, Switzerland, the UK and the U.S. and reveal how I operationalized the co-evolution of the two sectors in these countries.

Chapters five through eight comprise the case studies for the five countries. Each case study reviews the co-evolution of both sectors along the two main analytical dimensions (actor and institutional distinctiveness) as well as policy responsiveness in each of the four time periods. At the end of each chapter, I summarize my results and discuss them in the light of the theoretical elements that I have formulated. Chapter ten presents a comparative evaluation of the results. I summarize my main results, compare the co-evolution of the sectors and present a revised argument with more specific causal pathways that take into account other theoretical elements. In the concluding chapter, I discuss the

implications of the study's results for political science research more broadly and briefly assess the impact of different forms of sectorial coupling on health policy outputs and outcomes.

Chapter 2

Theoretical framework

To guide my analysis of the co-evolution of the health care and public health sectors, it is necessary to propose a theoretical framework that allows me to take into consideration the relation between two policy sectors as well as its change over time. In order to pursue this goal, I am starting with a definition of health care and public health as two different policy sectors. Harkening back to the concept of sectorial paradigms, I discuss how health care and public health can be defined as two different policy sectors and explain both actor constellations and institutions, which belong to each one. In order to analyze the horizontal relations of policy sectors, I define different degrees of sectorial coupling based on the literature on coupling in organizational systems and institutional analysis. Specifically, I am going to adapt four different degrees of sectorial coupling, namely tight coupling, loose coupling, de-coupling and non-coupling for the purpose of sectorial policy analysis.

After establishing the definition of policy sectors and different degrees of sectorial coupling, I am developing my argument to explain differences in sectorial coupling across countries. By positioning myself in the historical institutionalist literature, I contend that sectorial coupling depends on unified (in the sense of centralized) government and professionalism. However, there is one intervening variable, namely contextual elements, such as technological novelties or economic development, which need to be taken into account to understand the evolution of the relationship between health care and public health.

2.1 Health care and public health as two different policy sectors

2.1.1 Policy sector definition

The term policy sector refers to the basic unit of analysis in this thesis. Sectors are a subpart of the political system, regulating a problem with certain autonomy from the rest of the political system. In the literature on political science and public administration, scholars use a variety of concepts in order to refer to these subparts, for example: sectors

(Scott and Meyer, 1983; Jordan, Maloney and McLaughlin, 1994), fields (Lynggaard, 2007; Massey and Huitema, 2012), policy subsystems (Howlett, Ramesh and Perl, 1995), issue areas, policy domains (Laumann and Knoke, 1987; Burstein, 1991), iron triangles, issue networks (Heclo, 1978; Jordan, 1990), advocacy coalitions (Sabatier and Weible, 2007; Sabatier and Jenkins-Smith, 1999; Sabatier, 1993), policy networks (Brandes, Kenis, Raab, Schneider and Wagner, 1999; Van Waarden, 1992; Howlett and Ramesh, 1998) and policy communities (Rhodes, 1984; Howlett, Ramesh and Perl, 1995). What is more, sectors are a relevant concept in the literature on policy paradigms, ideas (Muller, 1990; Nahrath, 1999; Braun and Busch, 1999; Béland and Cox, 2011) and social learning (Hall, 1993). The institutionalist literature has a more implicit regard on policy sectors, as it mainly refers to the historical development of institutions (Steinmo, Thelen and Longstreth, 1992; Pierson, 2000; Thelen, 2004; Streeck and Thelen, 2005; Mahoney and Thelen, 2010) or the relations of actors and institutions (Mayntz and Scharpf, 1995; Scharpf, 1997). Starting from the reading of this long list of concepts, for this project I am defining a policy sector consisting of four elements:

1. The first element is a cognitive dimension, which I will call a *sectorial paradigm*. In the words of Peter Hall, a paradigm can be defined as follows: "policymakers customarily work within a framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing. Like a *Gestalt*, this framework is embedded in the very terminology through which policymakers communicate about their work, and it is influential precisely because so much of it is taken for granted and unamenable to scrutiny as a whole. I am going to call this interpretive framework a policy paradigm" (Hall, 1993, 279). Already before Hall, Pierre Muller had coined a similar concept for the understanding of policy sectors (Muller, 1990; Nahrath, 1999). As I will explain in the next section, this dimension will be the key to my conceptualization of health care and public health as two different policy sectors.

2. The second element is the *actors* involved in policy sectors. In the public policy literature that I cited, actors are the key to policy subsystems (Howlett, Ramesh and Perl, 1995) and advocacy coalitions (Sabatier, 1988; Sabatier, 1993). Whereas Sabatier takes into consideration a wide group of actors, such as members of administrative agencies, legislative committees, interest groups, journalists as well as policy analysts participating in the formulation and evaluation of policies (Sabatier, 1988, 131), I am focusing on a narrower concept of actors. Specifically, I am referring to the actor triangle, which Peter Knoepfl and co-authors developed for the analysis of public policies. The authors distinguish four main categories of actors. These are: political-administrative actors, target groups, beneficiaries and indirectly affected third parties. Thereby, the most important distinction is between the first and the three latter groups. (1) The first group refers to the legislative and ex-

ecutive institutions of the political system and the actors, which are vested with these powers. Sometimes, this can be private actors to whom the state delegated competences (Easton, 1965; Knoepfel, Larrue and Varone, 2011, 45, 50). On the other hand, there are the other three groups, which are mostly private actors. (2) Target groups entail those individual or collective actors who need to change their behavior in order to solve a certain problem, such as high mortality or high costs for health care. Usually, they are the cause of the problem. (3) End-beneficiaries are the second group. It entails actors who need to benefit from the policy in order to end the problem's negative effects on them. Mostly, these are groups that had been negatively affected by the problem to which the policy responds. Consequently, they will receive advantages from the policy, once it is put into place. (4) Eventually, there are third parties which the policy impacts indirectly, either positively or negatively. For instance, doctors, hospitals and the pharmaceutical industry are positively affected third parties of health care policy. On the other hand, doctors might also be negatively affected third parties, for instance if the state introduces mandatory public health insurance, which reduces the possibility for private practice. Another example for negatively affected third parties is companies, such as if a minimum wage becomes mandatory for an entire sector.[1] As I will show in the following sections, this distinction can be employed fruitfully to outline differences between the health care and the public health sectors because the structure of actor triangles shows important differences between them.

3. The third element that I am taking into consideration is the *institutional* one. This is especially important because it refers to how sectors are institutionalized. The aforementioned public actors can be affiliated in formal institutions, such as ministries or administrative units, but also parliamentary committees. The institutional affiliation is interesting because it helps to understand whether both sectors are institutionally connected or separate from one another. As I will discuss later on, this might have consequences for the health policy output with regard to the relations of health care and public health.

4. The fourth element is *policy instruments*. Although this literature is not really related to the above-discussed contributions on policy sectors and fields, it will help to understand health care and public health as two policy sectors. Particularly, I am referring to the basic distinction between regulatory, distributive and redistributive policy instruments (Lowi, 1972; Howlett, 2005; Braun and Giraud, 2009), which is useful to show a difference between the policy sectors. Thereby, regulative policies are prone to be more conflictive because they often come along with a disadvantage for a certain group. On the contrary, distributive policies are less conflictive, as the group that gains from this legislation tends to be much smaller (Lowi, 1972). In the following two subsections, I am going to apply the mentioned analytical dimension

[1] For a more in-depth discussion of the actor triangle, read (Knoepfel, Larrue and Varone, 2011, 53-56).

to the health care and the public health sectors and outline differences among policy instruments, actor triangles and possible conflicts between the two fields.

2.1.2 Distinguishing health care and public health

I define health care and public health as two separate policy sectors, starting with the distinction of the sectorial paradigm. To define the sectorial paradigm, I am leaning on the work by Niklas Luhmann, who used the concept of "communication codes" in order to differentiate various subsystems in society (Luhmann, 1984). Such a code had a binary structure. All systems of society function according to a specific code, such as the economic system *(pay/not pay)*, the legal system *(justice/injustice)* or the scientific system *(true/false)*, cause irritations and functional problems, which eventually lead to the differentiation of a new sub-system. Luhmann holds that a sub-system's code is universal to its function, which means that it cannot be separated or amended. It is necessary and sufficient to conduct a systemic operation (Luhmann, 1984; Luhmann, 2005). According to Niklas Luhmann, the health system is one of the sub-systems in society, which differentiated the process of modernization. Similar to the economic system, the political system and the system of science, it has its own binary functional code that distinguishes it from all other subsystems. Luhmann contends that the functional code of the health system is *sick/healthy* (Luhmann, 1990). One of his followers, Jost Bauch, suggests that the code of the health system needs to be changed into *life promoting/life endangering* for the health system because Luhmann's original code focuses too much on sickness (Bauch, 1996).

In the logic of Luhmann, health care and public health would be two sub-systems of the health system. However, the presence of subsystems is not possible, according to Luhmann. Nonetheless, some authors have worked on this issue. For instance, Schimank suggests that the economic system has become a dominant secondary code for many systems in the wake of privatization and a globalized economy (Schimank and Volkmann, 1999; Schimank, 2006). Franz Kasper König developed the problem of secondary codes further on. He contends that secondary codes serve as "analogue-digital converters" for a system to understand the demands of other sub-system in a society (König, 2007).

For the purpose of this project, I am using the structure of Luhmann's codes to specify the sectorial paradigm for the health care and public health sectors because this allows me to specifically distinguish them. However, they are not mutually exclusive communication codes in the sense of Luhmann, but they function as a sectorial paradigm with two main dimensions that can be found in the health policy and public health literature. Firstly, the target level of health policies in the sense of whether they focus on a population or a setting on the one hand or on the individual on the other hand. Secondly, they intervene against the disease either before the individual gets sick, i.e. if there is a health hazard, or when the disease has already arrived and the patient is ill (Tulchinsky and Vavravikova, 2009; Rosenbrock and Gerlinger, 2014).

The paradigm of the *health care* sector is *sick/individual-based.* Sick refers to the moment of intervention against the disease, which is when the patient is already suffering from an illness. Individual-based means that, in the health care sector, policies are designed to foster treatment of individuals by doctors responding to their individual needs. On the contrary, the *public health sector's* paradigm is *health hazard/population-based.* Health hazard denotes that the moment of intervention is when health is endangered, which is earlier in time than the possible intervention of the health care sector. Thereby, interventions are population-based, which means that they are designed to affect the entire population or population groups rather than just individuals (Baum, 2008; Rosenbrock and Gerlinger, 2009; Rosenbrock and Gerlinger, 2014).

However, before discussing coordination and conflicts of the two policy sectors, it is necessary to define health care and public health at the level of actors, policies and institutions in order to make clear how I understand them as different sectors. I defined policy sectors as subfields in policymaking, with a distinct sectorial paradigm, actor constellations, institutions and policies. Table 2.1 applies the definition to health care and public health, and connects it in an ideal way to the dimensions of actors, institutions and policy instruments. This means that this is an approximate generalization of the connection of the two policy sectors, which summarizes all the policies that are part of the respective sector that I am going to explain in the following. Some actors appear in two fields, because they might take different roles depending on the exact policy problem, since each sector comprises of several policies. What is more, there might be differences between countries.

2.1.3 Health care

According to my definition, the health care sector is mainly structured around the paradigm of policies focusing on individuals who are sick. Policies in the health care sector are mostly of a distributive or redistributive nature. This means that financing individual health care is the most important issue in health care policy, considering the budgets in different OECD countries (OECD, 2013). Although cost-containment is a recurring issue in health-policy making (Rothgang, 2010), individual health care expenditure remained relatively stable in many OECD countries (Wagschal and Wenzelburger, 2008). However, regulatory policies are also part of the health care sector as they are targeting and protecting industries, such as the pharmaceutical industry or the health insurance industry. Yet, they are also reducing the liberty of doctors with regard to free practice. In this sense, a public health insurance can have a regulatory function for the medical profession (Braun and Uhlmann, 2009).

The political administrative actors who are responsible for these policies are the groups operating the main institutions of the political system, such as members of government, parliamentarians and the bureaucracy. Specifically, for the health care sector, these groups consist of actors associated with the following institutions: the department of health, if it exists at the national level, the department of social insurance, but also health depart-

Table 2.1: Ideal-typical distinction of health care and public health as two different policy sectors

	Health care	**Public health**
Sectorial paradigm	Sick / individual-based	Health hazard / population-based
Policy instruments	mostly distributive policies, such as medical care, organization and - financing of hospitals and pharmaceutical policies, short-term goals; regulative policies less important	regulative policies of central importance, such as sanitary legislation, regulation of epidemics, higher taxation of tobacco, long-term goals; population based primary and secondary prevention
Political administrative actors (In sector specific institutions)	Department of health, social insurance department, treasury (professions / interest groups if delegation)	Department of health, public health services, medical authorities, local health departments (professions / interest groups if delegation)
Actors - beneficiaries	Individual patients. ***Positively affected third parties:*** *doctors, nurses, health insurance, pharmaceutical industry, hospitals*	Population / group. ***Positively affected third parties:*** *public health doctors, epidemiologists, health foundations (Cancer Foundation, Heart Foundation), pharmaceutical industry*
Actors - target groups	Doctors, nurses, health insurance, pharmaceutical industry, hospitals. ***Negatively affected third parties:*** *nurses, health insurance, pharmaceutical industry, hospitals*	Population / group, tobacco industry, alcohol industry, fast food producers, producing industry, chemical industry. ***Negatively affected third parties:*** *tobacco industry, alcohol industry, fast food producers, producing industry, chemical industry*

ments at the level of the member states and local governments. Depending on the political system of a country, institutions in the health care sector can be distributed over different levels of government. The medical profession and interest groups can also become part of the political administrative apparatus if they participate in health care governance, for example in the context of a self-governance system, such as the corporatist administration of health policy in Germany (Webster, 2002; Jonas, Goldsteen and Goldsteen, 2007; Duckett, 2007; Rosenbrock and Gerlinger, 2009).

Concerning the end beneficiaries of health care policies, the most important group is individual patients who suffer from a certain illness. It is for this group above all that health care policies are made. However, there is a long list of actors, including powerful interest groups and professions, that indirectly benefit from health care policies. Specifically, these are health insurance companies, the pharmaceutical industry, producers of medical appliances and health professionals, such as doctors and nurses. These groups have powerful material and ideational interests and often benefit indirectly from health care policies. Due to their professional situation and reputation, doctors are the most important actors in the health care sector. The differences between the medical profession and other professions is that doctors have a prolonged training of very specialized abstract knowledge, a common ethical code of behavior and a commitment to community services and values. These interests are often superior to interests of material self-gain because they are rooted in medicine as a calling, rather than a day job (Saks, 1995, 29). What is more, given their possibility to decide when someone is sick and how a strategy for a cure is chosen, the medical profession virtually enjoys power over life and death. Different from other professional groups, doctors enjoy considerable power that goes beyond immediate application of their knowledge (Gottweis, 2004). The special power of doctors has been confirmed in the literature on the sociology of professions (Dingwall and Lewis, 1983; Macdonald, 1995), including the medical profession especially (Freidson, 1970; Hassenteufel, 1997; Lupton and Najman, 1995; Willis, 1989; Hancock, 1999*b*).

However, it has also been shown that the political systems limit the influence of the medical profession on health policymaking (Immergut, 1990). This underlines that, despite their powerful status, all professional and corporate interest groups of the health care sector, including the medical profession, can become target groups of political action, as well as negatively affected third parties, however, with regard to a different reform, because a group cannot be a target group and benefit a third party at the same time, in a given reform. Degrees of regulation and targeting of these actors vary among health care systems (Wendt, Frisina and Rothgang, 2009; Rothgang, 2010). For instance, public health care systems, such as the National Health Service in England, directly regulate the medical profession (Webster, 2002), as does the Pharmaceutical Benefits Scheme for the drug market, in Australia (Duckett, 2007). Furthermore, during the 1990s, there were reforms that strengthened choice eligibility for consumers and reduced the benefits of professional and corporate interest groups. Notably, governments introduced managed competition and strengthened the rights and the choice of consumers, who are the actual beneficiaries

of the health care system (Enthoven, 1993; Enthoven, 1988), in some countries, such as Germany (Böhm et al., 2012).

2.1.4 Public health

Contrary to the health care sector, I defined the public health sector's paradigm as a focus on populations and health hazards. In other words, they primarily aim to prevent diseases from breaking out. These are completely different interventions than in the health care sector. Public health policies are mostly regulative and redistributive policies, such as those that prevent people from smoking in public, levy taxes on smoking or introduce mandatory screening for cancer. At the same time, they aim for long-term goals, which means that it is difficult to explain their immediate payoff (Tulchinsky and Vavravikova, 2009). A large part of public health policy is related to disease prevention. However, regarding prevention is necessary to distinguish between different forms of prevention, specifically primary, secondary and tertiary prevention (Holland, 2004; Egger, 2012). Primary prevention focuses on avoiding health hazards in the population, or at least reducing the likelihood that they occur. It entails policies such as smoking bans and sales bans for unhealthy products, but also immunization laws. Primary prevention can occur at three levels: the individual level, setting-level and the population level. Individual measures are, for instance, health counseling by doctors. Policies in settings entail health counseling in schools, for instance about the risks of tobacco. Population-wide preventive health policies entail campaigns demanding healthier nutrition or less smoking (Rosenbrock and Gerlinger, 2014). Secondary prevention means to recognize early stages of diseases, for instance by screening patients. Finally, tertiary prevention aims to slow down the disease and make sure that its course is much slower. It could also entail measures of rehabilitation after a heavy coronary heart disease (Egger, 2012). Harkening back to the distinction of the two sectors I made previously (Table 2.1), primary prevention at the setting and population level, as well as population-wide screening programs, fall into the category of public health. On the contrary, individual primary prevention is a case of sectorial overlap because it entails individual counseling to prevent further diseases. Concerning tertiary prevention, this is even truer, because it overlaps a lot with curative health care (Jonas, Goldsteen and Goldsteen, 2007).

The political administrative group of actors in this sector is different than in the health care sector; however, they can be in the same ministry or administrative unit. Specifically, the political administrative actors of the public health sector can be situated as public health departments, medical authorities and local health departments. These can be institutionally integrated (Achtermann and Berset, 2006) with the health care sector or completely separated (Lewis, 2003*b*; Porter, 1999). A third option is that both sectors are formally in the same institutional umbrella, but one is in a different region and operates independently of the main ministry, such as a public health agency. Nonetheless, it remains hierarchically subordinate to the main ministry of health (Rosenbrock and Gerlinger, 2009).

With regard to private actors, the main beneficiaries who should benefit from public health policies are primarily populations and groups. However, along with them comes a number of third parties that are positively affected by public health policies because they profit from them materially or ideationally. Specifically, these are individuals who have a Master's degree or a Doctorate in public health (MPH or DPH) as well as epidemiologists (Braun, 1994), who work either in public health departments or in health foundations, such as the cancer and heart foundation (Brößkamp-Stone, 2003*a*). In the public health sector, benefitting third parties do not entail as many corporate interest groups as in the health care sector. Most notably, this is the pharmaceutical industry that benefits for instance from large immunization campaigns (Rosenbrock and Gerlinger, 2014).[2] Compared to the health care sector, however, the possibilities for economic profits are considerably lower in the field of public health. This is due to the fact that most of the activities aim at preventing diseases, which means that little medication is needed. On the other hand, most job opportunities in the public health sector are in public health services, which often are not as well paid and provide fewer career prospects than in individual health care. In the latter, ambitious candidates can specialize much more and earn more money as private practitioners and leading doctors in hospitals (Starr, 1982; Fee, 1994; Fee, 2008; Starr, 2009).

Concerning target groups, public health policies focus also on the population, or certain parts of it, such as smokers, because their behavior might need to change in order to improve overall population health. At the same time, regulative public health policies target a number of corporate interests, which in turn are opposed to these public health policies. Especially, these are the tobacco industry (Hirschhorn, 2000; Bornhäuser, 2006; Givel, 2007). Although the tobacco industry is an extreme example, opposition to regulation might also occur from the chemical or the lead industry (Bero, 2003), energy suppliers or the alcohol and food industry (Bell, Salmon and McNaughton, 2011), which might also be opposed to public health policies. Having defined the two sectors, I will now turn to points of coordination and the situation of conflicts between them.

2.1.5 Connecting health care and public health

How do the two sectors relate to one another? Where do they overlap and how do they differ in terms of the interest groups' influence and attention they potentially get from political administrative actors? If I would follow the logic of Luhmann, it would be difficult to combine the two paradigms. Yet, as interaction and coordination are a crucial part of the co-evolution of policy sectors, I am conceptualizing the paradigm of the two sectors as shown in Table 2.2. The four fields show the differences and demands for coordination in the health care and the public health sector. Fields one and three depict the pure form of each sector. As discussed before, health care entails the treatment of sick individuals in hospitals or private practices by doctors, or nurses. Policies that are primarily related

[2] However, most of the pharmaceutical industry's profits are in the area of health care and individual treatment (Berndt, 2001; Reinhardt, 2001; Abraham, 2009).

Table 2.2: Pure and hybrid dimensions of the health care and the public health sectors

	Sickness	**Health-hazard**
Individual-based	Health care (1)	Health counseling by doctors (2)
Population-based	Population-wide treatments, such as antibiotics against an epidemic (4)	Public health (3)

to health care are, for instance, health insurance policies, hospital planning and financing, and pharmaceutical policies. To the contrary, public health primarily comprises preventive policies that aim to protect entire populations. These are various measures and activities, for instance health counseling and education of parents, generally and in schools, but also bacteriological interventions to restrict the spread of epidemics by cleaning water supplies. Public health policy encompasses a set of regulative policies such as sanitary laws, health protection in general and at the workplace, and also information and regulation of the consumption of food, alcohol, tobacco and other drugs. Yet, in reality, the sectors have a high potential to overlap and intersect with one another. These hybrid areas are shown in fields two and four. Field two entails the combination of health hazard and individual approaches. This could be health counseling by a doctor or the individual consultancy in a public health administration. The fourth quadrant entails treatment of a disease on a collective basis and might need the cooperation of doctors to be implemented, for instance in the case of a large epidemic. If a problem requires the coordination of the two sectors in order to be solved, coordination capacities of the two sectors might become important.

Based on the analysis of the health care and public health sectors, the two sectors have shown a number of differences and some similarities. This allows me to make some initial conclusions about the relationship between the two sectors, which will be important for the further analysis of the co-evolution of the two fields. Specifically, these are:

- **Complementary paradigms:** Both sectors have very different sectorial paradigms, which are both important for the provision of health in general. Consequently, I am assuming that there is a demand for coordination between them, for instance in case health policies need to be coordinated in order to combat infectious diseases, such as a highly contaminating virus infection, because prevention and treatment is needed on a large scale. On the other hand, this might be important for patients with complex non-communicable diseases who need treatment and prevention of a further outbreak of the diseases, as in the case of cancer.

- **Stronger interest groups in the health care sector:** However, the actor coalitions of the two sectors are very different, especially concerning private actors, namely interests groups who indirectly profit and loss from the respective policies of the sector. In the health care sector, a large group of actors profit indirectly from the

policies in the sector. Especially, these are doctors, the pharmaceutical and medical appliances industry, hospitals and health insurers, just to name the most obvious ones. As I have mentioned, authors have underlined that these actors have a strong influence on health care policy and can push their proper economic interests. Although they can also become target groups and subject to regulations themselves, or indirectly suffer losses due to reduction of benefits. On the other hand, in the public health sector, strong corporate interests, such as the tobacco industry or the chemical industry, are mostly target groups or negatively affected third parties. Compared to them, positively affected third parties of the public health sector that care about public health as a whole, such as public health doctors and health foundations, are much weaker and have less lobbying power because they do not have similar financial power and professional organizations as actors in the health care sector. This causes a double disadvantage for interest groups supporting public health policies. Firstly, in terms of financial resources and professional power, pro-public health stakeholders are weaker than those who are potentially negatively affected by these policies, such as for instance the tobacco industry. Secondly, pro-public health stakeholders are weaker than the interest groups supporting primarily health care policies, such as medical organizations and pharmaceutical companies. Consequently, public health policies need the strong support of public-administrative actors.

- **Salience of health care issues:** This brings me to a second point, which underlines that public health is likely to be disadvantaged compared to health care, although coordination might be desirable. A member of the Heart Foundation in Western Australia explained in one interview: "Given our state of knowledge about what is preventable, you would expect more to be spend on these areas, i.e. more than 20 to 25 percent. It has never been like this and never will be, because the health minister never receives a thanking phone call for the heart attack the patient did not have" (Int-AUS-27). This quote points at the fundamental difference between health care and public health, especially when it comes to lifestyle-related diseases, because there is little immediate payoff for preventive action. This is different with regard to a threatening infectious disease because in this case public health is very salient and population-based interventions are easier to legitimate.

- **Instruments:** From the perspective of policy instruments, public health policies entail more regulative measures than health care, although the regulative dimension is also important in the latter. Since regulative instruments per se tend to be more conflictive than distributive instruments, many public health policies should face strong opposition by targeted and negatively affected groups. Therefore, in addition to the asymmetric situation of private actors, the very nature of the policy instruments that policymakers need to implement. In the health care sector, the situation is similar with regard to regulation. However, some of the policies there are beneficial for interest groups, which creates more possibility for compromises

(Lowi, 1972; Braun and Giraud, 2009).

2.2 Horizontal relations of policy sectors

Since I am going to analyze the co-evolution of health care and public health in five countries, it is necessary to have an analytical concept that allows me to account for differences in the relations between both sectors, as well as their dynamics over time. To that end, I am proposing a typology that distinguishes different degrees of coupling between policy sectors.

2.2.1 Coupling of policy sectors

This thesis adds a new perspective to this literature by proposing a typology for different degrees of sectorial integration based on the concept of coupling. Such a framework is a contribution to the political science literature because the existing work regarding the horizontal integration of policy sectors does not provide a good concept to analyze different degrees of the relation between policy sectors. For obvious reasons, it is plausible to assume that in decentralized countries there should be a different type of boundary-spanning policy regime than in centralized nations. To deal with this problem, I am going to propose different degrees of coupling as a means to analyze horizontal relations between policy sectors.

Coupling has been used before in political science research. Primarily, authors have referred to loose coupling in the Europeanization and multi-level-governance literature to analyze soft forms of governance in networks, especially by means of negotiation opposed to rule by coercion and competition. Consequently, loose coupling should strengthen diffusion and mutual learning, which the EU implemented with the establishment of OMCs (Benz and Eberlein, 1999; Börzel, 2010; Eberlein and Kerwer, 2004; Jachtenfuchs, 2001). To the contrary, tight coupling refers to command and control as well as blame games (Papadopoulos, 2007; Koppenjan, Kars and Voort, 2009). The understanding of coupling as the relationship of different levels of government and arenas has also been used to examine the evolution of federations (Benz, 2013). A second way in which coupling has been employed in the political science literature concerns policy sectors. Researchers used loose coupling to better understand the implementation of national social policies in federal states (Berman, 1978), as well as to analyze internal structural elements of policy sectors, especially if there are many non-profit organizations involved (Nilsson and Sunesson, 1993; Wälti and Kübler, 2003) that operate in networks (La Porte, 1996).

A third way in which political scientists refer to coupling entails institutions and policies in the governance and comparative political economy literature. Renate Mayntz and Fritz Scharpf referred to coupling in order to analyze changes from hierarchical rule (tightly coupled) to more network styles (loose coupling) of governing and used coupling to define different forms of social coordination (Mayntz, 1993; Mayntz and Scharpf, 1995; Scharpf,

1997; Blatter, 2001). Hemerijck and van Kersbergen employ coupling with regard to institutional arrangements of welfare states and argue that institutional tightly coupled welfare states are better suited for policy learning than those that are loosely coupled (Hemerijck and van Kersbergen, 1999). Coupling has also been taken up by the Varieties of Capitalism literature, which distinguishes between coordinated and liberal market economies. In terms of coupling, coordinated market economies can be regarded as tightly coupled because sectors are more closely connected in terms of policies, whereas liberal market economies are rather loosely coupled (Hall and Soskice, 2001; Trampusch, 2010). Eventually, authors have been referring to coupling with regard to causality, as Mahoney refers to closely coupled causal chains in political analysis (Mahoney, 2000).

The goal of this thesis is to make use of coupling to analyze policy sectors' relations. Therefore, I am harkening back to the origins of the concept. Originally, the educational scientist Karl Weick proposed coupling as an analytical concept to analyze the relations of constituting parts of organizations. Loose coupling emphasizes that organizations have different parts, which interact in order to ensure that the organization keeps on functioning, but they are also different enough to ensure adaptability and effectiveness (Weick, 1976; Orton and Weick, 1990). The concept has been widely applied, especially in educational science (Meyer, 2002; Fusarelli, 2002), business and management sciences (Brusoni, Prencipe and Pavitt, 2001; Dubois and Gadde, 2002), legal studies (Maguire and Katz, 2002) and for the analysis of organizations and administrations (Waddock, 1991).

From the outset, coupling is rather underspecified, which makes it possible to apply the concept to a variety of contexts. Yet, it requires a specific definition when being put into a conceptual framework, as Weick has admitted himself (Orton and Weick, 1990). Researchers refer to loose coupling in many different ways and contexts, sometimes even with contradictory meanings. For instance, Askim holds that loose coupling could also be understood as the absence of learning (Askim, Johnsen and Christophersen, 2008), which is perfectly fine if we take into consideration that, according to the original text, such a reading would be possible (Weick, 1976). Specifically, there are two main understandings in which coupling has been used. On the one hand, scholars have distinguished tight coupling and loose coupling as two poles of a linear continuum, which is mostly how political science authors have been referring to the concept. The degree of coupling meant the extent to which organizational parts, ideas, hierarchies, organizations and environments as well as intentions and actions were coordinated or communicated (Weick, 1976; Orton and Weick, 1990). On the other hand, researcher defined coupling as a dialectical concept describing organizational elements on a two-by-two matrix, depending on distinctiveness and responsiveness of the organizational elements (Czarniawska, 2005). In their article regarding the reconceptualization of coupling, Orton and Weick hold that, "If there is neither responsiveness nor distinctiveness, the system is not really a system, and it can be defined as a *non coupled system*. If there is responsiveness without distinctiveness, the system is *tightly coupled*. If there is distinctiveness without responsiveness, the system is *decoupled*. If there is both distinctiveness and responsiveness, the system is *loosely*

coupled" (Orton and Weick, 1990, 205).

I am going to use this citation concerning a dialectic of distinctiveness and responsiveness to define four forms of coupling, which will be useful for comparing differences in the relationship between policy sectors over a longer time period. Specifically, I am going to differentiate institutional-, actor- and policy-related elements to establish distinctiveness and responsiveness between policy sectors. My aforementioned definition of a policy sector included a sectorial paradigm, institutions, policy instruments and private actors, which are negatively and positively affected by the policy. To make use of coupling, I am going to connect distinctiveness to the institutional dimension of policy sectors and responsiveness to the dimension of private actors and policy instruments.

Distinctiveness

Distinctiveness between policy sectors is present if it is possible to allocate them to different institutions, private actors and policies. Concerning the institutional dimension, this means that they are horizontally separated into different ministries and administrations (Grant and MacNamara, 1995). However, it can also entail that the two sectors are located at different levels of government, for instance that one sector sits on the national level and the other one on the subnational layer of government, such as in federal states (Hueglin and Fenna, 2006). On the other hand, distinctiveness is absent if the two sectors are institutionally merged, horizontally merged in the same institutional arrangement and vertically merged in the same level of government (6, 2005, 89).

Responsiveness

Responsiveness between two policy sectors is present if there is collaboration between the private actors in the two sectors with regard to policy output and/or policy coordination. Concerning private actors, responsiveness could be interaction between individual and collective actors, such as interest groups, professions or non-profit organizations, with regard to a specific policy. This can be communication in order to support a specific policy (Zafonte and Sabatier, 1998) or mutual learning between different interest groups, in the sense of substantial policy learning (Bennett and Howlett, 1992; May, 1992). Another way of responsiveness entails mutual support regarding support for putting issues on the political agenda (Kingdon, 1995; Howlett, Ramesh and Pearl, 2009). Thereby, interest groups and professions from different sectors work together regarding a specific policy and support it in public. This is especially relevant, if the actor constellation for a specific policy naturally has little support by strong interest groups, for example because the beneficiaries are not comprised of powerful interests. In this case, the support of interest groups or professions that originally are concerned with other problems can be crucial for the stakeholders of certain policies.

Another way responsiveness might occur is policy integration. In this case, responsiveness presents if there is some kind of a common output, such as a policy instrument

Table 2.3: Dimensions of coupling

	Responsiveness	No responsiveness
Distinctiveness	**Loosely coupled**:	**De-coupled**:
	Institutions vertically and/or horizontally separated	Institutions vertically and/or horizontally separated
	Private actors learn, communicate, support	Private actors do not learn, communicate, support
	Policy integration possible	Policy integration unlikely
No Distinctiveness	**Tightly coupled**:	**Non-coupled**:
	Institutions vertically and horizontally integrated	Institutions vertically and horizontally integrated
	Private actors learn, communicate, support	Private actors do not learn, communicate, support
	Policy integration possible	Policy integration unlikely

or common strategy, that explicitly connects the two sectors (Metcalfe, 1994; Jordan and Schout, 2006; Braun, 2008). An example is connecting health and environmental policies. A common policy output is different from an institutional merger (6, 2005, 89), such as a boundary-spanning policy regime (Jochim and May, 2010), which would be an indicator for institutional integration. Consequently, it is possible to use policy integration as a form of responsiveness between both sectors. In the same token, this includes the dimension of political administrative actors in the relationship between two policy sectors. Responsiveness is absent if there are conflicts between interest groups of the two sectors, no interaction between private actors, competition and conflicts, or only negative coordination among public actors.[3] Conflicts between sectorial actors can be ad hoc about political issues; however, they can also become more institutionalized due to transgression (Bednar, 2009) of one sector into the space of another sector. For instance, if sector x begins to provide a function or service that originally was assigned to sector y, this is absence of responsiveness. A more specific example is if diplomacy is done not by the diplomatic corps, but by the military or private actors.

Based on the presented combination of responsiveness and distinctiveness, I am able to define four degrees of coupling between two sectors, which include institutions, actors and policy instruments (summarized in Table 2.3). The advantage of this typology is that it allows one to take into consideration the dialectical relation between differentiation on the one hand (Lawrence and Lorsch, 1967) and coordination on the other hand (Peters, 1998).

What is more, the proposed typology of relations between policy sectors contributes to the literature on horizontal government (Mawson and Hall, 2013; 6, 2013; Bogdanor, 2005;

[3] Administrative coordination, such as the common implementation of policies (Braun, 2008), is a problematic area because it entails some common output with regard to coordination, but excludes political coordination. So, where should we place it in this logic of responsiveness? Since the main interest of this thesis is political coordination, I am not going to pursue this concept further, but it might be necessary for any author attempting to adapt this concept of coupling to a logic of policy implementation.

Christensen and Lægreid, 2007) and governance (Termeer, 2009; Phillips, 2004; Owen, Moseley and Courtney, 2007; Emerson, Nabatchi and Balogh, 2011) by connecting the institutional dimension and the actor dimension, namely the coordination between actors. Eventually, it is also possible to develop an argument about policy change based on the coupling of different sectors. If there is responsiveness between private actors of different sectors, there might be common advocacy, either for a policy that clearly belongs to one sector or for the integration of both sectors. Consequently, we could assume that responsiveness of private actors makes the development of a paradigm combining both policy sectors more likely because actors learn from one another and cooperate in policy advocacy. Therefore, the emergence of a boundary-spanning policy regime (Jochim and May, 2010) or a functional regulatory space (Varone et al., 2013) are likely. I am going to discuss this problem after the next section, which will focus on the implications of what I just said for the coupling of health care and public health.

2.2.2 Implications for health care and public health

What are the implications of the discussed typology regarding the coupling of policy sectors for the relation of the health care and the public health sectors? Table 2.4 presents the implications of the different degrees of sectorial coupling for the health care and the public health sectors. Loose coupling of health care and public health implies that both sectors are institutionally separated from one another because they are located in different institutional frameworks, such as ministries and administrations, or at different levels of government. At the same time, I am expecting responsiveness of private actors, which means that interest groups and professions from the health care and the public health sectors communicate, learn from one another and cooperate in policy advocacy. With regard to policy integration, it is possible that there are common policies between health care and public health because there is strong responsiveness between private actors in both sectors. This should especially be the case if interest groups and professions that we assigned to the health care sector support public health policies because the interest groups that are part of the health care sector ought to be politically more potent. For example, if the medical profession, which is part of the health care sector, advocates a public health policy, such as immunization programs or tobacco control policy, these policies have much stronger support than if they only received the support from actors belonging to the public health sector.

On the other hand, if health care and public health are de-coupled, the conditions of the institutional relations between the two sectors are the same as in the case of loose coupling. However, there are differences with regard to responsiveness. First of all, concerning private actors, this condition entails conflicts between interest groups and no or little communication and policy advocacy. For example, there could be serious conflicts between medical doctors and public health doctors instead of mutual policy learning in the sense that the medical profession considers findings of medical sociology or public health research to be interesting and important. What is more, in this situation, I am also expecting to

find transgression (Bednar, 2009), for instance when prevention is mostly executed by medical doctors rather than public health departments. Concerning policy coordination, common policy outputs do not occur in this configuration, mainly for two reasons. Firstly, both sectors are institutionally separated, which already reduces interaction between them and makes a hierarchical decision to integrate both fields more costly. Secondly, due to conflicts and lack of cooperation between private actors, policy integration becomes even less likely.

Contrary to loosely and de-coupled sectors, tight coupling of policy sectors entails no institutional distinctiveness. Concerning the relationship of health care and public health, this means that both fields are organized by and large in a single ministry of health, or a national health service, and not in horizontally or vertically different levels of government, nor with extensive delegation of power to interest groups or the market (Burau and Blank, 2006; Wendt, Frisina and Rothgang, 2009; Böhm et al., 2013). At the same time, there is responsiveness between private actors of the two sectors, in the sense that doctors or health foundations connect the paradigms of the two sectors in the agenda-setting process or that medical organizations actively support the agenda setting of public health policy issues. Due to the institutional connection and private actor responsiveness, policy coordination between the two sectors is very likely to occur.

The fourth category refers to non-coupling of policy sectors. It entails that both sectors are located in the same institutional environment, such as a ministry of health or in a common legislative framework. However, with regard to the interaction between private actors, there is a similar situation as I discussed when referring to non-coupling. There are mainly conflicts about resources or specific policies, such as managed care programs, and no learning between the groups that belong to each of the policy sectors. Rather than communication, adjustment of preferences and support in agenda-setting, unilateral action and transgression dominate. With regard to common policies, I have the same expectations as for de-coupling, namely the absence of policy integration. From the perspective of the absence of responsiveness of private actors, this logic makes sense. However, a possible objection is that the institutional integration of both fields might be an incentive for political administrative actors to coordinate policies. This is indeed possible, but with the expected opposition of private actors, there are some powerful obstacles to substantially integrated policy output.

To sum up, I put forward different degrees of sectorial coupling, which I constructed based on the concept of coupling according to Weick. To make this a useful tool for comparative public policy analysis, I connected coupling to the dimensions of policy sectors that I defined before, notably by distinguishing between private actors on the one hand and institutions and policies, respectively political administrative actors, on the other hand. As a result, I formulated four forms of sectorial coupling: Loose coupling, tight coupling, de-coupling and non-coupling and discussed what they imply for the relationship of health care and public health. This includes conflicts and mutual support between private actors, such as professions of both sectors, as well as institutional integration and policy coordination

Table 2.4: Ideal-typical coupling of health care and public health

	Responsiveness	**No responsiveness**
Distinctiveness	***Loosely coupled***:	***De-coupled***:
	Institutions: health care and public health in different institutions (horizontally and/or vertically)	Institutions: health care and public health in different institutions (horizontally and/or vertically)
	Interest groups / Professions: learning, communication, support etc. between medical profession, health insurance, pharmaceutical industry on the one hand and public health doctors' organizations and health foundations on the other hand	*Interest groups / Professions*: conflicts, no learning, no communication, no support etc. between medical profession, health insurance, pharmaceutical industry on the one hand and public health doctors' organizations and health foundations on the other hand
	Policy integration: specific policies entailing health care and public health elements possible	*Policy integration*: specific policies entailing health care and public health elements are very unlikely to exist
No distinctiveness	***Tightly coupled***:	***Non-coupled***:
	Institutions: health care and public health under the same "institutional umbrella" (horizontally and/or vertically)	*Institutions*: health care and public health under the same "institutional umbrella" (horizontally and/or vertically)
	Interest groups / Professions: learning, communication, support etc. between medical profession, health insurers, pharmaceutical industry on the one hand and public health doctors' organizations and health foundations on the other hand	*Interest groups / Professions*: conflicts, no learning, no communication, no support etc. between medical profession, health insurance, pharmaceutical industry on the one hand and public health doctors' organizations and health foundations on the other hand
	Policy integration: specific policies entailing health care and public health elements are very likely to exist	*Policy integration*: specific policies entailing health care and public health elements are unlikely to exist

of health care and public health.

2.3 Explaining differences in the co-evolution of health care and public health

The discussed forms of sectorial coupling could, theoretically, be found in many countries with regard to the configuration of different policy sectors, including health care and public health. However, it is unlikely that the coupling of these sectors is the same in all countries. Based on political science theories, I am going to develop some hypotheses that propose expectations to explain differences in sectorial coupling in developed democracies. As it is the trajectory of this project to understand the long-term co-evolution of health care and public health, its theoretical background needs to be rooted in theories referring to historical developments in the study of politics, policies and institutions.

As I explained in the introductory chapter, this thesis aims to contribute to the historical institutionalist literature. Thereby, my analysis departs from the main hypotheses of this literature, which I discussed previously. However, before explaining my own argument, I am reminding the reader of four key hypotheses and their implications for health care and the public health sector.

1. *Contingent events and increasing returns* (Mahoney, 2000; Pierson, 1994; Pierson, 2000; Pierson, 2004; Skocpol, 1979): With regard to the co-evolution of policy sectors, this implies that minor events might impact the coupling of the two sectors. Once established, the relationship of two sectors should remain rather difficult to change.

2. *Gradual institutional change* (Streeck and Thelen, 2005; Mahoney and Thelen, 2010): Concerning the co-evolution of policy sectors, this means that the relationship of sectors changes slowly, if at all.

3. *Different types of institutions and countries* (Steinmo and Watts, 1995; Steinmo, 2010; Thelen, 2004; Thelen, 2014): Regarding the co-evolution of policy sectors, this implies that the endogenous qualities of different constellations of policy sectors determine how they change.

4. *Convergence and complementarity* (Boyer, 2005; Campbell, 2011; Crouch, Streeck, Boyer, Amable, Hall and Jackson, 2005; Deeg, 2007; Hall and Soskice, 2001; Streeck and Yamamura, 2001; Yamamura and Streeck, 2003): This implies for the co-evolution of policy sectors that they emerge randomly and uncoordinated, but over time, they should become more complementary.

My main argument departs from these four hypotheses and focuses more on the horizontal relations of policy sectors. I am proposing that the co-evolution of policy sectors, i.e. sectorial coupling and its development over time, depends on professionalism and

unified government. Specifically, my argument that differences in professional roles and professional organizations in the political process are important for the relations between policy sectors but also the development of institutions in general, is an innovative argument in the study of comparative public policy.

2.3.1 Professionalism

A standard argument in the sociological literature is that professions are important. Most prominently, Max Weber proposed that professionalization is an important factor for the rationalization of society. Professional roles and organizations are important in the societal structure. Due to the competition among them, they are an important part of the inherent conflict in every society. As such, professional groups pursue economic interests, but this is not their only goal. Members of professions also seek social status. According to Weber, professions are important to the societal class system because they can create income based on their knowledge and qualifications. In comparison, other groups fulfill this function based on the powers of labor or capital. Consequently, professions play an important social role in society (Larson, 1977; Weber, 1980)(Macdonald, 1995, 30). Professionalism and the sociology of professions has become an important element in the social sciences in general, and has focused on a number of important professions, such as lawyers, doctors or accountants (Abbott, 1988; Abbott, 2005; Barber, 1963; Carline and Patterson, 2003; Dingwall and Lewis, 1983; Döhler, 1993; Döhler, 1997; Heinz and Laumann, 1978; Macdonald, 1995; Rueschemeyer, 1973*b*; Saks, 1995; Surdez, 2005; Dingwall and Lewis, 1983).

Before continuing with the argument, it is necessary to define the term professionalism. In the literature on the sociology of professions, professional roles have been distinguished from other occupations because they are more than just breadwinning roles, such as a day job as a construction worker or salesperson in the supermarket (Dingwall, 1983; Freidson, 1983). In addition to its economic functions, professions have a social function, which means that they fulfill an important role in society by providing essential services, such as medical care, legal advice or auditing. Subsequently, professions are subject to state regulation. On the one hand, the state intervenes with the aim to organize professional formation because professions entail a corpus of theoretical knowledge, which makes them experts in certain fields. On the other hand, professions need to be regulated to keep conflicting interests in balance, which come along with professional roles (Rueschemeyer, 1983). Individuals in professional roles face conflicting interests of personal economic goals and the need to contribute to the common good. Therefore, the state needs to intervene in order to oblige professions to act in public interests at least to a certain extent. For instance, one question that needs to be resolved is to what extent doctors' and lawyers' services can be organized by a free market and to what degree it is necessary to make them subject to state regulation (Abbott, 1988; Larson, 1977; Macdonald, 1995, 32).

Empirical research on the sociology of professions has distinguished different degrees of professionalization between countries. This means that professions do not function

as the same link between society and the state, in all nations. For instance, in some countries, such as the UK and the U.S., belonging to a profession is important for citizens due to economic reasons but also to form a personal identity. On the contrary, in other countries such as Germany, the professional identity plays a secondary role in comparison to a high school, occupational or university degree, which are crucial elements of the "Bildungsbürgertum." In countries with low professionalism, a general degree of education is more important for personal development and the signaling of personal status than belonging to a profession (Freidson, 1983, 23-26)(Rueschemeyer, 1973*a*, 63-122). This has consequences for the importance of professional organizations in the political process. In countries with strong professionalism, professional organizations play an important role as intermediary instances (Braun, 1993), which politicize problems and put them on the political agenda. On the contrary, in countries with low professionalism, professional organizations are also importantnot so much to politicize problems, but rather as a forum for the exchange of knowledge and scientific innovations. In this case, politicization occurs mainly by other actors, such as political parties.

The plausibility of this argument can be outlined further with a reference to the varieties of capitalism literature. In this theory, authors distinguish liberal and coordinated models of capitalist economies that explain institutional foundations of competitive advantages in different economies (Hall and Soskice, 2001).[4] The former come along with a competitive market, fluid employment relations, firm level wage bargaining, low unionization and high inequality. Job-related education is not publicly institutionalized. On the other hand, coordinated market economies have less free-market relations, more stable employment relations, industry-level wage bargaining, high unionization and lower inequality (Hall and Soskice, 2001, 1-68). Job-related education is highly institutionalized in apprenticeship programs (Thelen, 2004; Trampusch, 2010). Interestingly, countries that the literature on the sociology of professions has denominated to have high professionalism (i.e. UK and the U.S.) are at the same time liberal market economies, whereas those with low professionalism (Germany) are coordinated market economies. This makes sense, because in liberal market economies the economic advantages of belonging to a profession, such as lawyers, doctors, scientists or accountants, is extremely rewarding economically. Due to the liberal employment and wage-bargaining system as well as to lacking apprenticeship-system, membership in a profession is important for economic security. On the contrary, in coordinated market economies, even without a membership in a profession it is possible to establish economic security due to the encompassing wage-bargaining and apprenticeship system. A professional identity and formation has advantages, but it is not as necessary for economic security as in liberal market economies. In other words, a liberal economy came along with "free professions" that had protected but free-labor markets, whereas in coordinated economies, there were "professions of office." The former were more active politically than the latter because they had to protect their members

[4] A third group are mixed-market-economies, but for the sake of parsimony they are left out (Hancké, Rhodes and Thatcher, 2007).

from the forces of the free market (Rodwin, 2011, 321).

Therefore, I am arguing that if professionalism is high, there is a strong capacity for responsiveness between private actors of policy sectors. High professionalism signifies also that professional organizations play a politically important role as intermediary agencies. Firstly, this is the case because of course they need to defend their members against market pressures. Secondly, however, they are able to insert expert knowledge in the political process and are likely to act in favor of common sense due to their social responsibility. They can use their strong position in the political process to forge alliances, and therefore responsiveness, with the professional organizations of other sectors in order to solve a certain problem or to argue against powerful target groups of regulative policies. Of course, professions are prone to enter conflicts with other professions if the interests of their members are at stake. However, if they have an important political role as in liberal market economies, the social responsibility of professions makes it plausible to assume that they act in the common interest. On the contrary, in countries with low professionalism, professional organizations are less politicized. Due to the coordinated market economy institutions, namely centralized wage bargaining and institutionalized apprenticeship training, there are other options for citizens to attain economic security. This means that professional organizations are not as politicized and that they fulfill different functions than in countries with high professionalism. Consequently, they are less likely to be responsive to professions of other sectors and to politicize important problems, but rather to only focus on scientific debate and conflicts. Therefore, I formulate the following hypothesis:

Hypothesis 1: *In countries with high professionalization, responsiveness between private actors of policy sectors is likely if there are no special-interest conflicts.*

2.3.2 Unified government

The second part of my argument refers to the structure of government. Specifically, I am arguing that the degree to which the national government is able to make decisions that concern the entire country impacts the distinctiveness of policy sectors. The term "unified government" refers to two dimensions: federalism and veto powers:

1. *Federalism:* Above all, federalism refers to territorially shared powers between the central government and subnational governments. Some areas of legislation are in the hands of the national governments, whereas others are in the discretion of the member states. Federal states are different from confederations, where the business of the supranational level is dealt with mainly by the governments of member states, such as in the EU. On the other hand, federations differ from unitary states, which do not have subnational governments with the qualities of a state *(Staatsqualität)*, as for instance the states in the U.S., the cantons in Switzerland or the German *Länder* (Hueglin and Fenna, 2006). The literature on comparative federalism is vast and has put forward a variety of dimensions to distinguish federal countries. Such

dimensions include different degrees of centralization of legislative, administrative and especially fiscal powers; federations with shared powers vs. those with separated powers; holding together and coming together federations (Braun, 2000; Braun and Trein, 2014; Burgess, 2006; Requejo and Nagel, 2011; Stepan, 1999; Watts, 1996).

2. *Veto Points/Players:* The second major theoretical element concerning the political system refers to the idea of veto points or veto players. This argument has been framed in an institutional as well as in a rational-choice version. In the former, authors have insisted that in countries with many institutionalized veto points in their political system, it is easier for interest groups and political parties to veto a certain policy and influence the decision-making process (Henisz, 2000). In the literature, the authors referred to this problem as "divided government." This can be the division of power between parliament and presidency, or two chambers with similar powers in national parliament. Another feature of divided government is a strong proportional representation, which results usually in arrangements of shared government.[5] In the rational-choice version of the argument, George Tsebelis refers to veto players who seek to maximize their influence and utility in the policy process (Tsebelis, 2002). Particularly, he argues that alongside the number of veto players, the ideological distance between them is especially important for whether they will block political decisions, effectively slowing down the decision-making process (Tsebelis, 2000, 463).

The argument that emerges from these two hypotheses regarding sectorial coupling is quite simple. The degree to which the government is unified impacts the distinctiveness of policy sectors. In countries with strong decentralization of the legislative competences in one or both sectors that are under observation, it is less likely that both sectors are institutionally integrated at the national level, for instance in the same ministry of legislative framework. The same holds true for policy integration. However, if the competences of both sectors are located at the subnational level, it could be possible that they are integrated at the subnational level of government. Yet, this is not the main focus of this argument. Concerning political institutions and veto points, the argument is the same. If the government is divided, or if there are many veto players with different interests in the political game, it is more likely that policy sectors are institutionally distinctive from one another and that policy integration also becomes less likely. Consequently, I am proposing as a second hypothesis:

Hypothesis 2: *In countries with unified government, it is less likely that policy sectors are institutionally distinctive and that policy integration is more likely.*

Table 2.5 connects the two dimensions - professionalization and unified government - with the different forms of coupling that I discussed before. The combination of strong

[5]For a more profound discussion of different elements of divided government compare the following references: (Lijphart, 1999; Lijphart, 2012; Weaver and Rockmann, 1993).

Table 2.5: Dimensions of coupling

	Strong professionalism	Weak professionalism
Fragmented government	**(I) Loosely coupled**:	**(II) De-coupled**:
	Institutions likely to be vertically and/or horizontally separated	Institutions likely to be vertically and/or horizontally separated
	Private actors probably learn, communicate, support	Private actors rather do not learn, communicate, support
	Policy integration possible	Policy integration unlikely
Unified government	**(III) Tightly coupled**:	**(IV) Non-coupled**:
	Institutions likely to be vertically and horizontally integrated	Institutions likely to be vertically and horizontally integrated
	Private actors probably learn, communicate, support	Private actors rather do not learn, communicate, support
	Policy integration likely	Policy integration possible

professionalization and a fragmented government should come along with loose coupling of policy sectors because sectors are likely to be institutionally separated or fragmented due to federalism or many veto points at the national level of the political system. Furthermore, private actors, above all professional organizations, should be strong, which makes mutual support and politicization of problems by private actors from both sectors together more likely. Configuration two entails fragmented government and weak professionalization and should come along with de-coupling of sectors. In this case, the institutional separation of policy sectors remains the same as in the case of loose coupling, but due to weak professionalization, the interaction of private actors between the policy sectors should be rather faint. Politicization of issues would occur not by means of professional cooperation, but other instances, such as political parties. Field three presents the combination of unified government and strong professionalization. This configuration should produce tightly coupled policy sectors. On the other hand, if government is unified and professionalization weak, sectors are non-coupled. In the case of these two combinations, it is just the configuration of institutional separation or and interaction of private actors that changes.

Conflicts remain an important element that needs to be discussed a bit further here. I have argued that the presence of conflicts between actors, especially private actors, between different sectors equates to the absence of responsiveness. At the same time, I hold that if professionalism is strong, so is the possibility of responsiveness between private actors, such as common advocacy of problems by professional organizations of different sectors. However, it is important to keep in mind that stronger professional organizations also increase the capacity for conflicts between professions, for instance with regard to money. Yet, in case that there is weak professionalization, conflicts are also possible, but they are more likely because professional organizations play a less important role in politicizing

important problems that affect an entire society. As I will explain in the following section, we need to take into consideration contextual elements to understand what might trigger responsiveness or conflicts between of policy sectors including professions.

The second element that needs to be mentioned is public actors, such as administrators. In the literature on policy coordination (Braun, 2008; Peters, 2005; Mayntz and Scharpf, 1975), conflicts and cooperation between members of the administration and politicians are important, and they are in fact a dimension of sectorial responsiveness. In my argument, however, this element remains subordinate to the institutional separation of sectors and the coordination of policy outputs. Nonetheless, coordination issues and problems of administrative actors are included in the dimension of policy integration because in order for the sectors to produce coordinated policy output, there needs to be an interaction of actors from both fields.

Contextual elements

Although, the extent to which responsiveness between private actors might occur is not the same for every policy problem. Notably, there are some situations in which conflicts are possible between professions. Thereby, I have to entertain the possibility that such conflicts might become particularly visible if professional organizations are strong and politically active. Especially, conflicts between professions could appear with regard to economic issues, such as the allocation of resources to a policy that would make them beneficiaries. The same could be said for responsiveness between political administrative actors of different sectors, such as members of the administration. They might come into conflict about resources, but they might cooperate with regard to problem pressures. So far, I have accounted for these possibilities of conflicts, but I have not yet presented a theoretical element that accounts for situations in which conflicts between sectors might appear.

Therefore, I am introducing an intervening variable in the theoretical model that I presented before, namely contextual elements. The term context is not very specific and can refer to many things. In the worst case, it could become a redundant proxy for theoretical elements that are not properly defined and refer to something very unspecific that serves to explain some of the variance in the dependent variable, which cannot be uncovered by existing theories in the field. Yet, this does not need to be the case. Recently, researchers have made a significant effort to specify contextual elements and their role for the study of politics. Most notably, and encompassing in this sense, is the Oxford Handbook of Contextual Politics, which specifies a series of possible elements that can be understood as contextual factors for the analysis of politics and policy (Goodin and Tilly, 2006).[6]

However, the way in which context plays out concerning the co-evolution of policy

[6]The sections presented in the Handbook refer to following contextual dimensions, which are important: philosophy, psychology, ideas, culture, history, place, population, technology, as well as “old and new” (Goodin and Tilly, 2006).

sectors needs to be discussed separately with regard to the empirical examples. Otherwise there is the risk of randomly selecting some elements without having a substantial justification at hand. Therefore, I am going to specify this for the health care and the public health sectors in the following section and only formulate a very general hypothesis at this point.

Hypothesis 3: *Responsiveness between policy sectors depends on contextual factors.*

2.3.3 Implications for health care and public health

Until now, I presented my argument in a very general way. However, in order to put the discussed hypotheses to an empirical test, it is necessary to discuss their implications for the empirical example that I am going to use. In this thesis, I will focus on the co-evolution of the health care and the public health sector. To present the empirical implications of my argument for these two sectors, I am going to proceed in the following way: Firstly, I will summarize the implications of the main hypotheses of the historical institutionalist literature for the co-evolution of the health care and the public health sectors. Secondly, I am going to present my argument, namely that the combination of professionalization and unified government matter, and discuss the implications of this reasoning for the relationship of the two sectors in health policy.

1. *Contingent events and increasing returns:* In the health policy literature, especially the literature on health insurance models, some authors underline the fact that specific contingent events are responsible for institutional emergence and that they create increasing returns for certain groups. Jacob Hacker shows this in his comparative analysis of health insurance legislation in Canada, England and the U.S. According to Hacker, we need to look at path dependencies in order to understand why England has a National Health Service and why the U.S. did not succeed until the end of the 1990s to introduce a comprehensive health insurance program (Hacker, 1998). The same point has been made with regard to public health policy. Some authors refer to contingent events that are crucial for public health policymaking and influenced the further development of this policy field. For example, some researchers argue that the fact that the Nazi government enacted a lot of public health policies, such as tobacco control, is one reason for the weak public health regime in postwar Germany (Proctor, 1996; Schneider and Glantz, 2008; Weindling, 1989). For the dependent variable of the present thesis, this implies that the coupling of health care and public health depends on specific contingent events.

2. *Gradual institutional change:* A second important insight from historical institutionalism is the different ways in which institutions change.[7] Specifically, institutional drift and conversion have been analyzed regarding the reforms of health policies. They show that formal legislative reforms have proven difficult in the sector of

[7]Layering, drift, conversion and displacement (Mahoney and Thelen, 2010).

health care policy (Hacker, 2004*a*; Hacker, 2004*b*; Hacker, 2005), and therefore the main forms of institutional change are drift and conversion.[8] With regard to public health, concepts of gradual institutional change have not been applied. The implication of the theory of gradual institutional change for this thesis is that the coupling of the health care and the public health sectors should be subject to institutional drift and conversion rather than layering or displacement.

3. *Different types of institutions and countries:* Another point that we can derive from the literature on historical institutionalism is that institutional dynamics depend on the specific types of institutions. This argument has also been put forward regarding health policy. Explicitly, Sven Steinmo has held that rather than contingent events (Hacker, 1998), the specific institutional design is the reason for success or failure of health policy reform (Steinmo and Watts, 1995). Implicitly, the hypothesis that different institutions explain variance in health policy outputs can be related to the literature on different health care system types. In the comparative literature on health systems, authors broadly distinguished between statist, corporatist and private health care systems (Field, 1973; Terris, 1978; Frenk and Donabedian, 1987; OECD, 1987; Alber and Bernardi Schenkluhn, 1992; Moran, 1999; Burau and Blank, 2006; Wendt, 2006; Blank and Burau, 2007; Freeman and Rothgang, 2010; Rothgang, 2010). More recent contributions stressed the convergence of health care systems toward mixed systems (Saltman, 2004; Burau and Blank, 2006; Blank and Burau, 2007; Wendt, Frisina and Rothgang, 2009; Rothgang, 2010; Schmid et al., 2010).[9] The institution-type argument has also been made regarding public health policies. For instance, some authors made the point that in each country there is a specific way of pursuing public health policy that is not comparable with other countries (Baldwin, 1999, 524-525). This implies for the argument in this thesis that coupling of health care and public health follows a distinctive path in each country and cannot be easily compared with other nations.

4. *Convergence and complementarity:* The convergence argument, which says that institutions converge over time, has not been applied with regard to health policy institutions in country. However, it has interesting implications for the example in this thesis. Transferred to the health care and the public health sector, we can expect that over time complementarity between both fields increases. This means that actors learn from one another and that the likelihood for coordinated policy outputs becomes bigger, irrespective of sectorial coupling.

[8]To be precise, there are also instances of abrupt institutional change. For instance, the introduction of the *Patient Protection and Affordable Care Act* of 2011 shows (Beaussier, 2012) that institutional path dependencies can be overcome in health care policy. The same conclusion could be made concerning the Swiss health care reform in 1994/1996 (Uhlmann and Braun, 2011).

[9]A subsequent application of the typology in an empirical analysis shows that five of these health care systems exist in 30 OECD countries: National Health Service, National Health Insurance, Social Health Insurance, Private Health System and Etatist Health Insurance (Böhm et al., 2012; Böhm et al., 2013).

As outlined in the general theoretical discussion, **my main argument** departs from these four hypotheses. I am contending that the coupling of health care and public health depends on the professionalization of the society and whether government is unified. As I will explain in the following sections and chapters, professionalization in health care and public health concerns above all health professions, especially doctors, and their political activity. Concerning unified government, my argument implies that the coupling of both sectors depends on whether health care and public health are a responsibility of the national government and if there are many veto possibilities against the institutional unification of both sectors. This argument differs from the implications we can derive from the historical institutionalist literature. The main difference - and theoretical novelty - is the inclusion of the theory of professions and its combination with unified government into the debate on historical institutionalism and comparative public policy analysis.

Professionalism in health care and public health

The first hypothesis implies that the coupling between the two sectors depends on the professionalism in the field of health policy in general. Specifically, this means that in countries where professionalization is strong, the potential for responsiveness of private actors, particularly the medical profession and the public health profession, should be high.

To explain this argument, it is necessary to note the following things: It is important to mention that both fields have different professional roles. In the health care sector, the most important professions are doctors and nurses (Döhler, 1993; Freidson, 1970; Saks, 1995). The medical profession is subject to conflict of interests, which is inherent in professional roles. Generally, doctors ought to have a public interest due to their professional oath to help sick individuals. However, due to their specialized professional formation and knowledge regarding life and death, they potentially can earn high salaries on a free market (Barr, 2012, 243), which results in a potential conflict of interest. A large literature discusses this conflict between morals and personal economic interest of the medical profession (Döhler, 1993; Freidson, 1970; Freidson, 1986; Freidson, 1990; Hancock, 1999*b*; Lupton and Najman, 1995; Rodwin, 2011; Saks, 1995; Starr, 1982).

To relate the aforementioned argument to the professions in the health care and the public health sectors, it is necessary to connect them to the general role professionalism plays in a given society. If professionalism is strong, membership in a profession is important for individuals to form their personal identity, but also to create a stable income. Consequently, professional organizations will play an important role for securing economic interests of its members, which will come along with politicizing important problems in society. This implies responsiveness of the health care and the public health sectors so that, in countries with high professionalism, the medical organizations are likely to support policy solutions, including those of the public health sector, as long as they do not impact negatively the material interests of their members. This qualification is important because conflicts between health professions are likely, especially concerning money, such

as research funds (Braun, 1994).

In the public health sector, the most important professions are public health doctors, but also engineers who are specialized in areas related to health and sanitation (Carline and Patterson, 2003; Starr, 2009). In addition, many authors have argued that community action is important with regard to public health policies. They refer to the capacity to organize local support for public health policies by interest groups and professions (Chapman and Wakefield, 2001; Givel, 2007; Nathanson, 2007; Princen, 2007). With regard to professional dynamics, we can expect the same as for the medical profession. Higher professionalism ought to increase the role of professional organizations for the politicization of certain problems and consequently the capacity for visible responsiveness in supporting the policy issues of the health care sector. Of course, in case of contested material claims, professions from the public health sector are similarly likely to seek conflicts with those of the health care sector.

Unified government in health care and public health

The second part of my argument includes the unification of government, especially whether a country is a federal state and if there are many veto points in government. This implies for the coupling of the health care and the public health sectors that distinctiveness of both sectors is more likely to occur in countries with a fragmented government, such as in federal states, and/or countries with many institutional veto points, such as multiparty governments or presidentialism.

The literature on health care as well as public health emphasized the importance of veto points and federalism for the respective policy field. Regarding health care, political scientists argued that veto points are an important factor that explains to what extent governments are able to pass far-reaching reforms such as cost-containment programs (Hacker, 2004*b*; Hacker, 2005; Hacker, 2004*a*). Other authors insisted on the fact that institutional veto points, for instance divided government, impact health policy outputs rather than the medical profession's strength (Immergut, 1990; Immergut, 1992*a*). Other researchers underlined the importance of veto players in parliament and the distance between them for the understanding of health care reforms, taking Switzerland as an example (Braun and Uhlmann, 2009). In many countries, especially in old federations such as Germany, Switzerland or the U.S. (Watts, 2008), the presence of divided government comes along with the presence of federalism. This understanding of federalism emphasizes the retarding effect of federal systems on policymaking. If federalism and many veto points are so highly correlated, why is it then necessary to take into consideration both elements? The answer is that some federal countries have more nationalized policy regimes, such as national unemployment insurance or fiscal powers, than others (Hueglin and Fenna, 2006).[10] Therefore, the absence of distinctiveness is possible, despite the presence of federalism. Also taking divided government into account helps to consider this

[10]In the administrative type of federalism this is the case anyway (Hueglin and Fenna, 2006).

problem.

Concerning public health, the literature emphasized the importance of veto points and federalism. One finding is that a strong (or unified) government makes it more likely that public health policies can be passed easily (Nathanson, 1996; Nathanson, 2007; Mackenbach and McKee, 2013*b*). Others underline that the more veto points exist in the political system, the more difficult it is to pass public health policies because powerful interest groups have more venues to voice their opposition (Mayes and Oliver, 2012). Regarding federalism, some authors have argued that due to the general separation of powers in federal countries, competences for social policies are likely to be separated or shared between levels of government (Albaek, Green-Pedersen and Nielsen, 2007).

Regarding the coupling of health care and public health, these theories imply that there should be distinctiveness between both sectors in countries with divided government. Due to separated competences between levels of government, many veto points or multiparty governments, it is more likely that both sectors are institutionally separated from one another. In this case, health care and public health are more likely to be in different ministries or at different levels of government. For example, a possible scenario would be that public health departments are at the level of sub governments and health insurance and public hospital administration in the discretion of the national governments.

Table 2.6 shows the implications of my argument for the coupling of the health care and the public health sectors. Thereby, unified government comes along with the absence of institutional distinctiveness of both sectors. Transferred to the relation of the two sectors under study here, this means that institutions that are commonly associated with the health care sector, such as health insurance administration or the subsidies thereof, are regulated on one level of government, such as subnational governments. On the other hand, institutions that belong to the public health sector, such as public health departments, are connected to another level of government, such as the national government. If professionalism is strong in a country, responsiveness of private actors is high. This means for the example of the health care and the public health sectors that professions from both sectors, such as medical doctors and public health doctors, learn from one another (in the sense of policy and political learning), are politically active and advocate for the positions and problems of the other sector. In case professionalism is weak, conflicts are most likely to occur between the professions and interest groups of both sectors, rather than common advocacy. Another form of responsiveness that should occur in case of high professionalism is policy integration. Due to thepossiblybroad support by private interest groups, integration of health care and public health policies becomes more likely. This is especially the case, if there is prior institutional integration of both sectors, such as in the case of tight coupling. Thereby, the common institutional framework makes the coordination of public actors more likely.

The table combines the presence and absence of professionalism and unified government with the forms of sectorial coupling that I mentioned before. So far, I discussed the implications of my argument mainly with a focus on the horizontal relation between health

Table 2.6: Professionalism, type of government and coupling of health care and public health

	Strong professionalization	Weak professionalization
Fragmented Government	**(I) Loosely coupled**:	**(II) De-coupled**:
	Public health (i.e. public health departments) and health care (i.e. administration of health insurance, hospitals, pharmaceutical regulation) likely to be vertically and/or horizontally separated	Public health (i.e. public health departments) and health care (i.e. administration of health insurance, hospitals, pharmaceutical regulation) likely to be vertically and/or horizontally separated
	Professions (medical and public health doctors) and interest groups (health foundations, health insurance) probably learn from, communicate with, support the other sector	Professions (medical and public health doctors) and interest groups (health foundations, health insurance) actors rather do not learn from, communicate with, support the other sector
	Policy integration of curative and preventive policies (for instance with regard to risk factors, such as alcohol and tobacco, but also diseases, for instance cancer or diabetes) possible	Policy integration of curative and preventive policies (for instance with regard to risk factors, such as alcohol and tobacco, but also diseases, for instance cancer or diabetes) unlikely
Unified government	**(III) Tightly coupled**:	**(IV) Non-coupled**:
	Public health (i.e. public health departments) and health care (i.e. administration of health insurance, hospitals, pharmaceutical regulation) likely to be vertically and horizontally integrated	Public health (i.e. Public health departments) and health care (i.e. administration of health insurance, hospitals, pharmaceutical regulation) likely to be vertically and horizontally integrated
	Professions (medical and public health doctors) and interest groups (health foundations, health insurance) probably learn from, communicate with, support the other sector	Professions (medical and public health doctors) and interest groups (Health foundations, health insurance) rather do not learn from, communicate with, support the other sector
	Policy integration of curative and preventive policies (for instance with regard to risk factors, such as alcohol and tobacco, but also diseases, for instance cancer or diabetes) likely	Policy integration of curative and preventive policies (for instance with regard to risk factors, such as alcohol and tobacco, but also diseases, for instance cancer or diabetes) unlikely

care and public health. Yet, co-evolution also has a temporal dimension, and it is therefore necessary to account for time dynamics as well. In the model I proposed, coupling of sectors might change over time if the structure of government or professionalism changes. These two elements might adapt through slow but continuing evolution, or there might be abrupt institutional change as a result of a constitutional crisis, revolution or war (Streeck and Thelen, 2005, 8-9).

Contextual elements in health care and public health

The third hypothesis that I explained previously takes into consideration contextual elements. So far, I have not specified them very well, because this needs to be done with regard to a specific problem in mind. Concerning the co-evolution of health care and public health, there are three dimensions that are important if we want to understand the relationship between these two sectors, notably how they are coupled.

- *Problem pressure and ideas:* To understand the evolution of health policy over a long time period, it is necessary to account for changing patterns in diseases, as well as changing general ideas about health policy. The pattern of disease prevalence significantly changed between the late nineteenth and the early twenty-first century. In the late nineteenth century, infectious diseases were the most pressing health problem. This changed during the twentieth century towards more non-communicable diseases, such as cancer and diabetes (Especially, in developed democracies) (Baum, 2008; Rosenbrock and Gerlinger, 2014; Tulchinsky and Vavravikova, 2009). Depending on the prevalent type of diseases, we should expect different priorities concerning health policy. In case infections are the most important problem, integration of preventive and curative measures should be much higher on the agenda of policymakers than if non-communicable diseases are the most salient issue. Consequently, policymakers should develop different ideasin the sense of problem solutionsfor these two scenarios.

- *Technology:* The second important contextual element is technological developments. These can be new arms, new medicine or capacities to gain knowledge and information regarding the consequences of certain actions (Bijker, 2006). With regard to the co-evolution of health care and public health, the development of drugs and medical equipment is a very important contextual factor. For instance, with new medical technologies the cure of some diseases becomes possible, which before had to be prevented (Rosen, 1993 (1959); Porter, 1999). This might entirely change the priority of health policymaking with regard to the relationship of the health care and the public health sector. Notably, the combination of health care and public health policies might become less necessary.

- *Economic development:* Another contextual element that might be important for the analysis of the co-evolution of the health care and the public health sectors is

the economy. The literature on health care emphasizes that the economic situation of a country is an important factor for health policymaking (Hacker, 1998; Feldstein, 2011). Regarding the relations between the health care and the public health sector, this implies that in case of economic hardship when budgets of governments are tight, conflicts between both sectors become more likely. In this case, high professionalization and strong professional organizations might come along with strong conflicts between private organizations regarding the distribution of tax money.

In order to introduce context in my argument, I combine these three contextual elements. Specifically, I present two conditions that specify the conditional effect of context as I formulated in my third hypothesis: Firstly, a favorable context for responsiveness between policy sectors; secondly, a less favorable context for sectorial responsiveness.

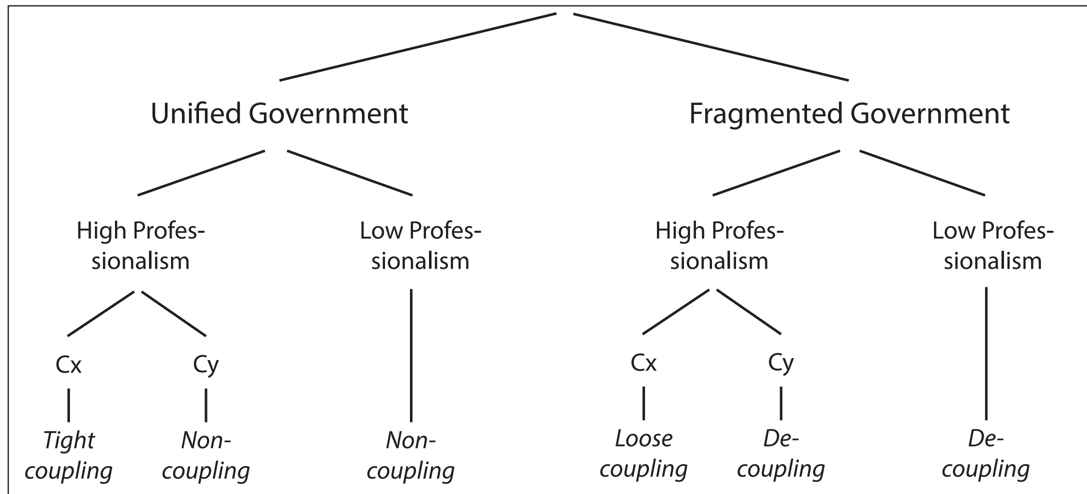
1. *Context favors responsiveness (Cx):* The first condition refers to a favorable context for sectorial responsiveness. This can be the case due to problem pressure and ideas that create a demand for the integration of health care and public health. The lack of technicalrespectively pharmaceuticalmeans is another context that might create a demand for more integration. Eventually, if the economic and fiscal context does not impose cost-containment pressures on policymakers, it is less likely that conflicts will break out between the two sectors' actors.

2. *Context does not favor responsiveness (Cy):* The second condition refers to a less favorable context for responsiveness between sectors. In this case, the problem pressure, namely the most important disease pattern that needs to be addressed, does not create a demand for policy integration - for instance, because non-communicable diseases are the most prevalent problem. At the same time, if the medical and pharmaceutical context allows for the cure of the most important diseases, prevention is not as important and consequently reduces the demand for responsiveness between the sectors. Eventually, in times of economic slump or fiscal retrenchment, distributional conflicts are likely to occur between the actors of the two sectors.

These two conditions are not mutually exclusive. This means that there could be a contextual condition that favors sectorial responsiveness, such as a disease problem pressure that needs to be addressed by a combination of preventive and curative measures. Yet at the same time the fiscal and economic situation could be difficult and therefore lead to conflicts between both sectors. What is more, some of the discussed contextual elements should be strongly correlated, especially the problem pressure and ideas as well as the technological context. Nonetheless, it is important to consider both elements as they might cause responsiveness between policy sectors in different ways and for different reasons. How they play out exactly remains to be seen in the following empirical research.

Figure 2.1 combines the two contextual conditions with unified government and professionalism. The crucial point of my argument is that to achieve responsiveness of policy

Figure 2.1: Overview of the argument



sectors, contextual pressures need to be recognized by stakeholders that hold the existing policy monopolies in order to appear on the political agenda (Baumgartner and Jones, 2009, 27). In the case of high professionalism, professional organizations ought to play an important role for defining the agenda concerning the relationship of health care and public health. If the problem under observation does not entail substance for conflicts between professions, for example regarding distribution of resources, this should lead to responsiveness between sectors because private actors will cooperate to politicize issues. However, if professionalism is low, professional organizations are not important for politicizing the problem pressure, which will be done by other actors, such as political parties. Professional organizations will mostly serve as arenas for scientific debates, but they will not be important for the politicization of health problems. Consequently, there will be little visible cooperation for certain activities, such as agenda setting.

The figure shows the same links that I discussed in the prior section, namely that low professionalism leads to non-coupling of sectors when co-occurring with unified government and to de-coupling in combination with fragmented government. If professionalism is high, there will be responsiveness and consequently tight or loose coupling. However, this depends on the context. In the case of Cx, context is favorable to cooperation between actors and will lead to responsiveness. If Cy is present, there will be conflicts due to shortage of resources. With responsiveness present, policy integration also becomes more likely, especially in the case of the unified government. In case of low professionalism, context does not matter because professional organizations do not play an important role in the politicization of problems in health policy. Consequently, there will be no responsiveness between private actors regarding health care and public health. Problems enter the political arenas by other actors, such as political parties. Policy integration of health care and public health is still possible but less likely because problems are more

politicized from a sectorial perspective. Especially from the perspective of public health, this is an unfavorable situation because it lacks the professional support from doctoral organizations, which is an important counterweight to the strong target groups in this sector.

2.4 Summary

In this chapter, I presented my argument. In a nutshell, I contend that the relationship between policy sectors can be examined by resorting to different forms of sectorial coupling. Harkening back to the literature on organizational studies, I conceptualize four forms of coupling that allow for the analysis of the connection between policy sectors on the dimensions of political and administrative institutions, private actors and policies. Tight coupling refers to integrated institutional elements and responsiveness between private actors, such as professions. Loose coupling entails institutional fragmentation and actor responsiveness. Non-coupling combines institutional integration with the absence of responsiveness and de-coupling institutional distinctiveness of the two sectors with no responsiveness. Concerning policy integration, I have been arguing that responsiveness of private actors, such as professions, is important and makes policy integration more likely. However, institutional integration of the two fields might catalyze the integration of policies.

Further, I argued that the specific form of sectorial coupling depends on two factors: unified government and professionalism. If a country has a unified government, sectors should be rather institutionally integrated, whereas in case of a fragmented government sectorial separation is more likely. The reason for this is that in countries with unified governments, there are fewer veto players and levels of government, and therefore the departments and institutions belonging to each sector are more likely to stick together. Whether there will be responsiveness in the sense of common political advocacy of private actors and professions of both sectors depends on professionalism in the society. Strong professionalism should come along with the presence of responsiveness of private actors, i.e. professional organizations, whereas weak professionalism leads to the absence of responsiveness. The term "professionalism" refers to the function professional roles play for individual education and job security. In countries with high professionalism, it is crucial to belong to a profession in order to have a secure job, whereas in other economies these pressures are lower because of a public organization of vocational training and better job protection. Consequently, in countries with high professionalism, professional organizations play an important political role, above all because they need to protect their members' interest in politics. However, this has implications for the responsiveness of policy sectors, including the health care and the public health sector.

In countries with high professionalism, responsiveness between private actors of both sectors is more likely because professional organizations play an important role for the politicization of important problems. On the other hand, if professionalism is low, profes-

sional organizations are not as important for politicizing problems, and therefore sectorial responsiveness is absent. In these cases, professional organizations are forums of scientific conflicts between professions, but the politicization of health policy problems occurs by other actors, such as political parties. Though, whether strong professionalism leads to responsiveness depends on contextual factors. Professions are prone to conflicts, especially around distributional issues that might touch upon the interests of their members, i.e. to defend free doctoral practice. Therefore, I argue that it is necessary to distinguish two contextual conditions: one that is favorable to sectorial responsiveness and a second one which is not. In the former, problem pressure and medical technology make the integration of both sectors necessary. In the latter, the opposite is the case, and there might be distributional conflicts between the professional organizations of the two sectors. Only if the context is favorable and professionalism is high can we expect responsiveness between policy sectors. Otherwise, there might be conflicts, and responsiveness should be absent. Furthermore, without professionalism being strong, context does not matter all that much because professions do not play an important role for politicizing important problems.

In order to analyze the connection between sectorial coupling, unified government, professionalism and context, I will now turn to the contextual factors and their evolution over time. After that, I will present the research design and method for the comparative case studies, which I am going to use in order to place my argument underneath an empirical analysis.

Chapter 3

The global context for the co-evolution of health care and public health

My empirical analysis of the co-evolution of health care and public health covers the period from 1880 to 2010. During such a long time period, contextual elements such as disease patterns, policy ideas, technological development and the economic situation are likely to change. In order to account for changes in context, I will look at the coupling of policy sectors, in four time periods. Specifically, these periods encompass the following time spans: Emergence of modern states, 1850-1918 (t0), interwar period, 1918-1945 (t1), consolidation of the welfare state, 1945-1974 (t2) and the new public health period, 1974-2010 (t4). I define these four lapses of time along the main critical junctures in history, which are used in many contexts. T0 refers to the second half of the nineteenth century, because this period is commonly associated with the completion of the shift towards a more modern state and the differentiation of the elements that political scientists refer to as being part of policy sectors.[1] I am separating t0 and t1, and t1 and t2, by referring to the First and the Second World War, since after both wars, a change in the context for health policymaking is likely to occur. I set the cut off point for the distinction between t2 and t3 in 1980, because at this time, infectious diseases began to reappear and continuously growing health expenditures could not be sustained anymore.

In this chapter I am going to discuss the evolution of the context for health policymaking and elaborate the contextual elements defined before - policy ideas, technology and the economic and fiscal situation. As a fourth contextual element, I will talk about disease pattern in the sense of the biggest health problem policymakers face. The goal of this chapter is to discuss whether the contextual condition is favorable or not favorable for responsiveness between the health care and public health sectors.

[1] I am aware that policy sectors in the sense of institutions, interests groups, and policy instruments looked very different then, and moreover that organizational elements of modern capitalism had already emerged much earlier (Padgett and Powell, 2012).

3.1 Emergence of health care and public health as two policy sectors (1850-1918)

In order to understand the socioeconomic and societal context of the co-evolution of the health care and the public health sectors, it is necessary to start the inquiry in the second half of the nineteenth century. This is the time when modern states began to take concrete forms and to differentiate policy areas, in the sense of sub parts of the political system. In this period, health care and public health emerged as two distinct policy sectors in the sense of the term, as I defined it before. The degree of sectorial distinctiveness and subsequent responsiveness varied across countries, which will be the subject of the following chapters that present the results of my case studies.[2]

During this time, public health policy instruments were very important to respond to the most pressing health problems. 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 legislation concerning food safety, building of sewages, provision of clean water, health legislation regarding medical degrees and planning of hospitals, bacteriological interventions, but also programs to improve the physical condition of the entire nation, medical inspection of children as well as hygiene education for the general population. This period was the onset of an increased intervention of the states in matters of health policy, which fully unfolded in the following period (Baum, 2008; Leeder, 2007, 19-20). Hospital reforms are one example of increased intervention by the state. Hospitals had been created in the environment of monasteries in the middle ages and turned into voluntary organizations after the Renaissance period. Although their goal was to help sick patients, they had become dangerous breeding grounds for bacteria and communicable diseases, due to the lack of knowledge and medical education of the personnel running them. In the second half of the nineteenth century, a period of professional reform of hospitals began with increased public funding and partial public control over hospital finances and politics (Tulchinsky and Vavravikova, 2009, 40).

However, 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 around a doctor and a patient in a more hierarchical way. However, it included preventive work of non-medical personnel as well. Yet, most of the curative services were provided by doctors on a fee-for service basis

[2]It is important to mention that in terms of ideas, the distinction of population and individual-based health policies had already existed for a long time (Rosen, 1993 (1959); Porter, 1999). However, it was in the late nineteenth century when they emerged as two different policy sectors, with different professions and interest groups, as well as a modern instruments of public health legislation, which covered large territories using the latest scientific advancements.

(Lewis, 2003*a*). At the time, 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 (Germany is an exception in this case, as we will see later: (Alber and Bernardi Schenkluhn, 1992)). The long economic crisis in the late nineteenth century made this effect even stronger (Capie, 1997). Public health services provided health counseling, planned population health programs, but they also registered and isolated cases of dangerous infectious diseases. Therefore, they became the origin for the development of public health as a profession, with different interests from the medical profession. The professional differentiation of public health officials (who often had medical training) was also the onset of conflicts between these two professional groups. As a consequence of these conflicts, debates intensified within the public health community about the way public health policies should be made (Porter, 1999).

As I am going to discuss in the following case studies, professionalization and health policymaking differed among countries. At this stage, it is important to consider the contextual factors these policies responded to. Following the main points regarding contextual elements that I discussed before, it is necessary to take into consideration the following elements:

1. Firstly, we need to look at the **health problems** that had been urgent in the second half of the twentieth century. At the time, infectious diseases and sanitary problems were rampant and the most pressing disease pattern during this period. For instance, from 1817-1912, eight global pandemics of cholera hit the world and inspired public health legislation in many countries (Lewis, 2003*a*).

2. Secondly, **technological development** understood as new and effective drugs and medical equipment only began to emerge. For instance, antibiotics were not yet available, which made findings 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. For example, the famous epidemiological study by John Snow about the spread of cholera through waterways helped to find a way on how to interrupt the transmission of infectious diseases, such as cholera and typhoid, and pointed out the importance to provide clean water (Snow, 1855). In 1882, Robert Koch isolated the tubercle bacillus when he headed the German Cholera Commission in Egypt. Similarly, Koch's works on the causation of diseases by specific agents or parasites were essential for the development of bacteriological science that was so essential for the advancement of public health policies. In between 1881 and 1898, many significant pathogenous organisms were detected and isolated, which made it possible to counteract them with public health measures. Amongst these organisms were typhus, lepta, malaria, tuberculosis, plague and many others (Rosen, 1993 (1959); Gottweis, 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 Vavravikova, 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. The fact 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 people, in order to have a population that 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 implication this context had for the contextual condition concerning the relationship of health care and public health is quite clear. Due to the pressing problem of infectious diseases and the lack of medical and pharmaceutical technology, the context was favorable to public health policies, but also responsiveness and integration of health care and public health policies. Necessarily, policy ideas should mirror this demand for public health policies. What is more, the importance of nationalistic ideas enhanced the contextual demand in a way that was favorable to the integration of both sectors.

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

3.2 The turn towards individual health care (1918-1945)

The second contextual sequence concerning the co-evolution of health care and public health can be dated to the end of the First World War. This makes sense for two reasons: Firstly, 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 in between the two sectors. I will be arguing in the following, that during the interwar period, we can expect conflicts to occur, because on the one hand, modern states set up more and more schemes to organize and pay for individual health care. On the other hand, public health policies remained important, because not all infectious diseases could be cured easily.

The turn towards individual health policy began with the establishment of comprehensive health insurance programs that were created in many countries, beginning in Germany in 1883 (i.e. England 1911 (Porter, 1999), Switzerland 1911 (Uhlmann and Braun, 2011),

France 1930 (Alber and Bernardi Schenkluhn, 1992)). In other countries, the introduction of comprehensive health policies failed and was postponed to later periods in time, such as in Australia (Lewis, 2003*b*) and the United States (Schild, 2003).[3] National health insurance plans were an important signifier for the increasing importance of health care policy, as they institutionalized 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.[4]

Yet, public health remained an important part of health policies in many respects during that time. For instance preventive care for women and children had emerged in the late nineteenth century and expanded over the 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 Vavravikova, 2009, 44). Public health policies began to change though, as policymakers adapted results of health research, especially bacteriology. Already in the early twentieth century, disease specific and restricted interventions were carried out 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 U.S., 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; Weindling, 2006).[5] In addition, the organization carried out and supported cross national studies concerning population health (Rosen, 1993 (1959)).

However, as I am going to discuss for specific countries in more detail later on, the interwar period was also a period of conflict in between professional organizations, such as medical organizations, professional organizations of public health, as well as political parties regarding the direction of health policy. Concerning health care and public health, conflicts occurred with regard to preferences on health policymaking, especially

[3]If we compare the introduction of health insurance in 23 countries, the mean year of introduction is 1924 (Germany first in 1883 and the U.S. last in 1965) (Schmidt, 2005*b*, 182).

[4]The coverage of health care policies varied across countries and over time. In the late nineteenth century, some countries, such as Germany, had, for the time, relatively encompassing health insurance programs, although they just covered a fraction of the population according to today's standards (Schmidt, 2005*b*). At the time, other countries, such as the U.S., did just have social assistance programs that targeted very specific groups, such as veterans and mothers (Skocpol, 1993; Skocpol, 1995).

[5]Already in 1908, the International Health Board had been established, in Paris. Its main task was to distribute and collect information between health departments across the world. It became the basis for the establishment for the League of Nations Health Organization, although the two bodies were not integrated, due to problems between the U.S. and some member states `http://www.who.int/archives/fonds_collections/bytitle/fonds_3/en/`. Last accessed on August 11, 2014.

the introduction of unified public health services. Members of public health professional associations, such as epidemiologists and representatives of social medicine, demanded the creation of national health services that united the provision of population-based and individual-based interventions aiming to cure sickness and prevent health hazards. However, such projects often failed due to the resistance of doctors and medical professional organizations, which found that their liberties of practice were threatened by such an institution, as well as due to conflicts in between the main political parties. The country where such a health service was closest to becoming reality was the Soviet Union and some of its satellite states in the post-World War II area (Schmidt, 2004). During the 1930s, in the Soviet Union, a national health service was created, which combined population and individual based interventions regarding health hazard and treatment of sicknesses. Yet the service evolved towards a medically dominated public health service, in the following decades (Tulchinsky, 1996). The fact that state governed national health services had been set up in Socialist countries supported the course of those who argued in opposition against national health services combining prevention and cure of diseases (Fee, 1994). Although, strictly speaking, this information should only be part of the discussion of my results from the country studies, I am already mentioning it now, because it helps to understand the context that caused these political reactions.

Originally, interest groups and policymakers argued for public health policies to increase population health and equality, irrespective of social origins and genetic predispositions. However, in the late nineteenth century, a competing perspective emerged. Based on ideas of Social Darwinism, Eugenics, which is the science regarding improvement of human genetics, became an important school of thought in the international scientific community, and received attention from policymakers, in many countries (Bashford and Levine, 2010). As mentioned in the previous section, the ideational context at the time fostered competition amongst nations, which eventually manifested in two world wars. In order to “prepare” the entire population for this process, Eugenics offered a solution to improve the health of the people by encouraging reproduction between healthy and “racially pure” individuals, thereby excluding those who are handicapped (Weindling, 1989).[6]

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 to 1945, infectious diseases still were the most urgent health problem. Especially tuberculosis 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 due to infant mortality from gut infections, smallpox and other pandemics. Once the latter, got under control in the late nineteenth century, tuberculosis became more

[6]Eugenics became the scientific justification for the racist public health policy in the “Third Reich” and a symbol for misled public health policies (Weindling, 1989).

visible and subject to health policies. Finding a cure was difficult, and consequently health policymakers put their main focus on preventing 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, concerning other diseases, such as tuberculosis, a cure was not yet possible. Therefore, infectious diseases remained the main health problem at the time. The development of antibiotics, such as penicillin, did not occur prior to the mid 1940s (Tulchinsky, 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. At the same time, 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. Subsequently, population-based measures, including medical inspection of children and hygiene education of the population had a high priority (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. On the one hand, many health care professionals supported suggestions to establish national health services. Such services would combine population- and individual-based measures. On the other hand, there were national health care policies. These entailed mostly insurance plans that would only cover treatment, based on a state, social insurance or a market and occupation-centered health care scheme. In the latter, the state would only provide services for the very indigent groups. These two opposing paradigms resulted in conflicts between the interests of health care and public health and were resolved in different ways, as we will see later on (Porter, 1994).

4. **Economic crisis and the Second World War:** Apart from specific health problems, technological development and ideas, external events played an important role with regard to the relation of the two sectors. During t2, there were two events that potentially had an important impact on the relations of policy sectors in general. Firstly, the economic crisis of the 1930s had a significant impact on health policies

in general. Consequently, demands for public health policies, 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, I am also expecting 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). Secondly, 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 the home front (Levy and Sidel, 1997). This implies for the context of coupling of health care and public health, that the war and the crisis should decelerate the development towards more individual health care and keep public health on the political agenda of national governments.

The discussed elements show that the contextual condition regarding the coupling of the health care and the public health sector allows for two conclusions. Firstly, due to the continuing importance of infectious diseases, the limited technological possibilities of curative medicine, and the public health situation in times of war, the context remained 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 amongst the actors of the two sectors.

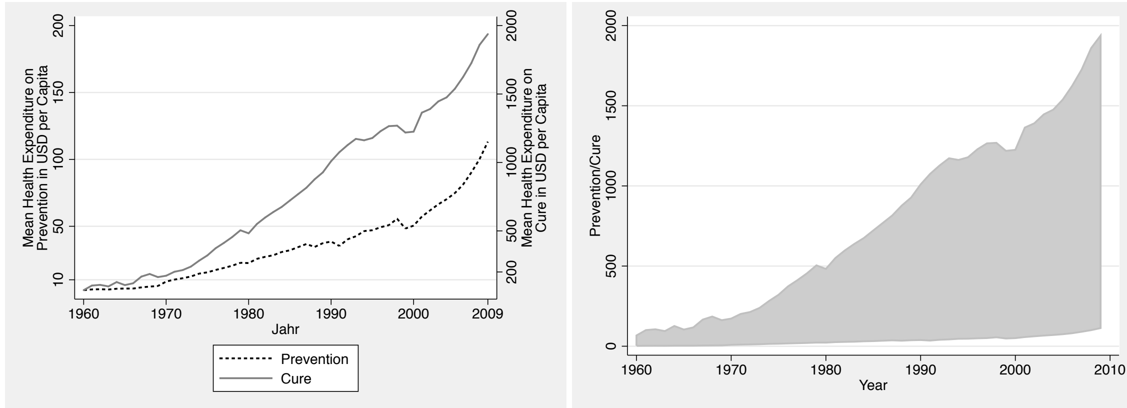
Contextual condition t1a: *During t1, infectious diseases, limited medical technology and the war situation created a demand for sectorial responsiveness and integration.*

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

3.3 Dominance of medical care and marginalization of public health (1945-1975)

After the Second World War, the relation of health care and public health changed dramatically. In many Western 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 manner. Preventive health policies often occurred in the form of individual counseling, for instance by doctors.

The dominance of health care in the aftermath of the Second World War 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 biomedical paradigm, which understands health policy as the need to cure sick bodies of individual patients (Lewis, 1999, 154). To the contrary, public health played a marginal role compared to health care (Baum, 1998). To illustrate this development, I am going to compare health expenditure in cure and prevention, according to OECD data. Graphs 3.1 and 3.2



(a) Expenditure on prevention and cure I

(b) Expenditure on prevention and cure II

Figure 3.1: Expenditure on health care and public health

show the evolution of health expenditures comparing investments into individual care and prevention. Based on the OECD average from 1960 to 2009, 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.[7] Graph 3.1 shows that there is a large discrepancy in between expenditure for curative medicine and for prevention. Whereas the left side of the Graph presents the difference of expenditures in the two sectors based on different scales, the right side depicts the difference of the two sectors based on the same scale and shows how much investments in the two sectors differed across time. I included information based on absolute data, without correcting for GDP percentage, in order to better demonstrate the difference in between the two sectors.[8]

Both graphs show that, from 1960 to 2009, there was an increase in the investments in public health and curative medicine overall. However the dynamics for the two sectors differed remarkably, as investment into health care exploded, compared to the amount that was put into public health policies. Expenditures for public health policy remained smaller and did not increase in the same way as those for health care. Yet, after 2000, expenditures for public health increased more steeply, however it remains only a tiny fraction of what states invest in health care.

Yet, these numbers also show something very important for the analysis of the two sectors, namely transgression of health care into the area of prevention. This means that actors from the health care sector began to provide public health services, in the sense that doctors started to perform services that were previously in the hands of municipal public health services, such as immunization and secondary prevention. The most common example of this is, as we will see in the following case studies, the provision of preventive health services by doctors, instead of public health officers. Apart from the transgression of health care onto public health, this dynamic entailed an increasing individualization of

[7]The source for all three graphs is (OECD, 2013). See the appendix for summary statistics and information regarding the countries that are included as well as the data that is missing.

[8]All of the mentioned figures show expenses for public health and health care in per capita expenditure in U.S. dollars.

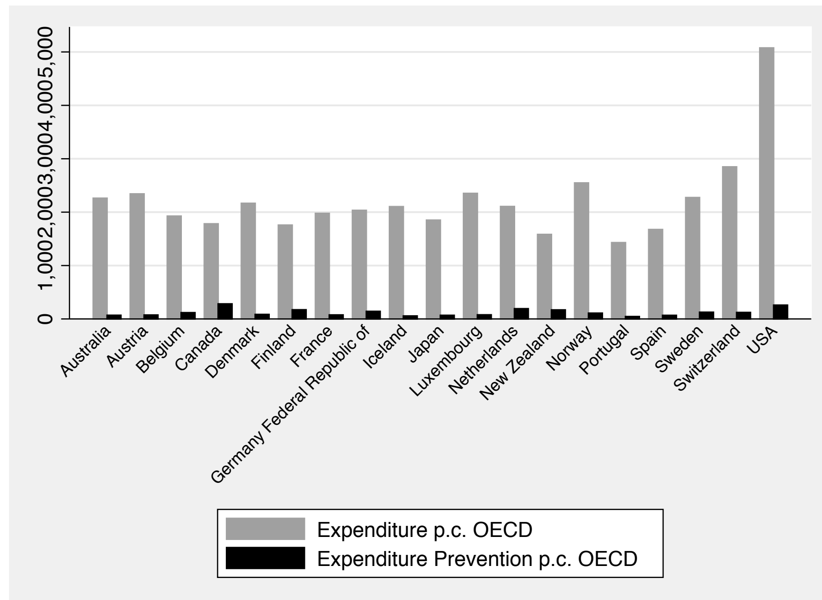
public health and a focus more on preventive health measures. The OECD health data that I am using to illustrate my argument allows me to distinguish the function of the health care expenditure and to separate between individual and collective health care. However, the data only permits us to distinguish curative and rehabilitative services on the one side, which contain all individual-focused health services, and population-focused public health services on the other side, which include health insurance subsidies for indigent groups, for instance (Gold, 2012).[9] In the measurement of the OECD data, there is an overlap of public health and health care, since secondary and tertiary prevention are included in the area of individual health care. For example, the items concerning diagnostic service and rehabilitative care entail elements of secondary and tertiary prevention (Gold, 2012). The fact that there is no classification of health data along public health and health care as they are distinguished in table 2.2, but rather a regrouping of all individual-focused health expenditure on individual care and the rest under population wide care, shows the transgression of health care onto public health - and indicates that it is necessary to be careful regarding the interpretation of this data as a measure for the two sectors. On the other hand, it is useful to show that existing analyses of health policy - in this case OECD data - focus particularly on individual health care. The difference concerning expenditure for individual health care and public health is similar across countries. Figure 3.2 shows the difference in expenditure for cure and prevention in OECD countries in 2008.[10] The results show that the difference between cure and prevention is similar in most countries.

The differences between investment in medical cure and prevention have continued to increase until today, although there are reasons to believe that the relation of the two sectors should have shifted towards more complementarity, since the 1980s. Despite the high priority of medical care in national health policies, public health policymaking continued, but more in the shadow of individualized health care, for instance by large immunization campaigns during the 1950s. Immunizations had already been carried out during the period of the early twentieth century, yet these policies returned to the political agenda in the period after the Second World War. Especially vaccination against polio and later on tetanus and pertussis were the subject of large public health campaigns, because at that time, the necessary medicines had been developed. These campaigns entailed individual prevention, of course on a mass-scale, but the policies were different than those intervening structurally, such as banning smoking in public or advertisement for

[9]According to the OECD database, the two main distinctions are: **1. Services of curative and rehabilitative care**, which contain amongst others: services of curative care, in-patient curative care, day cases, out-patient curative care, basic medical and diagnostic services, services of rehabilitative care (In-patient, day cases, out-patient, home care), long-term care, ancillary services to health care, as well as medical goods. **2. Collective health care**, which entails amongst others: Prevention and public health services, such as: maternal and child health, family planning and counseling, school health services, prevention of communicable diseases, prevention of non-communicable diseases, occupational health care, and all other misc. public health services. In addition, this item entails expenditure on health administration as well as the financing of health insurance. In the data that I am showing above, I am using the data on "services of curative and rehabilitative care" to measure health care, and "collective health care" to measure public health (OECD, 2013).

[10]Countries with no availability of data for this year are left out.

Figure 3.2: Expenditure on cure and prevention in OECD countries



liqueur. Sanitary installations, such as water provision and sewages existed and functioned properly. Public health services that were mostly staffed by public health officers with medical or military experience were responsible for medical policing along with the local governments. The general shift to a dominance of health care entailed a change from a sociological to a medical approach, as for instance the mentioned polio immunization (Tuberculosis is a similar example) as well as more and more cancer screening programs. Although public health continued to evolve during this period, some authors complained that it turned into the "poor cousin of medicine" (Baum, 2008, 27).

Why did this fundamental shift occur in health policy with regard to the relation of health care and public health after the Second World War? The contextual elements I am interested in, evolved as follows:

1. During and immediately after the Second World War, important events occurred in the **technological development** regarding health policy, namely pharmaceutical technologies. Specifically, 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 and Freins, 2009; Eckart, 2011). Another result of the progress in technological development was the development of vaccinations for dangerous infectious diseases, for instance immunization against polio (Tulchinsky and Vavravikova, 2009). These pharmaceutical innovations allowed for the curing of more diseases, but also shifted public health even further towards 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. The development of new medication had begun already in the early twentieth century, however its major breakthroughs occurred in the mid-1940s.

2. **Health Problems:** The context for public health changed also, due to the evolution of the prevalent disease pattern. 100 years of public health policymaking (approx. 1850-1950) had led to a significant decrease of mortality rates in Western countries. Improvements in the public health infrastructure, such as sanitary reforms, immunization, but also health education only reached its full impact in the middle of the twentieth century. Therefore, the challenges regarding health policies had begun to change in the 1930s and 1940s. Longer lives were possible, and the pattern of diseases changed (Rosen, 1993 (1959); McKeown, 1979; Nathanson, 2007). In addition, due to the possibility to use antibiotics and vaccinations, a major shift in the epidemiological pattern occurred. Infectious diseases, which had been the most pressing health problem for centuries suddenly no longer posed a major problem anymore, because they could, in many cases, be cured (Haines, 2001; Tulchinsky and Vavravikova, 2009). Longer lives however, came along with higher prevalence of other diseases, 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. Affluence made people perceive that public health is no longer relevant. In this situation, the formal public health sector still focused on infectious diseases that were declining at this time, and did not manage to immediately create a more holistic approach to public health. It makes sense to use the Second World War as a turning point, because during the war public health policies still were considered quite important. After 1945, it was going to take three more decades before "new public health" became the term denoting the renewed interest of policymakers in public health (Baum, 2008).

3. **Economic development:** The economic development was another quite important factor for the relationship of health care and public health in the postwar period, which boosted the dominance of individual health care. The postwar period 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 (Fee, 1994; Baum, 2008).

4. In this period **ideas** about social policy changed profoundly and also impacted the relation of health care and public health. Along with unprecedented economic growth, the postwar era was a time of welfare state enlargement. In many countries, the range of social policies increased greatly in terms of benefits and recipients. Health insurance made health care affordable for many people, which, in turn increased the incentive to pursue a career in private practice or as a GP rather than in public health offices. From the perspective of policymakers, there was little incentive to invest into

more public health policies. Eventually, the stronger focus on individualism in many policies, rather than communitarian ideas, favored the dominance of the health care sector (Castles, Leibfried, Obinger and Pierson, 2010). The cold war antagonism between "Western Liberal Democracies" on the one hand and the "Communist Autocracies" on the other hand did also have an impact on the relation of the two policy sectors. In Communist countries, health policy entailed the creation of huge national health services, which integrated individual health care and public health policies, although they also underwent changes by those who favored individual curative and preventive measures to population based preventive health approaches, as it was for instance the case in Russia (Tulchinsky, 1996). In the GDR, health care and public health were integrated in policlinics, which provided universal health care and were responsible for preventive health policy (Schmidt, 2004). The institutional integration of both sectors in the Communist countries caused opposition against public health policies, in the West. For instance, in the U.S., in the 1950s, popular opposition prohibited the implementation of public health policies, such as the fluoridation of drinking water for the prevention of caries, due to fears of Communism (Fee, 1994). Yet, whereas public health lost support amongst policymakers at the national level, population health remained important from a global perspective. The foundation of the WHO in 1948 was the starting point to lift prevention, control of communicable diseases and social medicine on 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 World Health Organization continued to keep the focus also on public health measures, which were still very important for less developed countries.

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

3.4 The long return of public health (1974-2010)

In the postwar period, there had been a large divergence of the two policy sectors that increased the distance in between them, which has not been reversed until today. However, in the mid 1970s, the landscape of health policies began to change again. 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 non-communicable illnesses that occurred due to behavioral factors, such as smoking, drinking and unhealthy dieting (Lewis, 2003*b*).

Specifically, the return of public health to the political agenda can be dated to the year 1974. One of the most influential documents in that regard was the Lalonde (Marc Lalonde was then Minister for Health and Welfare, in Canada) Report to 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; Hancock, 1986). Other countries, especially in the Anglo-Saxon World, published similar documents, such as the "Life. Be in it." (1975) campaign in Australia, the "Healthy People Report" (1979) by the U.S. Surgeon in General and the report "Prevention and Health" of the British government, which set the grounds for campaigns of risk factor control (Baum, 2008). Governments began to develop lifestyle programs, such as the North American Heart Programs and population surveys of risk factors. Regarding 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 on obesity. The focus of health policy shifted from the individual to health policies, which focused more on the collective level, such as health promotion policies that are concentrated on settings (Healthy cities, schools, worksites, hospitals).[11] In the 1980s, disease focused programs increased with the return of infectious diseases, especially the AIDS epidemic and gave rise to public health in another domain. Since the 1990s, the focus of public health expanded to international treaties and laws, such as the focus on bioterrorism, including measures against SARS, and the preparation of responses against pandemics (Baum, 2008).

The renewed focus on public health has also been labelled *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, next to the response to new epidemiological problems, such as AIDS. Policy instruments of the new public health approach go back to the Lalonde report of 1974, which introduced the "The Health Field Concept," that contained four elements: human biology, environment, lifestyle and health care organization, as four central principles for good public health (Lalonde, 1974). 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). In universities, old public health had become institutionalized in disciplines such as epidemiology and biostatistics, rather than the social sciences (Martin and McQueen, 1989). 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), which evaluated its member states and demanded more preventive health policies (WHO, 2000; WHO, 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, this was the abovementioned Lalonde Report and the

[11] These programs were also developed beyond the Anglo-Saxon World, for instance in Finland (Hunter, Marks and Smith, 2010).

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 Sunsvall Health Promotion Conference (1991), the UN 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, Powell, Taylor and Grey, 2003; Baum, 2008). In 2013, a global action plan against non-communicable diseases was passed (WHO, 2013*a*).

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). Beginning in the 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, 2013), 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 (Gilardi, Füglister and Luyet, 2009). One of the main challenges for health care policy since the 1970s was cost containment on the one hand, and on the other hand to keep up quality, as as well as equal access and a certain kind of liberty in choosing services (Weisbrod, 1991; Braun and Uhlmann, 2009).

Since the 1970s, the context for health policy changed again. Disease pressures, health policy ideas, and the economic and fiscal context changed in a way that created a more favorable context for integration of health care and public health.

1. **Health Problems:** Regarding health problems, there are two factors, which are important to understand the shift in the health policy agenda: Firstly, the increasing importance of non-communicable diseases that are caused by lifestyle and the return of infectious diseases. Beginning in the 1970s, the prevalence of non-communicable diseases became more and more clear. Cancers that are related to lifestyle peaked in the 1970s, especially lung cancer, which could easily be responded to by tobacco control policies. The development of other kinds of cancer and different non-communicable diseases, has, however been an increasing problem since the 1970s until today (OECD, 2013). Secondly, 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 Vavravikova, 2009; WHO, 2013*b*).

Although the danger of global pandemics is constant - as the Malaria outbreak in West-Africa shows -, the threat of an increasing prevalence of communicable diseases is not comparable to the late nineteenth and early twentieth century, when epidemics, such as the Spanish influenza after the First World War (Johnson and Mueller, 2002), affected millions of victims.

2. **Ideas:** Ideas have been another important element concerning changing relations of health care and public health in the last 30 years. This concerns two levels of the analysis. Firstly, 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 and at the same time more in preventive and collective services (Wagschal and Wenzelburger, 2008; OECD, 2013), however, the cost of health policy, especially health care, became a topic of public discourses (Baum, 2008, 29). Secondly, critical voices about the role of medicine became louder. Already since the 1970s, several authors, most of them doctors themselves, suggested 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 the conception of the relation between patient, doctor and disease (Adler, 2009; Fava and Sonino, 2008; McLaren, 1998; Herman, 1989; Schwartz, 1982; Schwartz, 1977; Engel, 1980; Engel, 1978; Engel, 1977). These authors hold that the classical biomedical model, which emphasizes only the clinical doctor-patient relation has failed. In his seminal article, G.F. Engel argues that "by evaluating all the factors contributing to both illness and patient-hood, rather than giving primacy to biological factors alone, a bio-psycho-social model would make it possible to explain why some individuals experience conditions as "illness," which others regard merely as "problems of living," be they emotional reactions to life circumstances or somatic symptoms" (Engel, 1977, 133). At this time, the authors demanded the inclusion of the behavioral and social dimension into the education of doctors and nurses, the research of medical systems as well as in modes and types of treatment (Engel, 1980; Kleinman, 1978). More recent works have shown that the works of Engel and others have indeed had an influence on the current medical research as well as on health policy. Research confirms that a stressful life, a high-risk health behavior as well as an unhealthy environment has significant consequences for individuals' vulnerability to illnesses (Adler, 2009; Fava and Sonino, 2008; Alonso, 2004). These arguments came along with the above discussed international public health policies and discourses.

3. **Economic Development:** A third element that could have played an important role for the shift of the health policy agenda back towards public health is the fiscal and economic development. Although there was no re-convergence in the expendi-

tures on health care and public health, it is plausible to assume that policymakers considered investing more in public health policies, in order to slow down the growth of expenditure on health care.

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

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

3.5 Summary

In this chapter, I discussed the context for the relationship of the health care and the public health sectors, during the period from 1880 to 2010, based on a review of the secondary literature, supported by some statistical materials, notably of health expenditure data. I have not explicitly shown the statistics on infectious diseases' development such as tuberculosis infection rates over such a long time frame, but relied on secondary literature.

My basic assumption is that this context is more or less the same for all developed democracies (I will present such data for the country studies that I am going to undertake in the next section). 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 the same (Colgrove, 2002; McKeown, 1979). Consequently, I assume that generally, the discussed impact of economic crises is similar in most of the OECD countries. At the same time, shifts in ideas occurred at the global level. In Europe, for example politicians changed the concept of the relations between the countries from dominance of military competition to a more peaceful order. As I explained it before, this ought to have an impact on health policy within countries. Not necessarily with the same effects in every country, yet I am hypothesizing that policymakers and interest groups should at least take note of them. Eventually, the same holds for the technological development in the medical sector. Here, it is similarly plausible to assume a rather quick diffusion of innovations, such as penicillin.

Table 3.1 summarizes the development of the health care and the public health sectors over the four presented sequences, the contextual elements as well as the contextual condition for sectorial responsiveness and integration. During the first sequence, t0, health care and public health emerged as two different policy sectors. The contextual condition at that time was very favorable to public health and the integration 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 in a context 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

Table 3.1: 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 integration
t1 1918-1945	Infectious diseases still important, improved medical possibilities (immunization), competition of nations, economic crisis	Favorable and not favorable to responsiveness and integration
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 integration
t3 1970-2010	Non-communicable diseases, criticism of medical focus in health policy, end of economic growth and begin of budgetary austerity (especially in 1990s)	Favorable to responsiveness and integration

health policymaking and the integration 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 fields.

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 the latter 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 integration of the two sectors. One reason for this is that the pattern of disease changed towards more non-communicable diseases, which are difficult to cure and need to be prevented, such as by promoting non-smoking. Another element that shifted the context of for health policymaking was that many scholars criticized the prevalent medical model, as being too much focused on the individual medical care while neglecting sociological elements.

Based on these contextual conditions, I will now turn to the country studies. Taking Australia, Germany, Switzerland, the UK and the U.S. as examples, I am going analyze how unified government and professionalism shaped the coupling of both sectors in these countries.

Chapter 4

Research design

To empirically analyze the co-evolution of the health care and the public health sectors, I am conducting a comparative historical analysis of five OECD countries. As case studies, I selected Australia, Germany, Switzerland, the UK and the United States. The main criteria for selection was that these countries differ regarding their condition of unified government and professionalism. Consequently, I am expecting to find different degrees of sectorial coupling between them. At the same time, they are subject to similar premises with regard to the temporal dynamics of the contextual conditions that I discussed in the previous section.

The goal of this chapter is to justify in depth the selection of these countries, to explain how I operationalized distinctiveness and responsiveness, to explain which material I am using as well as a discussion of the strengths and limitations of my approach. To operationalize distinctiveness and responsiveness of policy sectors over a long-term period, the most important data for my analysis is secondary literature. Based on an extensive review of works mostly by historians and political scientists, I am analyzing institutional distinctiveness, as well as the responsiveness between policy sectors, which entails the interaction of private actors, such as professional organizations, but also responsiveness at the level of policies, such as policy integration. Eventually, I am using interviews with experts, administrators and politicians, which I conducted together with my colleagues in the context of a larger research project on health governance.[1] The advantage of this approach is that it permits the tracing of the origins of sectorial coupling of health care and public health and connects them to current problems in health policymaking. Yet, it has the downside that due to the long time period under observation, the case studies can only give very concentrated and summarizing accounts, especially of the responsiveness between policy sectors.

[1]The title of the project is: *"Multilevel Governance in Health Policy: Comparing Australia, Germany and Switzerland." Research Project funded by the Swiss National Science Foundation (Ref: 26041044).* I am very thankful to the other collaborators on the project, in particular Dietmar Braun, Wally Achtermann, Dorte Hering and Björn Uhlmann for their help with the data collection and selection of interview partners. I also want to thank the Swiss National Science Foundation for generous support of my research.

4.1 Approach and case selection

The research design of this thesis follows prominent authors in political science, who pursued comparative historical analyses. According to Mahoney and Rueschemeyer (Mahoney, 2003), comparative historical analyses have a long tradition in the social sciences. Works in the field focused on the evolution of welfare states (Esping-Andersen, 1990; Immergut, 1992*a*; Huber and Stephens, 2001; Pierson, 2004), political economies (Thelen, 2004; Steinmo, 2010), state formation, and the emergence of democratic and authoritarian regimes, amongst 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; Pierson, 2003), which allows for a careful tracing of causal mechanisms by analyzing a small number of cases in a contextualized manner (Mahoney, 2003). Since it is the goal of this project to improve our understanding of the historical development of sectorial coupling, this is a suitable approach.

In this analysis, I am combining historical analysis with concepts rooted in comparative public policy analysis. Often, public policy analysis 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, Larrue and Varone, 2011; Weimer and Vining, 2005). Thereby, agenda setting and decision-making processes are at the center of attention, including partisan influence (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 or several policies in different countries or different policies in the same country (Dodds, 2012), often with the goal to promote learning between policymakers (Rose, 2004). In the following analysis, I am going to combine some of the actor-centered concepts of comparative public policy, namely the concept of the actor triangle (Knoepfel, Larrue and Varone, 2011) with comparative historical analysis. This allows me to forge a connection between professionalism, unified government and the coupling of policy sectors at different analytical levels, namely actors, policies and institutions over a long time period. At the same time, I am also taking into consideration economic and societal elements, as well as actors' interests (Pontusson, 1995).

To carry out my analysis at the country level, I am proceeding with a comparative analysis of the co-evolution of health care and public health in Australia, Germany, Switzerland, the U.S. and the UK. The selection of these countries follows a most similar systems design (George and Bennett, 2005; Gerring, 2007). From the outset, I am framing the comparative case study approach design according to what Blatter has called a co-variational 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 countries that I selected for this analysis are Australia, Germany, Switzerland, the UK and the U.S. They are similar

Table 4.1: Case studies and explanatory variables

	Strong Professionalism	**Weak Professionalism**
Fragmented Government	U.S. → *loose coupling*	Switzerland → *de-coupling*
Unified Government	Australia / UK → *tight coupling*	Germany → *non-coupling*

in the sense that they are developed democracies, OECD-members and followed similar paths in their evolution into modern states. They vary however, due to professionalism and unified government. Therefore, I am expecting to find differences in the coupling of the health care and the public health sector (Geddes, 2003). I will now discuss and explain in more depth the differences between these countries regarding the explanatory variables.

Table 4.1 shows the configuration of the two main independent variables in the selected countries as well as the type of coupling I am expecting to find (italics). The U.S. is a case of strong professionalism and fragmented government. Consequently, I am expecting that there is loose coupling of the health care and the public health sectors. Switzerland has a fragmented government and weak professionalism. Therefore, both sectors should be de-coupled. In order to analyze a case of tight coupling, I am going to examine Australia, because it displays a combination of unified government and high professionalism. 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), I am also including the UK in the analysis, which is a case of unified government, but also strong professionalism. Eventually, Germany combines low professionalism with unified government, because it is a centralized federation. Accordingly, there should be non-coupling of health care and public health.

However, this classification of the selected countries is simplifying the realities and it requires further qualification. Especially the dimension of unified government ought to be explained and discussed, notably that Australia, Germany and the UK are in the same group for the government structure variable. I am now going to discuss each of the countries and will then turn again to this problem.

I qualified the U.S., as a case for which I am expecting to find loose coupling of health care and public health, because it has a fragmented government and strong professionalism. Concerning fragmented government, this is easy to justify. The U.S. is a decentralized federation, in which subnational governments have many competences in health policy (Jonas, Goldsteen and Goldsteen, 2007). What is more, policymaking at the national level is difficult, as the political system has a series of veto points, such as the presidency (Edwards and Howell, 2011), two Congressional chambers (Eric and Lee, 2011), and the Supreme Court (Stern, Gressman, Shapiro and Geller, 2002). A look on a more objective measure for political constraints confirms this evaluation. In the indicator of political constraints by Henisz (Variable: POLCONV) (Henisz, 2000) (See summary statistics in the

appendix), the U.S. scores high, which confirms my analysis that it is a case of fragmented government.[2] Regarding professionalism, the U.S. is an example of strong professions. There are two main reasons for this: Firstly, professionalism is important for individual education and occupational formation, because belonging to a profession helps individuals to obtain a secure and well-paid job, because the state takes less responsibility for education (Freidson, 1983, 23-26)(Rueschemeyer, 1973*a*, 63-122) and employment protection (Hall and Soskice, 2001). Consequently, professional organizations are strong in the U.S. (Macdonald, 1995, 66-99) with regard to the politicization of issues - those that specifically concern their members, but also other problems of general interest.

In Switzerland, I expect to find de-coupling of policy sectors, due to the fragmented government and weak professionalism. It makes sense to classify Switzerland as a country with a fragmented government on the following grounds: Firstly, it is a decentralized federation, in which the 26 member states (cantons) have legislative competences in many policy fields as well as a high tax autonomy (Blöchliger and King, 2006), which grants them strong autonomy (Braun, 2003). At the same time, the cantons coordinate their policies in many inter-cantonal conferences (Vatter, 2014*a*), but there is no systematic formalized inclusion of the cantonal governments in policymaking at the federal level, as for instance in Germany (Braun, 2003).[3] Regarding the decision-making process at the national level, Switzerland has been characterized as a consensual democracy, which has many veto points and a high demand for coordination. When we look at a more objective indicator (POLCONV), this evaluation is correct.[4] More qualitatively informed analyses of the country confirm this evaluation (Lijphart, 2012; Sciarini, Fischer and Traber, 2015). I evaluated Switzerland as a case of low professionalization. Professionalization is different than in the U.S., since Switzerland has been considered as a coordinated market economy with wage protection and an important public role for education in general (Hall and Soskice, 2001). Weak professionalism has been found with regard to different occupations, such as lawyers (Siegrist, 1986), but also the political class in general (Wiesli, 2003). Consequently, it is unlikely that the demand for professional organizations to be politically strong is as high as in the U.S., and therefore I am not expecting to find responsiveness of private actors concerning coupling of the health care and the public health sector.

Australia is one of the two cases that combines a more unified and centralized government with strong professionalism. It is a federal state, which originated from the colonies of the British Empire on the Australian continent. Its government has been modeled according to the British Westminster model, where the governing party usually has

[2]Obs.: 53; Mean: 0.8520999; Std. Dev.: 0.0021507; Min.: 0.846112; Max.: 0.856592.

[3]Cantonal coordination occurs in a series of regional and national inter-cantonal conferences, in which the federal government participates; however the system is not a joint-decision-making arena, in which the participating actors need to come to a binding outcome for all participating parties (Füglister, 2012). Therefore, we can expect to find negotiations as well as well as competition between cantonal governments (Vatter, 2014*a*). In general, it is necessary to note that Switzerland is in many ways a special case (Widmer, 2008). This is especially, because public policymaking happens in many political arenas, including a strong direct democratic arena (Papadopoulos, 1998), which makes Switzerland a strong consensual democracy (Kriesi, 2008).

[4]Obs.: 53; Mean: 0.8767297; Std. Dev.: 0.0100129; Min.: 0.852924; Max.: 0.882792.

a parliamentary majority and the ability to implement its main ideas, due to a majority voting system with two large parties. The governing party controls the majority in parliament and does not have a strong coalition partner (Although the Liberal party in Australia often forms governments together with the smaller National Party of Australia) (Woodward, 2010). Although Australia has a second parliamentary chamber, the Senate, which should represent the rights of the state (and is a counter-majoritarian element at times), the British influence has been strong. Consequently, the colonial/state as well as the national governments passed many unifying laws in the country's entire territory. Australia experienced a continuing centralization, especially of fiscal powers during the twentieth century (Painter, 2009). To better coordinate policies between subnational governments, COAG (Council of Australian Governments) was established in the early 1990s (Braun, 2006). Due to the federal structure, the political constraints index for Australia is 0.86,[5] which is rather high and close to the values of the U.S. and Switzerland. Yet, the fact that it is a centralized federation and has a Westminster government justifies considering it as an example of a rather unified government (Braun, 2006). Concerning professionalism, I am expecting to find that this element is going to be strong, in Australia, because the country's national development is closely intertwined with the one in the UK, where professionalism has been strong. What is more, as with the U.S. and the UK, Australia is a liberal market economy (Hall and Soskice, 2001). Consequently, professional organizations should be strong, in the sense that they are politically active, because belonging to a profession is important for individual citizens, in order to create a secure income. Subsequently, professional organizations in the health sector should be strong and politically active, which makes responsiveness likely to occur.

The second country with a configuration of unified government and high professionalism is the United Kingdom. It is different from the other countries regarding political constraints in this sample.[6] The reason for this is quite simply that the UK is not a federal state, but has a unitary government. Concerning professionalism, the country is also an example for strong professionalism. In the literature on the sociology of professions, authors argue that professionalism is important in the UK, due to reasons of personal development, but also in order to secure a good income (Freidson, 1983, 23-26)(Macdonald, 1995, 66-99). What is more, the UK is a liberal market economy (Hall and Soskice, 2001). This means that professional organizations should be politically active, because they need to represent the interests of their members in the political arena. Consequently, I am expecting to find politically active professions in the health care and the public health sectors, and subsequently responsiveness between them.

Eventually, Germany is a case that allows for analyzing the configuration of a more unified government and the absence of professionalism. Concerning political constraints, Germany is rather similar to Australia.[7] The country is a federal state, in which member

[5]Obs.: 53; Mean: 0.8605759; Std. Dev.: 0.0072655; Min.: 0.839609; Max.: 0.868644.
[6]Obs.: 57; Mean: 0.7337626; Std. Dev.: 0.0189698; Min.: 0.6667; Max.: 0.7493646.
[7]Obs.: 53; Mean: 0.8415302; Std. Dev.: 0.0036113; Min.: 0.836685; Max.: 0.850025.

states have their own competences in many legislative areas, if there is no overriding legislation by the federal government (Hueglin and Fenna, 2006).[8] As a consequence, Germany is a rather centralized federation with nationalized legislation in many policy areas. At the same time, the German case is an example of weak professionalism. Membership in a profession is less important than, for instance, in the U.S. or the UK in order to achieve a stable economic position, because the state has taken a more prominent role for vocational training and jobs are more protected (Hall and Soskice, 2001). Consequently, professional organizations are less politically active. This has an impact on the political activity of the professions in the health care and the public health sectors. Accordingly, in Germany, the medical profession and public health doctors should not be very politicized. Subsequently, I expect to find no responsiveness between the health care sector and the public health sector, in the form I defined it before (Freidson, 1983, 23-26)(Macdonald, 1995, 66-99).

Regarding contextual factors, I am assuming that they are similar for all countries. Thereby, it is important to note that similar does not mean the same. However, the modernization cycle of economic development was similar in these five countries. This means that they became rich democracies in an analogical manner, during the twentieth century. Figure 4.1 illustrates this point by showing the economic development for the countries in Geary-Khamis-Dollars per capita.[9]

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, non-communicable diseases increased, especially different forms of cancer. I am not presenting the exact figures for each country regarding the evolution of diseases, because the available statistics are not really comparable. However, the trends are similar in all the countries under consideration in this thesis. The respective figures can be found in the sources cited in this footnote.[10] What is more, the main interest of my research is in the coupling of the health care and the public health sector. Therefore, it is not essential to discuss the evolution of these numbers in greater depth. Yet, it will be important to understand the perceptions of disease dynamics by interest groups and policymakers in each of the countries. How I am going about measuring this is the subject of the following section.

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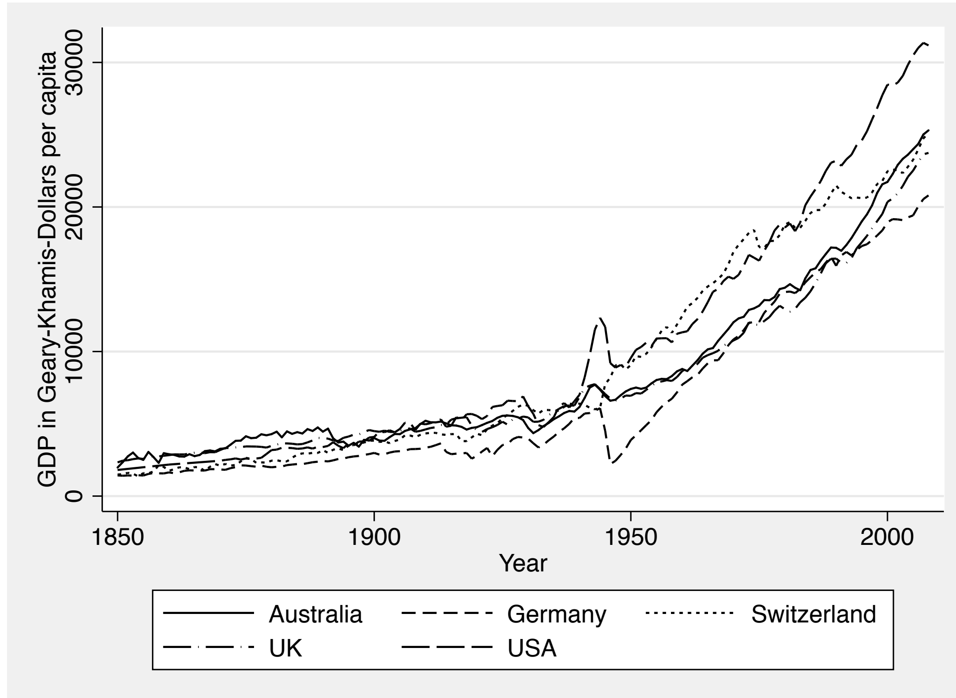
[8]However, in most policy areas there are federal laws and the member states are mostly charged with implementation issues (Obinger, 2002; Braun, 2003). What is more, the sub governments participate in the decision-making at the federal level, in the *Bundesrat*, which is the second chamber of the national parliament (Schmidt, 2005*a*). Votes are weighed according to the population share of each member state. Yet, in the political reality, the second chamber of the national parliament is often a place of party conflicts (Scharpf, 2009).

[9]Source of the data: The Maddison-Project, `<http://www.ggdc.net/maddison/maddison-project/home.htm>`, 2013 version. Last access: May 05, 2015. Regarding the method according to which this data has been collected read: (Bolt and Zanden, 2014).

[10]Australia: (ABS, 2011). Germany: (Sensch, (1875, 2013 [2006])). Switzerland: Database of historical statistics of Switzerland online: `<http://www.fsw.uzh.ch/hstat/nls_rev/ls_files.php?chapter_var=./d>`; Last access: May 05, 2015. UK: (Griffiths and Brock, 2003). U.S.A: (Service, 1900-1970), `<http://www.cdc.gov/tb/statistics/tbcases.htm>`; Last access: May 05, 2015.

Figure 4.1: Development of GDP between in selected countries



4.2 Data, operationalization and method

The next problem that needs to be addressed is the operationalization and the data that I am going to use to measure the main variables, as well as the method, according to which I am going to analyze the information I collected. In the following subsections, I will mainly discuss these three elements.

4.2.1 Operationalization

In order to examine the co-evolution of the health care and the public health sectors, I analyzed the institutional development of health policy, actor constellations, relations between private actors of both sectors regarding the politicization of the other sector's issue as well as the policy output of both sectors over time. This allows me to trace out the distinctiveness and responsiveness of the two policy sectors at the level of actors and institutions. Regarding actors, I am examining the groups that are important to put the main issues of the policy sector on the political agenda and if they belong to one of the two sectors. I am also examining whether the actors of the two sectors are responsive to one another, for instance if they support the other sector with regard to agenda setting or lobbying for specific issues. Concerning the institutional level, I searched in the literature with regard to the institutionalization of the two sectors. Firstly, whether they are institutionally different, or if they share the same or similar institutional arrangements. Secondly, I am researching if they 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 more precisely how I operationalized distinctiveness and responsiveness in the four countries and the specific indications I am using to understand the coupling of the health care and the public health sector. According to the definition of these elements that I discussed in chapter two, I measured coupling, as well as its relation to unified government and professionalization. Regarding coupling, I am examining the distinctiveness and responsiveness of policy sectors. Distinctiveness is the case, if the health care and the public health sector 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. Regarding responsiveness, I am also evaluating qualitative information. Specifically, I will look 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. On the contrary, if there are conflicts between both sectors, responsiveness is absent. Regarding policy integration, I am researching whether there are policies integrating both sectors, such as health strategies combining prevention and cure for cancer patients.

Concerning independent variables, I am also collecting information from secondary sources. To understand unified government, I will take into account the centralization of legislative competences, as well as the changes therein over time. Regarding professionalism, I am looking at the political activity of the health professions in general and how they operate as intermediary agents between state and society. Eventually, to understand the contextual elements, I am assuming that this does not vary considerably between the countries, but only over time.

The unit of analysis is the coupling of policy sectors. Consequently, I will look at sectorial coupling in five countries at five different time points. This will result in a comparative analysis with 20 observations overall.

4.2.2 Secondary literature and documents

The main sources of information for this thesis project are secondary literature and some documents that contain information concerning the relation of the two policy sectors. 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 around my topic. Amongst these keywords are: "public health", "public health policy", "health policy", "public health care" and "prevention" mostly in combination with one the five country names (Australia, Germany, Switzerland, UK/England/Great Britain, U.S./United States). In German I used respective equiva-

Table 4.2: Operationalization of key variables and sources

	Measures	Sources
Dependent variable (Coupling of policy sectors)	→ *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 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); i.e. 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
	→ *Policy integration*: Common policies that combine health care and public health principles. For example: Tobacco strategy, non-communicable disease strategy	Secondary literature, interviews, homepage of ministries
Independent Variables	→ *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*: 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*: I am referring to the information that I presented in chapter three; In addition, I am using some of the information that came out of the case studies, but no directed search for contextual elements in the countries	Secondary literature, interviews

lents, such as “Gesundheitspolitik”, “Öffentliche Gesundheit” or “Prävention” in order to find the essential books and articles for Germany and Switzerland. To select the most important articles and books, I focused on those that make a point concerning public health policy in general, and/or with regard to the historical development of public health or health care policies. I also selected articles on specific public health issues, such as tobacco control, if they present a general contribution to public health policymaking in one of my countries or examine public health policymaking from a comparative perspective.

4.2.3 Interviews

The second source of information that I am using in this Ph.D. project are semi-structured expert interviews, which were conducted in the context of the aforementioned research project by the Swiss National Science Foundation.[11] 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 of this report. The interviews were thematically structured around two topics: public health and health care policy in general, and tobacco control policy.[12] The interviews were conducted on the basis of a guide with some basic questions/topics, which I shared beforehand with the interview partners when needed. I 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. Particularly, the interview partners came from the following groups:

1. *Ministers and members of the administration*: This group entails current and former members of the executive at different levels of government. I interviewed ministers of health, but also officers at different levels of the administration, such as individuals who worked on a specific policy dossier, but also the head of administrative units, such as public health services.

2. *Politicians*: In this group there are members of parliament who have no role in the executive or the administration, but only participate in the political process. I tried to include members of different parties, in order to cover the most important parties in the political system.

3. *Experts*: These are academics, mostly professors of medicine and public health. They work either in universities or in private health foundations, which are financed by donors.

[11]Project: *“Multilevel Governance in Health Policy: Comparing Australia, Germany and Switzerland.* Research Project funded by the Swiss National Science Foundation (Ref: 26041044). I am especially grateful to Wally Achtermann, who helped me with the interviews.

[12]The research project focused on the analysis of tobacco control policies, which means that many of the experts that we interviewed in this context knew the most about this issue. Nonetheless, we discussed public health and health care in general, and I did complementary interviews with other actors, which could provide more information regarding the relationship of health care and public health.

4. *Interest groups*: The last group of interview partners comprises of private and not-for-profit organizations, which have interests in health care and public health policies. These are individuals who work as lobbyists either in health care and public health and represent the beneficiaries or target groups of the two sectors. Naturally, they overlap with the expert group, because some professors work in health foundations, which are also interest groups.

I conducted interviews in Australia, Germany, and Switzerland, as these are the three country studies that we included in the research project upon which this Ph.D. is based on. However, while developing my argument, it became clear that in order to better understand the co-evolution of health care and public health, it is useful to include the UK and the United States as additional cases, as they cover different configurations of unified government and professionalism. Therefore, I do not have interview material for these two countries, but only secondary literature data and comparative statistical material.

4.2.4 Descriptive statistics

The main focus of this thesis is on the distinctiveness and responsiveness of policy sectors. Health policy outputs are also important, but I am not including them on a systematic basis in the historical analysis, because obtaining the information on policies only would already be a research project of its own. Nonetheless, to further buttress the qualitative analysis, I am including some statistical information, which allows me to provide additional data to support my claim regarding differences in the co-evolution of the health care and the public health sector by looking at the policy output and outcome in more recent times. Specifically, I am looking at OECD data.

I am going to use the statistical information especially in the comparative chapter, where I am particularly comparing policy outputs in the area of public health and health care for the five countries. Specifically, I am looking at the number of doctors and hospital beds for health care. On the public health side, I am including the screening for cancer, immunization and tobacco control policy. I am using these indicators, because they represent different fields of public health policy, such as risk factors and secondary prevention. On the other hand, I have decided to include hospital beds and doctors as these are the most basic indicators for health care policy. However, the policy related analyses are by no means exhaustive and robust, but they serve as a first indicator for further analysis of the health care system and public health policy output. Eventually, I am going to show some information on the evolution of life expectancy in these countries to present the policy outcome. For the dimension of policy analysis, the data stems from the OECD health database (OECD, 2013).

4.2.5 Method of analysis

The method of analysis is qualitative data analysis, which entails on the one hand the record of events (Braun and Trein, 2014), which is in this case legislation/institutionalization

of the health care and the public health sectors. On the other hand, I am looking at actor coalitions to understand which are the actors, interest groups and members of public administration, who support public health issues and bring them to the political agenda and keep them on it. To a certain extent, I am doing a thematic (Krippendorff, 2013) analysis of health care and public health topics, but rather than confining them to a certain corpus of text, I am looking at themes within the health policy agenda and connecting them to a certain group of actors in a historical perspective.

The reader might object that I could also have done other analyses, such as a more profound content analysis of a text corpus regarding health care and public health in my countries. However I decided not to do so, because in this case the asymmetry between countries, and especially between the time periods, would have been too great. This means that I would have a very sophisticated analysis for certain policies and certain time periods in a specific country, however for the rest of my analysis something like this would be lacking. More substantially, since the focus of this research project is to understand the co-evolution of policy sectors, such an analysis is not necessary and would have bound a lot of resources into an analysis of a specific point in time for a specifically short time period in one country. However I did a discourse analysis of tobacco advertising restrictions in Australia, Germany, Switzerland and the U.S. (Trein, 2014). In this paper, I am able to show that there are significant differences in responsiveness between the health care and the public health sectors in different countries. Yet for the purpose of this report, I am tracing the evolution and the coupling of these two sectors in a historical generalist and ideal-typical way for each country.

4.2.6 Strengths and weaknesses of the approach

The research design and method I am using is in some ways unusual for comparative public policy analysis. Therefore, it is necessary to underline the strengths and weaknesses of this approach. The way I am approaching this topic, namely the combination of an actor-centered approach with a historical analysis of institutions provides interesting and unique insights on the development of two related policies. With this analysis, I am able to show how the health care and the public health sector evolved over time, by taking into consideration the relation of both fields. Such an analysis could also be used to examine the relation of other policy sectors.

However, the long time period and the many countries I am looking at necessarily come along with a cost. Particularly, I am not able to assess the relationship between the two sectors in the same depth as it is usually done in comparative public policy analyses that are based on qualitative case studies. This is less of a problem with institutional distinctiveness, since institutions evolve slowly and if there are rapid changes they are hard to miss. Yet, concerning responsiveness between policy sectors, it is difficult to get an entire picture of all the important events in which private actors supported the issues of another sector, especially because my research is primarily based on the reading

of secondary literature. Therefore, I cannot give the same granular account of sectorial responsiveness as analyses of focusing on one or two public policies.

Nonetheless, due to the long time period and broad definition of policy sectors, I am able to get a good sense for the actor coalitions that connect the two sectors in these five countries. What is more, the interview-material that I have for three of the five countries helps to fill this information gap.

The information that I am acquiring through the sources presented before is not the same for every time period. Since I only have more recent interview information, there is a considerable asymmetry in my information. This can be an advantage and disadvantage, because on the one hand my 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 I lack the knowledge of my interview partners regarding the coupling of health care and public health, in the other time periods. Yet, there is no satisfying solution for this, because interview information for earlier time periods cannot be generated. In order to account for this shortcoming, I did an extensive and encompassing research of the secondary literature that is available, which I described before. I could access the necessary books for Europe and North America through inter-library loan. Regarding Australia, I had the possibility to access some additional books that were not available in Europe during a research stay at the National Library of Australia, in Canberra.

4.3 Summary

The research design of my doctoral thesis is based on the combination of a co-variational approach to case studies with a comparative historical analysis of five different countries, namely Australia, Germany, Switzerland, the UK and the U.S. 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. I selected the countries based on their configuration of the main independent variables, namely unified government and professionalism. Based on secondary literature and expert interviews, I will now examine institutional distinctiveness, as well as responsiveness between policy sectors on the actor level from a historical perspective. This allows me to demonstrate how the health care and the public health sector are coupled, but by including a focus on the interaction of actors. Policy coordination, plays a role, but it is a secondary element of this analysis. In order to understand whether differences in coupling come along with different outputs in health care and public health policy as well as health outcomes, I take into consideration statistics, in the concluding chapters of this book.

Chapter 5

UK: From non-coupling to tight coupling

I will analyze the United Kingdom for the first case study. I have begun with this country because it is the only unitary state in my sample and is therefore different from the other four countries. I selected it as a case study because it allows me to extend the test of my argument beyond federal states. As I discussed in the previous section, the empirical expectations that follow from my argument regarding the coupling of the health care and public health sectors are the following in the UK: on the one hand, professionalism is high, which means that there should be responsiveness between the two sectors. On the other hand, due to the unitary government and few veto points, both sectors should be institutionally integrated (absence of distinctiveness). Compared with the other case studies, the UK is the country for which I have less information than for Australia, Germany and Switzerland, because I made no interviews specifically regarding the UK. Nonetheless, it is an important case because it has been a forerunner for public health policymaking in other countries in this sample, especially Australia and the U.S.

In this chapter, I will analyze the co-evolution of health care and public health in the United Kingdom by discussing the historical development of both sectors' relationships in different time spans. Notably, I will analyze the distinctiveness and responsiveness of the previously defined time periods. Therefore, I will begin with the emergence of modern health policy in the late nineteenth century and then focus on the interwar period. After that, I will examine the coupling of the public health and health care sectors, during the post-World War II period, before turning to the relationship between both fields from the 1980s until today. I will conclude this chapter with a discussion of the findings' implications for my argument.

5.1 Origins of public health policy (1850-1918)

During the second half of the nineteenth century, the UK was amongst the countries that were considered as forerunners of public health legislation, especially among other English-

speaking countries, notably its former, or at the time still current, colonies (Baldwin, 1999; Lewis, 2003*a*). In addition to the aforementioned reasons, the UK is a unitary state, so it makes sense to begin the discussion of health policy in the UK for this reason. Demand for public health policies was high during this time, due to the pressure of infectious diseases and the limited possibilities to cure contagious sicknesses.

5.1.1 Integration of both sectors in national public health legislation

The UK already had encompassing health legislation during the nineteenth century. During this period, the country experienced a full sanitary reform. Specifically, a series of public health acts was passed, most of which entailed public health regulations for England and Wales. These acts governed for instance waste removal and disease prevention, sewers, housing management, vaccination and the establishment of general boards of public health (Porter, 1999, 127).[1] Based on these laws, the national government pursued a restrictive and interventionist policy with compulsory vaccinations, such as against smallpox and other transmittable diseases. Non-compliance was subject to fines. The interventions were based on the arguments of advocates for state medicine. The basic idea behind these laws was that the individual's right to die and to be sick needs to be suspended in favor of the community. Yet, these measures did not entirely eliminate infectious diseases; for instance, a number of syphilis cases were transmitted during an epidemic in 1871 (Porter, 1999, 128-129).

Doctors protested against this legislation from its outset, arguing that this intervention into civil liberties went too far. Other opponents included members of popular movements, such as the Anti-Vaccination League and an association to repeal the Contagious Disease Act. Such organizations succeeded in the repletion of compulsory legislation on vaccination of infants, as well as the legislation permitting the arrest and detention of prostitutes (Porter, 1999, 130). Yet, most of the interventionist policies in England went unopposed. The government introduced most of these policies at the end of the nineteenth century, based on the findings of bacteriological research. For example, the Local Government Act of 1875 allowed public health officers to remove sick individuals from the community and place them in homes (Porter, 1999, 134-135). The British public health system was founded upon a philosophy of economics and politics that wanted to use regulatory politics in order to improve market relations. Specifically, the goals were to reduce the mortality of breadwinners and to provide a better environment for economic growth. Yet, philanthropical and humanistic ideas were also at the core of this innovation, because the policies were also aimed at enhancing quality of life - in the sense of the time - although

[1] Amongst these acts are: the Nuisances Removal and Disease Prevention Act, 1848; City of London Sewers Act, 1848; Metropolitan Sewers Act, 1848; Lodging Houses Act, 1850; Common Lodging Houses Act, 1851; Vaccination Act, 1853; General Board of Health Act, 1854; Disease Prevention Act 1855; Metropolis Local Management Act, 1855; Nuisances Removal Act, 1860; Vaccination Act, 1861; Nuisance Removal Act, 1863; Sewage Utilisation Act, 1865; Nuisance Removal Act, 1866; Sanitary Act 1866; Sewage Utilization Act 1867; Sanitary Act, 1868; Local Government Act, 1871; and Public Health Act 1872 (Porter, 1999, 127); <http://www.who.int/bulletin/volumes/83/11/866.pdf>.

with a focus on population health (Porter, 1999, 108-109).

The institutionalization of public health continued in this spirit at the turn of the twentieth century. England and Wales were separated into local and provincial sanitary districts. In 1891, London had compulsory notification of infectious diseases, which it continued to be implemented until 1899, when a new act made the notification of infectious disease compulsory all over England. Yet, the system depended on sufficient hospital provision, whose coverage was increased as a consequence (Porter, 1999). At the same time, other public health policies entered the political agenda. Due to social surveys from London (1902) and Rowntree (1901), as well as reports about the health conditions of recruits in the Boer War, both the public and policymakers became increasingly aware of health and poverty as well as of poor health and the necessity of acting with regard to preventive health (Report of the Interdepartmental Committee on Physical Deterioration (Cd 2175, 1904) and Royal Commission on Physical Training in Scotland (Cd1507,1903)) (Baggott, 2011). Local health authorities received the rights to feed children in 1906, and the new Education Act of 1907 granted local health authorities the power to perform medical inspections. This legislation was aimed at improving children's health and welfare, yet at the same time, local authority regarding health and welfare services for children began to expand (Baggott, 2011). On the other hand, from the beginning of the twentieth century on, eugenics was used to attack "weak" parts in the population, such as mentally retarded, alcoholics and women who had illegitimate pregnancies (Porter, 1999).

Around the end of the nineteenth century, the UK's public health sector was a very important part of health policymaking. MOsH (medical officers of health) were appointed throughout the country. They were part of the public health system and essentially responsible for an effective system of prevention. MOsH were hired by the local and municipal public health services, which the national government coordinated. As a consequence, they became part of a nationally constructed, bureaucratic public health service, with a proper group of professionals. In that period, the power of the medical profession declined with respect to preventive health, and administrators' roles became more important. "An era of preventive medicine" began during that period (Porter, 1999, 137). According to Dorothy Porter, "This was a movement much broader than state medicine, outside the central corridors of power and beyond the elite province of the medical and scientific communities. It was not, however, a 'lay' organization, but was associated with the growth of prevention as a professional practice distinct from cure." (Porter, 1999, 138). Prevention efforts involved a group of doctors focusing on community health issues supported by a "community" of interests surrounding preventive medicine, communicated through journal literature and high-profile conferences, and embodied in a variety of institutions set up for educational and research purposes (Watkins, 1984; Porter, 1999, 138).

The development of this preventive sector replaced the technical philosophy of environmentalism with a more technical imperative. In 1872, the British government created a national service of doctors responsible for prevention rather than treatment who were employed by local authorities. The main goal was the implementation of sanitary legisla-

tion in lodging houses, bakeries, and other public facilities or areas that involved working with food or dairy products (Porter, 1999, 281).

At the time, health policy clearly focused on public health policies. However, following the 1904 report on physical deterioration in the British population, the national government decided to focus British public health policy more on the development of personal health services, which is a development that is similar to those in other countries (Porter, 1999). Of course, facilities and structures providing treatment for diseases had already existed during the nineteenth century, yet they were not the first priority of health policy. Nonetheless, state-funded sanatoria sought to treat and reduce some of the most pressing health problems at the time. In the nineteenth century, the first sanatorium had been created in Nordach in the Black Forest. Subsequently, more similar facilities were established in Germany and Switzerland, but only for the poor. Bryder's book shows state-funded sanatoria were hard for their inmates to endure and were more reminiscent of a Soviet gulag than a wellness hotel. Instead of comfort and warmth, the physicians in charge tried to cure patients with fresh air and hard labor (Porter, 1999, 283). In the UK, as in Germany, sanatoria were funded by the state. Despite the discovery of the disease's bacteriological origins, the methods of treatment remained the same. Some British sanatoria were built with open windows and no heating to constantly expose the patients to nature. Yet cure rates did not match expectations of policymakers and and mortality rates remained very high despite treatment in the institutions (Bryder, 1988; Porter, 1999, 284).

With the passage of the National Health Insurance (NHI) Act of 1911, which established the reimbursement of medical services, the health policy agenda moved towards individual health care. According to the law, hospitalization became mandatory for all those who were chosen by the local health officer. On the other hand, the NHI did not affect laws for the poor or maternal legislation. Throughout the first twenty years of the twentieth century, a series of new health services developed based on contributions. Most of these services were welfare oriented, which means that they provided services directly to citizens. Local authorities and voluntary organizations began to provide milk supplies and infant welfare. The community health services provided district nursing and health visits. At the same time, there was close coordination among local authorities, voluntary organizations, and self-employed individuals to provide a dense web of health services. Beginning in 1912, schools began to develop medical services, such as school nursing and dental clinics (Baggott, 2011). However, at the same time, the treatment of many diseases remained difficult, simply due to the lack of medication. One pertinent example in that regard is TB, which, despite the discovery of the disease's bacteriological origins, was only possible to treat successfully after the invention of a vaccine and antibiotic cures, such as streptomycin, in 1946.[2]

[2]In the last several years, TB returned in cases of extreme poverty and in combination with an HIV infection. The newer antibiotic bacteria have been resistant to antibiotics (Porter, 1999, 284). See also (WHO, 2014).

What does this tell us regarding the institutional distinctiveness of the UK's health care and public health sector? Public health services were introduced all over the country under the responsibility of the municipal governments. A formal institutionalization of the health care sector came later, namely with the establishment of national health insurance. Strictly speaking, health care and public health were distinct from one another, in the sense that both sectors were not integrated at the national level in the same department, although this occurred later, in 1919. However, health care and public health were integrated at the local level, because the MOsH were responsible for the provision of health services, together with voluntary organizations, and on the other hand were in charge of preventive health. Yet, an analysis also shows that public health was professionalized differently than the health care sector, which already occurred during the late nineteenth century.

The structure of the government plays an important role in the institutionalization of the UK's health care and public health sectors. Due to its rather unified government, institutions within both sectors were created through national laws. However, strictly speaking, there was no real institutional distinctiveness between the two fields before the national health insurance law passed in 1911. Afterwards, both sectors became institutionally distinctive, a situation that lasted until 1919, when the government decided to pool health care and public health together, at the cost of welfare. However, it is important to keep in mind that municipal governments and local public health services were responsible for implementing the national public health acts. Consequently, there were differences in the public health services between various municipalities. It is also clear that actors from both fields interacted with one another at the municipal level, but how did this happen at the national level?

5.1.2 Responsiveness of actors from both sectors

Judging from my reading of the secondary literature regarding health care and public health in the UK, there apparently was interaction between private actors from both sectors, however that there were both conflicts and mutual support. This becomes clear when looking at the development of the medical profession and the public health professions. Beginning in the early twentieth century, public health had been run by doctors who saw it as "state medicine" and "preventive medicine." Public health diplomas were a specialization that was only possible for doctors, but not for engineers (Porter, 1991). In 1872, there were conflicts with private practitioners from the moment when the first medical officers were appointed. The obligation to report infectious diseases put an additional administrative burden on GPs, for which they were neither qualified nor reimbursed. This oftentimes caused hostilities within the same administrative district. In the context of the new sociological environmentalism, the public health sector identified more and more groups as needy and targets for stated funded services, thereby increasingly threatening the territory of GPs (Porter, 1999, 289). Concerning public health services, in Victorian times, public health developed from a social reform movement to a civil service. The public health system was bureaucratized and medicalized. At the same time, primary medicine

and hospitalized medicine became increasingly separated in the country. Clinical care became medical science; at the same time, primary medicine was deflected to the GPs, who were no longer permitted to treat patients in hospitals (Gottweis, 2004, 72).

Overall, however, little resistance came from the medical profession regarding the creation of the aforementioned public health acts as well as the nationalization of medicine and health services. First of all, the there was a strong public health profession that was differentiated from the medical profession, which in turn defended public health against the influence of other professional groups, such as engineers. At the same time, doctors participated in the establishment of state medicine, which entailed prevention and cure, and accepted to a large extent the reduction of doctoral freedom concerning private practice (Baggott, 2011).

In 1909, a royal commission produced two reports that evaluated the relationship between health and welfare. The commission was divided between reformists and abolitionists, with regard to the relationship between welfare and public health. The majority report favored a system that would increase health care services for the poor, but integrated into the national health service. The minority report suggested pursuing labor market policies, rather than providing health care for the poor (Baggott, 2011). Consequently, a strong public health coalition supported comprehensive public health legislation. However, at the same time, the proponents of public health in the UK opposed eugenic ideas and demanded more preventive medicine for matters of population engineering. In 1910, the chief medical officer of the Local Government Board, Arthur Newsholme, argued that public health required combining measures to change domestic hygiene, as well as public hygiene education and the identification of at-risk groups. Already during the Edwardian era, public health officers began to demand the creation of a national public health service funded by taxes that should include therapeutic and preventive services administered by the local authorities. The debate about it continued during the prewar years and was partially realized with the creation of the NHS in 1946. The main problem at the time was childhood mortality, which lead to the demand of integrating health care and public health (Porter, 1999, 177). However, the National Health Insurance act of 1911 failed to achieve a unified comprehensive system of public health and health care. The national health insurance included some reimbursements, such as a benefit for stays in sanatoriums. Although the public health profession, above all the MOsH, were a professional group that clearly viewed health as determined by historical and sociological determinants, more than the biological dispositions of humans including social behavior. They did not succeed in bringing their ideas into the creation of a national public health service. The MOsH regarded the act as a major defeat, with respect to the building of a universal health service (Porter, 1999, 145).

Regarding the responsiveness between both sectors, my analysis shows that there was, above all, policy responsiveness. I conclude this from the fact that health carewhich at the time was mostly primary careand public health had been carried out by the municipal public health services, which implemented the majority of public health acts. Between

private actors, namely those from within the medical and public health professions, there were conflicts regarding public health duties and the de facto "conscription" of doctors into the service of public health. GPs opposed that they had to participate in public health services. However, at the same time they received the monopoly on public health degrees, because it was only allowed doctors, but for engineers to become a higher degree in public health. This is an indication of interest and support for the public health sector by the medical profession in the UK. However, from the information that I am presenting here, there are no strong indications of positive responsiveness from either sector. Rather, the empirical analysis shows that the interactions between both sectors conflicted regarding the roles of the health care and public health professions in the emerging field of modern health policy.

To summarize, my analysis shows that both sectors were institutionally integrated and not separate from one another, in the sense of distinctiveness, during the second half of the nineteenth century. At the time, health legislation mostly entailed public health acts regarding food safety, infections, and quarantine. On the other hand, an important legislation in the area of health care, namely health insurance, was introduced in 1911. Before that, care for the sick, such as by hospitals, was closely connected to public health legislation. Regarding responsiveness, both sectors were connected by common policies, but not so much by cooperation between the professions or other private actors between the two fields; rather, they were connected by a continuing struggle over the rights and duties of the medical profession in the public health sector.

What do these findings imply for my argument? I hypothesize that health care and public health should be tightly coupled due to the UK's unified government and high professionalism, especially when the context is favorable to responsiveness, due to the problem's pressure. My results show that my argument is correct, with regard to unified government. Health legislation in the UK has been unified, and there was no significant institutional separation between the health care and public health sectors (only after the establishment of the National Health Insurance law in 1911, but this did not last for long). Notably, health care and public health were integrated, especially because the municipal governments were responsible for both public health and primary care.

Regarding professionalism, my results are different than expected. I was right in assuming that high professionalism leads to politically active professional organizations in the health care and public health sectors. Yet, their relationship was above all conflictive, especially with regard to the distribution of the roles for GPs, on the one hand, and MOsH, on the other hand. Judging from the material I have reviewed here, their relationship was not very cooperative, despite a context that was favorable to public health and should have led to responsiveness. At the time, the medical profession was not as powerful as the public health sector is today, which is the assumption I based my argument upon. Nonetheless, the basic logic of my assumption regarding the politicization of health policy issues and the involvement by professions is right. I will now turn to the interwar period, in order to see how the relations between both sectors evolved at that time.

5.2 Cooperation and conflict in the interwar period (1918-1945)

During the interwar period, the context for the relationship between health care and public health remained in demand for public health policy. Although the aforementioned public health policies showed some success, the most pressing health problems were still infections. At the same time, however, medical technology and drugs became more fully developed, although - especially European - states still operated in a context of competition between nations. Therefore, overall, I expect that there was a demand for public health and that there should be responsiveness between both sectors' actor groups.

5.2.1 Towards more institutional integration

In the UK, health care policy had been nationalized via the establishment of the 1911 national health insurance legislation, which created a compulsory social insurance program based on contributions and provided financing for private medical care as well as sickness benefits to salaried employees. Yet, the program did not cover hospital care or services for specialists; the coverage was mostly extended to manual laborers, and low-income, white-collar workers and their dependents were not included. The fact that such an act could be passed was the consequence of the British national government's political power. Although the national state did not have the same administrative power as Germany, for instance, it was quite successful in passing national social policy legislation. For example, even before the creation of the National Ministry for Health in 1919, many civil servants in the National Board of Trade favored social policies, such as social insurance programs like health insurance. However, the law of 1911 was not the result of a large consensus, but the fact that many members of the medical profession favored employment by the state. First of all, doctors were used to interacting with the state and public officials, due to the extensive collaboration and interaction between the state and the medical profession, in the context of the public health acts. Secondly, private practicing in England was not a well-remunerated task in the late nineteenth and early twentieth centuries. Before the legislation of 1911, about 50 percent of the male population in England had membership in friendly societies that paid an annual fee per capita, per patient to doctors, in exchange for their services. Many doctors, including the medical organizations, wanted to get rid of this system and be free from the friendly societies. Therefore, they agreed to fix the system through the national health insurance legislation of 1911 (Hacker, 1998). In this sense, the national health insurance legislation of 1911 was a success for the medical associations, which wanted to have a national legislation to escape the pressure of the friendly societies (Klein et al., 1992).

The Health Policy Act of 1911 was a defining element for the national health care legislation in England until the introduction of a the National Health Service, in 1946. During the interwar and Second World War periods, the system was complemented by some laws, such as in 1929, when a national assistance scheme in the form of a medical-

tested welfare scheme had been created (Porter, 1999, 289). However, during the 1940s, the Beveridge Report created the basis for the establishment of the National Health Service, which demanded the establishment of a tax-financed welfare state in England, contrary to the German model, which entailed the delegation of tasks to social health insurances and had a large influence on the following establishment of a national public health service (Abel-Smith, 1992). As I will explain in the following chapter, how these ideas resulted in the creation of a national health service.

In order to understand the institutional integration of health care and public health in the UK, it is important to turn to the public health legislation. In the post World War I period, public health public health policies advanced, due to the detrimental impact of the First World War on public health in all countries (Lewis, 2003*a*). Aside from the medical policies discussed before, the national government invested massively in the creation of public housing, in order to provide better working conditions, especially for the poor. Under the leadership of the Ministry of Health, new legislation in 1923 and 1924 permitted the use of subsidies to improve public housing, and the state became the main provider of housing during the interwar period. A series of laws had already been passed during the First World War in order to create better housing conditions. The measures entailed a steady stream of new housing legislation, such as the Rent and Mortgage Restriction Act 1915, the Housing (Additional Powers) Act 1919, the Housing and Town Planning Act 1919 (Addison Act), the Housing Act 1923 (Chamberlain Act), the Housing (Financial Provisions) Act 1924 (Wheatley Act), the Housing Act 1930 (Greenwood Act), and the Housing Act 1935. After the heavy bombardments during World War II, which destroyed 200 000 houses and damaged more than 3 million, the Dudley Committee developed new recommendation standards for council housing, in 1944 (Stewart, 2005).

What is more, until 1929, poor laws continued to be the major form of legislation that were used to assist the poor. Only in 1929 were they replaced by public assistance committees. The reform of 1929 strengthened the powers of local health authorities with regard to public health. The Local Government Act allowed local authorities to bring poor law hospitals under the control of local governments. In addition, local governments could interfere in maternity and child welfare and TB, immunization, as well as with regard to blind people and mental deficiency in order to develop a more comprehensive public health approach (Baggott, 2011).

This brief discussion on health care and public health policymaking in the interwar period shows the increasing integration of both fields, rather than the increasing distinctiveness of the two sectors. In particular, the creation of a national ministry of health that connected health insurance as well as public health problems is a strong indicator for this. As in the previous time period, the national government passed a series of public health acts; this time, however, they were more related to housing. This trend of institutionally integrating health care and public health continued with the Beveridge Report, which demanded the creation of an encompassing national health service.

5.2.2 Professional conflicts but cooperation among public actors

With regard to responsiveness between the two policy sectors, the interwar period shows, on the one hand, the responsiveness of public health and health care profession, in the sense that doctors were favorable to the idea of public health policy, although it was not their primary domain. However, there were also conflicts between the actors in both sectors, notably among GPs and MOsH.

In 1919, the government created the Ministry of Health, which was responsible for health care and public health. Its task was to prepare, carry out, and coordinate measures that might be conducive to the health of the people. Specifically, it was responsible for environmental health, child and maternal welfare, the water supply and sanitation, housing, local government, the NHI scheme, and poor laws. Other health-related functions were in the hands of the Home Office (industrial hygiene), Board of Trade (health and safety at work), and the Board of Education (school health services). However, the Ministry of Health was responsible for coordinating all of these agencies. What is more, the law also coordinated the Education Act of 1918, which made the treatment of certain diseases, such as skin problems and dental disease, in schoolchildren mandatory (Baggott, 2011). The Ministry of Health also played an important role concerning the promotion of housing legislation. Interestingly, it was the first minister of health, Christopher Addison, who promoted housing legislation. Consequently, health generally improved during the 1920s because living standards and health care improved. Better housing and local welfare services helped reduce the rate of communicable diseases. However, the numbers of individuals who were left in poverty and trapped in poor housing increased during the Great Depression, and efforts to improve housing were largely suspended at the outbreak of World War II (Stewart, 2005).

In 1920, the Dawson Report, which was issued by the Central Council on Medical and Allied Services under the leadership of the Ministry of Health, suggested the creation of health centers that would bring together independent GPs, nursing staff, and technicians and provide access to diagnostic and treatment facilities. Although the report was never fully implemented, it had some impact, in the sense that it signaled to GPs that it was worth claiming their position in this area. Yet, conflicts between the medical profession and medical officers of public health increased during the 1920s and 1930s (Porter, 1990). Both lacked prestige, but after the introduction of the NHI, the status of the medical profession increased in comparison to the public health profession. With the outbreak of the Second World War, the latter were superior in debates, which they later managed to use in order to successfully secure their privileges with the creation of a national health service (Baggott, 2011, 46-47).

What happened regarding the responsiveness of the UK's health care and public health sectors during the interwar period? From the discussion in this section, we can retain the finding that, along with the institutional integration of both fields, the coordination activities between the two sectors increased, because the Ministry of Health was in charge

of many health care - and public health - related activities (although not all of them). Yet, this is not as evident for private actors. On the one hand, GPs were favorable to increased activity by the state in public health and health care; however, there were also conflicts with the MOsH about the direction of the national health policy, as well as struggles for influence among the professions.

What are the implications of these findings concerning my assumption that the UK is a case of tight coupling? Since professionalism and the institutions remained stable in the UK, the only reason why the relationship between the health care and public health sectors should have changed was the difference in the contextual conditions. As I argued before, the economic crisis in the interwar period should have provided reasons for conflicts between the two fields. Again, institutionally, health care and public health were rather highly integrated. The establishment of a national ministry of health and the coordination of various health policies under its leadership support my argument that the national government was favorable to sectorial integration. On the other hand, there is little evidence for professional responsiveness at the time, but rather the impression that conflicts prevailed between the two fields. Therefore, my analysis shows that during this period of institutional formation, in which different institutions emerged, there was above all a struggle between the professions regarding their place in the new order of health policymaking.

5.3 Towards responsiveness in the shadow of the NHS (1945 - 1980)

After the Second World War, the context of the relationship between the health care and public health sectors changed. Medical technology had advanced considerably, and more and more infections could be cured. This was already the case during the war, but public health remained important as long as fighting and destroying went on. Yet at the time, a century of public health policymaking had passed; therefore, the most pressing public health problems should have been solved.

5.3.1 Institutional integration through the NHS

The UK experienced a landmark change after the Second World War, namely the establishment of the National Health Service, which became the most important institution of health governance ever since then. The National Health Service goes back to the Beverage Plan of 1942. The goal of this plan was to introduce a new system of social security and comprehensive medical care for everyone and also to improve the state of the population as a whole in the long run (Gottweis, 2004). It was a system of free health care services paid by tax-like contributions. This was a critical juncture in English health care policy (Hacker, 1998), as it put the focus on individual health care, yet it clearly had the goal of improving the health of the population as a whole and preventing people from becoming sick (Webster, 2002; Baggott, 2011).

Concretely, the implementation of the National Health Service began when the Labour Party came into government, in 1945 (Klein et al., 1992). The party achieved a landslide electoral victory - the first time in its history that the party had a vast majority in the national parliament - which consequently opened the pathway for encompassing political reform, also in the field of social policy (Hacker, 1998). The establishment of the NHS is often explained as an inevitable consequence of the National Insurance Act of 1911. However, the establishment of the NHS was rather the effect of a much more consensual reply to policy formation by interest groups and policymakers, which resolved the tensions that had been created by existing policies then in Canada or the U.S. In addition, it is also necessary to mention that the law has been the result of intensive bargaining between the medical profession and the Labour Party. To transform the existing national health insurance into the National Health Service required major reform efforts. The system was founded upon an implicit bargain between the state and the medical profession, which secured for the profession its clinical autonomy and the ability to allocate resources in the state's budgetary framework. This involved the definition of spheres of authority that were based on the functional expertise and that created two parallel authority structures, of which some were collegial and some others were hierarchical. They were then brought together via "consensus management" (Tuohy, 1999, 118).

The NHS became the defining element of health policy in England since the Second World War. It underwent major reforms in 1974 and 1982, which did not change the defining of relations within the health care system at all (Tuohy, 1999).

Parallel to the transfer of health care into the hands of the public, public health policy remained important on the agenda of health policy, but with changed priorities. As discussed before, the invention and introduction of better antibiotics increased the possibility of curing diseases, especially infectious diseases. This development also shifted the agenda of public health policy. The prevention of infections, especially genital diseases as well as TB, remained an important priority for public health policy, as did immunization, such as against polio. The fact that the UK had the National Health Service made the organization of these policies easier than, for instance, in Germany, where such structures were lacking (Lindner, 2004*a*; Lindner, 2004*b*).

Apart from infectious diseases, chronic health problems and risk factors also became more important in public health policy agendas. Above all of this was tobacco control policy. The UK was amongst the countries in which the first scientific evidence had been produced regarding the danger of smoking on health. After some preliminary studies in the 1950s (Berridge, 2003),), the Royal College of Physicians published a report in 1962 that established the connection between smoking and lung cancer (RCP, 1962). However, the tobacco control problem did not immediately transfer into changes in public health policymaking. In the first phase, during the 1950s and 1960s, smoking policy was marked by the cultural normality of smoking and the scientific and governmental uncertainty about the legitimacy of the new epidemiological research concerning the risks of smoking (Berridge, 2003).

In the 1970s, these ideas began to be transferred into more tobacco control policies, based on the premise of reducing the harm and risk from smoking. The tobacco control policies largely comprised health education campaigns and voluntary agreements between the government and the tobacco industry, as well as the scientific development of safer smoking, a strategy that also won support in public health circles. Overlapping with this phase was a new activist policy agenda that directly targeted the tobacco industry and stressed the roles of the media, both as an agent of indoctrination and also as a vehicle of public enlightenment about the risks of smoking. These new policies were based on a new report by the Royal College of Physicians. Another reason for the change in tobacco control policy was the creation of ASH (Action on Smoking and Health), which was a voluntary movement pressing for stronger tobacco control policy. It was oriented based on the U.S. Interagency Council, which had been formed after some civil servants had mentioned that tobacco control policy would become stronger if some pressure groups advocated for it (Berridge, 2003).

Other preventive health policies had remained in the hands of local health authorities, which were part of the National Health Service but operated as a team of public health workers, including mental health officers, health visitors, and welfare officers, who dealt with population health issues. The reform of the NHS in 1974 shifted medical officers and mental health officers into the National Health Service. At the same time, public health medicine had been recognized by the medical profession, because the first faculty of public health was established (Orme et al., 2003).

Yet, the reorganization of the NHS pushed public health to the margins, because public health services came under the auspices of the NHS's managers, who often set priorities in the service according to budgetary interests. It was a rare case that the management personnel advocated public health policy, but rather sought employees for public health policies who were clinically trained - a practice that workers and managers in the NHS did not oppose (Hunter, 2003).

To conclude, the institutional integration of health care and public health tightened even further during the postwar period. After the First World War, both sectors were already organized under the umbrella of a national ministry of health, but they moved even closer together after the Second World War, due to the introduction of the NHS. Above all, the reason behind this institutional integration was the national government's attempt to provide a more encompassing health service. Although the GPs dominated the service and the system evolved into a national health care service, the focus on the population was an important element indeed. Prevention played a similar role, but not as implicit as health care. What is more, the NHS shows the effects of a unified government. Although the support for more social policy action was broad in the UK, it is questionable whether the creation of the service in this way would have been possible without the Labour Party's vast majority in Parliament.

5.3.2 Conflicts and cooperation between actors from both sectors

As I explained in the previous section, health care and public health were not institutionally distinct from one another. After the Second World War, responsiveness between both sectors' public and private actors, which emerged out of the conflicts, had been present around the creation of NHS.

After the war, the public health professions lacked an encompassing theory for the prevention of diseases to deal with the changing context for health policy that I discussed in the third chapter, namely the success of prior public health policies as well as the possibilities of pharmaceutical technology. Consequently, the public health profession failed to determine the creation of the NHS, and the medical profession superseded the public health profession and claimed to be better at the management of chronic disease and clinical medicine (Porter, 1999, 145). Consequently, health care policy became dominant with the creation of the NHS (Baggott, 2011).

By the time the NHS was created, deep divisions existed between the professions of the two sectors. The local public health services were part of an organizational quagmire and suffered from fragmentation and coordination problems. Although rationalization was needed, it did not successfully occur during this reform period because public health officials became lost in the problems of epidemiological transition during the after-war period and lost the opportunity to develop their professional specializations. After the establishment of the NHS, public health officers' managerial roles increased steeply. Local health officers worked greatly to coordinate an increasing range of community services, such as environmental as well as social work administration. With the emergence of community service planning in the late 1960s, the role of public health officers was replaced by community medicine (Porter, 1999, 289).

Although public health remained integrated into the NHS, health care became dominant in the shadow of an integrated health care service. Nonetheless, with regard to certain diseases, such as Tuberculosis and genital disease, the National Health Service allowed for a better integration of prevention and individual care (Lindner, 2004*b*). Yet, the institutional integration and "statization" of health care in the NHS put pressure on the actors in the public health sector. In the early 1970s, an NHS reform integrated the MOsH into the NHS and increased the administrative charges of the public health sector. Although the reform was intended to provide better integration between the two sectors, it lead to burden shifting from the "stronger" health care sector to the "weaker" public health sector. The reforms of the 1970s were the demise the Medical Officers of Health (MOsH) and integrated them more into the NHS. In 1970 and 1972, social work and environmental health were separated from the responsibilities of the MOsH, which weakened their influence. In 1974, a further reform of the NHS transformed public health into community medicine. Public health officers became community physicians. Yet, a survey of community physicians showed that about 60 percent of their time was taken up by administration (Hunter, Marks and Smith, 2010).

Whereas the aforementioned administrative coordination between both fields was not free of conflicts between the two fields, there was responsiveness between professions from both sectors in another domain, namely health research. After the war, the Institute for Social Medicine pursued research on medical and sociological questions from the beginning. At the same time, medical sociology played an important role in demographic policy and science for influencing population health and society in general. In England, this view was especially proposed by John Ryle, although quantitative positivist research had already begun to dominate the population health sciences when he died. The British Journal of Social Medicine focused on biomedical and quantitative sociological research, rather than normative sociology. This development underlines the shift in health research towards the natural sciences and an explanatory-descriptive approach; however, this did not change the fact that health research focused on problems involving population health and individual health care at the same time, and that the medical profession conducted important public health research and influenced the health policy agenda.

The most prominent example for this is smoking and health. As mentioned before, the Royal College of Physicians published a report in 1962 that showed the connection between smoking and lung cancer. In it, doctors and public health doctors pushed the government to make more public health policies, above all regarding tobacco, but also in other areas of public health (Berridge, 2003). The reorganization of the NHS in the 1960s also impacted research. In 1969, the Royal Institute of Public Health and Hygiene renamed its journal into Community Medicine in the 1970s and addressed the question of what public health and hygiene were, thereby focusing on the role of the community physician (Porter, 1999, 295-96).

To sum up, the postwar period featured conflicts and cooperation, respectively, as well as communication between the actors, especially among the professions of both sectors. There were conflicts between the professions concerning the creation of the NHS during the postwar period, but GPs remained the more powerful group in the end. Yet, there was cooperation between both fields concerning newly emerging public health issues, such as smoking. Notably, the medical profession supported and advanced health research regarding the negative effects of smoking and advocated for policymakers to account for this problem. Additionally, during the 1970s, health foundations and health interest groups such as the ASH joined the struggle for new public health policies.

What are the impacts of these findings for my argument? I have argued that there should be non-coupling between health care and public health in t2 due to the unfavorable context. Yet, independent of the context, health care and public health could be tightly coupled due to the UK's high professionalism and unified government. My results partly confirm this argument. Notably, there was an absence of responsiveness regarding the creation of the NHS, because conflicts between the medical and public health professions about the right approach to health policy prevailed at the time. Once the NHS had been created, these conflicts did not end; instead, individual health care became very dominant. Therefore, the fight regarding the correct paradigm for national health policy had

been decided. In a way, the NHS illustrates the concepts that public health reformers had put forward during the 1920s and 1930s. Notably, they had demanded an encompassing national health service that combined population health and individual health care. Such a service had been already realized in the Soviet Union before the Second World War (Tulchinsky, 1996). The English NHS was no copy of the Soviet public health service, although it resembles the general idea behind it to combine population health and individual health care, given that the UK has a strongly unified government, which allowed such an encompassing health service to be established without a long process of consensus finding.

However, there was also responsiveness between the health care and public health sectors, notably regarding tobacco control policy. Here, doctors and public health professionals not only advanced research and established scientific knowledge that smoking is bad for health, but both actors also openly advocated for the government to enact more preventive health policies, notably in the area of tobacco control policy. In that sense, the responsiveness between both sectors had been established regarding public health policy, whereas there had been conflicts regarding the NHS. Interestingly, the context plays out differently than expected in theory. I had argued that there should have been no incentives for health care and public health to cooperate after the Second World War, because the context for public health had changed significantly. My analysis of the UK shows that there were indeed conflicts regarding the NHS, not regarding public health policy, but rather about health care issues such as the NHS. This indicates that during the formative period of the NHS, conflicts appeared about basic and economically important problems from the points of view of interest groups and professions, such as who would receive the most pay and say in the NHS. Yet, the situation changed regarding risk factorrelated public health problems, and the strong health professions played an important role in politicizing important public health problems, including those in the medical profession. Nonetheless, this process within the UK occurred in the shadow of a strong, unified national government.

5.4 Towards further integration between health care and public health (1980-2010)

The last time period that I am considering for the analysis of the health care and public health sectors' co-evolution spans the time period from 1980 to 2010. During that period, the context was favorable to the responsiveness and policy integration of health care and public health because public health problems returned to the political agenda at the time. However, budgetary problems also existed, which had the potential to cause disturbances between stakeholders from both sectors.

5.4.1 Remaining institutional integration despite delegation and liberalization

The National Health Service remained the defining institutional scheme for health policy in the UK during this time period. Some attempts were made to introduce private practice and health care services in the sector during the early 1980s, and some elements of competition were introduced. There were also some debates, in which the Tories underlined that the NHS should be abolished entirely. Despite these debates and the many suggestions to introduce private and corporative elements in the provision of health, the NHS was still intact when Thatcher left office (Porter, 1999, 252-53). One of the main reform suggestions had been to introduce co-payments for health care, especially from those with higher incomes. However, such a strategy would have produced the problem that the service would still need to pay for health care among the poor and needy, which needed taxation money, but the middle class would have to pay their own health insurance in addition. After this reform idea had been dropped, policymakers suggested creating an internal market for health care measures (Porter, 1999, 255).

In the NHS reform of 1982, district health authorities (DHAs) replaced area health authorities (AHAs) (Hunter, Marks and Smith, 2010). In the reform of 1988, there was a split among departments, between the Department of Health, on the one hand, and the Department of Social Security, on the other hand (Acheson, 1988). The report by Acheson also recommended that each DHA appoint a director for public health, replace the term "community medicine" with public health medicine, and resurrect the tradition of the annual reports of the MOsH (Hunter, Marks and Smith, 2010).

In the organization of the NHS in Britain, the medical profession had a privileged role regarding the formulation and implementation of policies, together with ministerial bureaucrats and NHS managers. The governance form of the NHS was a mixture of statism and corporatism. In addition, employers in Britain played a much more important role in England than in the U.S. and Germany, because the NHS was financing health care throughout the state, rather than the employers. In the reform debate at the end of the 1980s, Thatcher argued that the system needed to change due to its inefficiencies and the very long hospital waiting lists. In conjunction with other reforms she had proposed, market reforms were at the heart of her white paper for a reform of the health system in the late 1980s. Her main idea was to create market mechanism in the system by splitting purchasers from providers. This would come alongside more primary care to save costs on hospitals and increase the centralization of decision making. In the end, the reforms entailed more centralization of powers into the NHS but limited the market reforms. Thatcher used the majoritarian system of decision making in the UK to centralize health policy even further, in order to break the corporatist power of the doctors. However, solidarity and equity had significant public support. As a consequence, far-reaching reforms to introduce market elements were not possible (Giaimo and Manow, 1999, 971-974).

Nonetheless, the idea of internal markets remained important and continued to be part

of the debate concerning NHS reforms (Gottweis, 2004; Hunter, Marks and Smith, 2010). In April 1990, the British government created, the first time since the establishment of the NHS, a contract for practitioners working in the NHS. This decision was an epochal defeat for the medical profession, which was represented by the BMA (British Medical Association) (Klein et al., 1992). The NHS and Community Care Act of 1990 established an internal market with contracts between independent purchasers and providers. Ironically, however, the independent market relationship was introduced by a hierarchical order. However, the market was established in a context of hierarchical and collegial networks in the NHS, and the state remained the dominant source of finance. After receiving power in 1997, the Labour government abolished the language regarding the internal market but kept the central features of the reform (Tuohy, 1999).

The NHS again underwent some reforms after 1997. Most importantly for this research project was the appointment of a national minister for public health. However, apart from implementing the devolution of rights to some of the provinces, there were no changes in the system as such, because the NHS was an important issue in elections for the Labour Party. Apart from keeping costs under control, one of the most important issues in health policy for the government at the time was tackling health inequalities. In addition to the Ministry of Health, the Treasury claimed this goal (Hunter, 2003).

In the period since the 1980s, public health remained institutionally closely linked to health care in the UK. The British government had already published a report on prevention and health in 1976 and the Black Report on Economic Inequalities in 1980 (Marmor and Klein, 2012; Smith, Bartley and Blane, 1990). Although policymakers largely ignored the specific recommendations of these reports, such as those from the Black Report (Marmor and Klein, 2012), public health policies returned to the political agenda. In 1984, Liverpool produced one of Britain's first regional reports on public health. Moreover, a new public health movement created in Great Britain during the mid-1980s was aimed at combining environmental health and public health medicine. In 1987, the Public Health Alliance published a charter for public health, which included the importance of societal and environmental factors for public health policy; however, the Thatcher administration widely ignored these issues. "New Public Health" (See chapter 3) issues became part of the political discussion, yet it took more time until these matters were implemented (Hunter, Marks and Smith, 2010)

The appearance of the AIDS epidemic in the 1980s was another major issue that helped to re-shift public health issues to the political agenda. With regard to AIDS, the public health lobby followed some newspaper stories in tabloid papers that pressed the government to take action in this matter. The presence of AIDS was mainly confined to the greater London area. It was after 1986 when the national government became aware of the increasing number of infected and took action by launching a public education campaign and investing into research on the disease (Fox and Klein, 2012). AIDS was a return of the plague, but it was been regarded as a plague itself and came along with health-policing interventions (Porter and Porter, 1989). As with smoking, epidemiology

played a crucial role for combatting the disease (Porter, 1999; Gottweis, 2004, 302-03).

Public health policy changed in many ways when Labour took over power and entered government in 1997. Firstly, the required qualifications for obtaining a post in the public health sector changed. Prior to 1997, a medical qualification had been required to occupy a senior post in public health within the NHS. After 1997, the Labour government announced its intention to strengthen public health and open positions in the field to individuals with a variety of different professional backgrounds (Evans, 2003). Secondly, the Labour government published a series of public health strategies. These entailed the 1998 Acheson *Independent Inquiry into Inequalities in Health* an a new public health strategy in 1999 entitled *Saving Lives: Our Healthier Nation*. In 2000, the new Health Development Agency had been set up, with the goal of strengthening the evidence base of public health, as was a new NHS plan that criticized the limited focus on public health within the NHS. National health targets came out in 2001; the House of Commons Select Committee published a report criticizing the government's emphasis on public health. In addition, the chief medical officer of the NHS published two reports, one concerning the tackling of health inequalities, which was a consultation document, and a second document entitled *Vision to Reality*, which was a progress report regarding the tackling of inequalities. Eventually, the Wanless Report on future health trends and inequalities was published in 2002, stressing the connection between health and economic benefits (Hunter, 2003). These reports exemplify the renewed focus on public health policy, as well as the shift of policy sectors towards more sectorial integration, such as joined-up government and whole of government literature (6, 2004; Bogdanor, 2005; Christensen and Lægreid, 2007).

5.4.2 Policy instead of professional responsiveness

In the UK responsiveness of both sectors has increased since the 1980s. On the one hand, this occurred with respect to the interactions among actors when occupations other than only doctors were also involved in the public health sector, as discussed before. For instance, doctors have supported significant amounts of research in public health and the government has invested into public health research from a general perspective, including in health care and public health. One example of this is the research by the Marmot Commission, which had produced large reports on broader sociological causes of public health problems (Int-Ger-7).

However, judging from the secondary literature material that I have reviewed for this research, there was responsiveness between health care and public health, but only on behalf of political and administrative activities. The government demanded information regarding public health issues on a large scale and consequently initiated research and pursued further policy integration among both fields. For example, the increased public health activity of the national government coincided with the publication of the already mentioned Acheson Report (Acheson, 1988). One of the report's recommendations was that each public health authority should independently appoint a public health director, who would be chief medical advisor and set the agenda for the control of communicable

diseases and policies regarding prevention and health promotion. In his role as chief medical officer for England, Donald Acheson shifted the definition of public health towards a more population health approach, which had become dominant in the postwar area. He underlined the cross-sectorial aspect of public health by insisting on the importance of the connections between many policy sectors to create public health policy effectively. The publication of the first report on the health of the nation in 1992 underlined this development even further (Orme et al., 2003).

On the other hand, the inclusion of public health and especially health inequalities into the National Health Service, as discussed above, increased the political integration of health care and public health. This development had already begun with the *Health of the Nation Strategy* (1992-1997). With the election of the Labour government in 1997, the turn towards a new public health increased even more. It replaced the *Health of the Nation Strategy* by a new public health strategy involving new public health activities focused on inequality. Lead by Donald Acheson, a new inquiry into health inequalities made a new plan to reduce inequalities in public health (Hunter, 2003). The 1997 white paper entitled *The New NHS* demanded the establishment of 481 primary care groups and local authorities, with the statute of local authorities (which later became primary care trusts), and a minister of public health was appointed (Hunter, Marks and Smith, 2010).

Although the institutional connection between health care and public health in the NHS created some problems between community physicians, who were concerned with the health of the population as a whole, and medical practitioners, who were interested in individual health care, this approach allowed for a debate on health policy that was much more integrated than those in other countries. Some of the main criticisms were that the NHS was mostly concerned with health care services and that community physicians were relegated to managers in the public health service (Hunter, Marks and Smith, 2010). Nonetheless, this close connection between both sectors has had a positive effect on the adoption of public health policies, such as on tobacco control, which profited from the centralized authority in health policy as well as the powerful public health coalition (Berridge, 2003; Raw and Joossens, 2010*b*).

To conclude, based on my analysis of the secondary literature, the responsiveness between health care and public health became visible regarding policy integration, namely that the government pursued more encompassing public health policies, notably those that targeted health inequalities. On the contrary, my results do not show strong evidence for the responsiveness between the professions and interest groups that are parts of each sector. The evidence for responsiveness between them is rather indicative. Public health activities like the Acheson report and the establishment of a minister for public health did not cause opposition by the medical profession. Yet, I do not have strong evidence that these actions overtly supported the "public health turn" in English health policy.

What are the implications of these results for my argument concerning the relationship between health care and public health in the UK? I expected tight coupling due to the country's unified government and high professionalism, along with a favorable contex-

tual situation. Regarding this time period, I conclude that there has been tight coupling between health care and public health. On the one hand, both sectors remained institutionally integrated and there was even a minister for public health at times (although there was no large departmental reorganization). On the other hand, concerning research and development, both sectors responded to one another, especially regarding the renewed interest in public health issues that also extended to the medical profession. The findings of my last section confirm my hypothesis for the UK, to a certain extent. I have stressed the importance of a unified government before, in my discussions at the ends of the preceding sections in this chapter. What is interesting this time, however, is the role of the professions. Although they are strong and politically active and voice the interests of their members, the "state" - notably, a unified government - is important for understanding the members' limited role. Although t3 clearly entails a shift towards a favorable context for public health policy, responsiveness between professions did not play an outstanding role; rather, the stronger demand by policymakers for more public health research and more integration of health care and public health policies played a larger role, despite the fact that the UK has a strong and politically active medical profession.

5.5 Discussion

In this chapter, I examined the co-evolution of health care and public health in the UK. I will now review these results and discuss them with regard to my argument. Table 5.1 shows the co-evolution of the health care and public health sectors in the country. Thereby, the results show how the relationship between both sectors changed and co-evolved over time, from the dominance of non-coupling to tight coupling over the time period under observation in this thesis. Both sectors were non-coupled during the first time period because, on the one hand, unified government led to the institutional integration of both sectors, as expected. Yet, despite the favorable context, there were mostly conflicts between the professions of both sectors. During the second time period, both sectors remained mostly non-coupled. In 1911, a national health insurance had been created, and in 1919, the government established the National Ministry of Health, which was responsible for public health services and the national health insurance. This structure remained intact until the creation of the NHS in 1945. However, regarding responsiveness, there were was a consensus concerning the establishment of the public health acts as well as of the national health insurance. Yet, conflicts remained between the public health and medical professions concerning the role of each profession in health policy in general, as well as about particular reforms in national health policy. The idea of a common NHS that combined prevention and cure was considered a feasible political option at the time. Whereas GPs opposed such a service, public health professionals regarded it as a necessity, so conflicts arose around the setup of this service. However, both the public health and medical professions opposed the idea that public health policies should be based on eugenic ideas of population engineering by means of public health policies.

The conflicts between the professions during the interwar and Second World War periods ended with the establishment of the NHS, which also enshrined the dominance of the medical profession over national hygienists. However, the service takes a distinctive public health perspective, as it focuses on the provision of population health, yet primarily by means of individual treatment. The presence of such an institutional framework, however, made it easier to organize public health campaigns and support the municipal public health services. Since 1945, the NHS has remained the most important health policy institution in the UK. The 1974 reform of the service connected the public health services even further to the NHS. Although the coordination between health care and public health came along with conflicts between the professions at times, overall the coordination between health care and public health functioned rather well. What is more, concerning new public health policies, such as for tobacco control, the medical profession had an active role in providing research on tobacco control, but also for publicizing its findings and demanding more tobacco control policies, along with public health groups.

During the fourth time period, health care and public health became even more tightly coupled. Public health was again reinforced after Labour came into power in 1997, but with a distinctive focus on social inequalities. Aside from the institutional integration of both sectors, there was responsiveness among the actors, in the sense that the medical and public health professions were both interested in and occupied with public health issues. However, the national government takes the most visible role in pushing public health problems back to the political agenda. For example, the priority of public health research can increase, which we see from the frequent reporting on public health, such as the results of the Marmor Commission. This has clearly had a visible impact on health policymaking, which becomes shifted back to public health policy and integrates prevention and cures in health policymaking. However, in this last time period, the responsiveness between both sectors was above all due to policy integration and less so due to the interaction between professional actors.

5.5.1 Unified government and professionalism in the UK

What are the implications of these findings for my argument? I hypothesized that health care and public health are either tightly coupled or non-coupled in the UK. Generally, the chance for tight coupling between sectors is high in the UK because of its high professionalism and unified government. In combination with a favorable context for sectorial integration, there should be tight coupling between both sectors. To what extent do these expectations hold, in light of my results?

Concerning unified government, my findings are clear and support my prior argument. Specifically, my results show that health policy was an important task of the national government throughout the entire time period that I observed. The UK's strong national government was a constant element, from the public health acts in the nineteenth century, the national health insurance law in 1911, and the creation of the NHS, as well as the 1980s, which was a period of delegation and liberalization of public health services.

Table 5.1: Co-evolution of health care and public health in the UK

Time / Country	1880-1918 *(t0)*	1918-1945 *(t1)*	1945-1980 *(t2)*	1980-2010 *(t3)*
Coupling	*Non-coupling (Tight coupling):* Integration of both sectors through national public health acts; national health insurance legislation; conflicts between the medical profession and MOsH regarding their respective roles in health policy; policy integration in public health	*Non-coupling (Tight coupling):* Further institutional integration in a national Ministry of Health; conflicts and between actors of both sectors continued; agreement in the refusal of Eugenics	*Tight coupling (Non-coupling):* Continuing integration in NHS; dominance of individualized medicine; responsiveness among professions between both sectors	*Tight coupling:* Integration of both sectors; Public health focused on social inequalities; professional responsiveness, but above all policy integration of both sectors
Professionalism	Health care and public health became strong and politically influential professions that were very active	Doctors consented to the national health insurance legislation, as seemed it to improve their situation; conflicts between national hygienists and BMA regarding a national health service	Dominance of medical profession over public health; strong support from doctors for public health	Large public health coalition consisting of the medical profession and public health actors
Unified government	Westminster parliamentarian system; Strong role of central government; no member states; municipalities played an important role for the implementation of public health policies	Westminster parliamentarian system; national level dominated in health policymaking	Westminster parliamentarian system; national level dominated in health policymaking	Westminster parliamentarian system; national level dominated in health policymaking
Context	Infectious diseases; nationalism and colonialism → competition with other nations	Impact of the first World War; eugenics	Success of prior public health policies; pharmaceutical advancement; turn towards individual health care	Non-communicable diseases; risk factors; return of infectious diseases; international public health paradigm

At no point in time was there ever a serious discussion to disintegrate health care and public health entirely, either due to a privatization of health care services or because of a delegation of public health services to the municipalities. These results confirm the findings of other research on health care institutions. Especially during the second part of the twentieth century, health care institutions are said to have evolved by institutional drift (Hacker, 1998; Hacker, 2004*b*). My results show that this was also true for the institutional relationship between health care and public health. Although public health policies were added as layers of new legislation, depending on the most pressing public health problems, they remained closely linked institutionally with the NHS and the national ministry of health (although there were of course slight changes, there were no fundamental reforms). Similarly, the fact that a strong national government leads to more unified and comprehensive public health policies is a finding that confirms prior research on public health (Albaek, Green-Pedersen and Nielsen, 2007; Mayes and Oliver, 2012; Oliver, 2006; Nathanson, 2007).

However, my research provides new insights regarding the role of the professions. I hypothesized that strong professionalism leads to responsiveness among actors from both sectors as well as policy integration, especially in times when the context is favorable and demands such action. My results partially confirm this hypothesis. I find clear signs of professional activism in politics showing that the medical profession and also the public health profession (although it is a smaller and less differentiated profession than the former) are politically active. This means that my argument is partly right, namely that high professionalism leads to more political activism among professional organizations. However, it does not always lead to more responsiveness, even though I expected this to be the case. In a nutshell, my results show that conflicts between the professions of both sectors prevailed during the first half of the twentieth century, whereas this changed after the establishment of the NHS. From the turn of the century until the end of the Second World War, there were conflicts about the formation of health policy in general and the distribution of resources. This changed during the postWorld War II period, when the medical profession began to take new public health problems into consideration, such as tobacco control policy, and the medical and public health fields converged. There was some degree of responsiveness between the two sectors beforehand, but this was mainly responsiveness through policy integration.

The third explanatory elements that I presented in the theoretical chapter were contextual. I argued that the context was very favorable for sectorial responsiveness during t0 and t3, but less so throughout most of the twentieth century. Health care and public health should be non-coupled, especially during the post-Second World War period, because there are few incentives for sectorial responsiveness and the integration of health care and public health. Yet, my results also show a different picture in this case. Rather than following changes in the contextual demands, the health care and public health sectors co-evolved in a different way than expected from the discussion of the context. I expected to find more responsiveness between interest groups and the professions of both

sectors, especially during t0 and t1. On the other hand, during t2, I expected to find less responsiveness. My assumption regarding the context was only entirely correct concerning t3. These results show that the contextual elements played out differently than expected. They do impact the policy output, but not necessarily the relationship between the professions of both sectors, which I defined as a necessary condition to determine the form of coupling that is present.

5.5.2 Competing explanations

How can I explain the aforementioned differences between my theoretical expectations and the parts of the results concerning the coupling between the health care and public health sectors? In the following, I will put forward two competing theories that might help to illustrate the evolution of the coupling of the health care and public health sectors.

1. *Complementarity:* In chapter two, I discussed the literature on historical institutionalism and presented four empirical implications of the theory for the coupling of the health care and public health sectors. Amongst these, one element is particularly interesting for understanding the co-evolution of the health care and public health sectors, namely the theory of institutional complementarity. Thereby, one assumption of this literature is that institutions emerge rather randomly and not in coordination with other institutions. However, institutions evolve towards complementarity over time because they improve their combined output for society through learning and increasing coordination (Yamamura and Streeck, 2003; Crouch et al., 2005). This insight is important with regard to the co-evolution of health care and public health in the UK. Indeed, the creation and implementation of health care and public health legislation did not occur as a part of major plan from the outset, but as a reaction to the most pressing health problems and technological possibilities at the time. Specifically, the first public health laws emerged in the late nineteenth century, and health care legislation followed in the early and mid-twentieth century. Subsequently, professions and other private actors fought for their place in these new institutions and for their share of the "cake," rather than only cooperating regarding the combination of both sectors, when the context demanded this. According to my results, it seems rather plausible that the co-evolution of the health care and public health sectors followed the aforementioned logic of complementarity. In particular, health care and public health were differentiated from one another during the early time periods and became more specialized. After that, interest groups and professions in each sector sought their place within the institutional development and the emerging and differentiating modern state. Eventually, the NHS created an institutional equilibrium between health care and public health, which can be seen as the result of the preceding conflicts and developments, rather than as one contingent event. The responsiveness between health care and public health began to increase during the postwar period, as I expected theoretically, and the strong medical profession

in the UK contributed to cooperation between both sectors. Since the emergence of the "new public health" in the 1980s, learning and the coordination between health care and public health increased in the UK, mostly due to the activities of the professional community. In that sense, the co-evolution of health care and public health followed a similar pattern as described by the literature on the complementarities of capitalist institutions. Institutions within both sectors emerged rather randomly; throughout their evolution, they adapted to one another and learning and coordination increased.

2. *Policy learning:* These findings point to another field of literature that is important for the understanding of public policy, namely contributions regarding policy learning (Bennett and Howlett, 1992; Gilardi and Radaelli, 2012; Hall, 1993; May, 1992). In particular, these authors reflect on how innovations and new ideas enter the political process and become part of public policy. The results of my analysis show that the relationship between health care and the public health sector, as well as the evolution towards sectorial complementarity, entails a process of policy learning. The strong politicization of health professions that became apparent in the co-evolution of the health care and public health sectors shows that high professionalism comes along with more policy learning and therefore better policy integration. This is particularly the case regarding the tobacco control policy in the postwar era and the new public health, as of the 1980s. Public health policy in its broader sense played an important role during this period, and the medical and public health professions both contributed to lifting these issues into the political agenda. This implies that there should be less policy learning in countries with low professionalism, especially regarding tobacco control policy and new public health.

These two explanations stem from different political science theories from the insights I advanced in my main argument. In particular, the way health care and public health co-evolved resembles the institutional complementarity found in the literature on capitalist institutions. What is more, this case study also underlines the importance of policy learning, which comes along with high professionalism. It will be interesting to observe this development in the following chapters in order to generate more encompassing insights.

5.6 Summary

In this chapter, I analyzed the co-evolution of the health care and public health sectors in the UK, based on an evaluation of the secondary literature. I selected this country because it has a rather unified government and high professionalism, and I therefore expected tight coupling, in case the context is favorable to sectorial responsiveness. My results confirm my first hypothesis that unified government leads to the institutional integration of health care and public health, which remained constant over time. However, the link between the professionalism and responsiveness of the policy sectors only holds for the second part of

the analysis, namely the postwar period. It was only during the Second World War when the responsiveness between actors, notably the professions, increased. Similarly, the context also did not impact the findings exactly as I hypothesized. In particular, the economic dimension was dominant and caused conflicts between the professions of both sectors, even when the context was favorable to responsiveness and integration. This becomes apparent in the first two time periods, when there were still struggles regarding a national paradigm of health policy. However, this changed after the NHS was introduced, after which the responsiveness between the professions and public actors in the UK increased considerably. My results show that there are two further theoretical dimensions that are important for understanding health care and public health: institutional complementarity and learning. The former becomes apparent in the co-evolution from non-coupling to tight coupling over time, which shows that there was increased interaction and cooperation between both fields, in comparison to the first two time periods, when conflicts dominated. Policy learning is the second element that comes along with high professionalism, namely that innovations enter the political process quickly and without being filtered as much by partisan conflicts. In the following case studies, I will put my main argument and the aforementioned competing explanations to further tests.

Chapter 6

Australia: Loose and tight coupling of health care and public health

The next chapter of my empirical analysis deals with Australia. As discussed before, I selected this country because it has high professionalism and a unified government, and it therefore should also have tight coupling between health care and public health. However, Australia is different from the UK, notably because it is a federal state. The formation of Australia as a national state occurred in 1901, at a time when other countries already had modern and differentiated national governments. Apart from the lateness of its nation-building, Australia is also different from the UK because it has a second chamber, the Senate, in which the states and territories are represented. Therefore, this chamber can take the role of a counter-majoritarian institution. Something similar is lacking in the UK. However, there are a number of reasons why it makes sense to treat Australia as part of a similar category to the UK, although it is a federal state. Firstly, Australia's party and electoral system is similar to the UK (although there has been proportional voting for the Senate since 1948). This means that there is always one party with a majority or only a small coalition partner in the first chamber (House of Representatives). The government always controls the lower chamber and, consequently, agenda-setting therein. Therefore, it makes sense to regard Australia as a case of unified government, because the House of Representatives functions according to the Westminster system. What is more, Australia's colonial administration and policymaking resemble the British system of centralized government considerably.

In this chapter, I will analyze the co-evolution of the health care and public health sectors according to the same system as in the previous case study. I will begin with the period after 1850, before turning to the interwar sequence - the time after the Second World War - and conclude with the "new public health" era after the 1980s. Additionally, I would also like to remind the reader that I have more information available for the Australia case than for the UK, because I can base this case study on the aforementioned

research project and the interviews and materials that I acquired in the course of this research.

6.1 Loose coupling in times of sectorial emergence (1850-1918)

During the late nineteenth century, health policy in Australia was a matter of the colonial governments, which "came together" into the Australian Commonwealth, in 1901. The colonies were originally founded as penal colonies of the British Empire, and their governors had considerable discretion, which they used to intervene in all matters of public interest, including health, when they deemed it necessary. During this period, my contextual expectation was that the context was positive for responsiveness and policy integration of health care and public health. I could not uphold this expectation in my case study regarding the UK. In the following, I will examine the same hypothesis for Australia.

6.1.1 Differentiation in colonial times

To understand the emergence of health care and public health as two related but distinctive policy sectors in Australia, it is necessary to begin the analysis in the middle of the nineteenth century. At this time, population- and individual-based health policies were similarly important, as the predominant disease pattern made this necessary and the respective medical supplies were not available. In the nineteenth century, health policymaking in Australia was, above all, public health policymaking. As the overview in the appendix of this thesis shows, the colonies and, later on, the national government passed a series of public health acts that focused on population health issues.

Thereby, Australian policymakers and interest groups oriented their actions by the public health tradition in Great Britain. Public health legislation emerged in England during the late nineteenth century, specifically taking on two dimensions. On the one hand, it entailed actions to control disease by policing and isolating risk groups, which were essentially the poorer parts of society, and on the other hand entailed a more progressive approach aiming to generally make society a fairer place by investing in programs to adjust living conditions. Edwin Chadwick, who was a very important public health theoretician and had significant influence on the British public health legislation, supported the reactionary health policing approach (Ross, 1991). Friedrich Engels and Rudolf Virchow, on the other hand, supported the more progressive approach to public health in the nineteenth century. Engels' analysis of the working-class living conditions in Manchester during 1844 (Engels, 1993), as well as Virchow's research on workers' conditions in Silesia, in which he argued that environmental and political factors affected the poor condition of workers health, influenced on the emergence of health policy in England, and subsequently in Australia (Virchow, 1848; Bryder, 1994).

Britain's influence on health policy in Australia also extended to the medical area,

as many doctors pursued a post-graduate education in Great Britain. At the same time, British experts were present when the Australian government wanted to pursue reforms (Bryder, 1994). Concerning the place in the sense of geographical location, Australia was special in the sense that there was a great absence of many of the health problems in the old world, especially in Great Britain. Writers praised Australia for having a very healthy climate and it had a reputation of being an easy place to find work. The tardiness of public health reforms compared to Great Britain cannot be explained by a lack of knowledge, but by the failing acknowledgement of health problems. Since the colonial governments wanted to attract more new settlers, they ignored everything that would have been an obstacle to that, including health warnings and regulations (Bryder, 1994, 272-273). However, once introduced, public health legislation was similarly to the British Public Health Acts (Woodruf, 1984; Curson and McCracken, 1989), yet with the exception that the responsibility for administering public health laid with the central colonial boards of health rather than the local health administration. This was the basis for the strong involvement of state governments with public health after the creation of the Commonwealth of Australia in 1901 (Baum, 2008).

Of what nature were the aforementioned public health reforms and how did they relate to health care and public health? As I will explain in the following, during the pre - World War I period, there was no national institutional framework in Australia to connect health policy, including health care and public health, between the colonies. Health care and public health were rather institutionally separated, as individual care occurred through private organizations and provisions.

The first public health legislation mainly entailed quarantines and vaccinations; however, the first public health board established in Victoria had rather advisory roles. Yet, even before the beginning of immigration in the early 1850s, the fear that cholera would strike - like in Britain during the 1830s and 1840s - made fears of plagues arise. Policy-makers were afraid that large cities, such as Sydney and Melbourne, would be too dirty and suffer epidemics, as had occurred in other parts of the world, such as in Mauritius and New Orleans.

The Victorian Central Board of Health was created in 1854. Due to the many immigrants, the authorities had become very concerned with a possible increase in infectious diseases (Lewis, 2003*a*). In 1872, Queensland passed a public health act as a reaction to the smallpox epidemic in NSW. Other states followed until the end of the nineteenth century. Health legislation mostly originated from acts against specific infectious diseases and was then followed by comprehensive public health acts (Lewis, 2003*a*, 71). Along with the discussed public health acts, infrastructure was built to push back infectious diseases. For instance, in Sydney, epidemic measles and scarlet fever in the 1870s, as well as typhoid in the 1880s, had led to the creation of a sewage system. The return of the plague in the early 1900s turned the focus towards garbage disposal and its regulation.

At the beginning of the twentieth century, legal enactments concerning food safety were passed by state legislators. Again, the most populated states - New South Wales

and Victoria - took the lead and then other states followed. New South Wales passed its comprehensive Public Health Act in 1896, while Victoria passed the Meat Supervision Act in 1900 and the Dairy Supervision Act in 1905. Sanitary examinations commenced during the same decades, such as check-ups of dependent populations like schoolchildren (Lewis, 2003*a*; Lewis, 2008).

In 1889, Victoria passed an amendment to the Victorian Public Health Act creating a public health department responsible to a minister and increasing penalties for offenses against the existing public health legislation. The creation of the board clearly followed the ideas of the municipal officials who were important in the English public health system. As in Great Britain, disease reporting was also part of the public health system. For instance, South Australia created a mandatory reporting system for various diseases in 1898 (Lewis, 2003*a*). The public health campaigns of the 1870s90s also entailed measures regarding excessive drinking and youth smoking, such as cures for addictions. For instance, Victoria introduced legislation to provide medical treatment for addicted patients in 1872 (Lewis, 2003*b*). A the turn of the twentieth century, all Australian colonies had passed public health legislation in the English Style. One problem was the lack of administrative skills, resources as well as the opposition in the colonial settlement against strong involvement from the center. Consequently, health policy was controlled from each colony's central administration, which imposed preventive health policies (Lewis, 2003*a*).

Whereas these acts and legislation connected prevention and primary care for some problems, such as excessive drinking, health care was organized differently at the colonial level and was not under the same institutional umbrella. The individual-focused health care system, which plays the most important role in today's health policies, was different at the time and much less developed than today. Until the First World War, the Australian health care system had three pillars: 1. Charitable hospital care for the indigent population; 2. Contract practice through friendly societies for the provident working and lower-middle classes; and 3. Private fees for services for wealthy patients. The system was under stress after WWI, when a reform debate began (Lewis, 2003*a*).

Overall, most of the health legislation in the early twentieth century continued to regulate population-based health policies. For instance, the Health Act of 1900 created the position of a Commissioner of Public Health in Queensland and Western Australia, again due to dangerous infectious diseases, such as a plague epidemic in Western Australia. In 1903, a smallpox outbreak provoked the modernization of the public health administration in Tasmania, and in 1907, the commonwealth (CW) requested that all states carry out uniform physical examinations of all schoolchildren (Lewis, 2003*a*). The creation of the commonwealth in 1901 was an important date in Australian history and shaped the health policies in the following period, thereby increasing the nationalization and centralization of certain health policy areas. Yet, until the early twentieth century, policies and institutions of health policies were located at the colonial and state levels, respectively, which were the dominant actors in health policy.

To sum up, health care and public health were institutionally distinctive at the time.

This holds from a national point of view, because health policy was primarily public health policy. Individual health care was, for the largest part, privately organized at the time and separate from the institutions of the health care sector. What is more, we can also refer to institutional distinctiveness, with respect to the differences between the colonies and the fact that there was no common institutional framework of national health policy at the time. I will discuss this in more depth after analyzing actor responsiveness during the first time period.

6.1.2 Actor responsiveness between the two sectors

In 1872, the first association of health officials was founded in Victoria, which essentially was the forerunner of a public health professional organization. In 1889, Victoria began to appoint health professionals to the Department of Health. Six years before, the University of Sydney had appointed its first lecturer in preventive medicine, which indicates the emergence of a public health profession. In 1906, Melbourne followed suit and began to offer a post-graduate diploma of public health. Before, in 1897, a public health laboratory had already been established in the University of Melbourne. In 1896, Ashburton Thompson was appointed as the first public health doctor with modern qualifications in NSW. He was among a group of public health specialists who were trained in Britain and then came or returned to Australia, and he was involved in the drafting of various public health acts. Thompson is important because he was politically very active, had excellent international contacts in the public health scene, and served as a mentor and teacher for other public health officials. There was a similar development in other states, such as in Southern Australia, where the medical profession demanded a reform of the reporting system for infectious diseases, as well as increased powers for the central health authorities. In 1900, the city of Adelaide appointed its first health professional; other states followed soon thereafter. During the first years of the nineteenth century, local governments and health authorities employed the first official health visitors, who began to individually consult patients in order to teach them about healthy behavior and prevent diseases. This was adapted from the British model. Later, Australian officials became public health nurses in the fields of infant health, school health, and tuberculosis. During the First World War, the demand for health care and public health professionals continued to increase among wounded soldiers and invalids, as well as for treatment and prevention of communicable diseases among returning troops (Bryder, 1994; Lewis, 2003*a*).

The medical profession as well as non-governmental organizations (NGOs) played an important role in health policy during the nineteenth century, and the health professionsespecially the medical professiongained more influence in the late nineteenth to early twentieth centuries. Thereby, these professionals explicitly demanded more public health policies. For instance, from 1850 to 1950, friendly organizations provided assistance with financing health care for poorer people. Under contract, these organizations provided a limited range of medical care through medical practitioners under contract arrangements. Eventually, they became registered and ceased their contract practice. Since the late nine-

teenth century, governments at the national and state levels relied heavily on the support of volunteer organizations to cure drinking problems. For instance, the Victorian government established Lara, a retreat for male drunks, whereas there was a Salvation Army facility for women. Until the early twentieth century, NGOs played a significant role in the provision of health, individual care, and public health. However, this began to change at the beginning of the early twentieth century, when the British Medical Organization (BMA), under which doctors in Australia were organized, had almost achieved an autonomous state as an organization. Moreover, it had won control over health care from druggists and "quacks." Only a few medical graduates and immigrants entered the public services, which only employed a few health officials to keep expenditures down. Campaigns against diseases were often inefficient, as not enough doctors were involved. In this situation, doctoral organizations and public health boards argued in favor of more public provisions, which were seen as the path to the nationalization of medicine (Lewis, 2003*a*).

During the late nineteenth century, actors from both sectors were responsive to one another, especially because there were two different professional roles: doctors, in the sense of GPs, on the one hand; and public health officers, on the other hand. Both camps agreed on the health policy agenda and provided mutual support, such as when doctoral organizations advocated for public health measures. The presence of medical officers of health (MOsH), who were trained in the universities in Sydney and Melbourne, as well as previously in England, increased the public health sector's professionalization and formed a distinct actor coalition to demand more public health interventions. The medical profession was very open regarding public health legislation, such as sanitary measures. Other actors joined the coalition for more state intervention in health policy during the recession and great strikes of the 1890s, which brought "middle-class liberal reformers and the Labor Party into a pragmatic alliance to achieve social justice through such [public health] intervention" (Lewis, 2003*a*, 140).

Notably, these developments occurred in the context of problematic infectious diseases and ideas concerning public health policies. Infectious diseases were an important problem at the time. News about cholera in England, the U.S., and other colonies sparked fears of a spread into Melbourne and initiated public health legislation. The spread of smallpox through NSW was an important trigger for new public health legislation in New South Wales. In 1900, bubonic plague arrived in Australia, which became the critical juncture for sanitary reforms in many states and sparked many public health activities, such as the "crusade of cleanliness" in Sydney (Lewis, 2003*a*).

To conclude, this examination of the responsiveness between the health care and public health sectors shed light on the relationship between the actors of both sectors. My analysis shows that there was indeed a coalition of doctors and public health reformers that demanded more state intervention to improve public health. In Australia had a number of public health officials and doctors who had been educated in the UK, but returned to Australia and tried to implement public health policies there.

What do the results of the two preceding sections imply for the argument that I made

before? I proposed that Australia is a case of tight coupling between health care and public health because professionalism is high and the government is unified. Beginning with the latter case, the results are clear: During most of this time period (until 1901), Australia was no nation state and had no national government. Therefore, the institutional integration of health care and public health at the national level was impossible. Yet, looking at the colonies, we neither find clear integration of health care nor public health with public policy. The reason for this is simple: At the time, what we would describe as health care policy was a private service that doctors provided, and friendly organizations supported patients financially. Concerning responsiveness, first of all, the professionalization of health happened in a similar manner to that in the UK, and doctors were a strong profession. At the same time, public health reformers and the medical profession played an important role in politicizing public health problems and demanding more public health action. Therefore, they mutually supported the agenda of the other sector, notably that doctors make demands regarding public health issues. Indeed, in Australia, this time was a period of state formation and the creation of political institutions of the modern state, including public health services. Since the national government only emerged at the beginning of the twentieth century, the state was not very strong and professions and interest groups (including public health officials, which the state had hired) played an important role in demanding more public health policies. In this situation, the context indeed played out as I expected it to before, namely that health care and public health actors show responsiveness in times of threatening infections, limited medical possibilities, and competition between nations.

6.2 Nation building and the integration of health care and public health (1918-1945)

The second sequence regarding the co-evolution of health care and public health covers the interwar period. During this period, the context changed and the global economic crisis and improvements in the possibilities of medical care should have reduced incentives for actors from both sectors to cooperate with one another. At the same time, there was still a competition between nations, which I expect gave high priority to public health policies, including among interest groups.

6.2.1 Towards institutional integration

As I will discuss in the following section, the distinctiveness of health care and public health diminished, due to reforms that moved both sectors towards an integrated institutionalized framework at the national level. Beginning with policies at the national level, the Federal Quarantine Act was amended in 1920 with a provision that emergencies in the CW could override state law. This was a reaction to the influenza pandemic of 191819, during which the states did not fully comply with the agreement of 1918 that the CW should have control over interstate quarantine. The Federal Quarantine Act had already

transferred the powers of internal quarantine to the CW in 1908, although the CW agreed that it would not implement this law. In 1921, the CW Department of Health was created, which increased the CW's control even further in national health policies. The department was in charge of administering the Quarantine Act, as well as of investigating diseases and setting up necessary facilities to that end, administering the CW's serum laboratories, collecting sanitary data, investigating health within companies, educating the public in public health matters, controlling the Australian Institute of Tropical Medicine, controlling infectious diseases amongst troops, and leading the Division of Sanitary Engineering. This move followed a proposition by V.G. Heise, who was the representative of the Far East division of the Rockefeller Foundation's International Health Board. He had offered the expertise of American experts for the creation of a national public health administration (Bryder, 1994).

In 1923, the idea regarding a federal health care system became prominent in the political debate, and some actors demanded the creation of a national health insurance based on the British model. In order to obtain information and an independent evaluation of the existing health policies, the federal government created the Royal Commission on Health in 1926. Its primary goal was to review health policy. The results of its analysis opposed the plan for a comprehensive national health insurance policy, as it argued that health policy was part of the states' authority. The commission proposed a public health plan that entailed the creation of a federal health council, with representatives of the states and the federal health department, as well as a national public health scheme under CW leadership. It was to include 35 health districts, of which each had a professional health official. The proposition failed due to a lack of political support and costs that were too high. The commission was dominated by the medical profession and concluded in 1927 that there was a legal problem in creating a central health authority due to Australia's federal structure. However, knowing that the medical profession strongly opposed any federally funded health care scheme, it is plausible to assume that this legal argument covered the original interests of the medical profession, namely to be independent of public control. Consequently, plans for a national health policy were blocked due to party conflicts, and the public health plans of national hygienists did not become reality. Conflicts between the CW and states, as well as party differences about the correct form of health insurance, made it easy for doctors to successfully oppose the introduction of a comprehensive national health service (Bryder, 1994; Lewis, 2003*a*).[1]

[1] At the time, public health policymaking increased at the state level, often leading to coordination problems. For instance, in Victoria, the Health Act of 1919 replaced the Central Health Board with the Commission of Public Health. The commission's chairman was the chief health officer, and it included a representative of the metropolitan municipalities, one of the provincial cities, and one for county-shires. Theoretically, each local health authority was called upon to appoint a medical practitioner to as health inspector, which was supposed to be certified by the board. Yet, by the mid-1930s, only Melbourne had such an officer employed full time; the others used the service of doctors part-time. The first minister for public health in Sydney was put into power by the local Labor government. Between 1898 and 1914, the number of public health inspectors (pure food, dairy and meat, sanitary) increased from 5 to 69, and health professionals increased from 10 to 17. Ministries of health existed in all states but SA during the 1920s. However, one problem was that authorities were often divided amongst several departments and that the

After the demise of national health insurance, the NHMRC took over leadership in health policy. It had been founded in 1926 and held its first meeting in 1937. Its main responsibility was to encourage public health and medical research, which was mostly linked to public health issues [2] Most of the council's members were national hygienists, but there also were some members who represented the BMA. The idea of a national health insurance returned to the political agenda in the 1930s. During the recession, individuals could not afford as many privately provided health care services anymore and needed more to go to non-profit hospitals that were run by foundations. Under these premises, the medical profession became more interested in national health insurance. In this context, one of the proposals made in 1937 was the Kinnear Scheme, named after Sir Walter Kinnear, the former treasurer of the UK. He proposed cash benefits for the sickness disabled, old aged, and widowed that would be administered by a commonwealth insurance department. The plan particularly concerned the financial management of health care for these groups. National hygienists opposed this plan, because it simply provided financing for curative medicine but did not have prevention and preventive means (Lewis, 2003*a*). Nonetheless, Parliament passed the National Health and Pensions Insurance Bill in 1938, which covered basic health care costs for indigent groups (Lewis, 2003*a*, 251).

In Australia, there was a large debate regarding the introduction of health care financing, first of all amongst the political parties. During the 1930s, the ruling Conservative United Australia Party introduced legislation for a national health insurance, but Labor opposed it, as it wanted to have a tax funded health insurance system. Doctors also opposed the introduction of a comprehensive health insurance, as they were afraid of losing their business. Due to the lack of compromise amongst political parties and the strong opposition, the establishment of health insurance legislation failed prior to the war (Lewis, 2003*b*). This secured the importance of private practice in Australia, parallel to state health policies concerning prevention and research and it demonstrated the power of doctoral organizations to organize political opposition.

These interactions and conflicts between the health care and public health sectors occurred in a context of pressing health problems and a focus on a fit and healthy population. Although there were many actions to reduce infectious diseases in the late nineteenth century, large epidemics were still dangerous and could even partially reverse this trend. For instance, the 1919 global influenza epidemic reversed the downward trend in Australia. At the same time, other infectious diseases were still dangerous, such as poliomyelitis, tuberculosis, and venereal diseases, and the health of infants and mothers needed to be improved (Lewis, 2003*b*). During the first half of the twentieth century, when life expectancy increased, other possible sources of death moved into the focus of health policy makers, especially cardiovascular diseases. Yet, they were still one problem among many, as infectious diseases often impacted health policy making greatly (Lewis, 2003*a*). Nonetheless,

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legislative base for health was different in different states (Bryder, 1994; Lewis, 2003*a*; Baum, 2008).

[2] `https://www.nhmrc.gov.au/about/organisation-overview/history-nhmrc`. Last accessed, March 6, 2014.

aside from the 1919 influenza epidemic, there was already a progressive decline in mortality, which was mostly caused by better nutrition and public health achievements (clean urban water, health education, and better housing). Health policies during the First World War also had a significant impact on the national paradigm relating the two sectors. During the war, preventive health measures reduced troop morbidity from 30.2 percent in the Gallipoli campaign to only 1.18 percent at the Western front (Lewis, 2003*b*, 181). As discussed before, these successes gave an especially positive image to preventive health policies and pressured the commonwealth to have more responsibility regarding health policy (Lewis, 2003*b*).

Although Australia was a belated nation, in the sense that the CW was only formed in 1901, the ideological background of health policies was similar to that of other rich countries at the time. As in other countries, the dominant ideology of state action was to improve health, and ideas on health were interlinked with concepts such as vitality, efficiency, purity, and virtue. Health policy should particularly improve the physical condition of the nation (Baum, 2008). As in other countries, this included ideas about eugenics in the debates on health policy, although actual institutions and policies designed to implement racial health policies were less significant in Australia than in Europe (Garton, 2010). However, we need to take specific ideational factors regarding health policymaking in Australia into consideration. As it was a penal colony, the country had a strong tradition of state interventionism by governors. There was a strong interventionist state before the 1850s. Yet, at the same time, there was a strong belief in individual freedom and laissez-faire economics. However, a strong reform in working conditions occurred between 1894 and 1900. All states except Tasmania regulated the working conditions in factories. State interventionism continued to be a central feature of Australian capitalism (Lewis, 2008).

A second element that is specific to Australia, with regard to the values and ideas concerning health policy, is the Anglo-Saxon context. Australia was, and still is, part of the British Commonwealth of Nations, with culturally (and legally) close ties to England. At the same time, it developed intense exchanges with the United States and Canada. This development is also reflected in the influences on health policy. During the twentieth century, there was a constant influx of ideas from other countries that regulated their health systems in very different ways. For instance, Australian policymakers were already exchanging ideas regarding public health (especially health promotion measures) with U.S. politicians during the 1920s. In this decade, an influential group of scientists in the National Health and Medical Research Council promoted more sanitary legislation (Lewis, 2003*a*; Gleeson, Legge and O'Neill, 2009).[3]

Although coordination problems and conflicts between the state and national governments occurred, important parts of health policy, such as legislation regarding infectious diseases, health research, and a general scheme for basic health care services, were inte-

[3]However, Australia did not just copy every idea from these countries. For instance, although it was widely debated, Australia did not put forward a comprehensive national health care service right after the Second World War, when Great Britain introduced an NHS (Lewis, 2003*a*; Gleeson, Legge and O'Neill, 2009).

grated at the national level during the end of the 1930s. The extension of public health services during the interwar years covered the health of mothers, as well as control of tuberculosis and other venereal diseases, such as by the introduction of mass immunizations. TB had become a notable disease, first in SA in 1898 and then in other states afterwards. In order to respond to the diseases, sanatoria were set up according to examples in the European states. The Australian medical corps decided to undertake mass x-ray examinations in 1939. Strong support for mass scanning came from the high costs of treating TB cases in WWI (Bryder, 1994; Lewis, 2003*a*).

In 1944, the commonwealth attempted to legislate for the provision of free pharmaceuticals through the Pharmaceutical Benefits Act of 1944. Benefits were to be restricted to medicines listed in the Commonwealth Pharmaceutical Formulary, and only on the presentation of a prescription written by a registered medical practitioner on an official government form to a commonwealth-approved pharmacist. The Formulary Committee was established, with the role of advising the minister of health on the composition of the formulary. The committee was a precursor to the Pharmaceutical Benefits Advisory Committee. However, the Australian Branch of the British Medical Association (BMA) challenged the act, and the High Court subsequently declared it unconstitutional, because the commonwealth did not have the power to spend money on the provision of medicines. This finding led to an amendment to the constitution allowing for the commonwealth to provide pharmaceutical benefits. Subsequently, the new Pharmaceutical Benefits Act was passed in 1947. However, ongoing resistance by the medical profession forced amendments requiring practitioners to use commonwealth prescription forms or face a fine. Again, the BMA challenged the act, and again, the High Court found it unconstitutional. In November 1947, under Section 15 of the Pharmaceutical Benefits Act 1947, the commonwealth made arrangements to supply free products for immunization against diphtheria and whooping cough. Despite the High Court finding, the commonwealth attempted to implement the scheme through voluntary participation. Few doctors participated; however, the 1944 and 1947 acts laid the groundwork for the development of the Pharmaceutical Benefits Scheme (PBS) by establishing it as a component of a state-controlled health system. However, these reforms show that, other than the health service proposed by national hygienists, the scheme was not focused on a national service that provided an integrated curative and national health plan (Lewis, 2003*a*; Lewis and MacPherson, 2008).

To sum up, the relationship between health care and public health changed in Australia during the interwar period. Notably, the national Ministry of Health and the NHMRC were two important institutions that, in theory, connected health care and public health. However, there was no encompassing national health service or national health insurance, but only a pension scheme covering health care costs for the indigent and the Pharmaceutical Benefits Scheme, which originally had voluntary participation. Such policies did not pass, among other reasons, due to the opposition by the medical profession, which wanted to uphold free practice and the dominance of private health care. On the other hand, national hygienists demanded a national health service that combined prevention

and cure. Yet, a compromise could not be found and health care and public health remained institutionally separated, because individual health care for the majority of the population remained in private hands, whereas the national government focused on public health policy. Nonetheless, the first steps regarding institutional integration had been made, due to the PBS and the health care payments for indigent groups.

6.2.2 Conflicts and responsiveness during the interwar period

The battles of the First World War had a lasting impact on the agendas of health policymakers, with consequences for the relationships between health care and public health, both in Europe as well as in Australia. Already during the war, the Holman Labor government appointed a Minister for Public Health in New South Wales, in 1914. After coming to power in 1910, the party committed to the provision of a number of public health services. Following the First World War, the CW's responsibilities in health matters increased, especially in the area of quarantine. Consequently, many doctors were more eager to pursue preventive work, because they had the chance to find employment at the national level. J. H. L. Cumpston, who was the first general director of health of the commonwealth (19211945), as well as an epidemiologist and historian of public health, reported that Australian doctors had applied many sophisticated prevention techniques during the First World War. Many of them returned to Australia with great enthusiasm about public health, such as for bacteriological analyses, which had been well accepted in the Army. However, there was a strong sense of depression and disillusion when it came to the implementation of these ideas, due to the obstacles of administrative processe (Lewis, 2003*a*, 181). In the following years, the medical profession and national hygienists demanded more prevention and more activity in the area of health care.

Thereby, population engineering played an important role. For national hygienists - a group in the public health profession - the central factors for successful settlement in Australia were: (1) the successful institution of adequate measures of preventive medicine, (2) the exclusion of lower races, and (3) an increase in locally born inhabitants (Lewis, 2003*a*). Yet, in Australia, the racist discourse did not lead to the implementation of racist public health policies that were comparable to those other countries, such as in Germany.[4]

The professionalization of the public health sector continued with the opening of a school of public health at the University of Sydney, in 1930, which became part of the medical faculty at the University of Sydney and was set up according to the example of the London School of Hygiene and Tropical medicine (Lewis, 2003*a*). However, this period of nationalization came along with a medicalization of public health, which means that the concept of public health changed and targeted individuals as patients rather than structural measures, such as regulative policies (Baum, 2008). In 1936, the Victorian Anti-Cancer Council was founded as a reaction to private demands and could sustain itself from private donations, as the Australian Cancer Society did. Since it did not

[4] I am aware that eugenic and racist positions have played a role for population policy in Australia (Garton, 1994; Garton, 2010).

depend as much on private funds, it proved to be much more effective than partially or fully public organizations (Dick, 2001; Lewis, 2003*a*). The Cancer Council's activities are important and represented the onset of a long tradition of anti-cancer strategies in Australia (Montague, Borland and Sinclair, 2001).

During the Second World War, the NHMRC produced two important recommendations for a national health service that would integrate curative and preventive medicine. It even contained proposals for a replacement of free doctoral practice by salaried public health doctors. In the years 19411943, national hygienists' vision of an integrated health service that provided curative and preventive medicine, with a staff of salaried doctors, dominated the political debate. Specifically, an NHMRC sub-committee report proposed establishing a national system of hospitals and clinics staffed by salaried doctors that would officially supervise the preventive work of private practitioners.

However, these plans failed after a change in the institutional landscape in 1943, when the Centre of Health Planning moved from the NHMRC to the Treasury. The goal of the policy changed from "socialization" to the payment of cash benefits in order to buy services from private practitioners. This was the end of the plans that the previously quoted report had proposed. However, these ideas were not put into place because the national Labor government had made health a part of a larger social welfare - based scheme (Lewis, 2008, 230).

During the interwar period, there was some responsiveness among the actors from the health care and the public health sectors. Notably, my results show that there was an increased professionalization and institutionalization of public health. The creation of a national ministry of health and the establishment of the NHMRC occurred with the support of both the medical profession, on the one hand, and national hygienists, on the other hand. However, regarding state intervention into health care, conflicts came up between doctors and the public health profession. The latter demanded a national health service that connected public health with health care, whereas doctors opposed such plans, because they wanted to retain free practice. In the end, the government and national parliament followed the argument of the medical profession, although the creation of the national PBS scheme shows that this position was not unanimous.

What do these findings reveal for my main hypotheses? Depending on the dominant contextual element, there could be either tight coupling or non-coupling, because Australia is a case with a unified government and high professionalism. During the interwar period, I have found more national institutions of health care and public health but no actual integration among both sectors within state institutions because health care remained largely private. In that sense, my theoretical expectations do not hold up. However, this is not really surprising because I did not account for national institutional development during my discussion of my theory's implications for each country. Concerning professionalism, my expectation was that Australia has politically active health professions, regarding public health and health care. However, although there was a favorable context for responsiveness, I also found conflicts between the professions in both sectors, especially

regarding matters of health care. On the other hand, actors from both sectors supported common public health legislation. However, as predicted based on the possible contextual confounders, the actors did not fight over the distribution of public funds, but rather on whether there should be any publicly funded and regulated health care scheme or insurance. The medical profession opposed the latter and wanted to retain free practice. Given the absence of institutional integration but the presence and absence of responsiveness, I conclude that health care and public health were loosely coupled with regard to the latter, but de-coupled concerning questions of health care.

6.3 Dominance of medical care in the shadow of tight coupling (1945-1980)

The context for the co-evolution of health care and public health changed with respect to three aspects after the Second World War which was about a century after the first public health acts had been introduced in many countries including Australia. Consequently, mortality rates decreased as a consequence of these policies. What is more, pharmaceutical technology advanced, new cures and immunizations were available, and national economies entered a period of economic growth in the postwar area. Subsequently, ideas concerning the focus of health policy (and social policy in general) shifted towards individual care. Due to these changes in context, I assumed that the contextual conditions for responsiveness among both sectors were not the same as in the preceding time period. Given the reduced demand for public health policies, I also expected responsiveness by health care and public health.

6.3.1 Towards further institutional integration

In the period following the Second World War, opposition against publicly regulated and funded health care and the further integration of public health and health care continued. In 1946, the High Court ruled that the PBS was unconstitutional, due to action by the medical profession. Subsequently, the court forbade the CW from taking pharmacists and doctors under civil conscription, which basically meant that a national health service, as had been proposed by national hygienists, was no longer possible (Lewis, 2003*b*). In 1948, the resistance of doctors, insurance companies, and pharmacists prevented the introduction of a national health service based on the British model. One particular reason for this was the opposition from the medical profession. The proposed bill by the Labor party suggested that the NHS would only allow GPs to bill their activities to the state, but not to individuals. Subsequently, the commonwealth Parliament passed an amendment (Art. 51) that allowed doctors to operate independently under the Australian constitution (Alford, 1975; Palmer and Short, 2010; Wilde, 2005) (Int-AUS-4).

In the postwar period, doctors and politicians were convinced that health policy should focus on health care, specifically individual care for the sick. The national minister for health of the Menzies government from 1949-1956, Earl Page, who was a surgeon and

a member of the BMA, clearly spoke against public health care schemes and the NHS, since the latter would create “socialized medicine”. He contended that “any such scheme should contain elements of self reliance and a sense of personal responsibility. Also it should stress the obligation of the individual to make a least a part of his contribution directly to the [...] cost of the scheme.” In another case he stated, “No disease runs an exactly similar course in every person. Its course is determined by the constitution and heredity, previous diseases and condition of other organs. It is obvious, therefore, that human disease cannot be overcome by mass treatment” (Lewis, 2003*b*, 14). After the failure to implement a general national health service framework, the CW Labor government worked on an alternative to the coalition government’s national health service during the 1950s. However, opposition to an NHS not only came from interest groups, but the anti-communist atmosphere facilitated its emergence, which made it easy for those opposing national health insurance to denounce such policies as Communist interventions and to campaign against them (Lewis, 2003*b*). As a consequence, Australia remained one of the few countries without comprehensive health insurance during the era of liberal governments from 1950 to 1972 (Wall, 1996).

However, health policy reforms extended the responsibilities of the state in the field of individual care. For instance, the CW introduced the Page Scheme in 1951, which entailed a limited amount of public health care, including pharmaceutical benefits, hospital benefits, medical benefits, and pensioner medical service. The support for an encompassing health service diminished even further after this limited public scheme had been created (Lewis, 2003*b*). In 1953, the national government created the National Health Service, which paid benefits only to registered nonprofit organizations and created an incentive for the private insurance industry to grow. The scheme was primarily related to cost control and biased towards curative services, which doctors supported.

Despite the opposition of the medical profession against public health care, doctors remained supportive of public health services and state action regarding population health policy. In 1964, a survey from the Commonwealth Health Department and the Australian College of General Practitioners reported little support for preventive measures in clinics, but rather that preventive health should be provided by public health authorities (Lewis, 2003*b*).

In 1974, the Labor government introduced the National Health Service, which was dismantled by the liberal Whitlam government in 1978 but was reintroduced in 1983 and has prevailed since then. The system is tax financed through income tax. Yet, there was a strong opposition against the system; consequently, Australia is the only country that introduced a national health service and dismantled it again after (Palmer and Short, 2010; Duckett, 2007). The implementation of a national health service was the continuation of a process and debate that had begun in during the Second World War. It was decided in favor of the supporters of a public health care scheme, at a time when the context in the international debate regarding health policy changed towards more support of population-based health policy approaches.

Australia had gradually introduced reforms since the Second World War that increased public responsibility in the area of health policy. Although the introduction of a public health care service failed due to the opposition of the medical profession, Australia introduced the Pharmaceutical Benefits Scheme in 1948, in order to supply geographically isolated areas with medication at public cost. During the 1950s, the commonwealth government extended this scheme considerably, despite oppositional lobbying by the medical faculty. In 1959, the system was harmonized with the integration of already existing schemes, the expansion of the existing one, as well as the inclusion of new drugs. Today, the Pharmaceutical Benefit Scheme is an important section of the Australian public health care sector. Yet, aside from the public health sector, private health insurance has always been an important pillar of the health system. Its political representation is through the Private Health Insurance Administration Council (PHIAC) and the Private Health Insurance Ombudsman (PHIO). The private health insurance market is highly regulated. Since 1953, the community ranking of private health insurance ensures that private insurance is affordable, regardless of risk. However, private insurance coverage declined after 1984, when Medicare was introduced (Hall, 1999).

After the Second World War, the institutionalization of public health continued under the same institutional umbrella as before, namely through an increasing responsibility of the central government (CG). For instance, from 1945 to 1949, the Commonwealth Health Department carried out a national campaign against tuberculosis under the Commonwealth Tuberculosis Act; this action was coordinated with the member states to combat the prevailing epidemic (Dundas, 1952). Medical prevention mainly drove the campaign against tuberculosis (mass radiography was the key to detection). This is an example of coordination among the commonwealth and the states. It included a massive flow of funds from the CG to the states, which sub-governments used to construct annexes to state hospitals (Lewis, 2003*b*). For public health policymakers, the advancements in pharmaceutical policy provided an opportunity for large immunization campaigns. In 1956, Australia began to carry out mass-vaccinations against poliomyelitis (polio) under the National Health Act of 1953, which is the legal basis for the commonwealth's immunization policy even today. In the early 1950s, the states and the CW coordinated a large immunization campaign, both politically and administratively (Lewis, 2008). Public health measures were again extended in the context of the Community Health Program (CHP) 1973, as part of the Medibank scheme, which was aimed at introducing complementary health insurance in Australia. The community health program included municipal health centers that provided specialists in child health, mental health, family planning, dental services, health education, immunization, social work, domiciliary care, and rehabilitation, with an emphasis on illness prevention (Sax, 1984, 106-107). When the program was reviewed in 1976, it had already developed over 700 projects; although innovative, the system did not really change the existing health system, which focused on medical work. When the Whitlam government left office, the program fell back to the states. The CHP had created innovations during the responsibility of the national government; however,

there were differences at the state level regarding their interest in prevention programs. Nevertheless, the program remained reasonably coherent, as a review in 1986 showed that the program mainly provided tertiary and secondary prevention. The community health program made Australia one of the forerunners in public health and preceded many of the goals that later became part of international health policy programs, such as the Alma Ata Declaration of 1978 as well as the Health for All goal of the WHO established in 1981 (Baum, 2008, 45).

To summarize, the institutional relationship between the health care and public health sectors changed incrementally following the Second World War. Due to a number of reforms, the state, notably the CW government, increased its responsibilities regarding health care regulation and provisions step by step. It augmented the scope of the public provision of health care with the establishment of the PBS, firstly, and secondly through the establishment of a health care scheme for pensioners. Along with these changes, public health policy became increasingly nationalized. In a nutshell, the centralization of health care and public health increased, along with the institutional integration of both fields, and the states and the CW coordinated public health policies. The full achievement of institutional integration occurred with the establishment of national health insurance in 1974 (although it was dismantled for a short time period in the late 1970s).

6.3.2 Responsiveness despite transgression

Despite the dominance of medical care in the postwar period, there was positive responsiveness between the health care and public health sectors, in the sense of mutual support among actors concerning public health policies. The medical profession had become one of the most prominent players in Australian health policy during the 1940s. Until 1962, medical organizations in Australia were organized as branches of the BMA, and the British Medical Journal was part of the organization's membership services (Bryder, 1994). The profession had successfully opposed the introduction of a national health service as well as of urban and rural health centers (Lewis, 2003*a*). The empowerment of doctors had also consequences for priorities in health policies. After 1945, the main topic in health policy was the provision of access to individual care.

However, the increasing political influence of doctors also affected on public health. In the postwar area, there were three approaches to public health: (1) a medical approach including primary, secondary and tertiary prevention, (2) a lifestyle approach focusing on health education attempts to change the behavior of individuals, and, as of the 1970s, (3) "new public health," which included health promotion instead of health education (Lewis, 2003*b*). However, once individual care had become the core of health policy, the activities of doctors were also extended to individual prevention and counseling about lifestyle, especially smoking. Whereas doctors were undecided about smoking during the 1950s, smoking lost popularity amongst the medical profession in the following decade and doctors educated their patients about the risks of smoking. In 1962, the NHMRC recommended that the CW and states ceasing all tobacco advertisements. Moreover, it

recommended that the CW work on risk-reducing strategies with other countries. In 1965, the Australian Cancer Society brought together representatives of the Australian Medical Association (AMA), the Royal Australian College of Physicians (RACP), the Royal Australian College of Surgeons (RACS), Australian College of Pathologists, National Heart Foundation, and National Tuberculosis and Chest Foundation to call for more health education and tobacco control policy from the federal government, especially bans on tobacco advertisements (Lewis, 2003*b*). Health foundations supported this undertaking of doctors. The Victorian Anti-Cancer Council has existed since 1936 (Dick, 2001). Additionally, the National Heart Foundation had been founded in 1959. Its tasks mainly involved financing research, but also medical prevention by targeting risk cases. It provided a community health program that encouraged doctoral visits regarding health assessments and urged patients to increase physical activity. Additionally, it produced a newsletter on health education and a cookbook (Lewis, 2003*a*).

In 1961, the states founded the Australian Cancer Society as a federation of state bodies. In 1966, the Action Council on Smoking and Health (ACOSH) followed. Its goal was to reduce the smoking epidemic in Australia. The American Interagency Council on Smoking and Health inspired the founders, which had been established in 1964. Like its American model, ACOSH brought government agencies and health pressure groups together. The NSW Health and Education departments had representatives in ACOSH. The council quickly spread to other states (Lewis, 2003*a*). Non-governmental organizations were also important in other areas of public health. They not only played a major role in the treatment of alcoholism, but also in educating governments and politicians towards more restrictive drinking policies. In the 1950s and 1960s, NSW and Victoria witnessed the establishment of health foundations against drinking, which were soon federalized. Other examples include councils that researched treatments for drugs and alcoholism (1956, Foundation for Research and Treatment of Alcoholism and Drug Dependence of NSW; 1963, South Australian Foundation on Alcoholism and Drug Dependence; mid-1970s, Federal Body on Alcohol and Drug Dependence), as well as provided support in the area of immunization programs (Int-AUS-11) (Lewis, 2003*b*).

Public health changed significantly during the postwar period, from a focus on infectious diseases to non-communicable diseases. Actors carrying this message were often researchers or health foundations that were responsible for certain diseases. However, public health as a profession did not gain the same importance as doctors did in the health care sector, and they were less politicized. Although there was political action in the public health sector, activities were now much more focused on specific health issues, such as tobacco consumption, but political action was much lower for other issues, such as environmental problems and alcoholism. There was no new occupational role for the public health professions that could represent the sector and its activities in the way that doctors did for the health care sector. It took until the 1970s and the establishment of the Community Health Program, when the role of the community health officer was created. Before that, the workforce in the public health sector comprised employees of the health

promotion foundations (Hawe, Wakefield and Nutbeam, 2001). These organizations began at the forefront of promoting public health in the political arena, especially regarding tobacco. In the 1970s, the ACOSH in Western Australia employed the first full-time lobbyist in the public health sector. Other organizations emulated this step, particularly the Cancer Councils and the Heart Foundation in Victoria, which employed lobbyists that pursued agendas for more health promotion. Together with the Australian Medical Association, committed academics, and interested politicians - mostly doctors from both political parties - they pursued a highly successful political agenda for more political regulation in the areas of tobacco, alcohol, and more recently, obesity. Later on, they managed to convince the public and politicians very successfully that regulative public health policy, such as smoking bans and higher tobacco taxes, are necessary. Also, they drove alliances against more prevention out of the political game, based on arguments supported by scientifically grounded evidence (Montague, Borland and Sinclair, 2001; Chapman and Wakefield, 2001; Wise and Signal, 2000)(Int-AUS-10).

Responsiveness between both sectors resulted in a series of public health measures, as well as the combination of both sectors. This shows that prevention was transferred to individual health services with the creation of the Community Health Centers (CHCs), which the OECD counts as (primary) health care services. The increases in these measures reduced investment in public health policies. The CHC services were a public health instrument, but the medical profession dominated them and referred to the idea of combining measures that focus on health hazards and individuals, rather than on structural health problems. Health campaigns focusing on structural effects and population groups emerged differently. Since the 1960s, much of the funding for health promotion campaigns came from health foundations, such as Cancer Councils and Heart Foundations, rather than from other sources. For instance, during the 1970s, the Cancer Council in Victoria ran several campaigns against skin cancer in Victoria (Montague, Borland and Sinclair, 2001). Due to the research provided by health NGOs, the state governments began to introduce public health measures in the 1970s. For instance, Victoria introduced compulsory seatbelts in 1971, the first smoking bans during the same decade, and bans on tobacco advertisements at the state level during the 1980s (Lewis, 2003*b*; Lewis, 2008). In addition, during the late 1970s and early 1980s, the state governments created more anti-cancer activities, such as the Flip-Flop-Flap campaign (Int-AUS-4, Int-AUS-6). Governments created the first preventive measures for cancer, such as mammography screening, during the 1960s (Int-AUS-12).

The context in which the relations between health care and public health co-evolved during the postwar period included changes in health problems and the success of prior health policies, especially public health measures. Mortality rates have declined since the 1860s, especially in connection with the decline in tuberculosis infection rates. The Australian case is similar to the decline of mortality rates in Western Europe between the 1870s and 1950s (Lewis, 2003*b*). The average life expectancy at birth increased by ten years between 1920 and 1960 (ABS, 2008). Although the time for creating a national

health service scheme came along with a change in the international discourse, it also entailed learning from other countries, such as Great Britain and Canada. As a result, the Australian health care system resembles elements that originate in other countries. Among these influences is the American voluntary health insurance system, which in part served as a model for the voluntary health insurance system that Australia introduced in 1953. The Medibank System that started to operate in 1975 took the Canadian universal tax funded health insurance as a model (Palmer and Short, 2010).

To conclude the findings regarding responsiveness between both sectors, my analysis reveals that the role of the medical profession and doctors increased considerably during the interwar period. Specifically, this concerns the impact of the profession on health care policymaking, such as the opposition against a UK-style national health service. Doctors successfully defended the predominance of the private health care system, which included their right to exercise free practice and to be economically independent. At the same time, they participated actively in the creation of more public health policies, which included the establishment of organizations that support public health policies, along with health foundations, but also the direct support of more public health policies, such as immunization and tobacco control policies. However, at the same time, public health underwent a significant change, both in terms of its professional role and the policy instruments that were applied.

My theoretical expectations regarding Australia led me to the hypothesis that both sectors would have institutional integration and responsiveness, due to the unified government and high professionalism. Again, my expectations were partly confirmed, although they came closer than my results regarding the prior time period. Concerning the effect of unified government, my analysis reveals an increasing centralization of health policy after the Second World War. This is true for fiscal policy in general, but my analysis also shows this for the field of health policy. In particular, I observed more national legislation in the field of health care, but also regarding public health, including improved coordination among both fields. This came along with an institutional integration of both sectors in the political administration of the national government, which administered both sectors under the same institutional umbrella. Particularly following the integration of the health care and the public health sector with the establishment of the national health service, Australia fulfilled the conditions for sectorial integration that I formulated before. Concerning professionalism, my results show political activity among the medical profession in general, as I expected from the theoretical discussion of professionalism. However, my results also show a political investment by doctors in matters of public health and cooperation between actors from both sectors. Therefore, there was responsiveness between the health care and public health sectors during the postwar time period in Australia. As my analysis in the previous chapter on the UK and the preceding sections of this chapter show, the context does not necessarily play out as expected in all countries. Although the postwar period reduced the demands for public health policies regarding how they were made during the late twentieth century, there was no increase in conflicts between

both sectors, but rather continuing responsiveness. In addition, my analysis shows the importance of political parties, because without the left Labor party in government in the 1970s, there would have not been a national health service or the consequent integration of health care and public health.

6.4 Integration and tight coupling of health care and public health (1980-2010)

In the last time period, I expected to find tight coupling between health care and public health in Australia. Apart from the professional and governmental dimensions, I expect that the change in the context caused different dynamics in the responsiveness of both sectors. The reason for this is that during the 1970s, the pattern of prevalent diseases changed towards a higher prevalence of non-communicable diseases, such as heart attack, stroke, and cancer, which need the prevention of risk factors and screenings. On the other hand, criticisms concerning the existing concept of health policy became louder, demanding a re-focusing of health policy, with a greater emphasis on matters of health policy.

6.4.1 Consolidating integration and re-differentiation

The institutional integration of health care and public health continued in Australia from the 1980s onward. The eventual implementation of a national health insurance scheme (which I referred to as a national health service before) in 1983 moved the Australian health insurance system from a purely private character to a tax-funded public health insurance that granted universal coverage and fixed the integration of health care with public health. Yet, with the return of the Liberals to power in the 1990s, private health insurance was strengthened again, such as when the Howard government increased subsidies for private health insurance. The universalist principles introduced into the Australian health care system entailed access to public hospitals and rebates for private health insurance. However, some elements of the market also remained, such as levels of patient contribution in the PBS. In 2003, the LiberalNational government passed some reforms that were, again, more liberal, such as incentives for GPs to permit bulk billing only for pensioners and holders of health care cards. These policies are based on the view that bulk-billing should only apply for a specific group (Duckett, 2005). What is more, in 2009, for instance, the Rudd government announced the reduction of payable benefits, which might result in higher out-of-pocket payments for patients (Willis, 2009; Palmer and Short, 2010).

The introduction of the national health service entails another political dimension of the relationship between the CW and the states, and increased the coupling and integration of health policies between the levels of government. In Australia, states are responsible for portions of health care services, whereas the CW collects taxes. Therefore, the introduction of the national health service came along with health care agreements between the states

and the federal government. There have been five agreements between 1984 and 2008. The first three ensured the introduction of Medicare and increased the public provision of health services. Since 1998, they have been aimed at increasing accountability of state governments; the 20032008 agreement also reduced the commonwealth's investment into public health services (Duckett, 2002). The most important debates between the states and the federal government surround the aforementioned Australian Health Care Agreements. These are five-year programs under which the state must provide free hospital and medical care, including emergency services, but the commonwealth has to provide the funding for it. These agreements require timely ambulant treatment from the states, and waiting lists for hospital treatment are made public in order to increase pressure on the state governments to reform these services, if necessary (Willis, 2009). The relations between the two jurisdictions were formalized by the Council of Australian Governments (COAG) in 1992, in which the commonwealth and the member states coordinate their policies. As support for this ministerial council, leading members of the member states' health authorities meet in the Health Ministers Advisory Council (AHMAC) to support the decisions (Duckett, 2007).

Beginning in the 1980s, the CW, member states, and health foundations began to introduce public health strategies aimed at combatting risk factors, in order to avoid chronic diseases at later stages. These entailed policies against alcohol and tobacco, as well as traffic accident prevention and policies against skin cancer. One example is the draft for a national alcohol policy, which the National Standing Committee of Health Ministers put together in 1984. Moreover, the federal and state governments spend a lot on traffic accident prevention, and road and safety campaigns set up by the state-owned Transport Accident Commission of Victoria are central parts of the preventive health policies in Australia. Originally, the commission's mission was to pay for the treatment and benefits of people injured in road accidents. The prevention campaigns entail a series of nationally broadcasted videos, which show the consequences of accidents due to drunk driving or speeding in a very graphic way. Such campaigns are considered to be much more efficient for improving population health than clinical, face-to-face intervention. However, until the turn of the century, the number of accidents and injuries on Australian roads remained extremely high and the Australian Transport Council continued to pursue road safety policies, such as the National Road Safety Strategy 20012010. Activities regarding skin cancer included the Slip-Slop-Slap campaign (19801988) and the Sun-Smart Program against Skin Cancer (19882001). These were very successful health education measures that changed public opinion and behaviors towards cancer. In addition, advocacy and legislation for clean indoor air and tobacco advocacy started in the 1970s (Chapman and Wakefield, 2001).

At the same time, many of the states (Vic, SA, WA) established health promotion foundations that used tobacco tax money to promote better health, as well as cultural and sports activities (Baum, 2008). However, there were differences in community health and health promotion between the state governments in the 1980s. While NSW and

WA created statewide health promotion units, Queensland did not do much regarding primary health care and promotion of health in the 1980s, and Victoria and SA developed community-based initiatives. Victoria developed a network of community health centers, including 43 district health centers that had permission to focus on the health of their local populations and fostered community-based health promotion (Jackson and Mitchel, 1989); South Australia was a forerunner in public health, beginning in the 1980s (Jackson and Mitchel, 1989), by investing in primary health policies, as well as a Social Health Strategy that made WHO Health for all Strategy and Ottawa Charter relevant to SA.

Community health centers expanded and health city projects emerged at the same time, as did the number of tobacco control policies and mental health services. These new public health policies emerged parallel to traditional public health services (Baum, 2008, 46-47). The strong community health sector in Australia created a focus on a broader population view in health and emphasized health promotion and disease; however, there was frustration amongst community health workers about how doctors approached prevention, because they largely focused on behavioral change, as had been done in the late 1970s and 1980s. There were cutbacks in the funding of community health centers during the 1990s, above all in Victoria and South Australia, and the centers focused on chronic disease care and prevention. Thereby, community health centers were somewhat marginalized, but still very important for the delivery of new public health policies (Baum, 2008, 54).

Public health policies also extended to the national level. For instance, in 1992, the national parliament banned tobacco advertisement in print, only sponsoring of international sports events was allowed (Which was eventually banned in 2006) (Lewis, 2008). Regarding indoor smoking bans, the government of the Australian Capital Territory (ACT) led the way and introduced the first law in 1994. Other governments soon followed thereafter (Chapman and Wakefield, 2001). In Australia, there is high public acceptance for health promotion measures, such as smoking regulations, vehicle passenger safety restraints, gun control, fencing regulations for private swimming pools, and alcohol regulation policies (Hawe, Wakefield and Nutbeam, 2001). Apart from these public health activities aimed at non-communicable diseases, there were many public health developments in the areas of infectious diseases, such as strategies against SARS and funding for more vaccines. Interestingly, fears about SARS spread all over the news in 2003, but most of the national headlines in Australia focused on obesity; both issues concerned the Australian Health Ministers Council (AHMC) (Lin and Robinson, 2005).

The dynamics regarding the integration of health care and public health services seem to have fostered integration at the ministerial level since the 1980s. This process began with the merger of the Department of Community Health Services and the Department of Health in 1987. In the following years, the Department of Health increased its range, including to housing industry programs in 1991. The Department of Local Government was also added to the Ministry of Health in 1993. The joint ministry received the name Department of Human Services and Health in 1994. In 1996, the Supported Accommoda-

tion Assistance Program was added, and responsibilities for Aboriginal and Torres Strait Islander matters followed after that.

In the same year, children and family health services were taken away from the department again. Yet, after the 2001 election, the government merged the CW Rehabilitation Service back into the department and renamed it the Department of Health and Aging. After the election in 2013, aging research and active aging were taken from the department, and sport and recreation policy were added to the department.[5] At the same time, the Labor government created the Australian National Preventive Health Agency (ANPHA), which has the responsibility for large public health programs regarding the most important risk factors in health policy, such as tobacco, alcohol and obesity (APHTF, 2009). Legally, such a reform separated public health more from the national ministry of health; however, the liberal government abolished the agency again in 2014.[6]

To summarize, the institutional relationship between health care and public health remained integrated. Since the 1980s, the CW government has regained a central role in both sectors. Although there were some reforms, such as the establishment of a national public health agency, this did not lead to a strict institutional separation between health care and public health. Therefore, institutional distinctiveness has remained absent during this time period. Given that the public policymaking in Australia underwent even further centralization during these times, this development is not surprising.

6.4.2 Broad responsiveness and policy integration

At the same time, health care and public health remained responsive, in the sense that there was policy integration and cooperation among actors and interest groups from both fields. The previously discussed health foundations are important for this development, as I already discussed in the previous section. During the 1960s and 1970s, research showed increasing deaths due to environmental factors, such as asbestos and cigarette smoke. In order to bring these findings into politics, Australian health foundations, such as the Heart Foundations and Cancer Councils, advocated for more public health policies or created organizations designed only for advocacy, such as ACOSH in Western Australia and ASH in Victoria and at the national level. These organizations lobbied politicians in support of more public health policies and continued to conduct public health research themselves (Int-AUS-32). Such activities were often supported or initiated by doctors who were open to and interested in public health. For instance, the Cancer Council of Victoria's leadership role in tobacco control policies was largely based on the role of a doctor named Nigel Gray. The organization is staffed with a medically trained faculty that pursues research in health promotion and clinical treatment, and it pays full-time lobbyists to support public health policies. Oftentimes, doctors were at the forefront of these renewed public health actives, especially when they held an office at the same time. For instance, a

[5] `<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-history.htm>`. Last accessed September 22, 2014.

[6] ID of information on the legislation: BILLS DIGEST NO. 86, 2013-14 16 JUNE 2014.

surgeon started Victoria's campaign against road accidents in the late 1980s (Int-AUS-12). In South Australia, liberal health ministers supported smoking bans in public dining and coffee places (Int-AUS-2), and a Liberal commonwealth health minister created the first National Tobacco Strategy in 1997. Although they were members of the Liberal Party, which represents business interests, these politicians were also doctors. Moreover, during the 1990s, the Australian Medical Association was amongst the most active organizations to advocate a complete national ban on smoking advertisements, even though it is an inherently conservative organization (in the liberal/conservative sense) when it comes to state intervention and had fiercely opposed a national health service for decades (Int-AUS-19). Another example is the Australian program against AIDS, which was initiated by an Australian minister for health who was also a political scientist and knew a lot about public health problems during the 1980s. From an international point of view, the Australian anti-AIDS campaign was a model for other countries, as a successful public health initiative (Baum, 2008)(Int-AUS-1).

Although the medical profession played an important role in placing many public health issues onto the political agenda, such as tobacco and road-traffic issues, there have been conflicts and less support from doctors with regard to the mixtures of certain policy instruments. There are still debates between the community health side, which mostly entail health foundations and the medical profession, regarding which population-based instruments are appropriate, such as whether it is better to employ educative responses or environmental and legislative approaches (Int-AUS-31). Another point of conflict concerns individual prevention, such as coronary bypass operations, which are important from the viewpoint of prevention (Rosenbrock and Gerlinger, 2014). Community health doctors sometimes neglect such measures because they want to avoid sending patients to hospitals (Int-AUS-2). However, there was also resistance against the increase in preventive health policies. For instance, some states had opposition within their state governments regarding tobacco control policies. In South Australia, Health Minister Lea Stevens faced opposition within her own government to her tobacco strategy. She had to convince the treasurer and other members of the government who were afraid of the negative impacts on state revenues (Int-AUS-8). One of the major problems with many public health measures is that they are designed to have long-term effects, especially with respect to non-communicable diseases. Instruments that are supposed to prevent heart attacks, cancer, and diabetes are not very popular because they are often aimed at regulating individual behavior, either by banning the consumption of certain products or by informing against their use. Both go against affective human behavior and are very unpopular. One interview partner put it the following way: "This is not the same as if you had a major outbreak of malaria or cholera, when the media would be storming the minister's office and asking about what is [being] done to prevent the disease" (Int-AUS-24). A similar situation would come along with regard to a food poisoning outbreak. What gets the attention of ministers are issues with health care services, such as prices for pharmaceuticals or waiting times in ambulances, as well as other life-threatening health issues in Australia's system that become front-page

stories (Int-AUS-27). Despite these differences, however, Australia has developed strong public health advocacy for many health issues in the last 30 years, which include actors from the health care and public health sectors, in many areas, and continues to do so (Daube, 2006).

With regard to health care policies, medical organizations remained opposed to future public health activities. There were many protests by doctors during the early 1980s. The introduction of a national health service during the 1970s had come along with negotiations and compromises, due to opposition and demands from doctors, with respect to benefit levels and fees for doctors under the national health service (Sax, 1984). Doctors opposed the inclusion of new services in the national health service, such as clinical psychology and midwifery (Hancock, 1999*a*). Despite the introduction of state health care services, the AMA continued to favor private practice and fee-for-service payments over state health insurance and free services. However, during the 1980s, the organization tried to show greater concern for the public good, rather than only representing the interests of its members. In a sense, this was also due to the decline in membership, as well as the worsened public image of the profession (Wall, 1996).

At the same time, the policy integration of health care and public health increased during the period after 1980. For instance, disease-related programs and strategies became important in health policy. These programs often entail a combination of public health and health care measures. Mostly, they include strategies to cure the disease through the individual, but also a series of preventive measures aimed at health hazards among individuals, as well as population or settings-based measures. These strategies include the coordination of state governments and the central government in Australia at different levels. They focus on specific health problems or on disease in Australia in general. Regarding the latter, the report *Health for All Australians* (1987) emphasized the health inequalities amongst certain groups. It set 28 national health goals, including hypertension, nutrition, injury prevention, older people's health, and the prevention of lung and skin cancer. Another example is the National Better Health Program (Anderiesz, Elwood and Hill, 2006), which was put into place in the 1990s and demanded a focus on prevention and primary health care (Baum, 2008, 46).

The aforementioned National Preventative Health Strategy, with the stated goal to make Australia the healthiest country by 2020, is the latest example (APHTF, 2009). Other strategies are more disease focused. For instance, the National Cancer Strategies, which have existed on a national level since the early 1990s, are especially aimed at screening and immunization, but also financing, research, and the coordination of cancer treatment. Responses to the disease were institutionalized in the Cancer Australia Act 2006 (Cancer Australia Strategic Plan 20112014). These successful strategies are based on the capacities of the federal government to intervene in health measures, as it is responsible for the PBS, cancer screening, and other areas, such as the provision of radiotherapy. In addition, the longstanding support from the NGO sector, especially in the name of many NGOs such as the Cancer Councils, plays an important factor in this regard (Anderiesz,

Elwood and Hill, 2006).

Another example of actor responsiveness and its positive impact on public health policy is Australia's response to AIDS. The first national AIDS strategy (19911995) was the result of a

successful alliance comprising government officials, community health groups, and health care services. The path to the law helped to create a network of AIDS organizations, gay groups, drug users, and sex workers. As a consequence, the approach supported peer education as well as treatment. The goals of the strategy were to reduce infections and minimize their impact. It includes instruments such as education and prevention, the encouragement of personal responsibility, the elimination of discrimination against infected patients, cooperation amongst infected persons, and informed consent before testing. Additionally, the strategy intended to reduce the risk of infection at the workplace and encourage more legislation for assisting with education and other preventive measures (Baum, 2008, 494). The strategy was renewed in the following years, and some of the state governments created their own strategies.

Health strategies followed in other areas, such as for breast cancer, obesity, tobacco, and road safety on the national level. In addition, state governments have their own strategies, which include preventive and curative measures. The setup of these national health strategies increased the de facto dominance of health policy by the federal government, especially when it comes to the funding of health policy, since the central government has significant power when it comes to funding in Australia.

To sum up, there has been responsiveness between the health care and public health sectors since the 1980s. Notably, the medical profession had been involved in creating and advocating for public health policies, alongside other actors that belong to the public health sector, such as the Cancer Councils (although these organizations also take care of health care matters, they are very active in public health policy). The cooperation specifically concerned policies involving risk factors, such as tobacco and alcohol above all. Yet, concerning infectious diseases such as AIDS, there was also cooperation among actors from both fields. Another dimension of sectorial responsiveness concerns policy integration. Health care and public health were integrated with regard to many health problems. This concerned specific risk factors, but also sicknesses such as cancer or diabetes.

These results confirm my expectations concerning the hypotheses that I discussed for the Australian case. More unified government comes along with the institutional integration of health care and public health. Although there were some attempts to differentiate health care from public health, especially by Labor governments, the national ministry of health currently retains both sectors under tight control and as institutionally integrated. With respect to the connection between professionalism and responsiveness between policy sectors, the results confirm the theory that I put forward before. Notably, the medical profession has been very active in advocating for more preventive health policies. This time, the contextual conditions reinforced these efforts, because the demand for public health policies had become even more apparent to the professions and interest

groups in health policy, in addition to parliamentarians and decision makers. The presence of many examples for policy integration enhances this finding even further.

6.5 Discussion

What does my analysis mean for my hypotheses regarding the co-evolution of the health care and public health sectors in Australia? In the following, I will summarize my results and discuss the implications of this case study for theory. Table 6.1 provides an overview of my results and contrasts them with my explanatory variables.

The results show that health care and public health in Australia co-evolved from loose coupling during the colonial period towards tight coupling. In the beginning of my observation, both sectors were institutionally distinctive from one another. This changed incrementally over the course of the twentieth century, notably through a series of small reforms that increased the role of the state in health policy step by step. Examples for these reforms include the creation of a national pension and health insurance legislation (1938), as well as the first version of the Pharmaceutical Benefits Scheme (1944), both of which represent instances of integration between health care and public health at the national level. The integration of these sectors continued during the postSecond World War period, especially with the establishment of a national health service during the 1970s that integrated health care further into the national institutional framework. What is more, the creation of the community health centers at the municipal level established further integration among health care and public health. Since the 1980s, health care and public health moved towards further integration of both sectors, especially because there was policy coordination, such as regarding disease and risk factor prevention strategies. This entailed the integration of both sectors at the national level with the implementation of a national ministry of health and a medical research council (the NHMRC) that combines health care and public health research. In addition, a layering process increased the coverage of public health insurance and services throughout the twentieth century.

Regarding responsiveness, I found significant evidence for cooperation between health care and public health on the levels of the professions and interest groups, but also policy integration. Other than in the UK, I found responsiveness among health care and public health actors during the early time periods, prior to WWII. This means that despite the different professional roles in health care (essentially medical organizations) and public health (e.g., public health doctors, NGOs, and members of the administration), these actors responded to one another in the sense that they commonly advocated for health policies, specifically public health policies, both in colonial and in more recent times. Yet, there were also conflicts, especially between public health reformers, such as national hygienists on the one hand and doctoral organizations on the other hand, with respect to the implementation of a national public health service in the 1930s and 1940s, similarly to in the UK. After the Second World War, health care actors (e.g., health insurance, hospital companies, and doctors) claimed and secured most of the resources in health policy,

Table 6.1: Co-evolution of health care and public health in Australia

Time/ Country	1880-1918 *(t0)*	1918-1945 *(t1)*	1945-1980 *(t2)*	1980-2010 *(t3)*
Coupling	*Loose coupling:* Separation in colonies; health care mostly privately organized; a broad public health coalition; separation of health care and public health; actor responsiveness through the employment of doctors in public health services as well as political activity	*De-coupling (Loose coupling):* Less distinctiveness at the national level; responsiveness entailing conflicts regarding a national health service; coordination of policy outputs at the national level	*Tight coupling (Loose coupling):* Incremental integration of sectors at the national/state level; actor responsiveness: transgression of health care on public health; broad public health coalition; integration of health care and public health	*Tight coupling:* Continuing institutional integration at the national level; actor responsiveness: broad public health coalition; Policy coordination
Professionalism	Employment of doctors in public health services; support for more public health by the medical profession; opposition of the medical profession to a national health insurance scheme; conflicts regarding a national health service	Further professionalization of public health; cooperation and conflict between the public health profession and medical profession; opposition of the medical profession to a national health insurance scheme and a national health service	Support for prevention, despite the dominance of individual health care; opposition of the medical profession to a national health service	Doctors, medical organizations and health organizations were politically active and supported public health policymaking
Unified government	Colonial governments in charge, but also municipal control of public health policies	National government and states share responsibilities in health policy; → majoritarian system	Party difference: The Liberal party blocked the implementation of a national health insurance while in power; Labor created a national health service → effect of majoritarian system; Coordination between the state and federal government	Implementation and abolition of ANPHA; coordination among MS and FG → Council of Australian Governments (COAG)
Context	Infectious diseases; British Public Health Acts; colonial government; Fitness of population; infectious diseases	Impact of the First World War; American public health reformers; individualized public health; fitness of population	Success of prior public health policies; pharmaceutical advancement; turn towards individual health care	Non-communicable diseases; risk factors; return of infectious diseases; international public health paradigm

including some discretion with respect to prevention. At the same time, however, actors belonging to the health care sector, such as doctors, publicly supported and demanded more public health policies, such as for prevention in general, but also specific risk factors, such as tobacco control policy This broad coalition of actors in favor of health and public health entailed health foundations as well as doctoral organizations, which lobbied for public health issues. Beginning in the late 1970s, policy coordination between health care and public health emerged, as there were specific health strategies connecting cures with prevention for certain diseases, such as cancer, as well as risk factors such as smoking or alcohol.

6.5.1 Unified government and professionalism in Australia

What are the implications of these findings for my argument? I hypothesized that health care and public health in Australia are either tightly coupled or non-coupled, depending on the contextual conditions. Generally, the chance for tight coupling between sectors is high, because there is high professionalism and a unified government. To what extent do these expectations hold in light of my results?

Regarding the impact of unified government, the results for Australia are different than expected, especially for the first two time periods, when both sectors were rather separated institutionally. This is not so surprising, given that the establishment of a national state and accompanying institutions occurred rather late in Australia, compared to in other countries. Although Australia and the UK have similar systems of government today, there were differences in the late nineteenth and early twentieth centuries, as Australia was a federation coming together, in which much discretion rested in the hands of state governments. This changed during the course of the twentieth century. Health policy reforms integrated health care and public health in public institutions, especially during the post - Second World War period. In particular, the establishment of a national health service was a consequence of the unified government that empowered the left party, which did not need to make a compromise in Parliament to put this institution into place.

Concerning professionalism, health professions took an important role in politicizing health policy matters, as I expected, following the literature on professionalism. The medical profession was particularly active politically. This became visible with regard to the setup of the first public health legislation in the twentieth century at the colonial level and later at the national level, after the creation of the Australian Commonwealth. Concerning these aspirations, the medical profession had the same ideas as public health actors and consequently the same political goals. This responsiveness changed with respect to individual health care. During the 1920s, individual health care legislation entered the political debate at the national level. In this case, the medical profession opposed a national law on health insurance because they were afraid of losing their privilege of free practice. With regard to that end, they came into conflict with national hygienists, who wanted to establish a national health service that provided individual health care and prevention. This caused conflicts between the actors of both sectors. Yet, responsive-

ness between both sectors returned following the Second World War, when the context regarding public health changed. The medical organizations actively supported more public health policies, such as tobacco control, immunization, and other measures of cancer prevention. However, there was also a special professionalization of public health among health foundations, such as the Cancer Councils, which are important for public health research and lobbying for population health matters.

Along with the institutional integration and responsiveness between actors, health care and public health policies became more integrated. I have found evidence for this, particularly in the last time period after the 1980s. These policies entailed preventive and curative measures regarding infections such as HIV, but also risk factors such as tobacco and alcohol. Cancer and diabetes strategies were another element of integrated policies in Australia.

The contextual conditions that I discussed did not play out as I expected, but my predictions were better than those for the UK. During t1, when the demand for public health policies was high, there was responsiveness between actors from both sectors, which demanded more intervention by the state. There were conflicts and cooperation during the interwar period and the Second World War, as expected. During the last time period (t3), I also found responsiveness between the health care and public health sectors. However, in the postwar period, I did not find the conflicts between health care and public health that I expected, due to the contextual development.

Why did the contextual developments play out differently between both fields than expected before? In comparison with the UK, the difference in Australia is the later development of the state and the hierarchical governance in health policy. A tentative conclusion regarding responsiveness could be that the state took an important role in public health policy more quickly in the UK, in the sense that it governs the relationship of health care and public health by means of hierarchical governance. To the contrary, in Australia, hierarchical governance in health policy emerged later. In this situation, high professionalismwhich extended into the field of health policyplayed an important role in the agenda setting of health policies, including in the responsiveness of actors from both fields. In this case, the combination of unified government and professionalism led to health care and public health becoming integrated. Consequently, it seems that the mix of private and public intervention in public health is a significant element of the co-evolution of health care and public health. I will discuss this element, the timing of institutional emergence, and its interaction with professionalism in the comparative chapter.

6.5.2 Competing explanations

Yet, apart from unified government and professionalism, other theoretical elements emerged as important for the co-evolution of health care and public health: sectorial complementarity, policy learning, and political parties.

1. *Complementarity:* My analysis of the co-evolution of health care and public health in

the UK showed that both sectors co-evolved towards complementarity of institutions, but also policies. The findings are similar with regard to Australia. Health care and public health institutions emerged as consequences of particular health problems, but not as a coordinated institutional arrangement. Yet over time, they co-evolved towards complementarity, which means increased policy integration and learning in both sectors. However, other than in the UK, this came along with fewer conflicts between the professions of the health care and public health sectors.

2. *Policy learning:* Policy learning is important concerning the relationship between health care and public health in Australia. My analysis of the co-evolution of both sectors in the UK has shown that high professionalism comes along with policy learning. Notably, politically active professions adapt innovations regarding health care and public health policies, and put them on the political agenda, including towards tobacco control policy, cancer prevention, and infectious diseases, such as AIDS. Therefore, high professionalism not only causes responsiveness between policy sectors but also policy learning, because professional organizations play an important role in transferring innovations into the political process.

3. *Party differences:* Consequently, this impacts the role of political parties concerning the relationship between health care and public health. In Australia, there were conflicts between parties regarding health care institutionalization, notably in the creation of a national health insurance. Both parties were fiercely opposed to this reform. Labor supported the creation of a state-governed health care service, whereas the Liberal Party opposed this reform fiercely. However, regarding public health policies, there were no basic conflicts between both parties about the necessity of an encompassing public health agenda, especially in the 1980s. Naturally, we would expect that the Liberal Party would be more opposed to public health policies, because these instruments often target individual and corporate behavior and freedom. However, in Australia, some of the ministers in the Liberal Party were doctors who supported an encompassing public health agenda. What is more, the AMA was part of the liberal conservative base of the party and advocated more public health policies.

6.6 Summary

I selected Australia as a case study because I expected to find tight coupling between health care and public health, even though it is a federal state. The results of my analysis confirm my hypothesis, notably for the more recent time periods. Health care and public health were separated institutionally during the late nineteenth century. Only during the 1970s did health care become the matter of a national health service and therefore a case of institutional integration. On the other hand, regarding responsiveness, I find that the medical profession, public health doctors, and private organizations concerned with public

health matters were responsive and collaborated in health policy matters such as tobacco control policy. Similarly to the UK, both sectors coevolved towards complementarity. However, there are differences between both countries: In Australia, health care and public health institutions emerged later than in the UK, as did conflicts between actors and professions from both sectors.

Chapter 7

Germany: De-coupling of public health and individual health care

Germany is the third case study in my analysis of the co-evolution of health care and public health. I selected it as a country study because it allows me to examine the combination of unified government, low professionalism, and relatively low political activity among professions. Consequently, I expect to find non-coupling of health care and public health, even if the contextual conditions are favorable to sectorial responsiveness.

I am going to proceed with this analysis in a way similar to those for the UK and Australia. Notably, I will begin to analyze the co-evolution of the health care and public health sectors in the late nineteenth century. Then I will examine the relationship between these two sectors in the interwar period. The third section focuses on the coupling of both fields after the Second World War. Eventually, I will discuss the relationship of health care and public health since the 1980s.

7.1 Local public health in the shadow of the national health insurance (1850-1918)

I have argued that during t1, the context should be favorable for responsive health care and public health, because there is a demand for preventive health policy. However, in Germany, this element should have no effect; due to the weak professionalism, neither health care nor public health professions should play an important role in politicizing matters of health care and public health. Therefore, there is little responsiveness between these two fields, but conflicts are likely to arise between professions and other interest groups. At the same time, due to the rather unified and centralized government, the fields of health care and public health should be institutionally integrated

7.1.1 Institutional distinctiveness on three levels of government

During the second half of the nineteenth century, the institutionalization of public health entailed two dimensions. On the one hand there were institutions related to the control

of epidemics and health policing, which were situated at the state level. The tasks of the sub-governments were comprised of medical policing, sanitary policy, the evaluation of drugs by courts, and psychiatric expertise (Labisch, 1982). On the other hand, there were municipal health services at the community level. After the unification of 1871, health remained the responsibility of the states. Even during time periods when national administration centralized, public health remained fragmented. All the doctors that were trained by the state became district doctors *Kreisärzte* and were subordinate to the control of the civil service (Weindling, 1994).

During the late nineteenth century, health care and public health emerged as two distinctive policy sectors with different institutional roots. In Germany, the public health sector originated in the health policing *medizinische Policey* of the German states, such as Prussia in the 17th and 18th centuries. These policies entailed the regulation of health policing, which mostly aimed to protect against epidemics; this was nothing new, because laws regarding protection against infectious diseases had existed since ancient times. However, the emerging modern state extended these tasks to state areas. This traditional sense of public health referred primarily to the paradigm of population security and had the goal of retaining public order (Rosen, 1993 (1959)). In the revolutionary times, around 1848, the number of voices demanding the provision of health as a public good increased. Radical doctors in France and Germany demanded that medicine should play a more important role in national politics, which was important for the differentiation of health care understood as individual medicine on the one hand, and public health as population health on the other hand. In Germany, one of the leading scholars in this matter was Rudolph Virchow, who had been employed by the Prussian government in early 1848 to investigate typhus in the areas of Upper Silesia. He concluded that bad sanitary conditions were among the causes of the disease. Virchow did not have a remedy for the fevers from which workers were suffering; however, he argued that the subordinate political state of this group was responsible for the illness. His study became one of the most significant pieces of sociological epidemiology of the time because it connected public health to political rights. He concluded that political empowerment and democratization were necessary to improve the situation of the population - specifically by establishing a unified public health system (Weindling, 1994).

The democratic revolution failed in 1848, yet politicians understood that it was necessary to invest in population health (Porter, 1999, 106-107). In the late 1860s, Virchow encouraged the city of Berlin to build sewage and water supply systems. In the city of Munich, Max von Pettenkofer designed a public health program. The program entailed control of food, water, and air; control of work by women and children; improved hygiene in schools; and sanitary reforms. In addition, he demanded the creation of commissions consisting of doctors and non-doctors that would be responsible for city areas. Their tasks were twofold: on the one hand they had to control infectious diseases, and on the other hand they were responsible for questions regarding personal health (Schmiedebach, 2002). Pettenkofer argued that the financial investments in public health are justified, because

they provide returns by making the population more healthy and able to work more (Fee, 1994, 191-192). Many Germany cities throughout the German empire copied the public health reforms in Munich and Berlin - especially in the highly populated and strongly industrialized Ruhr area (Weindling, 1994) - except for Hamburg, “where rugged economic and political liberalism prevented collective action for the creation of a modern sanitary urban infrastructure” (Porter, 1999, 108).

At the turn of the century, public health policies in Germany changed, because the tasks of the *Kreisärzte* (public health officers) increased considerably. The problem was that the quality and activities of public health services varied greatly among various cities, because those services had emerged locally in very different ways and were subject to local politics as the public health officers were employed by the cities. Moreover, doctors working for communal health services were mostly Jewish, as opposed to the public health officials working for the state health departments. Because these groups had different approaches, the differences in public health practices between regions and cities increased even more, and with them the demand for a substantial reform. Following the Cholera epidemic in Hamburg, Prussia passed a new law regarding health services that increased the tasks of the public health officers. The *Kreisarztgesetz* of 1909 gave the following tasks to the *Kreisärzte*: medical oversight, sanitary oversight, and social hygienic tasks such as health education and delivery in schools, caring for mothers and children, and caring for handicapped, mentally ill, and addicted individuals. Additionally, these tasks entailed expertise in forensic medicine. The reforms not only unified the communal public health services and increased their tasks but also allowed the state governments to intervene in matters of health policing and to have more direct control of public health services (Labisch, 1982).

However, public health was not only in the hands of the state. Apart from the official public institutions of public health, voluntary non-governmental organizations were also concerned with public health. These health societies (*Bürgerliche Gesundheitspflegevereine*) played an important role for the emergence of a public health consciousness. Founded in the 1860s and 1870s, they were an organ of middle-class self-organization on a communal level, with the goal of controlling public health. Oftentimes the mayor or the municipal government played a leading role in these organizations (Schmiedebach, 2002). In Prussia, family welfare was externalized to philanthropic agencies, such as the *Kreisfürsogestellen* which were intermediate, semi-official agencies (Weindling, 1994). What is more, although prevention of epidemics was the most important issue for public health policymaking in the late nineteenth century, public health was already concerned with risk factors, which are the main subject of today’s public health policies. In the early nineteenth century, Prussia banned smoking in public and the police would seize tobacco from smokers. During the revolution, smoking was permitted again, but tobacco control policies had been an issue of public health policy since the second half of the nineteenth century (Porter, 1999; Gottweis, 2004, 300).

Contrary to the public health sector, health care was institutionalized on the national

level, in 1883. As other countries, Germany had a voluntaristic tradition of health policy, which included the provision of health by local and voluntary organizations. However, the state-led social policies of the late nineteenth century challenged the voluntaristic model by using interventionist policies, such as sickness, disability, old age, and unemployment insurance (Porter, 1999, 198). The motivations for introducing social legislation were to prevent socialist challenges to state authority from politically disenfranchised workers and to arbitrate disputes between employers and employees. Similarly, the purpose behind the introduction of public health insurance was to protect the population from impoverishment, because this would reduce political support for the radical, politically organized workers. In order to respond to some of their demands, Emperor William I passed a law introducing general health insurance in 1883 (Diederichs, Klotmann and Schwartz, 2008). The health insurance organizations that were established in 1883 were compulsory; one third of the financing came from employer contributions and two thirds came from employee contributions. Local *Krankenkassen* collected the contributions. Since 1876, the *freie Hilfskassen* had been legalized and had served as an alternative form of compulsory health insurance (Hennock and Peter, 1987; Mommsen and Mock, 1981; Porter, 1999). The origins of the *Hilfskassen* can be traced bad to the voluntary health insurance of companies, corporations and professional organizations since the Middle Ages. In the course of industrialization the interventionist state nationalized these insurance carriers in order to address social problems (Gottweis, 2004; Steindor, 2009, 191-193).

Although the officially announced goal of the health insurance was to prevent the impoverishment of workers in times of sickness, they focused on the provision of medical services. The insurance employed doctors under contract in exchange for their right to work for individual fees. This regulation of the medical profession was a subject of constant political quarrels between the medical profession and the state; for instance, in 1913, the medical profession went on strike against the poor working conditions and doctors were able to secure an agreement (the Berlin Agreement) that allowed them to close a universal contract that applied to all health insurance organizations (Porter, 1999, 199). On the other hand, however, the inclusion of doctors reduced their political power as a pressure group, because their position in the self-administration of the insurance programs secured important benefits. The introduction of a common health insurance was the onset of a period that led to the introduction of further social policies in Germany. Following the introduction of common health insurance, the government created an accident insurance (1884) as well as an invalidity and retirement insurance (1889). The special character of these laws for social inclusion in Germany was not that they were a consequence of democratization, but that they were used by the ruling elites in order to avoid it (Alber, 1982; Schmidt, 2005*b*; Rosenbrock and Gerlinger, 2014). In the following years, the scope of individuals covered by the insurance continuously increased, as did the services it provided. In the beginning, only a small group of blue-collar workers were entitled, but soon white-collar workers and pensioners as well as non-insured family members were also included. In 1885, just 10 percent of the population was insured; by 1924/25 the figure

was over 50 percent; and in 1975, 90 percent of the population was insured (Alber and Bernardi Schenkluhn, 1992).

Apart from political appeasement however, health and other social insurance pillars aimed at connecting the working masses to the state and to create and maintain a workforce that was able to perform and deliver economic growth in order to permit nationalist expansion politics (Ritter, 2010). However, the introduction of the national health insurance not only regulated professional politics; it also made medical care affordable for a much larger population group, basically opened a new job market for (academically trained and examined) doctors, and provided legal and financial grounds for medical practice. However, the introduction of the common health insurance did not provide resources for public health measures such as policies entailing primary prevention. In such cases, it was not necessary to visit a doctor. As a consequence, in Germany, national health policy abandoned the dietary component of medicine - along with hygiene, stress management, nutrition and gymnastics - in favor of a sole focus on medical treatment (Steindor, 2009). population-focused policies was also apparent in the accident insurance law of 1884, which put little focus on prevention. Its focus was on providing care in case of accidents that had already happened, as well as reimbursing the salary of victims (Milles, 2002). At the turn of the century and during the early twentieth century, health policy primarily focused on the strengthening of social insurance, including health insurance. For instance the *Reichsversicherungsverordnung* of 1911 created a unified social insurance legislation, which was comprised of health accident and retirement insurance. At the same time the regulations for payment of health insurance were unified. Because they had previously been used to compensate the lack of income in case of sickness, their profile changed in the direction of the goal to retain and recreate the health of the public (Gottweis, 2004).

To sum up, in the period from the late nineteenth until the early twentieth century, health care and public health were institutionally distinctive in Germany. To some extent, this is not surprising, because the German Empire was only reunited after the Franco-German War of 1870-1871. Yet, although Germany was a federal state, the national government had a great deal of leverage in policy making, due to framework legislation and the centralized bureaucracy. However, this did not lead to the institutional integration of health care and public health. Whereas the establishment of a national health insurance was a nationalization of health policy, the same did not occur with regard to the municipal and state public health services, which remained entirely the legislative responsibilities of lower levels of government.

7.1.2 Professional differentiation and political inclusion of doctors

In the late nineteenth century, professionalization in the health sector generally increased. In 1873, the National Society for Public Health was founded as an offshoot of the German Association of Scientists and Doctors. The members of this society had a strong admiration for British public health reformers. At the same time, public health research advanced considerably and became a thriving scientific discipline in Germany.

The interpretation of the evidence for infectious diseases changed constantly. Virchow and others argued in the mid-nineteenth century that the social position of the individual influenced sicknesses. Results of experimental research on hygiene showed that the origins of diseases could be found in soil and other environmental factors. Based on these findings, regulations regarding the improvement of public and personal hygiene were passed. These measures led to the reduction of mortality from infectious diseases. Later on, in the twentieth century the success of such public health policies became the basis for the criticism of medicine and health care-focused health policy (McKeown, 1979; Weindling, 1994). In the late nineteenth century, researchers found out that specific health conditions and the environment were mutually reinforcing causes of health problems. From this perspective, new preventive strategies such as social hygiene emerged. This form of prevention focused on certain disadvantaged groups and later became part of eugenics (Weindling, 1994).

In the late nineteenth and the early twentieth century, German health sciences had taken an important role in the advancement of the discipline worldwide and garnered international recognition. Some authors even argue that the development of "new public health" in the 1980s can be traced back to scientific contributions to public health made 100 years ago in Germany (Labisch, 2012, 55). The aforementioned Max von Pettenkofer is known as the founder of *scientific hygiene* in the middle of the nineteenth century; he often referred to England as an example for successful epidemiological research. One of his successors was Robert Koch, who developed bacteriological techniques in the late nineteenth century (Labisch, 2012, 55). *Medicinische Polizey* was another sub-discipline of public health that referred to how health policing could be implemented and legitimated in the best way. The discipline was originally part of legal rather than medical studies, but in the late 18th century medical research was included in this discipline (Labisch, 2012, 63). *Bacteriology* was another branch that profited largely from research in Germany. The discipline argued that an illnesses can be traced back to a single bacteria rather than a combination of societal factors. Under the leadership of Robert Koch, significant advancements were made in this field. Bacteriology changed the paradigm of public health, because it allowed policy makers to pursue campaigns that were specifically directed against certain diseases, such as typhus or yellow fever (Labisch, 2012, 62). Based on bacteriology another scientific discipline arose, which was called *constitutional hygiene*. Under the leadership of Ferdinand Hueppe (1852-1938), it combined the bacteriological findings with a focus on environmental factors. *Racial hygiene* and *eugenics* were other offshoots of public health sciences in the late nineteenth century. Reacting to the findings of hygienic and bacteriological sciences, eugenics and racial hygiene argued that hygiene and medicine would obstruct national selection and result in an increase of *weak (lebensuntüchtiger)* individuals. These Social-Darwinist arguments would later become the basis for the racist population policies of the Third Reich. *Social hygiene* was the last among the important public health sciences in the late nineteenth and early twentieth century and had many connections with new public health of today, as it traces certain illnesses back to specific groups and their often pathogenic lifestyles, and argues that primary prevention

is needed to change these problems (Labisch, 2012, 62-65).

Public health sciences came along with demands for state-employed doctors. After the 1890s, especially eugenically thinking doctors demanded schemes that made all doctors state officials, yet in reality, full-time public health positions remained rare. Until the early nineteenth century, public health policies had been made by states and cities without the participation of doctors, and sometimes even against their ideas. It was primarily the elites in city states that discovered the necessity for public health policy and eventually public medicine to sustain cities as social units (Labisch, 2012, 61).

The literature I am taking into consideration concerning Germany argues that public health also had a political dimension, as I will explain in the following. Many of the doctors who were employed in the communal public health services were part of liberal - and, after the First World War, socialist - political circles; often they were of Jewish origin (Labisch, 1982). For workers and voluntary organizations public health was an important field to pursue political activities and to demonstrate political autonomy and resistance in the authoritarian *Kaiserreich.* For instance, in 1892, there was a boycott of the Royal Charité in Berlin after a cholera epidemic, in order to protest against the poor public health conditions in the city state. Oftentimes, public health doctors were simultaneously the leaders of strikes and boycotts and justified their political activities using ideas of public health (Labisch, 1985). They regarded public health policy as a means to oppose the political establishment and politicized public health in a partisan fashion. During the late nineteenth century, public health policies were continuously extended; in 1871, factory inspections became compulsory and were applied universally after the unification of Germany (Porter, 1999, 198). In 1899, *Kreisärzte* were employed in full-time positions based on the British model. However, Germany did not have the same degree of professionalization and density as the British MOsH. Yet, at the same time, proponents of social hygiene and social medicine demanded a more encompassing national health service. Such demands were oftentimes colored in the political direction of the party that had voiced them (Porter, 1999, 109).

So much for the public health profession. On the other hand, however, in the late nineteenth century the state had already taken an important role in shaping the medical profession and separating it from the public health side, which reduced responsiveness between the two sectors. In Germany, doctoral organizations were founded in the late nineteenth century (Baden 1867, Prussia 1887) (Porter, 1999). However, at the same time, in Prussia, the privileges of the medical profession had been abolished, and whoever wanted to do so could offer medical services. Consequently, the medical services were subject to the same regulations as other businesses, in the northern part of Germany (Alber and Bernardi Schenkluhn, 1992; Huerkamp, 1985).

The introduction of a national health insurance also had an effect on the formation of the medical profession as well as on its political activity. With the introduction of the national health insurance, in Germany, the state took a much more important role in shaping the medical profession than in the U.S.. In Germany, licensing was rigidly regu-

lated early on, and doctors were integrated in the social health insurance system, which strongly controlled doctoral practice. In Germany, doctors wanted the help of the state in order to protect their professional autonomy and degrees. This had consequences for the politicization of doctors in interest organizations. To the contrary, doctoral professional organizations in the United States emerged bottom-up from the cities and states, whereas in Germany they were created with a lot of organizational help from the state. In 1887, doctoral chambers were created in Germany. Doctors were connected to the health insurance that dominated the market, whereas education happened at the universities. The main question in Germany was how the state should intervene, whereas in the U.S. the problem was whether the state should intervene in the regulation of doctors. Subsequently, German doctors were much more closely connected to the state than their American colleagues, and much less politicized, which also spilled over to the public health side. In Germany the business of doctoral organizations focused on scientific exchange as well as friendly being together, while the self-regulation of the American organizations politicized doctors to a larger degree than in Germany (Gottweis, 2004).

The creation of the German welfare state occurred in the context of a conservative, patriarchal understanding of the state. These characteristics became clear in the design of the health insurance system. The German health insurance entailed mandatory participation, financial participation of the employer to pay the insurance of the employee, health insurance-focus on employed people, as well as self-administration of the health insurance and premium adjustment based on income (Gottweis, 2004, 193)(Lindner, 2004*b*). What is more, the German health system was the prototype of a neo-corporatist system of negotiations (Lehmbruch, 1988). It entailed the participation of a centralized interest organization in policy formulation and decision making from the very introduction of the health insurance system. In 1883, the Federal Chancellor aimed to include workers in the system of interest representation, in order to create a counterbalance to the Social Democratic Party and organizations that were close to it (Bandelow, 1998, 22). As a consequence, health insurance interest groups related to health care, doctoral organizations, dentists, pharmacists, hospital organizations and other actors play an important role in the self-governance of the German health system until today. They participate especially in tasks regarding quality management and the distribution of resources. In particular, interest organizations participate in decisions about the types of services that are covered by public health insurance and how much they cost. This self-administration is the lowest layer of corporatism in the German health system (Bandelow, 2004).[1]

However, with the inclusion of the medical profession in the statutory health insur-

[1]The public health insurance in Germany also had an effect on the relation of hospital organization and the state. In the nineteenth century a large system of hospitals had been developed, in order to cover most of what is today Germany. Between 1820 and 1870, hospitals became an important component of the health system. From the beginning, they had two functions. Firstly the social function, which is to provide doctoral help especially for the underprivileged. Secondly they had an educational function, which was to train doctors. With the introduction of national health insurance, hospitals came closer under the control of the state. Oftentimes, the creation of health insurance came along with an insurance fund, which paid for the cost of treatment in hospitals (Gottweis, 2004).

ance, the state made a deal with the medical organizations. They were included in the administration of the health insurance and consequently reduced their political activities as pressure groups. This also had consequences for public health policies; specifically, it reduced responsiveness between the public health sector and the medical sector with regard to health policies, for two primary reasons. Firstly, their interests were located at different levels of government. District doctors *Kreisärzte* and public health professionals had a political interest at the state and municipal levels of government and had different educational and political backgrounds not only from doctors but also from administrators engaged at the national level with many health insurance organizations. Secondly, the foundation of a national health insurance in 1883 was important because it included doctors in the national health insurance system, which separated public health doctors from the medical profession and included the latter in the system of professional self-governance. This had consequences for the political activities of the public health sector, as it will become clear in the following sections. Yet, the emergence of public health as a policy sector in the late nineteenth century in Germany happened within an authoritarian regime. Consequently, public health is often associated with unity in Germany, because we assume that there is a strong interventionist state at work. However, the public health sector emerged with a lot of regional divergence and no strong public health authority within the central government. To be precise, public health emerged according to two different logics in the imperial period. On the one hand, the state led public health services had been created by authoritarian rulers as means for health policing. On the other hand, the communal public health services emerged from a sense of social responsibility for the population, mostly in the cities. The communal public health services brought together the mixed interest of communal magistrates, political groups, doctors, and citizens, and responded flexibly to regional demands and problems (Labisch, 1982).

Yet, demands for more public health policies also led to alliances between the medical profession and public health doctors, for instance with regard to increasing the autonomy and discretion of the medical profession in the self-administration of the corporatist health insurance. In the early years after the health insurance carriers were established, insurers had a strong position toward doctors, who were either directly employed by the insurance or bound to them by contract. However, doctoral organizations criticized the circumstances of their employment and protested against them. The medical profession campaigned in a coordinated manner against their inferior position in the insurance. In the course of the Berlin Agreement of 1913 (*Berliner Abkommen*), the health insurance's monopoly on the appointment of panel doctors was abolished. In this agreement among doctors and health insurance, the insurance lost the liberty to determine whom they would admit as a doctor and were forced to admit at least one doctor per 1350 patients (Alber and Bernardi Schenkluhn, 1992). At the same time, the dominance of university-educated medical professionals in the health care sector increased dramatically. In 1914, non-doctors were finally excluded from being reimbursed by the health insurance (Gottweis, 2004,

121).[2]

To conclude, during the late nineteenth and early twentieth centuries, there was not much responsiveness between health care and public health. Notably, the medical profession made a deal with the state and received a privileged role in the corporatist system of health care governance. In return, it did not act as a strong pressure group. Overall, doctors were less politicized with regard to public health than, for instance, doctors in Australia were during the same time period, but only focused on matters that directly concerned them, such as health insurance legislation. Therefore, public health did not have a strong professional lobby, because public health doctors and interest groups were rather weakly organized.

What do these results imply regarding the hypotheses I discussed before? I had assumed that Germany was a case of non-coupling of health care and public health, because it has a rather unified government and low professionalism. I hypothesized that there would be institutional integration, due to the framework legislation in place at the national level. On the other hand, I argued that low professionalism would come along with the absence of responsiveness between the two sectors. My assumptions regarding low professionalism were correct. As I argued in the theoretical section, the state controlled the education of doctors I Germany. The inclusion of the medical profession in the governance of the national health insurance system was an act of de-politicization, in the sense that it granted some employment to doctors (although there were still conflicts, of course). However, doctors were less politically active and did not defend public health policies and other matters in health policy as long as they did not concern their own material interests. Accordingly, there was less support for the agenda of public health from the side of the medical profession and partisan interests came into play in politicizing matters of health policynotably, public health. Population health policies became a political demand of left parties only, without the substantive backing of the medical profession.

Regarding unified government, my results are different from my expectations. Notably, although Germany had a unified government, there was no institutional integration of health care and public health. Public health policies remained at the discretion of the subnational and municipal governments, whereas health care policy became a national matter. As expected, contextual elements were not important for the German case.

7.2 Conflicts and integration of health care and public health (1948-1945)

In Germany, the interwar period can be split into two phases: the post-World War I period, which lasted until the NSDAP government and Hitler came into power, and the time under the Nazi-government, 1933 - 1945. The general context of the time was both

[2] In Germany, the most important interest organization of doctors is the *Hartmannbund*, which was dissolved in 1935 and newly founded after the Second World War. It represents residential doctors. Another important doctoral organization is the *Marburger Bund* that represents of doctors that are employed or are civil servants. The *Marburger Bund* was founded after the war, in 1947 (Groser, 1992; Gottweis, 2004).

favorable and unfavorable to responsiveness between the health care and the public health sectors. Infections were still the most pressing health problem, but earlier public health policies had some successes. At the same time, medical technology had improved, and many diseases could be cured. The increasing possibilities for curative medicine should have reduced support for public health policies in the medical profession. What is more, after the economic crisis of 1929, government austerity measures could cause distributional conflicts between these fields.

7.2.1 Between institutional separation and integration

After the First World War, public health policies took an important role in health policy. Prior to 1914 public health was mostly related to health policing in issues such as immunization and sanitary measures (Labisch, 1992). However, the First World War had strong implications on the population's health, and the state increased its responsibility regarding health policy in relation to voluntary organizations (Schleiermacher, 2002). In the early days of the Weimar Republic, the number and staff of public health services increased considerably, especially regarding the following target groups: (a) biologically valuable groups, such as newborn children and mothers; and (b) groups that were dangerous for the population's health, such as youth and individuals suffering from infectious diseases, particularly those infected with tuberculosis or genital diseases (Stoeckl, 2002).

In the time after the First World War, fears of the biological and social degeneration of the population began to rise due to the large number of mentally and physically wounded soldiers after the war. Consequently, public health efforts increased after the war. The tasks of the public health services were prevention and primary care, especially regarding tuberculosis, alcoholism, genital diseases, and mental illness. At the same time, the interest in preventive health policies was significant, because the cure of many diseases was still difficult if not impossible (Schleiermacher, 2002). Already during the war, public health measures had become important. For instance, the national government centralized the *Fürsorgestellen* into integrated health services (Porter, 1999, 192-193). Other measures entailed the reduction of infant mortality among the working classes by financing community health centers, which aimed at preventing diseases, especially among infants, by distributing milk and educating mothers on how to keep their children healthy. Thereby these centers combined primary care with health education (Steindor, 2009).

In this context, there were different propositions regarding the institutional relation of health care and public health. Public health reformers proposed to integrate health policy in a national ministry of health that would combine the municipal and state public health services and the national health care financing services into a common institutional framework, which would also coordinate the levels of government. Yet, such a proposition would have entailed the dissolution of the existing structures, namely the statutory health insurance, which were part of the social insurance legislation. The project to create a national ministry of health combining health care and public health failed. Health care financing remained part of the social insurance legislation and public health remained

institutionally subordinated to it the state and municipal level (Schleiermacher, 2002).

From 1910 to 1945, reforms in German health care policy focused on the expansion of statutory health insurance financing and coverage. The health insurance legislation of 1911 (*Reichsversicherungsverordnung*) created unified social insurance that was comprised of health, accident, and retirement insurance. At the same time the regulation for health insurance payments was also unified. Originally, the goal of the health insurance was to compensate for loss of income in case of sickness. With the passage of this legislation, its profile changed and payments for health care services became more important (Gottweis, 2004). At the same time, the health insurance increased the scope of included groups; incorporating women and children in the health insurance resulted in a significant improvement of the coverage of the population, as well as the state of the population's health in general (Steindor, 2009).

Rather than setting up a national ministry of health to pursue public health policies, reformers attempted to include prevention and public health in the statutory health insurance. Beginning in the mid-1920s, health insurance began to include preventive measures in their portfolios. In 1925, the federal parliament decided that doctors could bill for preventive measures, but only in case of concrete health problems such as tuberculosis or genital diseases (Labisch, 1991). Yet, the inclusion of prevention and public health in the statutory health insurance came with problems. Legally speaking, social health insurance could not be active with regard to preventive measures, because they were only allowed to pay for interventions that occurred once a sickness had already arrived and the funds in the health insurance could only be used when a doctor declared an individual to be sick. Policies and projects that aimed specifically at prevention could not be reimbursed by the health insurance. The second book of the *Reichsversicherungsordnung (RVO)*, the law regarding the health insurance, only allowed them to cover costs for general purposes of health prevention. However, the legislation also specified that such measures should focus on all members of the health insurance. The insurance focused on health education by distributing leaflets and setting up exhibitions that aimed at informing their members about health risks. This was an improvement of the situation; however, health insurance was not allowed to invest in individual prevention, especially secondary and tertiary prevention, to prevent sicknesses from breaking out. Such measures needed to be covered by the invalidity insurance, and patients were transferred there on a voluntary basis. Costs for prevention could only be covered if they were not aiming to prevent sicknesses rooted in prior dispositions, because this would cause a steep increase in membership fees. Therefore, those costs had to be transferred to the invalidity insurance (Moser, 2002; Steindor, 2009). Such a development was problematic, because it divided patients and focused the health insurance on short-term problems. A broader focus on secondary and tertiary prevention could have helped to decrease costs for health care for the elderly population. Moreover, chronically sick individuals were immediately relegated to the state of invalidity. These practices not only provided the basis for the racist health policies of the Third Reich, they also demonstrated the inability of the health insurance to act in the interest of public

health.

The proposed inclusion of public health in the national health insurance led to conflicts between medical doctors on the one hand and public health doctors, such as hygienists, on the other hand, which I will discuss in the following section. At the end of the 1920s, health care and public health remained structurally separated; health care continued to be included in the social insurance institutions, whereas public health remained located at the subnational and the municipal levels of government.

Institutionally, the relationship between health care and public health changed after the Nazis seized power in 1933, which brought profound changes in health-policy making. In the health care sector, the new government curtailed the corporatist autonomy of the health insurance system and the power of medical associations increased. Specifically, self-governance of health insurance came under the supervision of the state, especially the department of labor, and pluralist structures dissolved. A newly appointed commissioner for the organization of the German health insurance dissolved the self-governance structure, but also the possibilities for health insurance organizations to ran their own clinics, laboratories and dispense drugs (Alber and Bernardi Schenkluhn, 1992). The coverage of health care services was extended for the population in general, but some groups were excluded, among them Jews, disabled, but also members of the political opposition (Schwoch, 2002).

During the Third Reich, the Nazi government reduced the political influence of the health insurance, but doctors retained their powers and extended them even further (Lindner, 2004*b*). At the same time, the pluralist structures in the supply of health care, such as the health insurance, were deleted in favor of an oligopoly of private providers. The result was a consolidation of the position of general practitioners, the weakening of the health insurance, and the elimination of all other interests that suggested an alternative concept of health policy - actors that could have questioned the dominance of private practice in health care such as social hygienists and social medicine (Alber and Bernardi Schenkluhn, 1992, 55). In addition to exploring the similar interests of doctoral organizations and the Nazi government, researchers have argued that doctors and scientists were fascinated by the exclusive character of the national socialist racial hygiene and its ideas and phantasies of societal engineering by means of social and health policies. In his speeches, Hitler often referred to the Jewish race or other groups as diseases, parasites, or bacilli that threatened the body of the German people. The laws regarding sterilization and the ban of interracial marriages followed up on this rhetoric (Ernst, 2001). This systematic exclusion of unwanted groups preceded the mass killings after the beginning of the war and the invasion of the Soviet Union (Labisch, 2012). The German medical profession adopted the idea that besides curing individuals, they needed to heal the German popular body; they adopted ideas of racial hygiene and implemented these concepts as part of their patriotic duty. Consequently, the medical profession transgressed and monopolized public health, although in a perverted way. Resistance to these practices was rather minor, since the Nazi government systematically controlled the medical power,

which included the expulsion and incarceration of those who deviated from these ideas (Alber and Bernardi Schenkluhn, 1992; Ernst, 2001).

In the public health sector, under the Nazi government reforms entailed the inclusion of eugenic thought in public health policies and the nationalization of the public health services. The institutional consequences of this development were a merger of the municipal public health services with those of the sub-governments of the federation (Germany officially became a unitary state in 1934). Among the tasks of these new public health offices was the implementation of the new sterilization law of 1933, which aimed at non-Aryan population groups. This entailed a revival of the tradition of medical policing, which had been present in Germany during the nineteenth century, but this time on a more biological basis. As a consequence centralized health institutions supported by the medical professions became a central part of the execution of the Holocaust (Weindling, 1994; Eberle, 2002; Rosenbrock and Gerlinger, 2009). After the Nazis had seized power, the NSDAP subsidized the public health services from its own funds. Based on money that came from the National Socialist Party, they invested everywhere in the public health services, which had previously lacked funding but could now be more effective - for instance, in helping tuberculosis patients. However, most of the voluntary workers as well as public health doctors were dismissed if they were Jewish or had leftist views (Stoeckl, 2002). In 1934, a major reform merged the health police on the state level with the communal public health services (*Gesetz über die Vereinheitlichung des Gesundheitswesens - [GVG]*). This was the end of the dualism of health protection between the member states of the federation, which were responsible for prevention of and reaction to infectious diseases, and the municipal public health services, which had been responsible for secondary prevention and primary care at the individual level and had been an important element of the German public health sector (Labisch, 1982). The reform resurrected the medical police tradition - though based on a biological nationalistic concept and not as an individual democratic right as the post-1848 reformers had done it. The law replaced social with racial hygiene (Labisch, 1991). It created public health offices on a nationwide scale (Labisch and Tennstedt, 1985). The task of these public health offices was to take care of the population's health. This entailed health policing, racial and hereditary politics, health education, school health, counseling of mothers and children, prevention of tuberculosis, genital diseases, and the care of disabled and addicted individuals. They also covered preventive examinations that had to occur regularly. In 1935, ordinances to implement these policies were created and public health services established all over the country. Consequently, racial public health policies were institutionalized (Schwoch, 2002) in combination with the prevention of epidemics and environmental toxicology (Eberle, 2002). Eventually, the public health authorities became the legal basis for the support of medical support for the Holocaust (Rosenbrock and Gerlinger, 2009). For instance, the new public health offices (*Gesundheitsämter*) implemented the sterilization law of July 1933 and the marriage health laws of 1935. Medical officers played an important role in the implementation of the racial and population policies (Weindling, 1994; Gottweis, 2004).

It seems like an irony of history, but during the Third Reich, the unification of the public health services continued. What is more, Weindling has even argued that the area of Nazism had a decisive role for the expansion of Germany's welfare state, because it increased unification and professional autonomy of doctors. The unifying tendencies of Germany and the German state in the period of Nazism become very clear in the concept of health including the regime's attempts to engineer public health by means of eugenics. The leading role in this game was in the hands of the medical profession, an elite profession that was active at the forefront of national unification. In the authoritarian regime of Imperial Germany after the unification of 1871, a plethora of sciences had emerged; among them the medical profession took an elite position. Due to the lack of public accountability as a weak democracy, a vision of a nation based on health and population health policies had become apparent. According to the idea of eugenics, but also social hygiene, medical activities were supposed to be undertaken with the good of the public in mind, which meant that weak individuals should be eliminated for the good of the society.

Science had a popular as well as an elite function. In its popular version, scientific results were published to educate the masses based on new techniques of publication. The emerging dominance of the natural sciences provided elites with the temptation to solve popular problems with scientific methods. For individuals, medical degrees provided the means to enhance their social status and personal reputation, and were a foremost desire of the *Bildungsbürgertum*, who advocated the unification of Germany. At the same time, the industrialization, urbanization, and scientification of health led to a high demand for healthy lifestyles; in this context, eugenicists demanded power for doctors to control health care on a racial basis. Health reformers had always demanded the unification of health services headed by a doctor. However, in the course of modernization, they also demanded to be free from the control of public authorities and to have professional autonomy. In the late nineteenth and early twentieth centuries, society had become more and more dependent on doctoral services. In the course of this development, some doctors claimed that they had the authority to override the rights of individuals in the interest of the coming generations. In the context of authoritarianism, individuals lost their rights - first in the minds of health professionals, and then legally. Eugenics was a movement that endeavored to move beyond party politics and to improve societal conditions based on science. It was also the attempt to create a new professional role in response to the overcrowded universities and the large numbers of practicing doctors. Proponents of eugenics wanted to create new areas of scientific medicine including sexuality and mental illness. At the same time, they developed strategies to neutralize social problems such as poverty, crime, and addiction by medical and scientific strategies. Such ideas were of great interest to the Nazis and fit with the general fear of national unfitness at the time. There were similar eugenics movements in other countries - for instance, in France and Britain. However, in Germany, there was a strong populist movement of racial nationalism that was open to providing professional autonomy and social control in exchange for scientific support for racial socialist policies (Weindling, 1989).

This was the basis for racist public health policy in Germany from 1933-1945, which extended also to primary prevention. For instance, during the Third Reich, Germany had a restrictive tobacco control policy, which was also motivated by racist reasons, especially to protect the race from the effects of smoking. The tobacco control policies included smoking bans in street cars and bunkers, for soldiers in service, and in party offices. The actors that supported tobacco control policies included the NSDAP as well as many doctors who fiercely argued for tobacco measures. The Nazis justified tobacco control measures with reasons of racial purity. The tobacco industry opposed such claims as fanatical and unscientific; yet, tobacco control policy also shows that the public health policy in the Third Reich entailed a double face, because cigarettes were distributed to troops in the field (Proctor, 1996; Ellerbrock, 2002).

To sum up, the institutional relationship of health care and public health in Germany during the interwar period and the Second World War had two faces. During the Weimar Republic, health care and public health remained institutionally separated. Health care was governed at the national level, because the national health insurance remained the dominant paradigm of health care policy, and due to the fact that such insurance was mandatory. Public health was managed at the state (health protection) and municipal levels (secondary prevention, health education). There were some attempts to integrate both sectors by trying to include public health and preventive policies in the health insurance, but this did not work very well, because the principle of prevention was legally incompatible with the health insurance. During the Third Reich, health care and public health were institutionally integrated. Health insurance carriers lost their dominant role and a national public health service was created. Policies of both sectors became integrated - mostly, however, in the context of the Holocaust.

7.2.2 Conflict, cooperation and the decay of public health

Whereas health care and public health had been institutionally distinctive from one another during the 1920s, they were merged and integrated during the Nazi government period after 1933. With regard to the responsiveness between these policy sectors, conflict and ignorance of groups belonging mainly to either health care or public health prevailed before 1933, whereas there was responsiveness and even policy integration during the Nazi government. Yet, the conflicts had been solved by eliminating or expelling public health doctors and other workers in the public health sector who had different political opinions. At the same time, the laws on racial discrimination and the Holocaust can be read as the policy integration of health care and public health, because they entailed a distinctively population-based approach to eliminating "sick" elements in the population and preventing the creation of new ones by banning interracial marriages.

After the First World War, public health played an important role in German politics, and public health professionals demanded more public health policies. Drawing on physical and biological research related to hygiene, they argued that social components were essential to improving public health and demanded laws to reduce causes of sickness

in the environment; however, they also argued that for some people health improvement and prevention through health-based social intervention was impossible, due to heritable information. They were very clear in emphasizing that handicapped and badly educated individuals are a cost factor for society (Schmiedebach, 2002). Social hygiene, which was the driving force of the public health sector in Germany, got more and more connected to eugenics, which was concerned with the genetic improvement of humans. This stream of thought within the public health profession was an open door for the politicization of preventive health sciences by the National Socialists.[3]

As discussed before, the interwar period also was a time of the internationalization of public health, for instance with the creation of the League of Nations' health organization, which promoted public health programs all over the world. However, social hygienists from Germany opposed international public health ideas, such as those proposed by the Rockefeller Foundation, and refused their implementation in Germany on the grounds that they lacked scientific evidence and would lead to an "Americanization of health policy" (Weindling, 2002). Yet, despite the refusal of international public health policies, policymakers urged for more public health policies in the interwar period. For instance, the new Prussian minister for population health, Adam Stegerwald, who was a member of the centrist party *Zentrumspartei*, demanded in his first speech on May 22, 1919, that the state should create administrative structures to target population groups with high health risks in order to examine them and provide primary care and health education. Consequently, future doctors would need to know the basic techniques of social hygiene and be able to include a population-based perspective in clinical treatment.

However, demands for more public health policies came with conflicts between medical doctors and public health doctors. For instance, in 1927, at the national meeting of the German Doctors (*Deutscher Ärztetag*) in Würzburg, Bavaria, the majority of the congress voted against more prevention and public health and was opposed to the recruitment of

[3]Eugenics were part of the German health and preventive health policy during the interwar period and the Second World War. The goal of eugenics was to select the best human genetic material by the means of public health policy, because social and medical modernization came along with a degeneration of the population, because they strengthened those that are weak anyway (Weindling, 1994). German intellectuals had a leading role in developing ideas of hygienics. In 1895, Alfred Ploetz founded the Society for Racial Hygiene (*Gesellschaft für Rassenhygiene*), amongst others as a reaction to workers enfranchisement. Ploetz and others argued that encouragement of the poor would result in the reduction of the quality of German blood and should therefore be discouraged. Ideas of racial hygiene spread during the twentieth century and became an important pillar of public health, as a part of public health sciences as well as the racist population policies during the Third Reich. In 1903, the Journal of Racial and Social Biology was founded. In 1905, the Society for Racial Hygiene followed. The movement proposed selective breeding as a means to create a good race and discourage counter-selection, for instance through sterilization (Weindling, 1989; Porter, 1999). In Nazism, this concept was mixed with racial ideology to a form of racial hygiene, which became the ideological basis for the holocaust. Darwinian theories became also popular in another discipline of health: social hygiene, which was strongly connected to preventive medicine. Its major proponent, Alfred Grotjahn argued that social hygiene should be an independent science using social pathology for prevention. For instance, the *Fürsorgestellen*, which had been created during the 1890s, did also combat *racial poisons* such as alcoholism, tuberculosis and veneral diseases (Porter, 1999, 192-193). The issue of racial hygiene affected also other professions, such as sociology. For instance at the first national meeting of German sociologists (*Deutscher Soziologen*), members of the Congress pointed at possible conflicts between eugenics and Christian altruism, and argued that such issues only could be avoided if no weak elements for the population would be produced anymore (Stoeckl, 2002).

doctors responsible for public health measures. As a consequence, many public health doctors took this as an offense and increasingly favored the merging of the existing organizations of public health doctors into a strong national organization. The concerned groups were composed of municipality doctors, school doctors, public health doctors, and tuberculosis doctors, as well as civil servants responsible for public health matters in the municipalities (Moser, 2002). However, the conflicts among public health practitioners and free doctors who were mostly panel doctors for the national health insurance could not be resolved - above all, because there was no ministry of health, which could have regulated such conflicts (Weindling, 1994). Although the mentioned interest groups demanded more public health policies, these demands did not translate into more public health policies. During the Weimar Republic there were many doctors available. Along with the economic crisis there were conflicts among general practitioners (GP) and public health officers, who also were doctors. As a result, doctoral organizations opposed municipal public health services in 1927. On the other hand, during the financial and economic crisis of the 1930s, municipal health services became attractive employers for doctors, because private practices were difficult to sustain (Eberle, 2002). At the end of the 1920s, there was no change in the expenditures of the health insurance; they spent more on medical treatment and wage replacements for members than on preventive and public health measures (Moser, 2002). Moreover, during the economic crisis of the late 1920s public expenditures were reduced, which included investments in preventive health policies (Eberle, 2002). At the onset of the crisis of the early 1930s, the public health services lost most of their funding (Stoeckl, 2002). Public health depended again on voluntary services, which had also played an important role for public health in the interwar period (Ley, 2002).

The demands of social hygienists and other public health professionals to increase public health activities and enlarge publicly controlled health services fueled conflicts between doctors and health insurance, in which the public health doctors played an important role. In the years 1923-1924, a series of strikes by doctors could not be avoided. As a consequence, ambulatory services were founded in many cities, which hired doctors from all specializations for fixed salaries. Social hygienists were often responsible for this development. Later on, these ambulatory services would later define health policy in the Weimar Republic and then in the GDR in East of Germany. However the ambulatory services were not only the answer of the health insurance to striking doctors, but also a demonstration of the political goals in health policy of leftist parties and doctors, who supported integrated health services combining public health and healthcare measures (Schleiermacher, 2002)

After 1933, when the Nazi Party monopolized power and turned Germany into a unitary state with a dictatorship, responsiveness between the health care and public health sectors increased strongly. This did not occur because the new government adopted programs to increase understanding and integration between the two sectors, but rather due to the policies of the Nazi government against individuals with different ideological positions, ethnic origins, or religion, such as Social Democrats and especially Jews. As

discussed before, the public health profession had many Jewish and leftist members, who particularly felt the racial and ideological purification policies; even voluntary workers were dismissed. Members of the profession either emigrated, ceased to work, or collaborated with the Nazi government in order to implement a racist population health policy. What is more, public health services were also experiencing financial problems (Weindling, 1994; Stoeckl, 2002; Rosenbrock and Gerlinger, 2009).

On the other hand, many members of the medical profession became actively involved in the Nazi Party, as there was a possibility of being appointed in the administration of the health insurance and many positions had become free due to the expulsion of Jewish and leftist members. This development became visible in the high membership of the doctors in the NSDAP (Alber and Bernardi Schenkluhn, 1992, 51). In 1935, the Hartmann-Bund was dissolved and replaced by the Imperial Chamber of Doctors (*Reichsärztekammer*). These actions were part of the hierarchical structuring of the German health care system. Doctors were strictly controlled and selected for higher ranking positions only if they were considered absolutely loyal. The organization of socialist doctors (*Verein Sozialistischer Ärzte*) was dissolved. All those who wanted to occupy leading positions in the health care system needed to pass a special medical training program (Ernst, 2001). In 1936, the freedom of contract for the financing of hospitals ended; prices increases for hospital treatments were no longer allowed (Alber and Bernardi Schenkluhn, 1992). As of 1938, Jewish doctors lost their right to practice (Diederichs, Klotmann and Schwartz, 2008). These policies were also implemented in occupied areas. After the occupation of Austria, in 1938, the Nazis immediately sacked around 80 percent of the medical staff of the Medical School in Vienna (Ernst, 2001).

To sum up, in the interwar period there were conflicts between the actors of the health care and public health sectors. Notably, there were conflicts between the medical profession and public health doctors regarding inclusion of prevention in the national health insurance and the municipal public health services. Doctors opposed the connection of the two fields. After 1933, responsiveness between the health care and the public health sector increased, although these dynamics entailed the expulsion of the public health profession. Specifically, the part of the public health profession that had been in conflict with the medical profession regarding the implementation of a more state-centered public health approach was subject to political persecution. The result was a consolidation of the position of general practitioners, weakening of the health insurance, and the elimination of all other interests that suggested alternative concepts of health policy. These were actors that could have questioned the dominance of private practice in health carefor instance, social hygienists and social medicine (Alber and Bernardi Schenkluhn, 1992, 55). What followed was a high degree of responsiveness, mainly with regard to racist health policies, which excluded minorities from health services and also helped to construct and implement the Holocaust.

What are the implications of these results for my hypotheses regarding Germany? I had argued that health care and public health should be non-coupled, because of unified

government and high professionalism. My results were partially confirmed. For the first half of the interwar period, namely from the First World War until Hitler came to power, health care and public health were decoupled. Despite some attempts and an increasing centralization of other fields of social policy, most facets of public health remained the responsibility of sub governments and municipal governments. Policymakers tried to include secondary prevention in the health insurance at the national level, but without great success. After 1934, the Nazis set up a national public health service and integrated it with the national health insurance. This was soon after the abolition of the *Länder* governments. Consequently, there was also integration of the health care and public health sectorsmostly, however, in the context of racist public health policies. Before the Nazis came to power, there had been a distinction between health care and public health, despite a relatively unified government and centralized federalism.

Concerning professionalism, I expected that low professionalism in Germany would above all lead to the absence of responsiveness and conflicts. During the interwar period, the medical profession and other health professions were indeed politically active, but there were considerable conflicts between these professions not only regarding scientific questions but also because they were often linked to political parties. Public health doctors were often socialists or belonged to the political left, and the debate between health care and public health was politicized. Ironically, in 1934, the Nazi government integrated health care and public health, not as a reaction to the lobbying of public health doctors and the medical profession but in an effort to centralize all of the state institutions, similar to what happened in the Soviet Union. In that sense, the integration of health care and public health following a plan happened in non-democratic states. At the same time, there was responsiveness between the medical profession and those public health doctors who stayed in the country. Tragically, the common ground of both sectors in Germany was the justification and execution of racist health policies including the Holocaust. However, the political activity of health professions at the time focused on increasing their influence in relation to the national health insurance. For instance, they could not avoid including public health exams in the national health insurance in the 1920s. Politicization was different in Australia and the UK, where the medical profession in particular gained enormous political influence and had a lasting impact on political decisions.

7.3 De-coupling and subordination of public health (1945-1980)

I will now turn to the co-evolution of health care and public health in the period after the Second World War in Germany. During this time period, the context for health care and public health changed because of prior successes in health policy and the possibilities for curing infections. At the same time, notably in Western democracies, the focus of social policy shifted to benefits and services for the individual rather than the entire population. In the German case, I expected that due to the weak professionalism this context would

reinforce the absence of responsiveness even more.

7.3.1 Restoring institutional separation

Following the Second World War, health care and public health were institutionally (re)separated in the FDR. In the period directly after the Second World War, public health issues were crucial, since the infrastructure of the country was largely destroyed. Public health services had a crucial role in the prevention of epidemics, such as typhus, tuberculosis, and genital diseases. Based on experience and the technological developments of the past centuries, public health services were very successful in managing these challenges. Yet, at the time, important decisions were made for the future of German health policy. In the Western zones of occupation, ideas for a centralized health system were clearly refused. Rather than maintaining the integration of the health system with regard to public health and health care that had been present during the Nazi period, policymakers strove for a decentralization of the health system's administration and the restoration of the separation of health care and public health that had been in place during the pre-Nazi period. To the contrary, the Soviet occupying force restricted the political powers of the member states and administrative regions. It created a central administration for the health system (*Deutsche Zentralverwaltung für das Gesundheitswesen*), which became the basis for the central ministry of health that was eventually created in 1951.

In terms of public health, the two states followed two completely different principles. On the one hand, policymakers in the GDR pursued the principle of a collectivist social hygiene, whereas in the FDR public health was individualized in the shadow of individual health care (Labisch, 2012, 77-78).In the FDR, national health policy was above all health care policy. Specifically, the health care sector was reconstructed in the postwar area along the lines of the German welfare state and tightly coupled to it. This meant that the federal government retained the most power concerning the financing of health care, whereas prevention and public health went into the portfolio of the subnational governments (Int-GER-17, Int-GER-18). At the same time, the (re)construction of the (West) German welfare state occurred in contrast to centralization, collectivism, and a unified health service, because this was widely associated with National Socialism and Socialism in the Communist variety. Therefore, the government of West Germany followed the suggestions of the Allied occupying forces and the unions. Eventually, the founders of the FDR intended not to model their health policy according to the British and Scandinavian welfare states (Hockerts, 1991, 363-364)(Schmidt, 2005*b*).

Health policymaking in the new republic referred to competing policymaking between the Länder and the federal government. This meant that the federal government could interfere in areas regarding international agreements, such as agreements with the WHO, and measures regarding health protection. The rest was in the power of the MS. The federal power to take legislative initiatives referred only to health protection (Lindner, 2004*b*, 39). These constitutional arrangements were a strong protection against recentralization after the Nazi area. With the foundation of the FDR in 1949, health policy became

part of the concurrent legislation, but with a strong emphasis on the member states' role (Labisch, 2012, 79). This had consequences for the development of the public health services and their institutionalization. The most important institution of public health in the postwar area were the public health services (*Öffentlicher Gesundheitsdienst*), which were established at the communal level and had emerged from the territorial public health services of the territorial states on the one hand and the municipal public health services on the other hand (Labisch, 1982). The importance of these services declined significantly in the postwar area and they lost their central role in public health. Public health services remained important for health protection (Schmacke, 2002), but in the postwar area public health was "medicalized." This is a trend that occurred in many countries; however, in Germany, GPs not only informally used this trend to establish the superiority of public health but also made sure that they became formally responsible for prevention and therefore for public health measures (Labisch, 1991). To the contrary, all attempts to establish public health measures systematically under the auspices of public health services failed (Schmacke, 2002).

The marginalization of the municipal public health services in Germany was a consequence of the weakness of the central state in regulatory health policy, and public health turned into a marginal sector or a "rest-subsystem" (Labisch, 1982). After the war, health policy in Germany was regulated by a magnitude of bylaw regulations and decrees that had to be passed by the various levels of governments: interested communities, the states, and the federal level. In this process, the responsibilities for preventive health policies were distributed among the various levels government, as well as among the states and the corporatist health insurance. In a way, the public health sector in Germany reflects the healthcare sector because parts of the responsibility for the provision of preventive health as well as financing lay within these institutions. However, along with this system came a diffusion of the responsibility for public health among the various levels of government and the public bodies of statutory law governing the health sector in Germany (Schmacke, 1993; Schmacke, 1996). On the other hand, in the 1950s public health was mostly focused on pregnancy and education issues and was the domain of the panel doctors of the statutory health insurance (Int-GER-7).

The Soviet Military Administration had a health department with medical officers on its staff. In 1946, a central health administration was formed. It was the first central health authority in Germany. The proclamation of the GDR was followed by the establishment of a department of health in the Ministry for Labor and Social Welfare. This was close to the demand for a unified ministry of health, but the separate Ministry of Health was formed soon thereafter. The GDR continued the tradition of social hygiene based on unified social insurance, occupational health services, ambulances, and polyclinics. Primary care was provided by polyclinics that were localized in the workplace or residential areas in coordination with the insurance system, private medical practice, and church-owned hospitals. The system worked well in theory, but was heavily underfunded. In the Western occupation zones, the Allied forces did not have a separate health department and the

concern of health provision was limited to infectious diseases. [4] The rest of health policy they left widely to the Germans. Subsequently, the structures of the Nazi administration remained in place - for instance, the law for the unification of health services. The German Supreme Court confirmed this in 1957 (Weindling, 1994; Schmidt, 2005*b*).

Consequently, the federal government legislated very little regarding preventive health policy. For example, in 1953, the federal government passed a law regarding protection from genital diseases, but it was very liberal and gave little power to the state to coerce patients (Lindner, 2004*b*, 327-329). In 1956, the German municipalities debated public health measures and proposed increasing help for mothers and children as well as patients with tuberculosis, genital diseases, cancer, and rheumatic and heart diseases. However, these efforts did not result in specific programs (Schmacke, 2002). At the federal level, there was little effort by the national government to invest into public health in terms of preventive health care. For instance, in 1956, a federal law regarding preventive health care failed and was finally abandoned in the same year (Süß, 1998; Lindner, 2004*b*). The sub governments, which had most of the competences, did not fully use their possibilities in the area of public health services to create a public health system. An exception is North Rhine Westphalia, where public health services were more active than in other states (Lindner, 2004*b*). During the 1950s and 1960s, the *Bundesrat* (Second chamber of the German parliament) blocked the attempts of the federal government to further unify public heath services. In 1964, there was a debate about a law regarding dental services for kids (*Jugendzahnpflegegesetz*). Again, the *Bundesrat* denied that such a law was needed at all, and insisted that the federal government had no competences in this regard (Lindner, 2004*b*). Consequently, the federal government's powers remained confined to matters of urgent health problems; for instance a federal law regarding epidemics (*Bundesseuchengesetz*) was established in 1961 (Lindner, 2004*b*). This development has been criticized in the literature. Some authors even complain about a destruction of the culture of prevention in Germany (Schmacke, 2002, 182).

Postwar health policy at the national level focused mainly on health care and health insurance policies with a focus on increasing services and coverage based on the common pool resources. For instance, in 1954, supplementary payments of the communities or other public organizations were deducted from the hospital budgets (*Pflegesatz-Verordnung*). Subsequently, deficits increased (Alber and Bernardi Schenkluhn, 1992, 57). In 1955, a new law strengthened the position of the panel doctors (*Kassenärzte*). The panel doctors' organizations (*Kassenärztliche Vereinigungen*) were established as partners for the doctors (Alber and Bernardi Schenkluhn, 1992), and as a consequence doctors obtained a monopoly on providing health care (Labisch, 1991). Although the public health services were declared to be responsible for public health, public health funding was not raised in a similar manner (Schmacke, 2002). Doctors secured a monopoly for ambulant treatment and health insurance lost even more influence (Lindner, 2004*b*). The reforms of the public health insurance focused on increasing services and the scope of services. Reforms

[4]Nowadays, the Robert-Koch-Institut is the most important actor in this regard (Int-GER-2).

focusing on cost containment and sustainability proved to be more difficult. For instance, from 1958-196, the federal government tried to implement measures regarding cost containment, yet the program failed. This had significant consequences for the health system, because it demonstrated the power of the corporatist actors and arenas - especially the medical profession (Döhler and Manow, 1997; Gottweis, 2004). This dynamic continued in the 1960s, when the law regarding co-payments for the health insurance failed, in 1963 (Lindner, 2004*b*, 38). On the contrary, payments for health insurance increased again in 1965 (Lindner, 2004*b*, 39), and in 1969 the coalition of SDP and FDP set up another round of increases in health expenditures. In the period from 1965 to 1975, the expenditures for the national health insurance increased from 3.5 percent of the GDP to 5.9 percent; of that increase, 2.1 percent was in the period from 1970 to 1975 (Lindner, 2004*b*). Similarly, the percentage of the population that was insured in the public health insurance increased to 70 percent in 1950 and further to 91 percent in 1975 (Rosenbrock and Gerlinger, 2014, 43).

Institutionally, the health care sector was governed from the ministry that was responsible for social insurance. Until the mid-1960s, there was no ministry for health at the national level. However, many actors in the health sector demanded that such a ministry needs to be established, in order to govern the health sector properly. In 1957, the German Centre for Population Health Care (*Zentrale für Volksgesundheitspflege*) demanded the establishment of a national ministry of health to invest more in public health matters, but the SG denied this for reasons of principle (Soenning, 1957; Lindner, 2004*b*). Yet, demands for a national ministry for health increased. In 1961 the German Centre for Population Health Care again referred to the issue and argued that in many other European countries, such as Belgium, the Netherlands, France, Italy, and Luxembourg, health policy is a concern of the central state. This means that a national ministry is responsible for the most important areas in health policy. Consequently, they argued, the federal government in Germany needed to consider why it did not act in a similar way and create a national ministry for health (Lindner, 2004*b*, 42). In the same year a national ministry of health was created. It emerged from the section for health in the department of domestic affairs and was responsible for occupational health and occupational medicine, doctoral admission, dispense of pharmaceutical policies, health statistics, international health policy, as well as questions of environmental protection. Another institution was the federal public health office that was responsible for water-policy, food protection, especially dairy products, health education. However, the health insurance remained in the ministry for social insurance. The first minister for health, Elisabeth Schwarzhaupt, was especially active in women's and family policy. Following the creation of the Ministry for Health, most of the legislative reforms increased the services covered by the health insurance. In the public health sector, any further health reforms were not possible, because the SG blocked reforms in the *Bundesrat*. In 1969, federal Ministry for Health was included in the Ministry for Family Affairs and Women (Lindner, 2004*b*). In this sense, health care and public health remained largely separated and the health insurance principle dominated.

On the health care side, a series of reforms had passed in the beginning of the 1970s, aimed at cost containment and reforming corporatist self-administration rather than a general change of the health care system as had occurred, for instance, in Australia and Switzerland. In 1972, hospital financing legislation brought about changes, because it transferred responsibility for this policy area to the SG, which was now in charge of creating plans for the demand in hospitals. The health insurance only had to cover the costs of treatment, whereas the FG and SG would take over investments. New investments and retrospective fixation of costs caused an increase in costs in the health sector (Alber and Bernardi Schenkluhn, 1992). In 1976, a health insurance reform measure (*Krankenversicherungsweiterentwicklungsgesetz*) opened the phase of cost-containment reforms in health policy and the strengthening of the competences of the health insurance (Alber and Bernardi Schenkluhn, 1992).

In 1977, another reform created specific measures concerning cost containment and set up a coordination body to better facilitate reforms in the health system (*Konzertierte Aktion im Gesundheitswesen*). This coordination body was comprised of public and private health insurance, doctors, hospital organizations, pharmacists, unions, employer organizations, member states, and municipalities, as well as the federal Ministry for Economy, the Ministry for Social Insurances and the Ministry for Family Matters, which was also responsible for health policy. The creation of this institutionalized body aimed to facilitate reforms in health policy, especially with regard to cost containment; however, it remained close to self-governance, in the corporatist sense, of the providers and financiers of health-care. The establishment of this body entailed a new governance instrument that combined guidelines for the development of health policy in coordination with the discussed actors (Alber and Bernardi Schenkluhn, 1992; Gottweis, 2004). In the same year, the federal government passed a law to reduce the cost of health insurance. Besides addressing concrete measures regarding cost containment, the law transferred important reform competencies in the health system to the new body. Additionally, doctors and panel doctors were over-represented compared to the health insurance and patient organizations that were not even included in the council (Lehmbruch, 1988; Bandelow, 2004).

To sum up, in Western Germany, health care and public health were rather institutionally separated after the Second World War. Notably, health policy was essentially health care policy at the national level until the 1960s. Before that, no national ministry of health existed and public health was the responsibility of sub-governments. Even after a national ministry was set up, health care remained the responsibility of the Ministry of Social Insurances. Interestingly, this was in contrast to the GDR, where health care and public health were considerably more integratedfor example, in the polyclinics.

7.3.2 Transgression and ignorance on the actor level

After the war, American medical teams quickly began to set up measures against epidemics and to reinstall sanitary elements. They repaired water pipes and made sure that there was enough chlorine in the water. They offered hygienic services to individuals,

x-rayed fugitives, provided immunizations, and collected data to get an impression of the situation of the public's health in Germany. Above all, public health measures were focused on preventing epidemics (Ellerbrock, 2002). German public health doctors and TB doctors were very skeptical about these measures, especially about large scale immunization programs, because they were afraid of accidents. In 1928, there was an immunization accident in Lübeck, where schoolchildren had been infected with tuberculosis from contaminated serum and died. However, doctors from Sweden and Denmark urged German and American officials to carry out immunizations, which eventually happened. However, there were differences in approach and opinion between American and German doctors with regard to prevention of tuberculosis (TB). In the U.S., it was already clear before the First World War that TB from cows was responsible for cases of TB and milk should be sterilized. German doctors did not believe that this was a problem, which led to the infection of many children with TB from animals (Ellerbrock, 2002).

Generally speaking, due to the racist heritage of Nazi public health policies it was difficult to attend to matters of public health in Germany (Schmacke, 2002, 179). In addition to the differences between German and American public health officials, the establishment of professional structures in the public health sector proved difficult. As early as the summer of1947, there was a discussion as to whether a public health school should be founded in the Western occupied zones. The model for such a foundation would have been the U.S., with its 20 schools of public health such as the Public Health School at John-Hopkins University, which has been one of the models for public health schools around the worldfor instance, in Canada, France, and the UK (Brößkamp-Stone, 2003*b*). The postwar initiative in Germany was under the auspices of the Americans, who aimed at stimulating democratic ideas in the German health system. The Civil Affairs Mission of the military government financed this action. It caught the attention of the Rockefeller Foundation, which had been a supporter of public health schools in the U.S. for thirty years prior. J.H. Bauer, the leader of the Rockefeller Foundation in Paris, traveled to Heidelberg in June 1947 and found that the city, with its traditional university and working infrastructure, was well-suited to host this project (Ellerbrock, 2002). Yet, at the meeting at the Ministry for Internal Affairs in Baden-Württemberg, in early 1948, when the University of Heidelberg was supposed to present its concept, it became clear that its plans were too vague to be supported by the Foundation. Local professors had supported the creation of the school, but had not taken action themselves. The Rockefeller Foundation and American public health professionals, who had already prepared a dossier, stopped any further actions in disappointment. It is not clear why the university missed the opportunity to receive generous support for a new institute. On the one hand, this can be explained by the lack of interest in public health on the part of the German medical profession, following its involvement in the Holocaust (Ernst, 2001). On the other hand, such opposition is reminiscent of the similar but more overt reservations of German social hygienists toward international and especial American concepts of public health after the First World War (Weindling, 2002).

The goal of the American administration was to introduce public health as an Anglo-American concept. Another possible strategy would have been to put German social hygienists, who had emigrated during the war to the U.S.. However, any continuity with Weimar was to be avoided; therefore, the Americans ignored specialists such as Franz Goldmann in favor of sending young Germans to the United States to receive better public health education. For the Germans, on the other hand, public health was an American concept that had to stand back behind more important policies, such as health insurance matters. What is more, public health and social hygiene are similar in many substantial respects, yet their pre-war institutionalization was different. In the U.S., public health was a university-based science, whereas social hygiene in the U.S. was more communally oriented. In the U.S., public health was connected to university medical faculties; this was not the case in Germany, where the first course of studies in public health had been established at a university that had no medical faculty (Ellerbrock, 2004). The wider context of public health after 1945 was the same as that of social hygiene after the First World War. Yet, the possibilities of curative medicine had greatly advanced after the Second World War (Ellerbrock, 2004; Braun, 1994).

Throughout the postwar period, there was strong opposition in the medical profession to primary prevention. Panel doctors in the health insurance profited from the public health measures that were establishednamely, measures to improve pregnancy consultation and prevent sickness in mothers and children. In the early 1970s, when immunizations where introduced, this was also to the benefit of the panel doctors (Int-GER-7). This development entailed the transgression of health care on public health, because preventive measures came into the domain of public health doctors. Another example of the subordination of health care under public health and the transgression of the preventive by the curative sector is the case of anti-smoking policies. In the 1970s, when these policies entered the political agenda in Germany, courses to stop smoking were offered in popular universities, but there was little legislation regarding population- or setting-based approaches (Int-GER-9). Another public health issue that received political attention during the 1970s was workplace protection, which had been a weak spot in the German health system. Before the Second World War and in the early years of the Federal Republic of Germany, there was only little focus on health and safety at the workplace. Although unions and Social Democrats as well as the party of the center demanded more action in this area during the Weimar Republic, nothing had happened concerning workplace medicine. The first university professorship for workplace medicine was established in 1968. In 1976, a medical specialization in workplace medicine was created as a consequence of the workplace security law of 1974. In the GDR, the situation was much different, as workplace medicine had been established much earlier (Milles, 2002).

The institutional and professional differentiation between health care and public health was important, after all, and led to a loss of competences for the public health services, as in the field of health research and expertise. In daily practice, courts and social insurance demanded public health expertise from specialized institutions, such as experts in forensic

medicine. Prior to that, such tasks had been in the hands of the public health services. After the war, this development led to conflicts between general practitioners and public health doctors, in which the former accused the latter of being "public doctors," which was clearly derogatory because it made a connection to the role of public health professions during the Third Reich and to the health system in the socialist GDR.[5] Consequently, the majority of the medical profession opposed the concept of municipal public health services and disregarded the doctors working in them (Labisch, 1982). In the postwar era, one main argument against public health was that it had paved the path for the Holocaust. Opponents against a strong role of the state in health policy overall argued that the best prevention against the repetition of the Holocaust, and the perversion of public health that had come along with it, was to strengthen individual health care services in the postwar republic. Population-based and group-based preventive measures subsequently lost their agency (Eberle, 2002).

After the war, the rebuilding of the health system in Western Germany was closely tied to the role of clinically trained but freely practicing doctors. They took on the leading role in health care, but also generally in health policy. This was different from other countries, such as the U.S. or Scandinavia. Other health care professions developed in assistance to doctors. At the same time, the competencies of the health insurance carriers declined further. In 1951, the workers lost their representation in the public health insurance, which had been established in 1931. To the contrary, the GDR followed a different path than the FDR. The old system was replaced by a unitary insurance in which treatment and care were also provided by public offices. The center of the system was the Policlinic, where doctors provided ambulant and stationary services. Self-employed doctors were rare. In medical treatment, GP care was at the fore. With the end of the GDR, the West German system was transferred to the GDR, especially due to lobbying by doctoral organizations (Deppe and Müller, 1993; Schmidt, 2004).

The separation of health insurance and public health services had existed in Germany since the late nineteenth century and continued in the postwar area. Contrary to the GDR, a path-breaking reform did not occur in Western Germany. The federal minister for domestic affairs argued, in 1952, that the idea of social hygiene was alien to the idea of health insurance; therefore, it was difficult to integrated health care and public health in a common ministry of health (Lindner, 2004*b*, 42), as discussed in the preceding section. This argument sums up in a neat way what was going to happen with the ministry of health ten years later, as it did not receive competences in the area of health insurance. Directly after the war, the German health system was split along an organizational divide between social insurance and public health. The Ministry for Social Insurance was responsible for matters regarding the health insurance and health care. The Ministry of Domestic

[5] In the German Democratic Republic, the health system entailed state control, prevention was given a high priority, health education was important and occupational workplace protection was very important. The importance of health was even written into the constitution (Article 35). In this process, social hygienists, who had already been active in the discipline prior to the war, played an important role for the establishment of public health in the GDR (Lindner, 2004*b*, 39).

Affairs covered public health, doctoral admissions, public hygiene, infectious diseases, and food hygiene. Most of the SG had a similar institutional separation; only the city-states of West Berlin, Bremen, and Hamburg had senators for health policy. Coordination of health policies in the Länder were in the hands of the leading medical officers who met once a year and had an important role in the fragmented health system of the FDR (Lindner, 2004*b*). This created a strong path dependency in which public health remained subordinate to the health care sector, which could not be reversed by the creation of a national Ministry of Health in 1961.

As in other countries, health care was medicalized, yet in the case of the Western occupied zones this came along with the dominance and transgression of the medical profession. One of the major reasons for the subordination of public health to health care in the postwar Republic of Western Germany was that welfare policy was dominant. The interesting point about this is that welfare policy was in principle reactive to certain social or physical disadvantages; for instance, social assistance was only paid once an individual had already been injured, an accident had occurred, or a sickness had arrived. This is highly problematic for preventive health policy and structural public health measures, because they operate according to a different code or sectorial paradigm, as discussed in the theoretical section. Moreover, the public health services in postwar Germany were only available for those with low incomes. This meant that these services had a strong stigmatizing effect and not many people approached the public health services (Labisch, 1982; Stoeckl, 2002). Leading civil servants in the public health services of the Länder as well as public officers failed to explain in the debate that public health needs to exist complementarily to health care services and should be a high priority in the postwar society (Schmacke, 1993). As a consequence, the public health services did not make a general contribution to primary prevention and were not included in the health policy agenda of postwar Germany, and they never regained the important role they had in the Weimar Republic for population health (Eberle, 2002).

Consequently, policies related to health care and public health were separated after the war. Preventive health policies were included in the national health insurance and came into the hands of doctors. These were mostly prevention measures for the health of mothers and children. In the early 1970s, immunization programs followed and at the same time the first preventive exams were introduced. These prevention measures all entailed the participation of doctors and tried to include secondary prevention in the health care system. Therefore, a split occurred in German preventive health policy, in the sense that secondary prevention was included in the structures of the health care sector, whereas primary prevention lost its focus.

To sum up, actor responsiveness between the health care and public health sectors was absent. Notably, the medical profession strongly opposed public health matters for economic reasons, because doctors regarded public health professionals as competitors, but also for historical reasons, as public health had an explicit connection to the Holocaust in the Third Reich. This argument became the justification against public health policies in

the postwar era. However, the roots of minimal responsiveness between health care and public health had been laid before. Notably, the medical profession had made a deal with the state and participated in the self-governance of health policy. Consequently, it had not become a powerful pressure group. What is more, there was only a weak connection between health care and public health at the universities and in the process of professional formation, especially after the war. Due to the negative experiences of public health during the war, the restoration of the prewar situation strengthened the separation of the sectors even further.

What do these findings imply for my hypotheses regarding Germany? I had argued that health care and public health should be decoupled in the interwar periodnamely, because of unified government and the absence of professionalism. My results partly confirm these expectations. During the postwar period, health care and public health remained institutionally separated. On the one hand, this was the case because public health was a competence of the sub-governments, which in turn had very different methods of public health policymaking. On the other hand, despite the extension of the welfare state, public health policies remained separate from health care and rather underdeveloped. In other words, it was exactly because the focus of social policy was on cash transfers in case of sickness or poverty that the actual provision did not occur by the state as such, but was delegated to private actors. This paradigm overshadowed unified government in Germany and the central public health legislation that I expected to occur due to the strong state. On the other hand, professionalism remained weak in Germany, in the sense that the medical and public health professions did not join forces against the state to advocate public health. The medical profession did not take the role of a politically powerful pressure group, but remained included in the health care governance system along with other interest groups of the health care sector only. Doctors opposed public health professionals and their ideas for political reasons rather than trying to incorporate them in a national health policy agenda.

7.4 "New public health" in the shadow of sectorial de-coupling (1980-2010)

Beginning in the 1980s, public health returned to the political agenda in most countries across the globe due to changes in the context for health policy, such as the pressure of more non-communicable diseases, increasing budgetary pressures due to rising expenditures, decreasing economic growth, and critiques of classical medicine. This led, in many countries, to changes in health policymaking, with a focus on more public health policy. In the following section, I will discuss how this changed context played out in Germany, after the 1980s.

7.4.1 Public health policymaking in the shadow of institutional distinctiveness

As I will explain in the following, with the turn toward public health issues in the 1980s, the political reaction to them occurred on the basis of the social health insurance system, which lacked a legal basis for encompassing preventive health legislation, especially concerning primary prevention issues. Policymakers did not pursue major reforms to change health policy in a way that would have improved the legal basis for integrating health care and public health in a common legal framework. To the contrary, reformers sought to include public health and prevention into the existing national health insurance framework. For instance, the reform of the social insurance legislation, in 1989, extended the degree of preventive measures that were included in the public health insurance (SVRG, 1989). Yet this remained a limited instrument. Overall, health care and public health remained institutionally separated and distinct from another and the public health sector was subordinate to individual health care, as the legal bases for public health at the national level were limited and the responsibility for public health remained to a large extent with the member states.

Regarding health care reforms, a number of innovations passed that focused on cost containment and strengthened market elements in the provision of health care. In 1991, another law regarding cost containment in the health insurance sector went through Parliament (*Kostendämpfungsgesetz*). In 1985, a reform for hospital care passed (*Bundespflegesatzverordnung*). In the reform, the central government retreated from the financing of investments in hospitals the year before. In the new regulation, health insurance and hospitals now had to negotiate prospective tariffs for hospital care. Since 1977, all reforms had aimed at strengthening the competencies of interest organizations to create standardized guidelines for the provision of health care and to control the health insurance offices more strictly. Tasks that were the monopoly of doctors during the Third Reich are now common tasks of panel doctor organizations and health insurance carriers. Employers and unions have supported government initiatives to strengthen corporatist actors in favor of the pharmaceutical industry and the doctors (Alber and Bernardi Schenkluhn, 1992).

In the 1990s, further important reform projects were introduced in the health system. The health reform of 1993 (*Gesundheitsstrukturgesetz*) was very important in this matter. It was based on the Lahnstein-Kompromiss of 1992, in which the national government under the leadership of Helmut Kohl pushed through far-reaching reform proposals, which restricted the existing corporatist compromise, against the interest groups of health insurance and doctors. The main reform instruments were budgets for drugs, doctoral payments, and hospitals as well as the coupling of price developments to microeconomic indicators, which reduced the discretion of doctors regarding health insurance reform (Gottweis, 2004). This law stands out among the German health insurance legislation, because it is more than just a small adjustment of prior reforms. The law was a victory over pressure groups whose power has been a central element of German health policy since

the 1950s. The contents of the reform were several structural reforms, such as a change from the retrospective cost of coverage (*Selbstkostendeckungsprinzip*) to prospective and case payment. What is more, it was the first time since 1886 that all insured persons were free to choose their insurance provider (Giaimo and Manow, 1999; Carrera, Siemens and Bridges, 2008). Although the inclusion of interest groups remained an important factor and the structures of the financing and regulation system of the health insurance remained intact (Rosewitz and Webber, 1990; Döhler and Manow, 1997), the law of 1992 began a reform process that continued until the mid-2000s. During this process, policymakers continuously amended the set of political instruments governing health policy, in particular instruments concerning financing. These were, for instance, lump sums for payments, which increased the privatization of the health system (Bandelow, 2004; Gerlinger, 2009). Further reforms were the health insurance exoneration (*Beitragsentlasungsgesetz*), in 1996, the Second SHI Restructuring Act (*2.GKV-Neuordnungsgesetz*) of 1997, the Act to Strengthen Solidarity in the SHI (*GKV-Solidaritätsstärkungsgesetz*) of 1998 and the SHI Reform Act (*GKV-Reform 2000*) to equalize the law in SHI (*Gesetz zur Rechtsangleichung in der GKV*), in 2000 (Carrera, Siemens and Bridges, 2008). The German health reform of 2000 contains some measures aimed at strengthening doctoral rights, especially the rights of GPs compared to medical specialists (Gottweis, 2004). Also in 2000, Germany established a new payment system for hospitals (based on the DRG principle), which had the goal of reducing costs and improving transparency and quality. Implementation occurred in four steps and the system has been mandatory since 2004. In 2007, elements of competition in the health insurance were again strengthened (*GKV-Wettbewerbsstärkungsgesetz*). The reforms included DRG payments, co-payments, user fees, rationalization of benefits, and many other things. Among others, this reform strengthened primary prevention (Paquet, 2009; Carrera, Siemens and Bridges, 2008; Rosenbrock and Gerlinger, 2014). In 2008, occupational and public health insurance were merged into a new organization; one of the reforms' goals was to set up a workplace protection strategy (Rosenbrock and Gerlinger, 2014).

On the other hand, public health in Germany has remained separate and subordinate to health care since 1980. Although issues of preventive and public health were on the political agenda, they did not lead to major changes in the institutions of the health system in the sense that they better integrated health care and public health. Public health policymaking remained separate from health care policy.

The reaction of the German government to the returning demands for public health and prevention is a case of institutional drift (Hacker, 2005). When the global revival of public health policies set in during the 1970s, the German government attempted to solve these problems, on a national level, based on the SHI. In the health insurance reform of 1972, preventive examinations were introduced in the catalogue of services of the public health insurance (Lindner, 2004*b*; Alber and Bernardi Schenkluhn, 1992, 61). The left-liberal coalition that came into power in 1969, quickly passed some legislation increasing prevention and health education, but also the possibility of cancer screening

exams. However, these were mostly measures for individual-based prevention, which means that doctors were in charge of implementing these policies (Int-7-Ger). Some initiatives in this regard came from the health insurance themselves. For instance, in 1982, the local health insurance AOK (*Allgemeine Ortskrankenkasse*), in Mettmann, North Rhine-Westphalia, set up the first prevention project, named *Aktion Gesundheit*, which had the goal to encourage individuals to participate in sports. In 1982, eight other AOKs followed due to the positive evaluation of the program. The goal was to make a contribution to health education and cost containment, especially with regard to risk factors for heart and circulatory diseases. In addition, the AOK supported a program promoting dental health in schools and kindergartens. With the return of public health measures in the early 1980s, when the public health insurance began to create preventive measures, the same conflicts occurred as in the 1920s and 1950s. Doctoral organizations, in particular - such as the national medical association - argued that public health and especially prevention and population-based measures should be the tasks of doctors. However, in reality, GPs were rarely interested in preventive health, as they preferred to pursue the health care business. Consequently, preventive health policy remained a side activity of the individual care sector (Eberle, 2002).

During the 1990s, public health extended especially to workplace protection. The 1996 law on workplace protection extended public health to the prevention of health dangers in the workplace. Prior to that, this area of public health was in the hands of public insurance and the employers' liability insurance coverages. However, similar to the principle of health insurance, only accidents that had already occurred were covered by these arrangements. Based on the reform of 1989, in 1996 the insurance received a mandate to pursue preventive health policy. The intervention of 1996 was based on the European framework (Int-7-Ger).

Following the German reunification, health policy was reorganized, in Germany. Specifically, the national health insurance laws were transferred to the *Neue Länder*. In order to implement this reorganization, the Kohl government set up the Ministry of Health and made it responsible for health insurance - which had previously been under the purview of the Ministry for Social Insurances - as well as prevention and health protection. Preventive exams had been integrated in the health insurance law already in 1989. In 1991, the main competences for health policy at the national level were merged into a common ministry.[6] Since then, there has been more institutional integration of health care and public health; however, most tasks related to prevention and health education, such as infectious diseases, risk factors and health education more generally are a competence of the federal agency for health education BZgA (*Bundeszentrale fr gesundheitliche Aufklärung*), which is a subordinate but separate agency to the Ministry of Health.[7]

However, on the other hand, the policies of the federal government with regard to public health were ambiguous. In 1993, the conservative federal minister for health, Horst Seehofer, demanded to include more preventive measures in the programs of the health

[6] `<http://www.bmfsfj.de/BMFSFJ/Ministerium/geschichte.html>`. Last accessed June 9, 2015.
[7] `<http://www.bzga.de/die-bzga/aufgaben-und-ziele/>`. Last accessed, June 9, 2015.

insurance (Eberle, 2002) although, in conjunction with the reform of 1996, the scope of non-medical preventive services was drastically reduced. In 2000, prevention was reintroduced in the catalogue of services of the public health insurance, though with clearer focus on socially disadvantaged groups as well as modern concepts of prevention in the workplace. However, a coherent vision could not be established with respect to how prevention, especially primary prevention, could be included in a health system focused on individual health care possibilities. Yet, the expert advisory board on health policy (*Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen*) of the federal government demanded that public health measures had to be cost-efficient in order to be implemented (Eberle, 2002). In 2007, primary prevention again became part of the portfolio of the health insurance, in which prevention was made mandatory (Rosenbrock and Gerlinger, 2014).

The context of the social health insurance system creates problems for public health policymaking that are outside of the area of medical prevention. This becomes visible with regard to tobacco control policies. In this area of public health, the negative effects of smoking on health have been long known (Committee, 1964); however, in Germany, there was a remarkably successful resistance against the implementation of comprehensive tobacco control policies, contrary to Anglo-Saxon countries and Scandinavia (Studlar, 2006). Although there was some activity in favor of tobacco control policies already during the 1990s, civil society actors did not achieve a similar consensus to that established Australia. For example, in 1998 an initiative by parliamentarians from the governing Christian Democratic Party that aimed at introducing a general smoking ban failed (Int-GER-21).

The same year the German federal government successfully pursued a lawsuit against the European ban on tobacco advertising. Only after the documents of the American tobacco multinationals were published in the course of the Master Settlement Agreement in the United States of 1998, did tobacco control policy in Germany change. The documents showed how the tobacco industry had created strong ties to the German parties and had a strong influence on public health research in the country. The weak public health sector, and especially the weak public health profession, had made it easy for tobacco companies to obtain prestigious research projects and grants. Once these links were published, and the first epidemiological data on smoking from Germany was available, the situation changed; eventually, tobacco control policies were introduced after 2000 (Int-GER-16). For instance, in 2007, the federal government passed a partial smoking ban and in the years after that the member states followed. Similarly, smoking in the workplace was banned. However, Germany did not become active in all areas of tobacco control. For example, regarding the restriction of tobacco advertising, German policymakers only acted after the EU forced them to implement its directive on tobacco control (Int-GER-13)(Bornhäuser, 2003; Cooper and Kurzer, 2003; Frankenberg, 2004; Gilmore and Nolte, 2002; Grüner, Strünck and Gilmore, 2008; Grüning, Gilmore and Mckee, 2006; Grüning and Gilmore, 2007; Poetschke-Langer and Schunk, 2001; Proctor, 1996; Simp-

son, 2002; Thyrian, Bandelin and John, 2008; Hirschhorn, 2000).

Speaking from the legal basis, public health in Germany lacks a common ground for encompassing legislation, as the responsibilities are separated between different ministries and areas (Int-GER-1). There is already separation between sub-governments and the central government concerning public health issues, but at the national level they also vary between various ministries. The public health sector, as discussed in previous sections, is distributed across many areas of the political system in Germany, but above all, it is separated from medical care (Int-GER-2, Int-GER-5, Int-GER-7, Int-GER-9, Int-GER-17, Int-GER-18). In that sense, public health continues to reflect the corporatist model, which is highly inclusive and comprises different levels of government, non-profit organizations such as the Federal Organization for Health and the Federal Organization of Health Promotion, and other self-help organizations and their legal entities on the regional and national levels, as well as consumer protection and sports clubs. Based on this, there is a large network of institutions and actors responsible for public health (Int-GER-5). Yet, at the same time, it is a network with little power to rule hierarchically - unlike the UK, for instance (Int-GER-5, Int-GER-7, Int-GER-12), which renders the aforementioned collective action problems of public health even more important.

In order to have a better legal basis for public health policies, it would be good to have a legal framework that allows for more and better public health legislation, even if it had mainly symbolic value in the beginning (Int-GER-5). In 2005, there was an attempt to enact a national law on preventive health by the federal government (SPD and Greens), which passed the first chamber of the federal government but failed in the second chamber that was led by the CDU and FDP (Rosenbrock and Gerlinger, 2014). Such a law would have made clear that prevention is important, especially from the nonmedical sector; necessary regulations include campaigns and projects in the area of primary prevention that need to be funded with public money, but also projects from NGOs NGOs (Rosenbrock and Gerlinger, 2014). In 2004, when the federal government began to formulate a general law on prevention, it had hoped that more investment in primary prevention would reduce the cost of health care in the future - or, to put it more bluntly, it had hoped to put brakes on the expected growth of expenditures on individual care. The federal government argued that avoidable disease is a factor that can be influenced, whereas demographic changes and rising costs of new treatments cannot be governed by political action.

Nonetheless, the grand coalition of Christian Democratic Party and the Social Democratic party that followed the Red-Green government made a new attempt to create a law on prevention; however, in this version of the law, public health was again placed in the hands of the social insurance, and there were no attempts to create a new institution in health policy focused on prevention (Steindor, 2009). This law also failed, for reasons similar to the previous one. Firstly, the proposition entailed creating a national council on prevention, which was a legal problem because it would have been a mixed administration that combined the competences of the federal state and the sub-governments. Secondly, the grand coalition could not find any consensus regarding a law on prevention. The prob-

lem was that the ideas between the two parties regarding a law on prevention were too different, and health insurance as well as doctors lobbied strongly against the proposition. The member states, which were governed by the Christian Democrats, proposed in coordination with the doctors that secondary and tertiary prevention should be included in the law in addition to primary prevention. This would have meant that, again, medical prevention would have dominated non-medical concepts. Eventually, the law failed because the federal minister for health, who was a member of the Social Democrats, did not want to make a law that worsened the current situation (Steindor, 2009) (Int-GER-04, Int-GER-05).

With regard to prevention and public health, Germany has a clear partisan divide because the issue is debated in the context of social inequalities, which are not the interest of the Liberal Party (Int-GER-18, Int-20-Ger). What is more, health insurance organizations have a strong role in health policy and they are not very fond of the idea of investing in public health projects that are governed by the federal government (Int-2-Ger). The government of the Christian Democrats and the Liberal Party (2009-2013) had a national prevention plan (Rosenbrock and Gerlinger, 2014).

As the EU assumed a leading role in public health policy, however, it forced the German national government to become more active in this area. Since the 1990s, the competences of the EU in the area of public health have increased in order to better respond to the increasing challenges of infectious diseases, in particular. However, the European Union also extended its competences to the area of risk factors and passed a series of directives regarding tobacco control policy, for instance (Greer, 2012), which entailed warning labels, and advertisement restrictions. The latter became the subject of controversy between Germany and the European Union. In 2003, the EU passed a second directive on tobacco advertisement, which the European Court of Justice confirmed. Subsequently, the EU insisted that Germany implemented this regulation. As mentioned before, the EU played a similar role with regard to workplace protection, which makes clear that the dynamics in the public health sector in Germany have also occurred because of the activities of an external enforcer (Duina and Kurzer, 2004).

However, there are also examples of successful public health policies in Germany that are not only related to external pressure. Firstly, the German response to HIV/AIDS received wide attention and is commonly evaluated as a successful example of public health policy. In order to respond to this infectious disease, the German federal government combined state intervention and community activity by the affected population. The response to HIV/AIDS was first time since the Second World War that the state intervened on a large scale in the public health sector. The programs entailed material and cultural support for affected groups, which were mainly homosexual men, with the goal of achieving behavioral changes. Consequently, over 70 percent of the risk-affected population changed their behavior with respect risk avoidance. Therefore, this response to public health was one of the most successful public health strategies in Germany. What is also remarkable is that this was a public health strategy that clearly involved non-medical instruments.

The second example is health promotion within companies. Since 1989, health insurance carriers, companies, and some managers and union representatives in Germany have made important pioneer work in this area. They were supported by public health professionals. The projects combine health education, screening risk reduction in work processes, and improvement of the relationship between members and the company. These interventions achieved a considerable reduction in the use of sick days - about 30 percent (Rosenbrock, 2001).

To sum up, health care and public health have remained institutionally separate since the 1980s. Although there were some attempts to create a national public health framework legislation, which would have created the legal basis for non-medical health policies at the national level and included them in the national Ministry of Health, such a law was not passed. Instead, policymakers tried to use the existing health insurance legislation to include preventive measures, with moderate success. The problems were the same as after the First World War - namely, that public health measures are difficult to integrate in a legal framework that was designed for individual health care and that the health insurance and doctors have only a marginal interest in primary prevention measures. Nonetheless, some public health policies were put into place, notably regarding HIV and workplace protection; yet the landscape of public health policies in Germany remains fragmented and different from those in Australia and the UK.

7.4.2 Conflict and coordination in the shadow of subordination

Under the coalition government of Social Democrats and Liberals (1969-1982) was the first time that the relation between the medical profession and non-medical occupations in Germany changed not in favor of the medical profession. This occurred in the context of an increasing critique of health care as being overly focused on sick people, as well as the politics of the medical profession (Döhler and Manow, 1997, 89). As a consequence, the hierarchical structure within medical education loosened. This meant that as the dominance of the medical profession became weaker, other health professions became more professionalized, for instance by developing their own university degrees. However, compared to the U.S. and the UK, the medical profession remained strong and had an exclusive role in the health system, exactly because the state had delegated some of its power to doctors in the context of self-governance by health insurance organizations. The fixation of the German health system on the doctor as the central actor in the health system remained a strong factor. Generally speaking, however, in Germany as in the U.S., the medical profession lost influence during the 1970s, especially because cost containment began to play an important role in health policy and led to the rise of reforms such as patient classification schemes and managed-care programs (Gottweis, 2004, 141-144).

In order to better understand the lack of responsiveness between health care and public health, it is instructive to take a closer look at professionalism and education for health occupations after the Second World War. A major difference between Germany and the English-speaking countries was that Germany had no university-based system of public

health education or public health traditions. It was only in the early 1990s when public health as a scientific discipline was re-established in Germany. With the support of the Federal Ministry for Education, schools of public health were established in Hannover, Bremen, Hamburg, Bielefeld, Düsseldorf, Köln, Dresden, München, Ulm and Augsburg. The schools cooperate in research and education and over the years they have created seven postgraduate courses of study in public health at the master's level; in recent years, many public health studies at advanced technical colleges (*Fachhochschulen*) have followed. However, as discussed before, public health and especially social hygiene in Germany were perverted during the Third Reich, and lost their positive reputation. The first attempts to recreate public health as an academic discipline after the Second World War occurred in the 1970s. At that time social medicine and medical sociology were included in doctoral education, but in the context of a focus on individual care. Yet, advocates of public health policy understood that in order to have credible public health research, it would be necessary to have results of public health research that was done in Germany. Therefore, the federal Department of Health, in cooperation with health research foundations such as the *Robert-Bosch-Stiftung*, the DFG (*Deutsche Forschungsgemeinschaft*), and the federal doctoral organization found that Germany needs a modern public health concept and research agenda (Braun, 1994; Maschewsky-Schneider, 2005).

Due to the structure of the corporatist health care system and the subordinated role of public health research, there was little responsiveness between policy sectors. The main stakeholders in public health had neither strong financial nor professional support from the main players in health policy, such as health insurance and doctoral organizations, nor were they supported by a medical profession putting forward public health issues. Of course, doctoral organizations are interested in public health issues, yet it is not a foremost priority for them, especially primary prevention (Int-GER-1). At the same time, there are strong conflicts between non-medical health sciences and the medical profession. Although conflicts between professions happen in all areas, the example of health care and public health in Germany is striking in this sense, as there is remarkably little coordination and positive responsiveness in the sense of cooperation and mutual support between doctors and public health actors when it comes to health issues (Int-GER-7). What is more, public health in Germany is split between those who are interested in it from a medical point of view and those who consider sociological, political, economic, and educational factors, which renders the support for primary prevention policies aiming at structural and lifestyle factors less important. Consequently, priorities in public health research are set with regard to natural sciences - for instance, genomics - rather than a broader sociological approach to public health (DGfPH, 2012). This happened at a time when the research group for public health at the WZB was closed (2012) (Int-GER-2, Int-GER-18). In generally, the health research that is put forward and funded by the Ministry for Science and Education in Berlin is more strongly focused on natural sciences and individual health problems than on context and education (Int-GER-17).

Of course, there are doctors, who support public health policies, especially in the con-

text of their daily practice as GPs. But such activities depend to a large extent on the will of individual doctors as well as their preferences in this regard. In the professional organizations and their branches at the national and the member state levels, there is of course support for preventive health policies, but ideas in that regard mostly focus on immunization programs, which always have been in the hands of doctors, or individual health counseling. However, in general, there is no strong pressure from doctoral organizations for a general public health concept (Int-GER-8). Similarly, the health insurance's interests, which are to a large extent responsible for preventive health policies, entail mostly individualized programs such as health counseling and individual health promotion. In addition, some sub-disciplines of the medical profession in Germany, such as pediatricians or lung and throat specialists, are active in demanding more public health measures. However, from a general point of view, the support of the medical profession from these organizations is not strong; they do not publicly put strong pressure on elected officials (Int-GER-17).

This is the case because these organizations have neither the interest nor the competences to invest in population-based health policy, because their original purpose is to pay for individual health care in the case of sickness. Yet, with the establishment of corporatist self-governance and delegation of a large portion of health policymaking to interest groups on the national level, health insurance, doctors, and others became the main governors of health policy (apart from the protection against epidemics). However, public health policies are not their main business, and they do not have the necessary competences to make these policies. In this sense there is less responsiveness, because public health is generally less popular within the medical profession in Germany than in the U.S. or in the UK (Int-GER-10). Moreover, Germany does not have health foundations that hire professional lobbyists for certain public health issues, such as the cancer councils and heart foundations in English-speaking countries, which employ doctors to do public health research, deliver public health education, and serve as important organs in lobbying for public health policies. There are organizations concerned with these diseases in Germany, but they are less independent from state money and less powerful as political pressure groups (Int-2-Ger).

The weak responsiveness between health care and public health is also apparent with regard to most politicized public health issue of the last fifty years: tobacco control. The evidence that smoking is bad both for smokers and for those surrounding them has been overwhelming since at least the early 1990s.[8] Whereas many countries began to pass laws that restricted smoking in public, Germany remained a laggard in international tobacco control (Raw and Joossens, 2006; Raw and Joossens, 2010*a*; Raw and Joossens, 2010*b*), especially in comparison to other European countries (Studlar, 2006; Studlar, Christensen and Sistari, 2011). The literature is unanimous about the fact that this is due to the strong influence of the tobacco industry, which had been able to maintain links with

[8]The first important publication concerning the negative impact of smoking on health had been published in 1964 already (Committee, 1964).

the administration and political parties in Germany and could therefore oppose national legislation restricting advertising of tobacco and smoking in public (Bornhäuser, 2003; Cooper and Kurzer, 2003; Frankenberg, 2004; Gilmore and Nolte, 2002; Grüner, Strünck and Gilmore, 2008; Grüning, Gilmore and Mckee, 2006; Grüning and Gilmore, 2007). Part of the influence of the tobacco industry spread to the research community, because the tobacco industry covertly financed public health and medical research (Hirschhorn, 2000; Bornhäuser, 2006).

However, it is also true that due to the lack of responsiveness between health care and public health, there was no strong advocacy coalition for tobacco control policy. Although doctors from all over the profession supported stricter legislation (Int-GER-2, Int-GER-21), health care actor, such as medical organizations and national health insurance did not make the issue a high priority or pressure the national government to pursue more action in this regard and to mobilize parliamentary fractions in order to pass encompassing tobacco control legislation. The initiatives in the matter came from the back benches of parliament, where individual MPs picked up the issue of tobacco control and put it on the political agenda (Binding, 2008).

In German health politics, medical organizations did not play an important role in putting health policy topics, including public health issues, on the political agenda. To the contrary, an expert committee (*Sachverständigenrat*)regularly published reports in which it suggested reforms in health policy. Some of this propositions also included better integration of health care and public health. For example, the mentioned report of 1989 had already suggested to include more prevention the health insurance. Again in 2001, the expert committee proposed that health care policies should be complemented with more prevention and health education (Schwartz, Wille, Fischer, Kuhlmey, Lauterbach, Rosenbrock and Scriba, 2001). The head of the committee was even a public health doctor, which signifies that policymakers also realized and understood the increasing importance of preventive health measures in Germany. However, these scientific reports did not unfold the same political pressures as achieved by politically active and powerful professional organizations in the U.S. and Australia.

The problem of creating encompassing public health legislation with regard to chronic diseases is a general problem of health policy in Germany (Gottweis, 2004, 53). As theoretically expected, there was little responsiveness between health care and public health as a policy sector, which remained separate and rather subordinated to individual health care. Nonetheless, there have been some policies integrating the two sectors to a certain extent.

In Germany, policymakers followed the international trend in passing some policies that integrated health care and public health. On the one hand, these were focused on disease management programs, which attempt to help patients in a more structured way by combining treatments, but also secondary and tertiary prevention programs. In 2002, the federal government passed such programs for six diseases, and provided financial incentives for the health insurance in the way that they receive remuneration for each patient enrolled

in these programs (Int-GER-7). Yet, as DRGs, which are lump-sum payments for each patient that receives an operation, such instruments lead to the shift of patients in the programs for economic reasons. Nonetheless, they provide a first step and important contribution to improving the connection between health care and public health.

As in other countries, health strategies and goals have been passed at the national as well as the subnational level in Germany. As a reaction to the increasing international debate concerning the connection of cure and prevention in health strategies, some of the German *Länder* began to pass health strategies. The first member state to pass a health strategy was Hamburg, in 1992, followed by North Rhine-Westphalia (NRW), in 1995. Most other states passed health goals in the years after 2000. Today, NRW has the largest number of health goals (10 in 2012). What is more, health goals are very heterogeneous with regard to their content. Most common are the following topics: health of children and adolescents (9 MS), health of elderly (7 MS), cancer (7 MS), and tobacco prevention. After that, there are many specific themes, such as diabetes, immunization, stroke, back pain, and so on. A recent contribution evaluating these goals argues that despite many positive steps and starts there is a lack of transparency, networking, coordination, and cooperation from a general perspective. Particularly, a common strategy to implement these health goals - from a national perspective as well as a coordinated approach by the *Länder* - is lacking (Thietz and Hartmann, 2012). On the other hand, the national government has also passed health strategies, and there have been attempts to coordinate health strategies by the sub-governments. In 1999, the conference of the health ministers in the *Länder* demanded a more coordinated health policy across sectors and levels of governments, including coordination in the implementation of health strategies. Soon thereafter, the federal parliament proposed topics for national health strategies, which appeared on the parliamentary agenda (Angele, 2003; Wismar, 2003). As a consequence, the federal Ministry of Health and the Society for Insurance Research and Reform (*Gesellschaft für Versicherungswissenschaft und -gestaltung [GVG]*) established the corporatist platform *gesundheitsziele.de*, which is the coordinating body for the federal government, sub governments, municipalities and NGOs, and has the task of administering the health goals (Maschewsky-Schneider, Klärs, Ryl, Sewöster, Starker and Saß, 2009).[9]

To sum up, these results show that responsiveness between the health care and public health sectors exists in the sense of policy integration, which has been established at the subnational and the national level, although later than in Australia, but in similar areas. However, regarding professions and interest groups, there is no responsiveness among the policy sectors. Specifically, there is a lack of mutual support for policy proposals and a strong voice from the medical profession to implement more encompassing public health

[9]The health goals are: Diabetes mellitus Typ 2: Goals are to reduce the risk to become sick and employ early treatment (2003); Breast cancer: Reduce mortality and improve life quality (2003); Reduce tobacco consumption (2003); Growing up healthy: Education, Movement, Nutrition (2003; 2010); Improve health competences and rights of patients (2003; 2011); Depression: Prevention and treatment (2006); Healthy Aging (2012) (German originals can be found here: `<http://gesundheitsziele.de>`. Last access: October 13, 2014.

laws. In Germany, opposed to Australia, health strategies and progress in primary prevention (especially tobacco control policy) occurred as a reaction to international political pressure and a change of the discourse therein. The establishment and implementation of health strategies is discussed as a consequence of the changing international discourse, and the EU played an important role in establishing tobacco control policies on the international agenda. Germany is also subject to the absence of actor responsiveness between the health care and public health sectors. However, there are integrated policies, such as health goals and disease management strategies, as well as new public health policies, such as tobacco control, although to a lesser extent than in Australia.

What do these results imply for the hypotheses I formulated regarding the relationship of health care and public health? I had argued that unified government and low professionalism should lead to the non-coupling of health care and public health in Germany. Similar to the preceding section, my analysis of this time period reveals that there was no full integration of health care and public health, as a national law for preventive health failed. Despite the strong state and unified government, in this case the secondary chamber in parliament stopped this legislation on the grounds of partisan differences. Professionalism as I have defined it remained weak, because the public health profession did not evolve as a powerful political pressure group; neither did the medical profession, which remained closely aligned to the focus on health insurance and its dominant role even in matters of public health. At the same time, professionalism was low in the sense that public health did not become a strongly defined professional role that entailed a feeling of responsibility for the common good, but rather became an occupation. Despite the de-coupling of health care and public health, to some extent there was policy integration during this time period - due to the pressure of the EU in matters of tobacco control policy, for example, but more so due to policy learning and the adoption of innovative ideas in health policy that the context provided at the time, such as national health strategies.

7.5 Discussion

What can we retain for the theoretical discussion from this case study? In the following, I summarize the results of my analysis, and discuss the implications of the case study for the theoretical expectations I formulated. Table 7.1 provides an overview of the results and puts them in the context of the aforementioned theoretical elements. It reviews the degrees of coupling between the policy sectors, their power relations, the political activity of health professions, the political system, and contextual elements.

The results of my analysis show that, overall, health care and public health in Germany co-evolved but were decoupled, in a way in which both sectors were institutionally distinctive but at the same time responded to one another. With the exception of the Third Reich, health care and public health had separate institutions, horizontally as well as vertically. For instance it was mostly the national government that was in charge of financing and implementing health care, whereas subnational governments and municipalities were

Table 7.1: Co-evolution of health care and public health in Germany

Time/ Country	1880-1918 *(t0)*	1918-1945 *(t1)*	1945-1980 *(t2)*	1980-2010 *(t3)*
Coupling	*De-coupling:* Separation in three levels of government: National health insurance, public health and prevention on the state / municipal level; mutual ignorance / competition of health care and public health actors; political differences (left-right)	*De-coupling (Tight coupling):* Separation in three levels of government: national health insurance, public health and prevention on the state / municipal level; integration of public health during NS; Conflicts between professions during Weimar Republic; Public health profession virtually "extinguished" during NS → responsiveness	*De-coupling:* Separation in three levels of government: National health insurance, public health and prevention on the state / municipal level; transgression of health care on public health; weak public health coalition	*De-coupling (Non-coupling):* Separation in three levels of government: national health insurance, public health and prevention on the state / municipal level; little communication, interaction between health care and public health; policy integration
Professionalism	Doctors and medical organizations are included in the self administration of the SHI → Deal between state and the medical profession; public health doctors at the municipal level	Conflicts and cooperation between medical and public health profession; public health doctors at the municipal level → "Extinction during NS"; doctors obtain a public health monopoly	Medical professions focus on health care policy; little interaction between medical profession and public health actors	Medical professions focuses on health care policy; little interaction between medical profession and public health actors
Unified government	National health insurance system; responsibility for public health at the sub governmental / municipal level	National health insurance system; responsibility for public health at the sub governmental / municipal level; emphasis of sub governmental authority → Federalism; changes after 1933	National health insurance system; responsibility for public health at the sub governmental / municipal level; emphasis of sub governmental authority → Federalism	National health insurance system; responsibility for public health at the sub governmental / municipal level; emphasis of sub governmental authority → Federalism
Context	Infectious diseases; Fitness of population; Germany among the leading public health nations	Impact of the First World War; individualized public health; fitness of population; racism and Holocaust	Success of prior public health policies; pharmaceutical advancement; turn toward individual health care	Non-communicable diseases; risk factors; return of infectious diseases; International public health paradigm; EU pressure

in charge of governing public health. The origins of this separation are to be found in the nineteenth century. The foundation of the social health insurance shifted health policy-making at the national level toward individual care, and separated it from public health policy, which had been located at the level of member states and municipalities. This separation remained in the post-World War I period, until the Nazi government came into power. Under Hitler, the public health system was integrated into a national public health service; actors from both sectors played important roles in the Holocaust, in designating targets of euthanasia and implementing these policies. After the Second World War, in the FDR, health care and public health returned to the pre-NS institutional separation. On the one hand, the health care financing system at the national level was separate from public health (especially everything that went beyond disaster management) and was the responsibility of the sub-governments as well as the municipalities. At the federal level, competences for public health emerged only gradually and remained separate from the health insurance administration, which was part of the Ministry for Social Insurances. In 1991, the government created a ministry for health, which formally integrated health care and public health. However, most competences and expertise in public health remained in the BZfGA , the federal agency for health promotion. BZfGA is a separate agency but subordinate to the federal Ministry of Health.

Concerning the responsiveness of health care and public health, my analysis shows little communication and support between the two sectors. During t0, there was little interaction between them because doctoral organizations had been included in the administration of the health insurance and were also employed by them. However, they had few connections to the public health profession at the municipal level and public health doctors who supported and demanded more public health policies. After the First World War, professional support for public health policies increased, especially from public health professionals, who were among the world's leading researchers in this field (especially social hygienists). However, many researchers in Germany refused interventionist public health actions such as large immunization campaigns as they were advised by international representatives of the profession. On the other hand, conflicts between the medical profession and public health researchers concerning more public health services and preventive examinations arose, especially concerning the question of whether preventive exams should be financed by the national health insurance. During the Third Reich, responsiveness between the health care and the public health sector increased, but this came at the price of a large part of the public health profession emigrating or being subject to political persecution. At the same time, during the beginning of the Nazi period, the medical profession reinforced its deal with the state and took a leading role in the governance of health care.

After the war, health care policy was connected to the expansion of the welfare state in Germany, which disconnected it from public health. Public health took a minor role, especially in Western Germany. This development also entailed decreased responsiveness between health care and public health and resulted in a weak coalition connecting the two sectors; this problem remains prevalent to this day.

7.5.1 Unified government and professionalism in Germany

To what extent do my results confirm or refuse the hypotheses that I put forward regarding the German case? I had assumed that unified government and low professionalism led to the institutional integration of health care and public health and a lack of responsiveness between both sectors. Consequently, there should be non-coupling of health care and public health, above all. At the same time, contextual elements should not play an important role.

In a nutshell, my results show that there is indeed weak responsiveness between these sectors due to professionalism, but no institutional integration. The federal structure of Germany's political system significantly impacts the lack of distinctiveness between them, because public health is to a large extent a competence of the subnational governments; this did not change throughout the period I observed, except during the Third Reich.

Germany's political system has been a rather centralized federation, except for the twelve years of Nazi rule, in the sense that the national government handles legislation and the member states have a more administrative role. Therefore, I had expected to find more integration of health care and public health at the national level. However, as my analysis showed, this is not the case; the two sectors have remained institutionally separate from one another. Especially after the Second World War, and since the 1980s, it was the second chamber of the national parliament, the *Bundesrat*, that blocked national public health legislation. Members of the sub-governments sit in this chamber. Oftentimes, its political majorities are different than those of the first chamber, where the governing parties have a majority and control the political agenda. However, unlike Australia, which also has two parliamentary chambers but a different electoral system, it is much more difficult in Germany to forge parliamentary alliances - especially regarding the integration of health care and public health.

One reason for this is the weak professionalism and the absence of responsiveness between the two sectors. This is especially visible with regard to the medical profession's interest in and support for public health. My research shows that the political activities of German medical professionals regarding public health are different from those of their colleagues in Australia. It seems that doctoral organizations are much less active in lobbying for and suggesting preventive measures going beyond secondary and tertiary prevention. The German medical profession focuses mainly on the individual and is much less concerned with new public health perspectives, which put a strong emphasis on environmental factors. The big medical organizations are less politicized than in Anglo-Saxon countries and less interested in public health policies. Most active in this area are pediatricians, but pulmonologists and cardiologists are also politically active, especially concerning smoking. For instance, there is a doctoral working group against smoking that has been active for quite some time in Germany. It is often the case that doctors are against community-based interventions because they are afraid to lose their dominant role in health policy (Int-20Ger). Another important factor in Germany is that there are no strong health

foundations like the cancer councils and heart foundations existing in English-speaking countries, which include doctors engaged in public health research, deliver public health education, and serve as important organs in the area of lobbying for public health policies. In Germany there are organizations concerned with these diseases, but they are less independent from state money and less powerful as political pressure groups (Int-2-Ger).

Overall, however, the medical profession is not very active politically in cooperation with public health professionals. This is rooted in the low professionalism, which I defined before and which entailed the strong role of the state in protecting employment by establishing the national health insurance that guaranteed doctors' employment. Consequently, the medical professional association was not politically active and did not, as a byproduct, support public health policies. Therefore, matters of public health are often partisan issues.

7.5.2 Competing explanations

However, regarding the preceding case studies, there are competing explanations and important theoretical elements that need to be mentioned and discussed in terms of the co-evolution of the two sectors in Germany. Notably, these are the following elements:

1. *Complementarity:* The German case study provides interesting insights with respect to the impact of the general relations of health care and public health. Although the health care and public health sectors are decoupled and public health remains to a large extent subordinate to health care, there is to a certain extent complementarity, especially if we take into consideration policy integration. The fact that the German national government initiated national health strategies and disease management programs that combine health care and public health shows that, despite the institutional separation of the two sectors and the weak responsiveness between them on the level of professions and interest groups, there are common policy outputs that also exist in other countries with different degrees of sectorial coupling. However, the adoption of these policies is the consequence of diffusion mechanisms rather than of responsiveness between the health care and public health sectors. On the other hand, with regard to certain public health policies, such as tobacco control policy, the lack of coupling between the two sectors is a big problem and leads to reduced policy outputs.

2. *Policy learning:* Germany shows an interesting dimension of policy learning regarding the relationship between health care and public health. Concerning Australia and the UK, I argued that due to high professionalism there is policy learning, because the political activity of the medical profession leads to the infusion of new ideas in the political process. According to this logic, there should be no policy learning in Germany, at least not from the medical profession. However, there has been co-evolution toward the complementarity of health care and public health. Yet in this case, the adoption of new ideas such as public health policies has occurred

through international pressurefor example, from the EUbut also by means of policy learning from international institutions and other countries, following the logic of the policy diffusion literature (Gilardi and Radaelli, 2012). For example, the adoption of national health strategies did not occur as a reaction to the pressure of the medical profession, but by means of learning from international institutions.

3. *Partisan differences:* Germany is also an interesting example of partisan differences regarding the relationship of health care and public health. As I have argued in the preceding sections, there was a partisan difference regarding public health above all. Left parties supported public health policies, whereas conservatives and liberals opposed them. The reason for this is that public health reformers could not manage to forge a coalition across political parties due to the lack of professional support, Unlike in Australia, where many doctors played an important political role in the liberal party and supported more public health policymaking, such a dynamic did not occur in Germany.

4. *Autocracy - Democracy:* The German case has another particularity, which might be important for understanding the co-evolution of health care and public health: the impact of autocratic and totalitarian government. There are two ways in particular in which these factors impacted the co-evolution of the two sectors and changed the impact of my main explanatory variables. On the one hand, it came along with a centralization of government, notably the abolition of federalism. Soon thereafter, this led to the institutional integration of health care and public health. Moreover, after the Nazi government came into power there was a shift toward authoritarianism and an erosion of human and political rights. This had consequences for professions, which adapted and conformed to the ruling Nazi government. Many doctors joined the NSDAP, whereas members of the public health profession had to leave the country or were jailed, either because of their political ideals or because they were of Jewish origin. During that time the government institutionally and politically integrated health care and public health in a national health policy. Specifically, there were policies that combined both fields, including racist public health policies such as the national health service and sterilization laws and, eventually, the Holocaust. However, the responsiveness of interest groups and professions, as I conceptualized it in the theoretical chapter, did not play an important role because it demands the presence of a democratic polity. During the Third Reich professionals were politically more active than before - not because they chose freely to defend their interests, but due to fear of oppression, as membership in the NSDAP and participation in its political rallies were advantageous for their physical and economic security.

7.6 Summary

In this chapter, I analyzed the co-evolution of the health care and public health sectors in Germany. I selected Germany due to its combination of a rather unified government and weak professionalism, which I expected to cause non-coupling of the two sectors. However, my results are different than expected regarding sectorial coupling. My hypothesis concerning professionalism was correct, in that the medical profession was not a very strong pressure group and did not support public health actors in a very loud way. Consequently, doctors did not act as interest groups that competed for the attention of policymakers in the service of public health issues, but rather guarded their privilege and defended the autonomy of the corporatist arrangement. As a consequence, policymakers did not see a necessity to become more active concerning the institutionalization of public health under a general institutional framework at the national level, and partisan divides eventually obstructed such reforms. The fact that Germany has many veto points regarding legislation at the national level, as well as the demise of German public health sciences during the Third Reich, increased de-coupling. However, despite the de-coupling of health care and public health in Germany, both sectors co-evolved toward complementarity and there has been policy learning regarding the relationship between health care and public health.

Chapter 8

Switzerland: From de-coupling to non-coupling

I will now turn to the next case study, in which I will analyze the co-evolution of health care and public health in Switzerland. This is an interesting example for testing my argument because it combines the absence of professionalism with a rather fragmented and decentralized government and competences in policymaking. Based on my theoretical predictions, I expect to find de-coupling of health care and public health.

My analysis of the Swiss case will proceed similarly to the studies of the other countries. I will start by examining the distinctiveness and responsiveness of both policy sectors in the late 19th and early 20th centuries. Then I will focus on the interwar and Second World War period. After that, I will examine the relationship of both sectors in the post-World War two era. In the last section, I will analyze the coupling of both sectors in what has been labelled the "new public health" era. Discussion and conclusions follow.

8.1 De-coupling at the national and cantonal level (1850-1918)

The story of the Swiss case begins in the second half of the 19th century. As for the other countries in this sample, this was a period in which the demand for public health policies was high. Notably, the most pressing health problem was infectious diseases, and it was difficult to cure them based on the medical technology of the time. At the same time, the emerging nationalism provided an intellectual and policy context that was favorable for the integration of both sectors.

However, according to my argument, these contextual elements should not have an effect. The fact that there is low professionalism - and therefore not very politically active professions - should cause absence of sectorial responsiveness between actors, even if the context is favorable to integration, as in t0.

8.1.1 Sectorial emergence: national and cantonal health policies

As in other countries of Western Europe, in Switzerland, health policy was differentiated into the field of health care and public health policy during the late 19th century (Achtermann and Berset, 2006). During this process the regulation, financing, and delivery of services concerning curative medicine took an important position in the Swiss health system, distinguished from public health and prevention. The dominant idea of this process was that health policy should above all entail health care. Accordingly, the goal of health policy was to provide care and to regularly control the quality thereof. This principle became the basis of cantonal and national health legislation. In the early 19th century, medical care in hospitals was already becoming more and more important. Subsequently, big hospitals were put under the responsibility of the cantons (for instance in Lausanne in 1806). In the following decades, many hospitals were founded in other cantons, including four in the canton of Fribourg alone (Bulle-Riaz in 1863, Romont-Billens in 1866, Morat-Meyriez in 1868, and Chatel-St.Denis in 1892). Cantonal governments and private actors shared the responsibility of funding hospitals. Yet there were differences among the cantons regarding the share of funding from the cantonal governments and private actors, as was the case in Neuchatel and Wallis. The general problem for the municipal health services was a lack of funds, and consequently their quality was rather bad (Achtermann and Berset, 2006, 20-21).

In order to finance health care for as many individuals as possible, local health insurance was established. In Switzerland, the first forms of health insurance emerged in the early 19th century. During the second half of the 19th century, in the context of industrialization and social changes, a plethora of health insurance providers were founded, mostly at the municipal or communal level. In 1906, an itinerary of existing health insurance in Switzerland showed 2006 insurance carriers. In the following decades, the institutionalization of the Swiss health insurance landscape built on these structures. For instance, in 1890, an article was added to the Swiss constitution that affirmed the role of health insurance providers as implementing organs of Swiss health insurance, and the national health insurance law of 1911 again emphasized their importance in the same way (Kaufmann, 2010).

Following the implementation of a national compulsory health insurance scheme in Germany in 1883, politicians discussed a similar proposition in Switzerland. However, before the constitutional reform of 1890, the federal government did not have any power to regulate health insurance. Prior to this date, (private) health insurance providers replaced salaries in case of sickness and paid the fees for treatment. However, there were often discussions between health insurance providers regarding their liability. The existence of these health insurance providers connected the problem of health legislation to accidental insurance issues. Consequently, the parliament added a new article to the national constitution that granted the federal government the right to pass legislation on this matter. Based on the German model, the MP Ludwig Forrer developed a proposal

for a national health insurance law that entailed compulsory health insurance, including regulation and subvention of public and private health insurance. Despite support from the most important actors in the national government, the proposal failed in a popular referendum (Alber and Bernardi Schenkluhn, 1992; Degen, 2008; Kaufmann, 2010). In 1911, the national government adopted a reduced version of the law that entailed the subvention of health insurance providers (if they complied with federal supervision), as well as obligatory accident insurance, and granted the right to the cantons to introduce compulsory health insurance for part or all of the population (Vatter and Rüefli, 2003; Degen, 2006; Degen, 2008; Vatter, 2014*b*; Santésuisse, 2014). These reforms concerning health insurance legislation shaped Swiss health policy and, except for a smaller reform in 1964, no major modification of the Swiss health insurance system occurred until 1994 (Uhlmann and Braun, 2011).

In light of these reforms, the Swiss health system has been characterized as a mostly liberal health care system different from the liberal/private health care system in the U.S., where health insurance providers have much more leverage concerning profit-oriented actions. The reason for this evaluation is that the Swiss system of the early 20th century emphasized a minimum of public intervention and a maximum of individual responsibility, which fit the political orientation of the national government at the time (Vatter, 2002; Uhlmann and Braun, 2011). However, I argue that at the same time, the Swiss health care system had a strong socialist and communitarian element. This becomes particularly clear if we take into consideration that the private and non-state/non-profit health insurance providers at the municipal and regional levels played an important role in shaping health policymaking (although they did not cover a majority of the population at the time (Degen, 2008)) and that the reform of 1911 permitted cantons to implement compulsory health insurance (Alber and Bernardi Schenkluhn, 1992; Degen, 2008). In that sense, the opposition to the proposed national health insurance can also be understood as resistance to the federal government's intervention in cantonal matters, but not to communitarian health policy in general. Consequently, it is possible to expect that in the Swiss health system, health care was differentiated from public health, which led to a separation of both fields, and, as I will discuss in the following section, to a lack of responsiveness. A similar point was made by Leimgruber with regard to the Swiss pension system. According to this author, Switzerland had a considerably encompassing pension system that depended not just on state regulation but also on private provision. In this sense, despite the fact that the introduction of general retirement insurance came late due to the multiple veto points in the Swiss political system, private compensation plans were set up, which created a certain solidarity among citizens (Leimgruber, 2008). A similar point can be made with regard to the Swiss health care system, which was based on a net of local health insurance carriers without a basic health care provision by the state (Cheng, 2010).

Turning to public health, there is a different situation regarding the distribution of competences between the federal government and the cantons. Public health, understood

as population-based and preventive health policies, emerged into different institutions than the health care sector. Adopted in 1848, the federal constitution transmitted the responsibility of combating dangerous epidemics to the federal government. Thus the national government began to legislate on public health issues. Specifically, the federal government used this discretion to legislate in the area of workplace protection (1877) and concerning epidemics (1887) (Achtermann and Berset, 2006, 21). In 1893, the Federal Office for Public Health (BAG - *Bundesamt für Gesundheit*) was established. Its task was to implement federal law regarding the epidemics of 1887, public hygiene and health policing. In addition, the federal office had the task of passing national regulations on the examination of medical professions. At the beginning of the 20th century, five laws formed the legal framework for health policy in Switzerland: a federal law of 1877 regarding work in factories, a federal law of 1877 regarding free movement of doctors, a federal law of 1886 regarding measures against epidemics (Revision 1970; 2012), and a federal law of 1905 that regulated traffic of food and other perishable goods (Revision 1992). Parallel to the public health legislation on the national level, the cantons passed laws concerning population health. Specifically, they began to set up laws on health policing, focusing on the health of cattle and hygiene of water and meat, as well as regulation of health occupations. On the cantonal level, however, health care and public health were in the hands of the cantonal health departments, and therefore both sectors were under the same institutional umbrella. In the bigger cantons, a doctor was hired to oversee and implement public health measures *(Kantonsarzt)* (Achtermann and Berset, 2006, 21).

However, aside from the separation of competences between the cantons and the national government, public health also had a private component. Following the principle of subsidiarity, Swiss officials left the creation and adoption of specific programs for prevention to private actors, such as doctors, nurses, and preventive doctors. One example of this was the activities of Charlotte Oliver. In the early 20th century, 1911-25, she was heading the center for the treatment of tuberculosis in Lausanne, founded in the canton de Vaud as a broad movement to inform the population about the sickness, realize its consequence for the population, and educate citizens how bad hygienic relations, malnutrition, and lack of health education could help to spread the disease. In 1912 in the canton of Vaud, she organized a campaign against tuberculosis, along with the cantonal league against tuberculosis. The goal of the initiative was to educate the population on matters of hygiene. What is more, she developed preventive measures and ordered house visits of nurses. Eventually, the work of the cantonal league against tuberculosis in Vaud helped to create the federal law against tuberculosis in 1928.

Another example concerning public health on the private side involved activities to inform the population about chronic diseases such as cancer. For instance, in 1913, the national cancer league, which had the mission to inform the population about cancer through publications, talks, and exhibitions, published its first flier regarding cancer. The organization printed 1000 fliers in Italian, 3000 in French, and 6000 in German, which focused especially on the cancer of female genital organs. The members of the league

judged that actions concerning active prevention were rather weak, and therefore private activities were necessary. The flier was also published in newspapers, and the organization decided to post them at train stations. Interestingly, in a discussion within the board of the cancer league, the board refused the suggestion of one board member to prepare a leaflet for doctors regarding possible preventive measures, but the board decided to serve as a point of information for interested doctors (Kauz, 2010, 11-13).

To sum up, this overview of the institutional co-evolution of health care and public health shows that health care and public health were separated institutionally in late-19th-century Switzerland. Above all, the federal office for public health was in charge of public health but did not administer the national law regarding social insurance, which had been a responsibility of the federal office for social insurance, after its foundation in 1912.[1]

8.1.2 Responsiveness between jurisdictions rather than sectors

Regarding the period of the late 19th century in Switzerland, it is difficult to evaluate the responsiveness of the health care and public health sectors because it is hard to identify different groups that were mainly responsible for either health care or public health and communicated with one another in the political realm. The development of interest groups and professional roles in the health sector, such as doctors, dentists, and nurses, occurred in a similar manner as in English-speaking countries and Germany. However, with regard to public health, this was different (Brändli, 2008). In that sense, although the sectors are clearly distinguishable institutionally, they are not distinguishable in a professional sense. In Switzerland, voluntary organizations such as the cancer leagues emerged as functional equivalents to the public health profession. These organizations were nationalized, but they were not politically active pressure groups. Although doctors were involved in the provision of public health, for instance as cantonal public health officers, I have found little evidence for large public health coalitions before the First World War.

Similarly to the Swiss federal state, political organizations of doctors emerged from cantonal organizations that had been formed in the first half of the 19th century. As early as 1788, doctors founded the first federal medical organization, the Helvetic society of corresponding doctors and surgeons *Helvetische Gesellschaft correspondierender Ärzte und Wundärzte*. With the growing importance of cantonal politics more doctoral organizations were created, also at the cantonal level: in 1805 in Aargau, 1809 in Bern, 1810 in Zürich.[2] However, there were conflicts between the medical organizations with regard to how national coordination should occur. The constitution of 1848 did not bring a clear regulation of doctoral and medical professions. In order to find a solution, the medical organization of Berne demanded a concordat - a confederal solution - in which the bureaucracy and the cantonal governments regulated doctoral organizations. As a reaction to

[1] <http://www.geschichtedersozialensicherheit.ch/institutionen/bundesamt-fuer-sozialversicherungen-bsv/>. Last accessed October 16, 2014.

[2] <http://www.fmh.ch/ueber_fmh/portraet/geschichte.html>. last accessed October 17, 2014.

this, the cantonal organizations of doctors began to be better organized and put together regional organizations. In 1870, the cantons of Argovia, Basel-Country, Basel-City, Berne, Lucerne, St. Gallen, and Zurich founded an organization named *"Aerztlicher Zentralverein der deutschen Schweiz."* In the French-speaking part of Switzerland, resistance against a concordat (national medical organization) brought together Geneva, Neuchatel, and Vaud into a regional medical organization, which other French-speaking parts of the Swiss medical profession joined later. The difficulties for the doctoral organizations to create a national organization reduced after the constitutional reform of 1874 and the changing political culture in Switzerland, which turned toward more regulations by government(s) but also increased inclusion in the decision-making process through more hearings, etc. The unification of the doctoral organizations occurred in 1901 with the Association of Swiss Doctors *(Verbindung Schweizerischer Ärzte)*, which became a powerful political pressure group. Already before that, doctors in Switzerland had had an important influence on political life, but with the foundation of the national medical organization, the political activities of the medical profession could be united under a common umbrella (Braun, 1985, 350).

During the late 19th century, the medical profession was also included in public health, specifically the implementation of public health policies. In the secondary literature that I reviewed, I found little evidence for active responsiveness of both sectors with respect to public health policies, in the sense that the medical profession publicly advocated public health policies. In the late 19th century, doctors in Switzerland had become a wealthy interest group and gained a lot of influence in public health policymaking. At the same time, they had an important role in the implementation of public health policies such as immunization, factory inspection, hygiene, and mandatory exams (military, schools, etc.). Medical organizations were politically active; for instance, they resisted state intervention in their business, such as attempts to regulate public health insurance. This is different from the case of Germany, where doctors and doctoral organizations are much more included in hierarchies, such as restrictive laws regarding business (until 1869) and state-owned health insurance (Braun, 1985, 356-357).

However, in Switzerland, there was no large public health coalition, which meant that public health doctors and administrators and medical organizations demanded more public health policies, as was the case in Australia. On the one hand, this was due to the absence of the professionalization of public health; this was the case in Australia, where the first postgraduate diploma of public health was established in Melbourne in 1906. In contrast, in Switzerland the professionalization of public health began in the second half of the 20th century. In Switzerland, the first courses in public health were taught in the early 1960s, and an academic title was created only then (Bern, Geneva, Lausanne, and Zurich established institutes for preventive medicine thereafter).[3] As mentioned before, the tasks of public health that were in the hands of the state mostly referred to policies against epidemics, but apart from that subsidiarity (the delegation of public tasks to private actors)

[3] <http://www.ispm.ch/index.php?id=150>. Last accessed October 20, 2014; Int-CH-13.

played an important role. Consequently, we need to look at non-governmental organizations in order to understand the public health sector in Switzerland. As mentioned before, the *Gesundheitsliegen* (leagues to combat certain diseases) were important in this field, such as the cancer league or the lung league. One example of this is the activities of the league against tuberculosis in the canton de Vaud, which started activities against cancer in the early 20th century and helped to advocate a national law regarding tuberculosis (Achtermann and Berset, 2006, 41).

The original mission of the health leagues was to take care of patients and to complement the services of doctors, which means they can also be considered part of the health care system. What is more, their activities focused on the cantonal level; however, their impact on the national level of health policy was limited. The national organization of the Swiss Cancer League was founded in 1910 as a small group of medical doctors with the goal of improving research on cancer in Switzerland. This means that the federal board of the cancer council also functioned as a platform for exchanging new results of cancer research and discussing questions regarding new methods of treatment (Kauz, 2010, 11-13).

The cancer leagues focused on helping ambulatory patients and supported cancer research, but they were not politically strong pressure groups that advocated public health policies in the modern sense. Another reason for the lack of responsiveness from the health care and public health sectors was that there was fragmentation of the sectors among cantons and little communication between them in general. For example, on December 1, 1908, the director of the Federal Office of Public Health, Friedrich Schmid, received a letter from the International Society for Cancer Research in Berlin notifying the federal public health office of Switzerland that the *Institut pour I'etude des maladies cancereuses* in Geneva, which had been founded in 1907, was demanding to become a member of the international society on cancer research. The fact that such a request came from Geneva and not from Bern confused the organizers in Berlin, but for the purpose of this paper, it shows that there was little communication between the federal institute for public health and health foundations and organizations (Kauz, 2010).

To conclude, based on my review of the secondary literature, there was little responsiveness between the health care and public health sectors. The medical profession was not very active politically. On the other hand, public health was not very well developed as a profession, and the organizations that served as functional equivalents were not politically active either.

What do these results imply for the hypotheses that I discussed regarding Switzerland? Specifically, I had expected to find de-coupling of the two sectors because of institutional fragmentation and low professionalism. My results confirm this hypothesis. Firstly, because of the distribution of legislative power between the cantons and the federal government, there was no institutional integration of health care and public health at the national level, and the cantons remained in charge of the majority of health policy. National health policymaking remained fragmented. The national office for public health was in charge of some of the policies related to public health. On the other hand, there was no national

health insurance to connect public health to health care policies. Although there was a proposal to implement national health insurance, the proposed law failed in a popular vote. The only health care legislation that passed was a law that permitted additional payments by the federal government to the cantonal health insurance providers, yet the administration of this legislation was the responsibility of the ministry of social insurance.

As I expected theoretically, the absence of responsiveness between sectors was due to low professionalism of the medical profession. Doctors, public health professionals, and health foundations did not form an alliance that advocated more public health policy, but medical organizations served as a platform for scientific exchange with little impact on the political integration of prevention and health care. Eventually, regarding the contextual elements, despite a favorable contextual situation regarding responsiveness and integration of health care and public health, context had no strong impact on the relationship between the two sectors.

8.2 De-coupling of sectors, but coordination between cantons (1918-1945)

In the next section, I turn to the interwar and Second World War period. I have argued that during this time, the context for the co-evolution of health care and the public health sectors changed. Demands regarding public health policies changed because more sophisticated medication was available, and conflicts over the distribution of resources between actors of the two sectors were likely, especially because of the economic crisis in the late 1920s. Regarding Switzerland, these factors should increase conflicts between the two sectors even further.

8.2.1 Institutional separation at the national level

During the interwar period, health care and public health remained two separate sectors at the national level because their institutions were institutionally independent. The federal office for public health administered public health laws, and the national office of social insurance took responsibility for the national part of the health care legislation. At the cantonal level, it remained difficult to draw a distinction between the two sectors. In larger cantons, there was a cantonal officer for public health (although named *Kantonsarzt*), who was specifically given responsibility for public health and prevention, whereas in the smaller cantons, this role did not exist. Nonetheless, the cantons played an important role in health policy regarding health care and public health. In the interwar period, many cantons founded cantonal and university hospitals. Thereby, the cantonal governments got more and more involved in financing or co-financing hospitals as their demand for cash increased in the modernization process (Achtermann and Berset, 2006, 22). Concerning health policy, the competences in health policy remained separated between the federal government and the cantons. The remainder of the legislative powers over health policymaking remained with the cantons, which legislated in the following areas:

health policing, hospital planning, planning of care, and prevention of non-communicable diseases (Achtermann and Berset, 2006, 31).

As discussed in the previous section, legislation regarding epidemics was delegated to the national government. Concerning health care, at the national level, the law of 1911 remained the only legislative milestone during the interwar period. There were quite a few attempts to reform the law that failed in several instances during the 1920s and the 1930s (Degen, 2008; Santésuisse, 2014). These debates regarding reforms began immediately after the First World War, in 1918. The health insurance law was successful, as it led to an increase of insurance providers and their members. Yet the financial situation of the health insurance providers became difficult, and federal subventions covered not 40 to 60 percent of the cost of the health insurance, as had been foreseen, but only 10 percent. Because of the bad economic situation, it was impossible to increase the insurance contributions for the population. To solve this problem, the federal government paid additional subsidies, and the insurance providers increased out-of-pocket payments (Alber and Bernardi Schenkluhn, 1992, 186-187).

On the other hand, a main issue of health policymaking concerned health care pricing and the remuneration of doctors. According to the national law regarding health insurance legislation, doctors could negotiate their fees with health insurance companies. With the onset of the global financial and economic crisis after the crash of the stock market in New York, the salaries of doctors were reduced. Since the early 1920s, there had been ongoing debate over doctors' practice of demanding high fees (to be paid by health insurance); insurance companies argued that the fees demanded by doctors were too high. In 1932, the national medical organization, FMH, agreed to reduce fees because of the crisis (Vuagniaux, 2002).

Another element of the Swiss health care system that is important to the relation between health care and the public health sectors is the differences between cantons concerning the role of the state, and the respective role of the public concerning the treatment of diseases. This is especially apparent regarding cancer treatment. In Geneva and Lausanne, centers for the treatment of cancer were founded after the First World War. Especially the Centre Anti-Cancéreux Romand (CACR), which was established in Lausanne, played an important role in providing therapy and counseling on cancer-related matters and coordinating the activities of the cantons Vaud, Valais, Fribourg, and Neuchatel. In contrast, in the German-speaking cantons, there was strong opposition to centralized and publicly visible facilities for the treatment of cancer, as well as records for cancer patients (*Krebsregister*) and screening programs (Kauz, 2010). The same differences are visible with regard to "self-dispensation", which is the right of doctors to distribute drugs and bill this to the health insurance (Dummermuth, 1993). In the Western part of Switzerland, doctors are not allowed to dispense medication, whereas they are in the German-speaking cantons.[4]

[4]Statement by the Swiss national medical organization concerning the right of doctors to distribute medication, <http://www.fmh.ch/files/pdf9/2012-02-27_Positionspapier_DMA.pdf>. Last accessed

The cantons played an important role in national health care legislation. After the establishment of the Conference of Cantonal Directors of Public Health (CDP), the cantonal directors for public health played an important role in putting health policy issues on the political agenda. As I will explain in the following section, although the conference mostly worked on public health issues, it also interfered in health care policymaking, especially pharmaceutical legislation. The cantons agreed that pharmaceutical matters should be legislated by the federation and that a proposition by the CDP would make a positive impression for this project. In 1930, the CDP proposed a national law that would regulate substances that were declared "poisons" in national legislation and require substances that were classified as "medication" to be governed by a concordat, which would take into consideration the different positions of German-speaking and French-speaking cantons in the matter of pharmaceutical policy. A concordat is a contract between all or several cantons regarding the harmonization of their regulation. This allows different positions of the cantonal governments with regard to certain issues to be taken into consideration. Although the proposal by the CDP regarding the law on pharmaceutical legislation had already been made in the 1930s, it took until the 1970s for the federal law to be put into place (Minder, 1994).

The CDP was more active with regard to public health policies. After its foundation on August 29, 1919, it immediately became a key player in setting the national public health agenda. The organization followed the creation of the inter-cantonal office for the control of drugs, which was established in 1900, because the cantons considered it important to have an inter-cantonal conference to consider health policy issues. In its early days, the CDP dealt with issues of public health, such as the implementation of the federal law regarding the transport of food, which had been adopted in a popular vote in 1909. Other issues on its agenda were the decline of birth rates, improvement of drinking water provisions, improvement of housing hygiene, regulation of waste disposal, and health in schools. Apart from health protection, the members of the CDP debated and discussed actions regarding risk factors such as alcoholism, which was regarded a major cause of physical and psychological degeneration (Minder, 1994).

At the same time, the cantons cared about public health topics such as health protection and prevention, especially with regard to environmental factors. They were concerned with issues such as infectious diseases, childhood mortality, alcoholism, improvement of drinking water supply, improvement of living hygiene, trash, and health in schools. In addition, they implemented the public health legislation of the federation (Workplace protection, epidemics). Oftentimes they played an important role in putting public health problems on the agenda of the federal government, for instance with regard to the federal law against tuberculosis (1928) and the federal law on alcohol (1932) (Achtermann and Berset, 2006, 22-23).

Especially concerning the federal laws on tuberculosis, the cantons played an important role and quite a bit of interaction happened between the federal government and the

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cantonal governments regarding this matter. In 1920, the CDP demanded help from the federal authorities regarding drinking water provisions, but the national government did not even reply. This was different with respect to the law on TB, because the CDP played an important role concerning this dossier. In 1920, the CDP had two meetings concerning a revision of the national law on epidemics. In 1928, the federal government passed the national law on epidemics, and the members of the CDP claimed that they had quite some influence in the process and were able to implement some of their preferences in the law.[5] The legislation concerning this reform had been planned for 1913, but the process was interrupted due to the war. As a result, the newly founded CDP could introduce its preferences into the legislation and influence the national law, a fact that the members of the CPD emphasized as an important success of their work (Minder, 1994). However, apart from the cantons, private actors, such as the league against tuberculosis of the canton de Vaud, played an important role in the formation of this law, as discussed before (Achtermann and Berset, 2006, 41).

To sum up, during the interwar period, health care and public health remained institutionally separated. National health policy was mostly public health policy. There was a great extension of the state's role with regard to its interference in matters of health policy, especially with regard to infectious diseases. The CDP took a very broad role in advocating more public health policies. The cantonal ministers of health connected the high rate of infections with TB to housing problems. They also recognized the necessity of improving primary care and individual prevention, and they saw that economic growth is good for public health. However, the conference did not have the means to implement these policies. Prevention was the most important paradigm in the discussion of the Swiss health system before and during the war. Yet it was understood as a paternalistic method of intervention. It was not really implemented, because in the mainstream liberal and conservative parties, population-based health policy was discredited because of the racist population health policies in the fascist states, especially in Germany (Minder, 1994).[6] On the other hand, there were no reforms of the existing health care legislation, which would have increased the regulatory power of the national state. The only adaptations were the national government's reforms increasing health care co-payments.

8.2.2 Coordination of cantonal governments rather than responsiveness of professions and interest groups

What happened regarding the responsiveness of the health care and public health sectors during t1? Public health issues were put on the political agenda by the Conference of Cantonal Directors of Public Health (CDP) during the First World War. On October 5, 1918, Dr. Fritz Aemmer, a member of the cantonal government in Basel, invited the directors of public health from the other cantons to join him in a national meeting,

[5]<http://www.admin.ch/opc/de/classified-compilation/19280017/index.html>. Last accessed October 22, 2014.

[6]However, it is important to note that, in Switzerland, several cantons implemented policies that were influenced by eugenics, such as sterilization. For a discussion of these policies compare: (Mottier, 2008).

which resulted in the foundation of the CDP. The reason for the meeting was that the cantonal public health directors believed that the federal office for public health had not taken enough action concerning the most pressing public health problems, such as the Spanish influenza, improvement of drinking water provision, and support and education for midwives (Minder, 1994).

In particular, public health issues related to the war were a problem. Although Swiss troops did not participate in battle, military mobilization involved sanitary problems, such as the spread of infectious diseases, due to the movement of troops and the gathering of many people that came along with it. The cantonal directors of public health noticed that infectious diseases that were already known became even more virulent in wartime. Consequently, sanitary conditions became even worse and epidemics broke out, such as smallpox, cholera, dysentery, spotted fever, typhus, influenza, genital disease, and malaria. Yet, CDP members also observed that diseases were a pressing problem in warring countries and that, except for the Spanish influenza epidemic (1918/19), Switzerland had been spared from the epidemics. However, the impact of this influenza epidemic was significant, as 56 percent of the Swiss population was infected and 25 000 died. To get a grip on these problems, the national and the cantonal governments communicated on how to improve the coordination of public health policies (Minder, 1994).

In the CDP, coordination of public health policies occurred between the cantonal governments and the federal government. However, I did not find evidence of responsiveness from the health care and public health sectors in the sense of communication and coordination between interest groups or professions of the two sectors, such as the medical profession on the one hand and public health doctors on the other hand. Although the national medical organization in Switzerland developed a more professional organization during the 1920s,[7], it was not very politically active.

In fact, it was the CDP that set the agenda for health policy, including public health issues. Its activities included proposing measures against genital diseases in 1921, 1933, and 1937. In 1933, the CDP proposed to the federal department of domestic affairs to draft a national law to combat epidemic diseases. The impulse for these activities was the smallpox epidemic from 1921 to 1926 and the increasing incidence of polio in the second half of the 1930s (Minder, 1994).

On the other hand, the CDP itself also became an important arena for discussing issues of population health. In the debates within the CDP, some cantonal public health directors argued that "socially valueless subjects" (those who were addicted to substances such as alcohol, psychopaths, and tuberculosis patients) were reproducing without obstacles, whereas educated cohorts have fewer offspring. Consequently, some members of the CDP proposed framing tax advantages for married individuals and even more tax reductions as well as favorable housing policies for families with many children as public health issues.

[7] Indications for this is the publication of a newspaper for doctors *(Schweizerische Ärztezeitung)*, in 1920 and the establishment of a General Secretariat, in 1923: `<http://www.fmh.ch/ueber_fmh/portraet/geschichte.html>`. Last accessed October 22, 2014.

On the other hand, ideas of social hygiene did not play a very important role and if anything, their focus was on supporting weak and sick individuals rather than selecting the healthiest groups in the population. However, during the 1930s and 1940s, members of the CDP articulated eugenic ideas for population health policies more explicitly. An example is the popular initiative to protect families, when the debate in the CDP clearly showed admiration for public health policies in the totalitarian states, which did not shy from strongly discriminating against or even eliminating individuals, such as those who were sick, handicapped, or belonged to a different ethnic group. Supporters of these ideas argued that such measures were useful to protect the population (Minder, 1994). It is not surprising that we find such arguments in Switzerland, given that eugenic ideas were widespread at the time and that some Swiss cantons had implemented sterilization policies (Mottier, 2008). On the other hand, during the Second World War, the CDP had an important role because it had to deal with the sanitary problems that occurred due to mobilization and fugitives. However, after the war, when the racist elements of such population health policies came to light, the admiration of these policies subsided quickly in Switzerland (Minder, 1994).

However, in the Swiss case, there was also policy integration of both fields with regard to the prevention of accidents in the workplace and the provision of treatment facilities and payment in case of accident. In 1918, the Swiss Accident Insurance Company (SUVA) began to operate. It was an independent company under public law that insured all employees in Switzerland against workplace accidents. At the same time, the SUVA instituted a large prevention program to avoid workplace accidents. After its foundation, all employees working in difficult conditions were put under SUVA legislation. This included industrial plants, construction companies, metalworking, woodwork, and stonework. In addition, those who worked in companies producing and handling explosives and flammable materials, as well as employees of the public administration, had SUVA insurance. From its early days, the SUVA was responsible for workplace accident prevention and reimbursement of insured workers. One reason for the establishment of the SUVA was that companies were not very interested in regulations concerning the prevention of accidents, as these were considered normal incidents. In addition to developing regulations for workplace protection, the SUVA developed technologies to prevent accidents (SUVA, 1993).

The law establishing the SUVA entailed the subvention of health insurance companies, as well as obligatory accident insurance. The SUVA was charged with the implementation and supervision of workplace security in companies (Achtermann and Berset, 2006, 22). The SUVA was not part of the federal administration, but was a public company that operated to a large extent independently. The principle was to merge the concept of social insurance with the idea of a free enterprise (SUVA, 1993). This is typical for Switzerland, which has a rather conservative welfare state with a tight coordination of health care to other institutions of the welfare state. This occurred in the case of pension politics (Leimgruber, 2008), supporting my argument that health care is closer to other institutions of the welfare state than to the public health sector.

To sum up, based on my analysis, I did not find responsiveness of the health care and public health sectors as two different policy sectors in Switzerland. In previous chapters, I have discussed support for public health policies from doctoral organizations as a main indicator for responsiveness between health care and public health. In the Swiss case, however, it seems that the interaction between cantons played an important role in understanding the relations between health care and the public health sectors. Since public health was in the hands of the cantons, coordination between cantons is the key to understanding public health policymaking as opposed to responsiveness of policy sectors.

What do these results imply for my argument? My hypothesis for the Swiss case is that health care and public health are de-coupled because government is fragmented and professionalism is low. My analysis confirms this assumption. Regarding sectorial distinctiveness, health care and public health were separated, notably at the national level. On the one hand, the federal and cantonal governments shared public health legislation, yet the residual powers remained at the cantonal level. On the other hand, health care, notably health insurance legislation, was a cantonal responsibility. At the national level, there was a health insurance law that only subsidized health insurance. Any obligations were a cantonal responsibility. The national health insurance legislation was a responsibility of the social insurance department, but not the federal public health office. Decentralization of the legislative competences and many veto points made up the institutional context, which caused the separation of both sectors in the way I discussed previously.

At the same time, there was little responsiveness between sectors in the political arena. There was little political activity by the medical profession and patient organizations in general. At the same time, public health had not emerged as a profession similar to that of doctors in the health care sector. Therefore, private and professional interest groups did not play important roles in putting health policy issues on the political agenda, and consequently they did not forge an alliance across sectors. The cantons played an important role in politicizing public health problems and coordinated these activities in the CDP, however. Responsiveness between both sectors occurred at the cantonal level, if at all, but I did not explicitly focus my empirical research on this dimension.

8.3 De-coupling and subordination of public health to health care (1945-1980)

Following the Second World War, the context for health policymaking changed globally. The focus shifted to health policies that focus on individuals, rather than on the population in general. The reasons for this were the success of public health policies, pharmaceutical innovations, and prominence of public (population-focused) health policies in authoritarian states. These elements would also have an impact on health policies in Switzerland by aggravating the absence of responsiveness between the two sectors even more.

8.3.1 Institutional separation and subordination

After the Second World War, national health policymaking in Switzerland focused on individual health care, which was separate from public health. Shortly after the war, the discussion regarding a "complete revision" of the federal law on health insurance returned to the political agenda. However, the national government's main idea of creating mandatory health insurance for needy groups was soon abandoned, as the economic situation and problems of financing the existing health insurance were already a pressing problem. Furthermore, the proposal did not pass in the national referendum (Kocher, 1967; Alber and Bernardi Schenkluhn, 1992; Vatter, 2014*b*). During the 1950s, the federal government abandoned the idea of completely revising the national health insurance and only aimed at a partial revision of the health insurance legislation that increased the obligatory services that insurance companies had to provide and adapted federal subventions. However, the reform did not include a national health insurance obligation or more strict regulations of medical practice (Vatter, 2014*b*).

To the contrary, the federal government implemented other legal projects that strengthened social health insurance and health care. For instance, in 1948, it created the system of public retirement insurance *(AHV - Alters- und Hinterlassenenversicherung).* In 1950, the modernization of hospitals began. In 1951, parliament passed the federal law concerning narcotics, and in 1959, national invalidity insurance was established. In addition, the national government created some laws focusing on the treatment of specific diseases, such as rheumatism. This legislation followed the same pattern as the previously mentioned laws and focused on the care of individuals (Achtermann and Berset, 2006, 23).

In 1964, the national government partially revised the national health insurance law. The reform created new services, especially for mothers, changed the regulation for subventions, and included insurance against tuberculosis. According to researchers, in this revision of the health insurance law doctors and health insurance acted as "countervailing powers" and neutralized each other in the public debate. Therefore, the parliament and the administration in particular had a large influence in the process (Kocher, 1967; Santésuisse, 2014). However, soon after the implementation of the mentioned reform, a new proposal entered the political debate. In 1974, another revision failed in a popular referendum. The same happened with a proposal by the national government concerning a proposal for the health and mothers' insurance, in 1987 (Alber and Bernardi Schenkluhn, 1992; Vatter, 2014*b*). These reform proposals aimed to increase a national obligation to institute health insurance, but they all failed. In this context, medical organizations were indeed politically active, but in coordination with right-wing and liberal parties.

As mentioned before, because of the failure of these reforms, the public regulation of health insurance providers remained at the cantonal or even the municipal level. Consequently, there were many differences in the regulatory structures for health insurance among the cantons. In 1979, health insurance was obligatory in the cantons of Neuchatel and Jura, but it had not yet been implemented. In the cantons of Appenzell (Innerrho-

den and Ausserrhoden), Basel (Land and Stadt), Fribourg, Geneva, Luzern, St. Gallen, Solothurn, Ticino, Thurgau, Vaud, Valais, and Zug there was a partial obligation to have health insurance for financially weak households and individuals. In part, the legislation for this matter had been delegated to the municipalities. In Bern, Graubünden, Schaffhausen, Schwyz, Uri, and Zürich, the legislative power and implementation of laws concerning the partially obligatory health insurance had been completely delegated to the municipalities. Eventually, in Aargau, Glarus, Nidwalden, and Obwalden, there was neither partial nor completely mandatory health insurance (Uhlmann and Braun, 2011, 85). Due to this strong decentralization of health insurance legislation, as well as the manifold veto points at the national level, it was difficult to create a health insurance legislation. Therefore, the strong decentralization explains why there was no further transfer of rights in health insurance legislation to the national level and consequently no further integration of health care and public health at the national level.

After the Second World War, the CDP, which had been the main stakeholder in public health before the war, did not play an important role regarding the expansion of health care legislation, which occurred above all at the cantonal level, yet with little coordination. In the postwar period, cantons improved and renewed health care facilities, especially hospitals. However, beginning in the mid-1960s, it became apparent to the cantons that this undertaking was expensive and that there was a need for better coordination to better control rising costs in the health sector. Based on a demand by the organization of Swiss hospitals, the CDP agreed to provide financing support for the foundation of the Swiss Institute for Hospitals *(SKI - Schweizerisches Krankenhausinstitut)* (Schaad, 1974; Minder, 1994)

In many ways, health care legislation remained in the hands of the cantons, which had very different approaches concerning health insurance regulation, but also coordinated their efforts regarding cost containment. Consequently, there were no major reforms at the national level in the sense that the federal government would have acquired more material consequences in health policy but instead played a subordinate role in health care that was complementary to the cantonal health care policy.

Public health remained institutionally separate from health care at the national level, and the federal office for public health retained some specific competences in public health policymaking. One attempt to increase the national public health legislation was made directly after the Second World War. In the context of its annual conference, the CDP proposed an amendment to the national law on tuberculosis of 1928. The proposition entailed mandatory exams for tuberculosis for the entire population. In a popular vote on May 22, 1945, the voting population refused the proposal with a large majority. The result of this vote is yet another example that policies that regulate individual freedoms are difficult to implement in Switzerland. Another reason for the rejection of the law is that mortality from tuberculosis was already declining at the time, and therefore the population did not perceive this as a really pressing problem that needed to be regulated immediately (Minder, 1994).

After the war, the third, non-state sector played an important role in health policy in Switzerland, similar to the pattern in other countries. As mentioned before, the first national health leagues had already emerged in the early 20th century (the lung league in 1903, the Swiss Cancer League in 1910). Originally, the health leagues were cantonal organizations that criticized the emergence of national organizations. Nonetheless, the nationalization of health leagues continued after the Second World War (the Swiss Heart Association in 1967, the Swiss Rheuma League in 1958). The funding of these organizations came partly from taxes and partly from donations. These organizations played an important role in preventative health policy in Switzerland because they promoted such policies to policymakers. In the postwar period, preventive health policies focused on individuals, such as cancer screening. New gynecological exams were another method that had been developed. Some clinics founded cancer research consultation offices. In 1948, the Swiss Cancer League had already donated 350 000 francs for prevention. In addition, to acquire more funds, the national league implemented its first postcard mailing to collect donations. In the cards it argued to the citizens that cancer research, prevention, and cure are very important. In addition to measures that targeted risk factors, there were also new interventions regarding infections, such as new exams concerning tuberculosis (Kauz, 2010). However, I did not find evidence that these organizations were very politicized and actively organized political campaigns for more public action, especially national laws, in the field of public health and prevention.

While there were no political majorities for more public health policies at the national level, the cantonal governments took action in that respect. For instance, in 1962, the CDP discussed prevention of caries because some dentists had demanded that health education include dental hygiene in schools. The canton of Zurich considered introducing mandatory toothbrushing for school kids, and the CDP recommended using fluoridated salt (Minder, 1994). As in the UK, smoking and its possible health effects became part of the debate, among those in the medical profession. The national cancer league also discussed smoking as a health problem in its national report of 1962. However, despite a lot of evidence to the contrary, many observers regarded smoking especially dangerous for youth, whereas it was seen as a deserved enjoyment for the elderly and pensioners (Kauz, 2010). Despite the scientific debates regarding cancer, I did not find evidence that the medical profession or other pressure groups lobbied forcefully to pass these policies.

Most public health policymaking activity occurred at the level of the cantons, yet it did not turn into comprehensive public health legislation at the cantonal and national levels, and there were no outspoken or strong public health campaigns by the actor groups of the two fields. There was some timely national public health legislation, such as an increase of tobacco taxation (1969) (Achtermann and Berset, 2006, 23), the ban of tobacco advertisement on TV (BAG, 2014) and a new law regarding epidemics (1970) (BBl2011311, 2010). Like in Germany, there were some attempts to legislate public health by including prevention in health insurance legislation (which was mostly at the cantonal level), which the CDP had demanded in the context of the revision of the health insurance legislation of

1972. As a consequence, a foundation for health education was founded, which distributed materials concerning health education and prevention in schools, doctors' offices, and public places and ran an office for the documentation of health education. Yet overall, prevention moved in the background compared to other issues in health policy, such as the financing of hospital reforms and deficits (Achtermann and Berset, 2006, 23). Some members of cantonal governments, such as Adolf Blaser in the canton of Bern, demanded more investments in preventive medicine in order to avoid further cost-explosion in the health care sector (Minder, 1994). At the same time, public health policymaking increased at the cantonal level. The cantons Ticino and St. Gallen can be considered pioneers in health reform. In Ticino in 1976, the "Sezione sanataria" was created as an autonomous unit in the administration, which was responsible for public health. In St. Gallen, an office for preventive health was created in 1979, which included the position of a doctor for preventive health (Achtermann and Berset, 2006, 26). However, it remained difficult to find a majority for further public health policies at the national level, and these policies often failed due to the many veto points, such as a popular initiative to ban tobacco and alcohol advertisement at the national level (Guttempler-Initiative).[8]

To sum up, following the Second World War, in Switzerland, health policy making changed in a way that put the focus on individual health care policy, as was the case in other countries. In this context, the public health agenda, which had been weak before, lost even more credit. The institutional separation of health care and public health was retained because there was no main institutional reform of health policymaking, and at the national level there was no legal basis (such as a legislative framework) for public health policymaking (except for disaster management).

8.3.2 Continuity of responsiveness

As I will explain in the following section, there was little responsiveness between the health care and public health sectors in the sense of policies to coordinate interest groups and professions. One reason for this was that public health, understood as preventive medicine, was established at Swiss universities in the mid-20th century, which was rather late in international comparison. The first public health school emerged in the late 1950s when the vice-director of the federal office for public health returned with a Master of Public Health degree from the U.S. and received a teaching position at the University of Zurich. About ten years later, social and preventive medicine became part of the general exams for medical doctors as of 1968. The content of the subject "Sozial- und Präventivmedizin" involved mostly medical aspects of occupational health, but not many other concepts and instruments of preventive health policy. In the following decades, the Universities of Zurich, Lausanne, Geneva, and Bern established institutes of public health and preventive medicine.[9]

[8] <http://www.eav.admin.ch/org/00558/00579/index.html?lang=de>, last accessed December 9, 2014.

[9] <http://www.ispm.ch/index.php?id=150>. Last accessed June 29, 2015.

However, the new field did not reach the same status as public health in the U.S. Doctors of clinical medicine did not appreciate the new field or easily integrate it with classical medicine. For instance, at the University of Bern, many professors of the faculty of medicine regarded the first professor for social and preventive medicine as an intruder. What is more, the fact that the new subject had been introduced as a decree by the federal government caused fears in the medical profession that this would come along with the establishment of a state medicine system (Such as a national health service), and public health turned into a negative label (Int-CH-13, Int-CH-25).

Nonetheless, public health issues entered the political agenda and the public debate, as I explained in the previous section. However, the politicization of public health and lobbying activities concerning these issues were not very professional. The federal office for public health and the national cancer league organized a commission for public health relations, which had the goal of informing the public regarding cancer problems and run projects to collect money for cancer research. However, in the literature, the political activities of the public health sector have been regarded as unprofessional. The commission for public health relations noted that compared to Anglo-Saxon countries, Switzerland is lagging behind regarding public health information campaigns, including political activity on this matter (Kauz, 2010).

With regard to a public voice for public health policies, it was again the CDP that was an important platform for this issue. In 1967, the CDP demanded to be informed about the fund for Swiss health research that had been created at the time and demanded to also be used for social and preventive medicine, as well as to research economic, sociologic, legal, and statistical problems of population health. Specifically, the CDP demanded to create a section for this purpose in the National Science Foundation, which had been founded in 1970 (Minder, 1994).

However, although there was little professional lobbying activity regarding public health issues from the medical profession, doctors were interested in public health issues. For instance, in 1966, the president of the national cancer league, Martin Allgöwer and Meinrad Schär from the University of Zurich published a contribution in the Swiss newspaper for doctors defending the usefulness of cancer registers as a means to learn more about cancer as well as to better prevent and cure the disease and demanded a better coordination of the cantons. However, until the mid-1970s, only the cantons of Geneva, Vaud, Neuchatel and Zurich (the latter only temporally) had cancer registers (Kauz, 2010).

In doctoral practice, individual prevention had already played an important role in medical practice in the early 20th century, specifically concerning the prevention of cancer, such as bans of carcinogenic substances in the chemical industry. Similarly, in the early 20th century, recommendations had been formulated concerning nutrition; for instance, doctors recommended eating less meet and more vegetables and dairy products because a lifestyle that is closer to nature effectively prevents cancer. This information was transmitted by means of leaflets, talks, demonstrations, essays, exhibitions, films, and radio and TV shows. Like infectious diseases such as syphilis and other issues such as

alcoholism, cancer was regarded as a consequence of a bad and possibly morally wrong lifestyle (Kauz, 2010).

Although the concept of individual prevention had already been formulated in the early 20th century, it did not have a strong impact on national public health policymaking. Doctors and medical organizations did not make this a high-priority issue on their political agenda, nor did health foundations hire lobbyists to invest more in public health and prevention. The issue was widely debated in the CDP, and the cantonal directors put public health issues on the political agenda, such as in 1975, when the council demanded reductions of speed limits within built-up areas (Minder, 1994). What is more, the previously mentioned tobacco issue was not pushed by doctoral organizations as it was in Australia, for instance. Members of the medical profession were particularly included in health care governance at the cantonal level, whereas in Germany, they participated in a rather corporatist method of health care politics, but rather at the cantonal level (Int-CH-32).

To sum up, postwar health policy created serious challenges for health policymaking in Switzerland. On the one hand, there was strong popular resentment toward regulative national public health policies. On the other hand, there was strong opposition concerning national public health policies in the population. Consequently, most national health policy projects focused on health care, whereas public health and prevention played a subordinate role. However, on the other hand, the increasing complexity of health policy problems in general made coordination of health policy and care as well as prevention more necessary, especially because many financially weak cantonal governments could not afford such policies anymore. With regard to the responsiveness of health care and public health, the lack of public health professionalization and the orientation of the medical profession toward individual care, also with regard to political activity, supported the subordination of public health under the health care sector.

What do these results imply for the hypotheses that I discussed for the Swiss case? I have argued that in Switzerland, health care and public health are de-coupled because government was fragmented and professionalism was low. My results mostly confirm this hypothesis. Regarding institutional distinctiveness, legislative decentralization and the many veto points and players at the national level were crucial for less institutional integration of health care and public health. On the one hand, the cantons kept many of their prerogatives in health policy. On the other hand, the medical profession and popular opposition prohibited further state regulation in the field of health care. Consequently, there was less institutional integration of both sectors under the public umbrella. At the same time, the low professionalism in Switzerland came along with little political activity by the medical profession and health foundations. Therefore, there was no political responsiveness from the actor constellations of both sectors. Nonetheless, public health issues were on the political agenda, but only for some specific problems.

8.4 Non-coupling and policy integration (1980-2010)

As in other countries, in Switzerland, public health returned to the political agenda during the 1980s. This was due to the changing context, which I discussed in the third chapter. As a reminder, during this time period, the focus shifted back to public health because the pattern of dominant diseases evolved to more non-communicable diseases. What is more, the ever-rising cost of individual health care led to demands for more prevention for reasons of cost containment. In the following section, I will discuss how health care and public health co-evolved in that context in Switzerland.

8.4.1 Nationalization of health policy

In the early 1980s, the landscape of hospitals began to change in Switzerland. This entailed the construction of big university hospitals, which were either newly constructed or modernized and put in common networks. (The situation was similar for regional hospitals.) At the same time, applied medical technology changed and became increasingly expensive. Consequently, the demand for more efficiency in medicine increased and critical voices became louder, demanding fundamental changes in the health system. Critical questions included how the rising health expenditures could be stopped. Specifically, the effectiveness of traditional medicine was called into question, as was the role of companies in medicine, such as the pharmaceutical industry (Achtermann and Berset, 2006, 23).

However, along with the dramatic increase of health expenditures, reforms of health policy at the cantonal level became increasingly complicated due to conflicts in the cantons regarding these issues. This was a problem because most competences in health policy were in the hands of the cantonal governments. To resolve the stalemate, the federal government began to regulate health care policy by federal decrees. The federal government tried to reduce problems by balancing risks, increasing subventions, and proposing new models for health insurance. This practice to nationally govern health policy by decrees de facto increased the power of the national government and entailed a centralization of health policy by stealth, but it lacked broad democratic support (Kocher, 2010; Vatter, 2014*b*).[10] The problem was however, that new national health legislation was difficult to pass and reform projects failed regularly, such as a new insurance law for mothers, in 1987 (Minder, 1994).

However, in the early 1990s, the old model of a voluntary social health insurance, which was based on predominantly local health insurance, did not function anymore because of the increased mobility of citizens with "good risks" and cost pressure. Throughout the 1980s, politicians tried to regulate these issues with decrees, but for experts it became clear that the best solution was to create obligatory health insurance (the majority of the population already had some kind of health insurance) and to regulate the insurance market (Int-CH-22). In the early 1990s, a complete revision of Swiss health insurance

[10] One exception is the separation of health and accidental insurance, in 1981, which extended accident insurance to all workers (SUVA, 1993; Santésuisse, 2014).

began (Achtermann and Berset, 2006, 22). In 1994, a national health insurance law passed in parliament as well as a referendum. The new law created an obligation for each resident of Switzerland to have health insurance and required health insurance providers to accept everyone, irrespectively of health status and age (in the basic health insurance package). With this reform, Switzerland finally joined the group of countries with a social health insurance system because the existing health insurance providers remained the centerpiece of the health insurance system. The fact that the Swiss national government did not create public health insurance, in contrast to countries with a national health service or a national health insurance, underlines this judgment even more. On the other hand, Swiss health insurance retains an important element from private health care systems, namely that insurance premiums are not calculated according to income (regressively) and employers do not have to pay a health insurance contribution (Bertozzi and Gilardi, 2008; Cheng, 2010; Indra, Januth and Cueni, 2010; Böhm et al., 2012; Uhlmann and Braun, 2011).

Since its establishment, the national health insurance law, the main instrument for governing health policy nationally, has been revised regularly with regard to some problems that have occurred, such as risk equalization between cantons and health insurance carriers (Uhlmann and Braun, 2011; Bonoli, Braun and Trein, 2013). What is more, there have been popular and parliamentary initiatives to reform health insurance more in the direction of national public health insurance. Supporters of such a model hope for a simplification of the system and consequently possibilities to reduce expenditure. However, these proposals failed in referendum in 2007 (Kaufmann, 2010) and 2014.[11] This means that despite having a social health insurance system with regard to governance, Switzerland retains a strong private element in the provision of health care. Recent reforms in the health care sectors were aimed to improve managed care in the ambulatory sector. What is more, the cost calculation for hospital reforms changed, especially with regard to the creation of the Swiss DRG, a platform connecting canton providers and insurers with the goal to organize the details for DRGs (Bonoli, Braun and Trein, 2013).

The Swiss health insurance law includes the medical professions and health insurers in a corporatist mode of coordination in order to define tariffs for doctors and regulate other matters related to the price of health care. Because prices differed among cantons, in 2004, the TARMED system was set up to include health insurance providers, doctoral organizations, hospital organizations, and members of the accident insurance SUVA in a committee to fix health insurance prices. The federal government only intervenes when these partners do not find any solution.[12] This reform is important to understand because it underlines the argument that I made before, namely that the delegation of health care regulation and financing to societal actors that create solidarity based on a network impedes the political activity of medical organizations. Specifically, medical professional organizations and other interest groups from the health care sector were included in the

[11] For details read the respective projects in the national parliament: 05.089 and 13.079.

[12] <http://www.bag.admin.ch/themen/krankenversicherung/06492/06494/index.html?lang=de>, last accessed December 9, 2014.

administration of health insurance policy. Consequently, they became part of the politico-administrative actors and are therefore less likely to act as a private pressure group, which has also impacts on their advocacy for public health. The nationalization of health policy affected not only health insurance but also the field of drug policy. In 2002, a national law for the governance of Swiss health policy was established. It entailed setting up Swissmedic, which is a regulatory agency that is responsible for the admission of medications on the Swiss market. Before that, the inter-cantonal authority for medicaments *(Interkantonale Konstrollstelle für Heilmittel)* had been in charge of governing the medical problems (Achtermann and Berset, 2006, 28).

However, apart from the national health insurance law and the national law governing drugs, so far there has been no major legal project to govern health at the national level. However, coordination efforts among the cantonal governments have been improved, aside from the conference of the cantonal directors of public health. Specifically, a platform for a dialogue in national health policy was founded that coordinates cantonal and national actors with respect to important aspects of health policymaking. The platform produced some common outputs, such as national strategies against cancer or for the prevention of non-communicable diseases.[13]

The national dimension is important with respect to public health and its institutionalization. Since the 1980s, public health has returned to the political agenda. The return of public health activities began at the cantonal level. Particularly, the cantons Ticino and St. Gallen can be considered pioneers of public health reform. In Ticino in 1976, the “Sezione sanataria” was created as an autonomous unit. In 1994, it was transferred into the “Uffizio di promotion e di valutazione sanataria.” In the canton, there were many programs of preventive health; for instance, from 1984 to 1989 there was a program to prevent cardiovascular diseases by reducing smoking, high blood pressure, lack of movement, and overweight. In 1989, health promotion was written into a new cantonal health law. In the 1990s, many cantons revised their health legislation to adapt to changing demands, following the examples of Ticino and St. Gallen, which focused on health as a multi-sectorial problem. Between 1998 and 2004, 13 cantons renewed their legislation on health. The term “prevention” has mostly been used in the cantons of Western Switzerland, whereas the German-speaking constituencies prefer “health protection” *(Gesundheitsschutz)*. More and more there is a change toward encompassing programs of health prevention instead of only having sectorial approaches. However, there are large differences among the cantons with regard to expenditure for prevention. For instance, in 2002, Uri spent 55 CHF, whereas Geneva invested 60 million in 2001 (Achtermann and Berset, 2006, 26) (Int-CH-16, Int-CH-21, Int-CH-25).

In addition to the reforms to health legislation, data collection regarding public health issues improved. For instance, during the 1980s, the registration of cancer patients also began in cantons that had already established such practices. Specifically, these were

[13] `<http://www.nationalegesundheit.ch/nc/de/uebersicht/index.html>`. Last accessed on June 29, 2015.

Zürich (1980), St. Gallen (1980), Appenzell Innerrhoden and Ausserrhoden (1980), Basel-Stadt and Basel Landschaft (1981), Graubünden and Glarus (1989), Wallis (1989), Tessin (1996), and Freiburg (2006). In 2010, more than 60 percent of the Swiss population was covered by cantonal or regional cancer registers. In 2008, the National Institute for Cancer Epidemiology and Registration replaced the old organization of the Swiss cancer register (Kauz, 2010).

At the national level, there was also an attempt to implement a national law for preventive health in the early 1980s. In a statement about the (defeated) referendum concerning advertisement of tobacco and alcohol, the federal council announced that it would soon propose a national law regarding preventive health, in 1978. Such a law should regulate health education and provide better coordination of the measures taken by the cantonal governments as well as the federal government. What is more, such a law would better harmonize the national health legislation in the cantons and improve research on health prevention while taking into consideration economic aspects of preventive health, as well as the cultural differences of Switzerland. The proposed legislation was, as is usual in Switzerland, subjected to an extensive consulting process. The result showed that a small majority supported the legislation. Most economic interest groups and the majority of cantons were against the law, however, as they were afraid of more state interventionism and reduction of individual liberties. In contrast, health leagues and parts of the medical organizations supported such a law. As a consequence of the negative feedback from cantonal governments and interest groups, the federal government decided not to pursue a national law for prevention but rather to seek preventive health programs based on issue-specific projects and legislation. As compensation, the national government sought to create a national fund for preventive health. Based on the initiative of the canton Vaud, the federal government and the cantons created the Swiss Foundation for Health Research in 1989, which today plays an important role under the name *(Gesundheitsförderung Schweiz)* (Achtermann and Berset, 2006; BAG, 2007). However, the foundation also competed with the federal office for public health, as it had a more encompassing concept of public health, which was more related to the Ottawa Charter (Achtermann and Berset, 2006, 25).

The national government also increased public health activities in this period. In 1985, a national program to prevent AIDS was implemented (Kübler, Neuenschwander and Papadopoulos, 2001; Achtermann and Berset, 2006), as well as an ordinance for clean air (Achtermann and Berset, 2006). In 1987, the federal office for public health created a “prevention” section (Tobacco, Alcohol, Drugs, and Immunization). In addition, in the same year, the national government established more than ten national research programs, which had the goal to improve research on preventive health and were complementary to medical research done by private and academic actors. Cornerstones are programs to prevent cardiovascular diseases (NFP1), neurological diseases (NFP 38), muscular illnesses and chronic pain (NFP 53), environmental health determinants (NFP 26), and affordability and efficiency of the Swiss health system (NFP 8). Nonetheless, clinical research remains dominant, although it receives less public means and more private financing (Achtermann

and Berset, 2006, 24).

At the same time, the cantons wanted to reform their health policies. Federal activities in the areas of HIV and drugs led to an increase of public health activities in the cantons that either implemented federal programs or made their own (Kübler, Neuenschwander and Papadopoulos, 2001; Kübler and Wälti, 2001; Kübler, 2001). In 1987, there was an inter-cantonal meeting in Lausanne in which the federal government, Bern, Geneva, Tessin, and Vaud participated. The group declared it would strengthen prevention and make hospitals more rentable by the use of DRGs. Inspired by the WHO Strategy "Health for everyone," cantonal governments began to also consider more preventative health policy. Following the inter-cantonal conference, many cantons began to implement broader prevention policies according to the new public health paradigm (1980-2000). The focuses of the program were addiction, HIV, cancer, sexual health, work, nutrition, age, psychological health, and gambling. More recently, cantons began to consider integrating health care with public health, for instance in multi-sectorial projects such as "Netzwerk gesundheitsfördender Spitäler" and health impact assessments (Achtermann and Berset, 2006, 25-26).

The meeting also produced a debate on the relation of the federal government and cantons with regard to the distribution of responsibilities between them. Beat Roos, former director of the Federal Office for Public Health, held that the existing separation (health protection at the federal level and health care at the cantonal level) should be upheld. He said that he could not imagine the federal government gaining more competences in health care from the cantons. Yet this had already begun to change. Federal involvement in AIDS prevention and the revision of health insurance started a dynamic of centralization and changes in the distribution of competences among the federal state and the cantons. Following the inter-cantonal conference of 1987, the cantons also put forward the goal to strengthen health promotion instead of increasing the capacities of health care, according to the WHO Charter health for everyone of 1984, and the Ottawa Charter of 1986. Yet, de facto this also ended the separation of competences between the federal government and the cantons. This began with the federal law on health insurance, which gave the federal government the authority to interfere in the planning and administration of health care, something that had previously been in the hands of the cantons. The consequence was an unintended undermining of cantonal competences, which increased the problems of coordination in the Swiss health system (See 1994) (Achtermann and Berset, 2006, 33).

In the 1990s, the federal government pursued more programs and activities in the field of public health policy. In 1991, a national program to prevent drug use was established (Achtermann and Berset, 2006), but some parliamentarians demanded more, such as a national law to prevent drug addiction.[14] The aforementioned Swiss public health foundation published a national action program that had the goal of replacing the missing national health strategy. The federal government, the cantonal conferences for public health, and the national conference of health leagues supported this program (but not

[14]Reference: Parliamentary Motion 93.3673 of the federal parliament of Switzerland.

explicitly the medical associations). The program advocated better use of resources in the health sector for the optimal development of the health potential in the society by improving quality of life through the prevention of diseases (Domenighetti, Florio, Gutzwiller and Krafft, 1993; Minder, 1994).

The mentioned public health activity was a reaction to increasing figures in the consumption of drugs, tobacco, and alcohol, as well as the renewed attention to public health issues. However, the mentioned actions were programs by the federal government, such as the national program to prevent alcohol of 1997, the national tobacco program, or the controlled distribution of hard drugs to addicted individuals of 1993. National legislation covered only illegal drugs, however, such as the federal law on narcotics, which passed parliament in 1995. There were no majorities in parliament or popular referendums for national laws regarding tobacco and alcohol. For instance, in 1993, a proposal to ban tobacco and alcohol advertising got forcefully turned down in a popular vote (Cornuz, Burnand, Kawachi, Gutzwiller and Paccaud, 1996; Achtermann and Berset, 2006; Vatter, 2014*b*). The defeat of the proposition for a national ban of tobacco and alcohol advertisement was a strong blow to the ambitions of national public health policymakers because it underlined how little support public health issues had in the population and that the "anti-public health regulation coalition" was able to mobilize much better support among voters (Cornuz et al., 1996) (Int-CH-2, Int-CH-30). However, after 2000, many of the cantonal governments began to become active and pass regulative policies in the fields of tobacco and alcohol (Sager, 2003; Sager, 2004; Trein, 2015).

Consequently, from a national perspective, Switzerland has lagged behind other OECD countries with regard to public health policymaking, and especially the prevention of risk factors and the measures taken in the 1990s and early 2000s were rather careful (Int-CH-30) (Raw and Joossens, 2010*b*). Similarly, the national foundation for public health has not been very efficient, and investments in public health remained small. What is more, ideas of prevention and health education were barely known in the population (Rosenbrock and Gerlinger, 2009).

In 2004, the federal department for domestic affairs demanded that the federal office for public health evaluate the possibilities for a new national law on preventive health and to find out whether it would be possible to integrate the existing public health programs and decrees into a national legal framework. From the outset, the law received significant support from relevant interest groups in the health sector, as well as the cantons. Similarly, reports by the OECD and WHO demanded better integration of health policy in general, including public health matters (OECD, 2006; BAG, 2007; Kocher, 2010; OECD, 2011). However, at the same time, there was strong opposition to such a law. For instance, Swiss business corporations and organizations founded a platform that advocated modest prevention and opposes most forms of national public health legislation.[15] A new proposal

[15] It is named AWMP (*Allianz der Wirtschaft fr eine massvolle Präventionspolitik* - Alliance of economic organizational for a restrained preventative health policy) `<http://www.awmp.ch/mitglieder-awmp.html>`, last accessed December 9, 2014.

for a national law concerning prevention was deposited, in 2009. After three years of debate, revisions and negotiations, the proposal eventually failed because the coalition of health leagues, public health doctors, parts of the medical profession and left parties was too weak and could not mobilize support among the liberal party and Christian conservatives. But neither did it succeed in convincing the liberal part of the medical associations to do more lobbying. Instead, those who argued that such a law would restrict individual freedom even more won the debate against those who emphasized health risks (Int-CH-9, Int-CH-16).[16]

However, with regard to infectious diseases, public health reforms were possible in Switzerland. In 1999, immunization campaigns against influenza started (Achtermann and Berset, 2006, 24). Generally, the protection against infectious diseases in Switzerland is good. In 2002, the percentage of children who were immunized against infections was similarly high to those of other OECD countries (Paccaud and Chiolero, 2010). In 2011, the national law regarding epidemic diseases underwent a general reform. With respect to new forms of infectious diseases, such as SARS, and pandemic forms of influenza, such as H1N1, the federal government and the CDP demanded the federal office for public health to revise the national law of epidemics. After the passage of the H1N1 influenza wave in 2010, an evaluation of the coordination of the federal government and the cantons found that the coordination and distribution of immunization drugs was insufficient. The revision of the law passed the national parliament with a strong majority, as well as the referendum (Int-CH-17).[17]

Eventually, the administration of health policy became more centralized. In 2003, the administration of the national health insurance legislation was integrated in the federal office for public health. According to the criteria that I discussed before, this can be regarded as an instance of institutional integration of both sectors because both sectors are in the same ministry. The effects of this reform have been evaluated differently. Some policymakers praised this as a good idea because it brought together health care and public health (Int-CH-19). However, others did not think that this reform was useful because it took all the attention in the federal public health office away from public health in favor of health care (Int-CH-9). Within the administration, this reform caused conflicts and irritation, especially in the area of public health.

To sum up, the institutional relation of health care and public health evolved during the fourth time period. Due to the continuing decentralization of legislative competencies, health care and public health remained to a large part institutionally separated because the national government as well as the cantons had responsibilities for health care and public health. The most important institutional dynamic at the time was the increasing centralization of health policies in health care as well as public health. For example, the nationalization of health insurance matters and more national public health strategies show that the national integration of both sectors increased considerably. Concerning

[16]Reference: Federal Government 09.076 in the database of the federal parliament of Switzerland.
[17]Reference: Federal Government 10.107 in the database of the federal parliament of Switzerland.

horizontal integration, health care and public health had been institutionally separated until the administration of the national health insurance law was integrated in the federal office of public health. As a result, health care and public health were institutionally integrated in Switzerland, although the fragmentation of competencies between levels of government remained a problem.

8.4.2 Many voices, but little harmony: struggle for more public health activism

With respect to the responsiveness from the health care sector and the public health sector, the situation has changed since the 1980s, notably regarding the coordination between the cantons. Along with the discussed nationalization of health care and public health policy, the interaction between the national government and the cantons increased through coordination in the CDP as well as the national dialogue on health policy, as I will explain in the following. Concerning the interaction of professional actors, medical doctors on the one hand and public health doctors on the other hand, not much happened.

With the return of public health to the political agenda during the early 1980s, public health gained more importance. Accordingly, prevention was also included in the national health insurance law, which passed parliament in 1994. An article of the new health insurance law (Art. 19 Abs. 1 KVG) includes prevention in the national health insurance. However, for preventive health policies to be reimbursed by health insurance, their effectiveness needs to be scientifically proven, which is the case for all services that health insurance can pay for. In addition, the law demands that the national government and the cantons create an institution that coordinates prevention and health education nationally. The aforementioned Swiss foundation for preventive health has been charged with this task (Rosenbrock and Gerlinger, 2009). Overall, in Switzerland, about 50 percent of the public health measures are funded by public money (from the federal government, cantons, and large municipalities). The other half of the money comes from non-state organizations such as the Swiss public health foundation or the health leagues, as well as directly from health insurance providers and households (Paccaud and Chiolero, 2010).

The integration of prevention and public health in the national health insurance law created national legislation in the field of public health and more funds for public health (Int-CH-16). Yet, as was discussed in the chapter on Germany, this form of public health law subordinates public health to health care because it only regulates the financing of public health and does not give additional regulative power to the state, which is an important part of public health policy. It is done this way because the corporatist health insurance providers, as in Germany and Switzerland, have neither the competences nor the interest to make public health policy.

In order to better improve the interaction of health care and public health, the federal government transferred the responsibility for the national law for health insurance to the federal office for public health. The responsible minister argued that this reform was necessary to improve the coordination of both sectors (Int-CH-19). On the other hand,

some of the responsible personnel who were in charge of public health and prevention at the time complained that this reform shifted the internal preferences in the office to health care policymaking and that there was little room for public health policymaking (Int-CH-9, Int-CH-16). Whether this reform was problematic for Swiss health policy in the long run remains to be seen. However, it shows that in times when other countries, such as Australia, were increasingly investing in public health reforms, in Switzerland, there was a major overhaul of the national health care system that tied up many resources in the national government as well as in the cantonal governments (Int-CH-16). Moreover, the integration of public health and prevention in the national health insurance is problematic as long as they remain private enterprise that operate in a highly regulated market and are included in the self-governance of the regime, because they have neither the interest nor the competences to make public health policy. However, a possible model for the integration of health care and public health has existed in Switzerland for a long time, namely the SUVA, which combines accident insurance and prevention into a functioning model but is publicly owned (SUVA, 1993). Some commentators argue that a reform of the Swiss health insurance system according to this model would allow better combination of prevention and cure (Int-CH-13). The same suggestions have been made with regard to the initiative for public health care insurance, which got turned down in a popular referendum in 2013.[18]

With respect to the interaction of health care and public health as professions and interest groups, Switzerland is quite similar to Germany. Especially, public health groups and the medical professions did not advocate public health issues, as this was the case in Australia. Although the professionalization of public health has increased in Switzerland since the 1970s, for instance by creating more courses of study regarding public health, Switzerland is still seen as lagging behind with regard to the inclusion of public health in medical education (Brauchbar, Chastonay and Mattig, 2014). At the same time, public health research has not resulted in more public health legislation, especially with regard to risk factors. Despite the slowly increasing professionalization of the public health sector and louder demands for more public health policy, increasing education and science have not led to a more coherent and politically active public health coalition including the medical professions (Int-CH-32). The newly created preventive health activities have often not been very professional with regard to the implementation of public health policies, but also with respect to lobbying activities. Of course, there are single doctors and interested citizens who have begun to take action for more public health and to lobby for more systematic public health legislation, such as in Geneva (Int-CH-25).

Another potential important actor for more substantial public health lobbying is health leagues, such as the cancer league and the lung league. During the 1990s, these organizations began to professionally organize their activities. For instance, the national cancer league pursued more professional donation campaigns, produced merchandising articles to increase donations for cancer activities and increased the political lobbying in the national

[18]Reference: Dossier 13.079 in the database of the federal parliament of Switzerland.

parliament (Kauz, 2010). However, traditionally, the cancer leagues had been organizations that focused on patients' social and psychological support rather than cancer prevention. The leading voices in the cancer leagues were medical doctors and scientists who had opposed preventive health measures, as it is difficult to prove their effects and therefore there is no legitimate investment. This changed during the 1990s, when then-President Bruno Meili informed the board that ten to fifteen percent of the league's finances needed to be invested in prevention. With respect to tobacco and smoking, the league had recognized the connection between smoking and cancer but refrained from being too outspoken against smoking since many of its donors were smokers. Today, this development has changed, and the leagues are trying to gain attention by being outspoken against smoking (Int-CH-15).

However, the fact that there was little responsiveness from the health care and public health sectors in the sense that strong and politically active medical organizations supported public health campaigns can also be seen in the example of the national strategy against AIDS and HIV. In analysis of the advocacy coalitions concerning the national and cantonal strategies, it becomes clear that doctors played a role, but only a specific part of the medical profession was involved, specifically the organization of doctors against drugs *(Vereinigung Schweizer Ärzte gegen Drogen (VSAGD))*. However, this group did not have the financial means to pursue lobbying and lacked the full support of the national medical organization. Consequently, it was the federal office of public health that took the lead in the fight against the HIV epidemic (Kübler, Neuenschwander and Papadopoulos, 2001). This supports my hypothesis that there was little responsiveness from the health care and public health sectors on the actor level. Therefore, the chosen example is a strong test because HIV is an infectious disease that should be politically much more salient than tobacco control policy, for instance. Whereas the AMA (Australian Medical Organization) played a major role in the AIDS campaign in Australia (Baum, 2008), this seemed to be less the case, in Switzerland.

The lack of responsiveness from health care and population health interests can be seen with regard to the example of the Ebola epidemic in 2014. In this case, in Switzerland, doctors and public health experts refused to set up mass screenings of passengers at airports because such a program would not help to find infected individuals, as we never can be certain of finding those who are infected (SRF, October 10, 2014). Therefore, it was deemed unnecessary to set up screening programs. This action implicitly took into consideration that infections could occur but that the preferred strategy for handling them would be to treat infected patients rather than begin to preventively search for remedies.

Like other countries, Switzerland began to pass a series of health strategies regarding important diseases such as AIDS, cancer, and eventually tobacco and alcohol abuse. With regard to cancer, the national cancer league was involved in the establishment of the national programs (Kauz, 2010). Recently, the federal government passed a national health strategy, *Gesundheit 2020*, which entailed various general topics, such as prevention of risk

factors, long term care and workplace safety (Bonoli, Braun and Trein, 2013).[19]

To sum up, since the 1980s, there has been more public health policymaking, but no similar increase in responsiveness of health care and public health. Notably, there was little political activity by the medical profession or by the health foundations and other actors that could advocate more public health policies as private actors. On the other hand, doctors did not support public health policies very much because many members of the medical profession questioned the effectiveness of these instruments. Scientific debates prevailed over political activism in professional organizations.

What do these results mean for the hypotheses that I discussed before? I argued that health care and public health should be de-coupled in Switzerland because of the fragmented government and low professionalism. My results partially confirm this contention. Until 2003, health care and public health were institutionally separated, but then the national government decided to institutionally integrate the two sectors. Nonetheless, the institutional separation of health care and public health remained between cantons and the national government. Any project to further integrate both sectors failed because of political opposition. The integration of health care and public health could be undertaken through a governmental decree. However, further political integration was not possible. Concerning responsiveness, professional organizations were not politically active but focused on scientific controversies, for example concerning the effectiveness of public health policies. Yet they did not forge a political alliance that advocated changes in health policy. Therefore, health policy issues, especially problems of public health, were politicized along partisan lines.

8.5 Discussion

In Switzerland, health care and public health co-evolved differently than in Australia and the UK and similarly to those in Germany. On the one hand, from the 19th century onwards, there was de-coupling of health care and public health because both sectors remained institutionally separated until the early 21st century. At the same time, there was little interaction between health care and public health by interest groups and professions. On the other hand, since the competences in health policy - individual care as well as prevention - are distributed between the national government and the cantons, there has been increasing interaction between both levels of government with regard to health care and public health issues, as well as the integration of both sectors. Table 8.1 compares the results for the co-evolution of both fields during the four defined time periods, as well as for the main explanatory variables.

My results show that health care and public health co-evolved in a de-coupled manner in Switzerland. Throughout most of the time period that I examined, the two sectors were

[19] An overview of the strategies can be found here: `<http://www.nationalegesundheit.ch/nc/de/uebersicht/index.html>`, `<http://www.bag.admin.ch/themen/gesundheitspolitik/index.html?lang=de>`. Last access: November 3, 2014.

Table 8.1: Co-evolution of health care and public health in Switzerland

Time / Country	1880-1918 *(t0)*	1918-1945 *(t1)*	1945-1980 *(t2)*	1980-2010 *(t3)*
Coupling	*De-coupling:* Separation of competences between the national and the cantonal government; informal interaction; no interaction between sectors	*De-coupling:* Sectors remain institutionally separated; very little interaction horizontally between health care and public health, but increasing coordination between cantons	*De-coupling:* Sectors remain institutionally separated; very little interaction horizontally between health care and public health	*De-coupling (Non-coupling):* Centralization of health policies → Regarding health care and public health policy; little responsiveness between actors
Professionalism	Weak political activity in favor of public health from doctors and medical organizations	Little professionalization of public health organizations; medical professions not active in this regard; cantonal governments lobby for public health	Public actors rather than professions lobby for public health	Public actors rather than professions lobby for public health
Unified government	Direct democracy and federalism make national public health laws difficult to implement	Direct democracy and federalism make national public health laws difficult to implement; consensual government, liberal party in power and separation of competences between levels of government remain strong	Direct democracy and federalism make national public health laws difficult to implement; nationalization of many health laws fails in referendums (Health care as well as public health)	Direct democracy and federalism make national public health laws difficult to implement; consensual government, liberal party in power, popular vote as well as separation of competences between levels of government make national laws regarding health care and prevention, but more success than before
Context	Infectious diseases; slow emergence of national government and state	Impact of the first World War; NS in Germany; degeneration of public health abroad	Success of prior public health policies; pharmaceutical advancement; turn towards individual health care	Non-communicable diseases; risk factors; return of infectious diseases; international public health paradigm

institutionally distinctive from one another. In general, responsibilities for health policy-making were distributed between two different levels of government, the sub- national and the federal government. Yet at the same time, they had different institutions from a horizontal as well as a vertical perspective. The federal office for public health was responsible for public health, and the federal office for social insurance had the task of administering the national health insurance legislation. In 2003, this changed with the inclusion of the national health insurance law in the federal office for public health. However, health policy still remains institutionally separated between national and cantonal health policy. Although there was considerable centralization of health policy, especially since the 1980s, the demand for coordination between the national and the cantonal government is still high.

Regarding responsiveness, Switzerland is similar to Germany with respect to the absence of responsiveness concerning both sectors. Since the emergence of health care and public health as two different policy sectors, there has been a lack of responsiveness of health care and public health regarding political activity and the interaction of professions and interest groups of both sectors. GPs have never taken an important role in advocating public health policies, a task that had been fulfilled by members of the administration. This does not mean that doctors were not interested in public health issues or prevention. However, they did not act as the most powerful pressure group in this area, together with public health foundations or other actors. To the contrary, support for public health initiatives often came from members of cantonal governments or the public administration, such as the national public health administration or cantonal directors of public health, especially those who were active in the CDP. However, these actors did not unfold the same political pressure as doctors and health foundations in other countries. Doctors were mostly concerned with the administration and inclusion of the health insurance providers, as well as opposition to a mandatory national health insurance (until 1994). On the other hand, health foundations were not very active with regard to support for public health, an issue that only changed in the 1990s.

8.5.1 Fragmented government and absence of professionalism in Switzerland

What are the implications of these findings for my argument? I hypothesized that in Switzerland, health care and public health should be de-coupled. The reasons for this are absence of a unified and centralized government and low professionalism. These results should hold independent of whether the contextual condition is favorable or unfavorable for responsiveness between the two sectors.

The decentralized structure of the Swiss federation and the multitude of veto points at the national level have impacted institutionalization in the field of health policy. Originally, the residual powers to legislate in health care as well as public health were on the side of the cantons. Competences were only gradually transferred to the national government, first concerning public health and then regarding health care. Thereby, the cantons jealously

guarded their competences. This dynamic contributed to the institutional fragmentation of health care and public health and created coordination problems in the Swiss health system that still exist. Nowadays, since health policymaking has become ever more complex, the cantons in some cases even want the federal government to take on new tasks in health policy because they do not want to pay for it. The decentralization of legislative power was a key argument for the opposition to a comprehensive national health insurance, which would have signified institutional integration of the two sectors. Such a reform only passed in 1994, but had failed before many times in parliament of popular votations before.

Another feature of the co-evolution of health care and public health is the absence of political responsiveness from the two sectors in Switzerland. Notably, this is due to two reasons: On the one hand, the professionalism is low overall compared to other countries. Public health, in particular, did not evolve as a profession in a similar way to in the UK, Germany, or especially Australia. For example, a university education in the field of public health was only established in the middle of the 20th century. At the same time, the medical profession was very active politically, except for its own interests. In other words, doctors did not stand out for being politically active with regard to health policy. This concerns health care specifically, but also more generally public health. The medical organization did not participate in forging alliances that spanned across the health care and public health sector. However, the absence of political activity also holds for other actors of health policy, notably health foundations and more public-health-focused organizations.

Contextual elements were not important for responsiveness from actors and interest groups of the two sectors because the necessary predisposition, namely high professionalism, was lacking. With respect to the international context, Switzerland was in a peculiar situation. On the one hand, its proximity to Germany and the decay of public health in the Third Reich, in which population health policies became a key justification for the Holocaust, were a negative example for encompassing public health policies (Minder, 1994). On the other hand, the diffusion effect after the development of an international public health paradigm beginning in the 1980s had an effect on Switzerland, and as a result public health policies were adopted, although the national public health coalition was rather weak. However, contextual elements played a role, and especially since the 1980s, there has been a renewed impact of international elements, such as WHO strategies, on the relationship of both sectors.

8.5.2 Competing explanations

As in the three preceding country studies, there were other theoretical elements that were important to the co-evolution of health care and public health that I discussed already in the previous sections. Notably, these are sectorial complementarity, policy learning, and the difference between political parties.

1. *Complementarity:* In Switzerland, health care and public health co-evolved towards two complementary sectors, although this did not entail extensive responsiveness

between professions and interest groups or much policy integration. A comparison of health care and public health between the late 19th century and today shows that there is much more coordination between both sectors, for instance in various health strategies. However, the development toward complementarity occurred by adapting new ideas regarding public health policies from other countries and international organizations, such as the WHO. At the same time, the main challenge of health policymaking in Switzerland is the coordination between the cantons and the national government. Therefore, all efforts in national health policy need to be coordinated between the levels of government. The co-evolution of health care and public health in Switzerland is also the history of more interaction between the national and cantonal governments and an increasing centralization of the competencies in health policymaking.

2. *Policy learning:* In Switzerland, policy learning occurred differently than in other countries with regard to the co-evolution of health care and public health. Specifically, policy learning did not happen as a transmission of innovations regarding the coordination of health care and public health by the medical profession and the public health profession, but rather internationally. Swiss policymakers adopted WHO norms and ideas in order to pass innovative health policies that connected ideas of care and prevention. I am not certain about innovative health care policies, such as DRGs and HTA, but according to the literature, there are good reasons to assume that the adoption of new innovations in health care also occurred in the context of policy diffusion rather than based on domestic experiences only (Gilardi, Füglister and Luyet, 2009).

3. *Party differences:* In the Swiss case, the partisan differences in health policy became apparent. I have argued before, that low professionalism came along with politicization of important issues in the party arena. If professions were politically inactive, political parties played a more important role in putting problems on the political agenda. Many of the health reforms that I discussed were subject to large differences between the political parties, especially concerning public health policies. The medical and public health professions did not play a politically integrating function as in other countries that I discussed here. Thereby, the ways in which parties differed are not very surprising. On the one hand, left-wing parties supported more public health policies and more public health care services, such as a nationalized health insurance. On the other hand, the liberals and the Christian democrats supported less public intervention.

8.6 Summary

As theoretically expected, in Switzerland, health care and public health co-evolved in a de-coupled manner. Due to the fragmentation of government, health care and public

health were institutionally separated between levels of government. Low professionalism and little political activity of the medical profession led to the absence of responsiveness between the two fields. As in the two other countries, the salience of public health issues changed with the aforementioned business cycle of public health. In the late 19th and early 20th century, infectious diseases were rampant, and public health became important. As in other countries, individual health care became the main paradigm of health policy after the Second World War, but after the 1980s, the issues returned more prominently to the agenda of health policy in Switzerland. Nonetheless, both sectors were de-coupled at the national level and only integrated in the federal office of public health after 2000. In contrast to Australia and similarly to Germany, the medical profession in Switzerland did not think in terms of public health but rather focused on individual care and prevention. Consequently, it had a prominent role in the governance of health care, which occurred in a corporatist manner, traditionally at the local and cantonal level (until the 1990s). On the other hand, public health activists themselves were not as professionally organized or backed up by a strong professional coalition of medical and public health doctors

Chapter 9

U.S.: Loose coupling of both sectors

In this chapter, I will present the results of the last case study in the thesis, which is the United States (U.S.). I selected it as an example for my empirical research because it combines a fragmented government and high professionalism. Therefore, health care and public health should co-evolve in a loosely coupled manner; the contextual conditions are favorable for responsiveness. In other words, if the context demands an integration of health care and public health, or more public health policies, there should be responsiveness between health care and public health in the U.S. On the other hand, instances of economic crisis or conflicts regarding the distribution of funds should lead to serious conflicts between the two sectors.

In the following, I will present the results of my analysis in the same structure I used in the preceding sections. I will start my analysis in the late nineteenth century and examine the co-evolution of the health care and public health sectors, until the beginning of the twenty-first century. For each of the defined time periods, I will write a separate section that elaborates on the institutional integration of and responsiveness between actors and policies of the two sectors.

9.1 Emergence of public health in the municipalities and states (1850-1918)

During the first time period, the most pressing problem for health policymakers involved infectious diseases. At the same time, the possibilities of pharmaceutical technology were very limited. Therefore, an incentive should exist for policymakers and interest groups to connect health care and public health policies.

9.1.1 Institutional separation

During the second half of the nineteenth century, policymakers in the U.S. sought to avoid as much intervention by the central state as possible, except in the case of infectious

diseases. In fact, up to the present day, the rights of the states have been an obstacle to the even spreading of federal public health regulations, beginning with the cities in the East and moving westward. The first coherent sanitary administration existed during the Civil War. Until the early twentieth century, coordinated public health responses were in the hands of the Marine Hospital Service, which was a quasi-military institution and would only be transformed into the National Public Health Service in 1912.

Contrary to the English model, public health legislation emerged bottom up, initiated by voluntary efforts. Instead of being created by the professionals, it originated from Puritan ethics regarding social cleanliness and godliness; the idea of a centralized health service never overcame the tradition of criticism of the central state and the belief in the superiority of local rights (Porter, 1999, 147). In contrast to European reformers, policymakers acted out of evangelical piety (Porter, 1999, 151). For the U.S., Dorothy Porter contends that "Individualistic voluntarism, missionary zeal and militarism subsequently characterized the development of U.S. health policy. A society which prized self-sufficiency recoiled from paternalistic government which undermined the sovereignty of individual rights. Challenged by escalating urban squalor and disease this predominant ideology was supplemented by moralistic and militaristic sanitary reform." (Porter, 1999, 152).

Thereby, the establishment of public health services began in cities in the Southern and eastern parts of the country. The public health legislation, however, needed some form of coordination on the regional and national levels. Consequently, statewide and regional boards of public health were set up. On the state level, the first state board was established in Louisiana in 1855. New York City had already established a department of health before the Civil War; however, it was subject to budget cuts during the depression of the 1870s despite a huge demand for vaccination and health inspection in schools, conditions that the public administration ignored. In 1890, meat and milk inspections began along with the promotion of sanitary conditions in schools. In addition, since 1866, a sanitary bureau and laboratories have existed in the state of New York. Similar reforms took place in other eastern cities, such as Newark, Chicago, Louisville (Kentucky), Cleveland (Ohio), and St. Louis. Yet, the expenditures for preventive health measures remained low. In St. Louis, an inspection of prostitutes, including licensing and medical inspection, also took place, yet after outrage from church members, the measures were repealed in 1874. Compared to other states, Kentucky was successful in reducing mortality. Generally speaking, however, the public health situation was worse in Southern states. In the west, the first public health office was established in San Francisco, where infectious diseases and immigration caused the most pressing public health problems (Porter, 1999, 153-154).

Although the first state board was established in Louisiana in 1855, it was Massachusetts that set up the first effective board of public health in 1869. The Massachusetts board was more effective because Lemuel Shattuck, a statistician, had been recruited to set up the board. He understood that in order to achieve a solution for the pressing health problems, a more rational and systematic approach was needed. Massachusetts created

a board that was allowed to pursue investigations but not make reforms. The work by Shattuck was inspired by the British public health reformer Edwin Chadwick, and Shattuck conducted similar works in the U.S. After the 1860s, health departments or boards of public health were established in forty states (Medicine, 1988). Due to its efficient water supply, Massachusetts became the model for health boards in many other cities. However, most of the public health facilities that were established before 1890 were ineffective, and only after the mentioned introduction of statistical exams did decision makers understand that a more scientific and rational government was needed in health policy (Porter, 1999, 155).

During the last decade of the nineteenth century, social reformers tried to respond to the social conflicts in the country, including in the area of health policy. In the U.S., the Progressive Movement had a large influence on public policy at the turn of the century, including on health policy. Specifically, progressive reformers promoted increasing the professionalization of governments in policymaking and implementation. The movement criticized the social order and demanded reforms based on scientific and humanitarian principles. Regarding health reforms, they demanded sanitary reforms in order to combat poverty without having to restructure society. Progressive reformers, such as the later founder of the Johns Hopkins Medical School, John Welch, contended that such reforms made sense economically, as the investment in a healthy population would cost less in the long run. Part of the progressive reformers' demands also entailed the establishment of a public health profession, centrally planned public administrations, and especially the creation of a central department of health (Porter, 1999, 156-57).

Ideally, such demands would entail an institutional integration of health care and public health because investments in a healthy population entail not only prevention but also primary care measures. In principle, the newly founded national public health organization also supported this cause. In 1872, a group of engineers, physicians, and citizens created the American Public Health Organization. It was no professional organization but rather a non-governmental organization (NGO) based on goodwill (Porter, 1999, 156) (Fee, 1994, 188-189). By 1884, the American Public Health Association had increased its influence and attracted members from Canada, Central America and later also Mexico. Its goal was to coordinate and standardize public health practices amongst authorities. At the same time, it was difficult to agree on the standardization of public health services (Porter, 1999, 153).

At the national level, the institutionalization of public health occurred punctually and with regard to specific problems. In 1879, Congress created the National Board of Health, which existed until 1883 (Gottweis, 2004, 74). However, the board was not transferred into a national public health agency because the responsibility for public health had been distributed among many agencies that did not want to give up their powers (Mullan, 1989). At the time, the Department of Internal Affairs dealt with sanitary conditions and hygiene in schools. Health in factories and housing was the responsibility of the Census Bureau and the Department of Commerce and Trade. The Surgeon General in the War Office

conducted epidemiological research and was responsible for the health of the Army. Surgeon General Wyman, who came to office in 1891, was opposed to any new administration that might have restrained his authority. After the election of William Taft as president, the reformers could hope for a new administration. When the legislation for a new public health service came on the Congressional agenda, the National League for Medical Freedom opposed health legislation that was supported by the American Medical Association and others. They argued that such legislation would create a medical trust controlled by a federal elite with federal authority, and they campaigned successfully against the health legislation. In 1912, Congress passed a law that transferred the Marine Hospital Service into the United States Public Health Service. Its task was to research the state of population health and to disseminate this information from time to time. By 1915, the U.S. Public Health Service and the Rockefeller Foundation were the major players involved in public health services. They were supplemented by a web of local state and city departments for health (Fee, 1994, 198).(Medicine, 1988; Fee, 1994; Jonas, Goldsteen and Goldsteen, 2007). Although sanitary reforms were largely accomplished by local initiatives and organizations, the Surgeon General received the power to demand annual meetings of the public health services in all states and to ensure universal standards. On the other hand, U.S. public health officers did not have anything to do with the engineering revolution in the states but instead provided biomedical assistance and managed the disease collectively (Porter, 1999, 285).

In the U.S., during the late nineteenth century, health policy was mostly public health policy. The regulation and financing of individual health care was in the hands of the market and the actors operating on it. Thereby, the non-governmental and not-for-profit sector played an important role in the expansion of the health care infrastructure. The running costs of hospitals were financed by non-governmental organizations, religious groups and churches, and the state, whereas private hospitals were founded much later. Most hospitals were funded as a result of the public initiatives at the municipal level. The federal government only financed hospitals for the military, especially the Marines. Out-of-pocket contributions played an important role in the financing of medical care and hospitals. These institutions of health care provision were simultaneously a place of social control in the sense that being able to afford medical care in hospitals meant that the individual or the family had achieved an elevated social status and that hospitals could sanction sick people in order to protect the community. In contrast, burglars, prostitutes, and simple workers had to go to "almshouses" in order to get the medical care (Schlesinger, 1997). Public assistance for health care payments existed only for indigent groups, such as soldiers and widows, yet a national health insurance - as, for instance, in other countries - did not find a political majority (Skocpol, 1995).

To sum up, health care and public health were institutionally separated during the second half of the nineteenth century in the U.S. Specifically, institutions of public health were established at the levels of states and municipalities, such as public health boards and public health services. On the other hand, individual health care was a responsibility

of private actors and was barely regulated by the state.

9.1.2 Responsiveness of professions and interest groups

I will now turn to the responsiveness and actor conditions between both sectors. The predisposition for public health policy changed significantly at the end of the nineteenth century. Between 1880 and 1890, bacteriological research produced new insights on the origins of diseases and provided new possibilities to prevent their outbreak. In the eyes of many researchers, it offered an even more efficient approach to counteracting infectious disease compared to environmental reforms. In addition, the new science cast doubt on the arguments of those advocating for social reforms (Fee, 1994, 194). On the other hand, many public health reformers, who supported ideas by the Progressive Movement for social intervention, embraced the new techniques, and preventive health officials used this method to justify their challenge of clinical (curative) medicine. At the same time, many doctors and the medical elite embraced it but were skeptical about the immediate effect of preventive bacteriological interventions (Fee, 1987). The consequence was that some of the reformers wanted to create a science of public health entirely centered around the bacteriologist interventions, such as Charles Chapin. The consequence was that some of the reformers wanted to create a science of public health entirely centered on bacteriologist interventions, such as that of Charles Chapin. They believed that bacteriological interventions would make it possible to wipe out infectious diseases entirely. Others - for instance, Charles-Edward Winslow at Yale - believed that public health also needs a non-medical component and non-medical expertise. However, the most prominent school of public health's mission was to do biomedical research, not to train public health administrators. This model was challenged inside the public health sector, especially by those who had been trained as engineers (Porter, 1999, 160) (Fee, 1994, 192). Practically, however, bacteriological methods helped with responding to infectious diseases, which were a crucial public health problem.[1]

Consequently, by the early twentieth century there was a high demand for well-trained public health specialists (Fee, 1994, 198), to use Army methods as widely as possible for domestic purposes. For instance, the Marine Hospital Services and the state health board in Louisiana used public health techniques developed by the Army during an epidemic of yellow fever. The measures were successful in controlling the epidemic (Porter, 1999, 157).

The Progressive Movement in the American Association for the Advancement of Science (AAAS) demanded the creation of a federal public health organization. President Roosevelt responded that he would do this only when there was a real public demand

[1]For example, in the Spanish-American War in Cuba, 968 men died on the battlefield, and 5438 died from infectious diseases, which showed that public health campaigns are important. As a consequence, in a campaign in the Philippines, the U.S. gained some control over malaria, dysentery, dengue fever, and beriberi. With regard to the construction of the Panama Canal, public health measures were considered equally important for establishing control (Fee, 1994, 194-197). Concerning the Panama Canal, the French abandoned their plan to build it due to the mortality in the workforce. The U.S. government finished the project only after campaigns for the prevention of yellow fever and malaria had been conducted (Porter, 1999, 157).

for it because he did not want another federal office with encompassing powers. This was because advocates of states' rights were against such an office as well as members of other federal agencies that did not want to be in competition with a federal office of public health. The coordination of health services had been in the hands of the Marine Health Services since the late 18th century. Since the 1870s, a corps of officers had been providing public health services to communities during periods of crisis. Gradually, the corps became a force upon which officials could call in times of crises. By 1902, the Marine Hospital Service was the largest single agency in the federal government (Porter, 1999).

Many of the members were organized in the American Public Health Organization (Porter, 1999, 158-59). Doctors were the most prominent group in the national public health organization. In addition, there were engineers and public-spirited citizens with an interest in improving sanitary reforms. At the turn of the century, the diversity of scientific disciplines contributing to public health has been underlined again because like bacteriology, epidemiology quickly became a scientific cornerstone of the then "new public health." Again, in 1901, it was Chapin who published an influential text on municipal sanitation. He concluded that many of the efforts to clean up cities were wasted and that public health officials should instead control specific routes of infection (Fee, 1994, 194). The American Public Health Organization comprised various disciplines that combined coordinated actions - in contrast to the debates and quarrels within the American medical profession (Fee, 1994, 190-198).

Although in the U.S., from a general perspective, health care and public health were institutionally separated in the sense that the state controlled public health and the market controlled health care, there was interaction between the fields with regard to actors. This becomes apparent when we take into consideration that the focus of health policy was mostly on public health. With the increasing interest of states and the federal government in public health, the demand for education and specialized training rose. Public health was concerned with medicine, engineers, lawyers, economics, and nursing, yet medicine had the strongest position. By 1912, twelve states demanded that all members of their boards of health be physicians, and 23 states required at least one physician to be on the board. The other states had no requirements. From the mid-nineteenth century to the early twentieth century, physicians were eager to participate in public health activities because this offered them intellectual distinction - for instance, with participation in social reform movements - or because this offered them income above and beyond what they received through their activities as doctors (Fee, 1994, 199).

Another indication of responsiveness between health care and public health is the establishment of public health schools. The creation of schools of public health was initiated by the Rockefeller Foundation, which set up the School of Hygiene and Public Health at Johns Hopkins University. Rapidly, other universities such as Harvard University, Yale University, Columbia University, University of Toronto, University of Michigan, University of North Carolina, and the University of Minnesota followed. Those schools had a preference for physicians, but members of other professions were also admitted. The plans

of studies mostly emphasized biological and laboratory sciences, which further institutionalized the biomedical paradigm in public health (Porter, 1999, 198). At the same time, there was often some interaction between actors at the highest level of health care and public health. For instance, Rupert Blue became head of the U.S. Public Health Service (Surgeon General), but also the AMA (Mullan, 1989). He supported the demands for the creation of a national health service, although this endeavor eventually was not successful (Porter, 1999, 287).

However, there were also conflicts between health care and public health. The fact that local health departments provided treatment services became the subject of controversy and conflicts between private practitioners and public health officials; however, these conflicts would become more urgent in the 1920s, when opposition by the medical profession and public health reformers would lead to the restriction of public intervention in health care. Although the responsibilities of the national government with regard to the provision of health care increased incrementally throughout the twentieth century, there was a strong tradition of individual responsibility for health. This meant that the local government's interventions in matters of health policy had to be confined to promoting good sanitary conditions and counteracting communicable diseases. With regard to curing disease, the role of the public needed to be confined to helping the poor. Neither federal nor state constitutions entailed any reference to responsibilities for general medical care of the public (Jonas, Goldsteen and Goldsteen, 2007). Consequently, in the late nineteenth century, the function of health policy focused on sanitary engineering and environmental hygiene. Whereas the state kept out of individual health care, many physicians joined public health organizations and actively supported government efforts in public health matters, creating responsiveness in the sense of actor connections between health care and public health (Medicine, 1988).

In the U.S., the American Medical Association (AMA) quickly became a very important actor in national health policy. The AMA was created in 1847, earlier than the National Academy of Sciences, which was one of the first nationwide public institutions interested in health (founded in 1863). The already mentioned National Board of Health (1879-1883) had the task of controlling public health acts in the states; however, the fact that it was soon abolished again underlines that health care was distinct from public health, and its provision as well as regulation and financing were in the hands of voluntary organizations in the late nineteenth century. The expansion of state competencies in health matters - although mostly related to the education of doctors - began in the early twentieth century, a time then when national standards of quality were implemented within the American Medical Association (Gottweis, 2004, 177). In the U.S., the professionalization of doctors appeared as a pluralistic process in which homeopathy, osteopathy, and the other subsections played an important role (Gottweis, 2004, 115-116).

Whereas the medical profession in Germany was already established as a professional and scientific organization at the beginning of the twentieth century, in the U.S., there were still debates on whether it is necessary to have the medical profession, which is

controlled by the states, or if it is sufficient to have professional self-control. In the U.S., the key conflict between doctors and the state was whether the government should intervene in the regulation of doctors, whereas this issue had already been regulated in Germany long before the end of the nineteenth century. In Germany, due to the inclusion of doctors in the national health insurance program, the connection between doctors and the state was much closer than it was in the U.S., and German doctors were much less politicized. Whereas doctoral organizations in Germany focused on scientific exchange as well as a friendly being together, self-regulation of the American organizations was more politicized earlier on. What is more, the homogenization of the medical profession in the U.S. occurred much later in the U.S. than it did in Germany. Only in the late nineteenth century American did doctors achieve European standards (Gottweis, 2004, 111-114).

To sum up, beginning in the late nineteenth and early twentieth centuries, the medical profession developed into a politically active and strong professional organization that successfully opposed public health care programs or a national health insurance program. However, at the same time, doctors supported public health policies because they wanted to avoid public action in the health insurance sector. Along with health reformers of the Progressive Movement, a group of public health specialists even developed activities and lobbied for a national public health program that combined primary care services with structural measures in order to improve environmental conditions for health. The plan, however, failed due to the opposition of the federal government.

What do these results imply for the hypotheses I presented regarding the coupling of health care and public health? I have argued that the sectors should be distinct from each other because legislative competences are separated between different levels, and many veto points exist at the national level. On the other hand, there should be responsiveness due to the high professionalism, which implies that professional organizations are politically active. My results partially confirm my hypotheses. Regarding the fragmentation of government, my analysis clearly shows that the decentralization of competences had an effect in the sense that local and state governments took action with regard to public health policy instead of the national government. Because many veto possibilities existed at the national level, a national health service could de facto not be implemented against the resistance of the states. Concerning professionalism, the medical profession and public health organizations were politically active, in order to represent the interests of their members. A side effect of this was that doctors and public health reformers cooperated and advocated more public health legislation. There were some conflicts between medical practitioners and public health reformers about treatment in public health services, but overall, actors from both sectors cooperated with one another.

9.2 Cooperation and conflict in the interwar and Second World War period (1918-1945)

In the interwar period, the contextual condition changed slightly. Notably, the prevalence of infections was reduced, and the technical possibilities for the cure of diseases increased. What is more, particularly due to the difficult economic context, there was a potential for conflicts between the two sectors.

9.2.1 Continuing institutional separation

As of the 1920s, health care, especially clinical practice, gained strength and became more important than public health with regard to policymaking in the U.S. Salaries from private practice increased strongly, whereas those in the public health sector stagnated. Medical technology and practice improved greatly and became more scientifically grounded, technologically advanced, and dependent on hospitals. This development attracted physicians aiming for professional status and income, whereas positions in the public health sector became less attractive due to low income and little professional autonomy. Subsequently, health departments no longer required degrees in public health because they wanted to attain physicians at any price. This reduced the incentive to take a degree in public health even further (Fee, 1994, 200). The increase in the salaries of physicians augmented their prestige as a profession and contributed to the following success of medical science, which had its onset in the 1920s. It was in the same decade when the organization declared its general opposition against any compulsory health insurance system based on contributions with the purpose of organizing payment for treatment. The rising membership of doctors in the organization confirmed this policy (in 1901, about 7 percent of physicians were members in the AMA, and about 65 percent were members in 1930) (Hacker, 1998).

During the interwar period, a number of health care policies passed. For instance, the Sheppard-Towner Act of 1921 provided federal funding for maternal and child health, which was an extension of the previous U.S.-American social policy schemes that provided services mainly to veterans and widows (Fee, 1994; Skocpol, 1995). At the same time, however, private health insurance remained an important element in the American health system. At the time of the Great Depression (1929), noncommercial health insurance organizations dominated the markets. These were Blue Cross for stationary care as well as Blue Shield for ambulatory care (Gottweis, 2004, 179). The AMA opposed any regulation of insurance organizations, neither did it agree to voluntary health insurance policies. Consequently, the medical societies set up their own insurance policies during the 1930s. However, this policy was dropped soon thereafter (Starr, 1982; Hacker, 1998).

However, most important for the relation of health care and public health during the interwar period in the U.S. was the New Deal legislation of 1935. Amid the pressing economic crisis of the 1930s, the national government passed a series of social policies, such as retirement insurance, unemployment insurance, and support for families (Schmidt,

2005*b*). The New Deal legislation has been regarded as the onset of social policy in the U.S. and had a fundamental impact on the field in the following years in the U.S. It came with a large shift in voting behavior in the country, as it revived support for the Democratic Party, which celebrated a landslide victory in the 1932 Congressional elections (313 to 56 seats in the House of Representatives and 59 to 36 in the Senate) (Hacker, 1998).

The New Deal legislation of 1935 introduced new public health legislation, as it provided a means for the financing of public health programs at the state level, but it did not introduce mandatory comprehensive health insurance. The proponents of the law decided to leave out comprehensive health insurance from the reform because otherwise, it would have been hard to find enough support for the New Deal legislation even among the Democratic majority in Congress. Especially the AMA that managed to organize enough support against the introduction of comprehensive health legislation to cut it out of the legislative package. Particularly, it was a coalition between Republicans and Southern Democrats, which was susceptible to lobbying by the AMA (Hacker, 1998; Schild, 2003). Although the law was very popular among the people, the conservative coalition defeated it in Congress (Marmor and McKissick, 2012).

During the Second World War, the situation improved for health insurance legislation. In 1942, the War Labor Board permitted companies to include fine benefits in working contracts in an effort to attract employees to the labor market. Consequently, enrollment in hospital insurance plans that were sponsored by employers increased dramatically, even more after the war when the unions gained achieved the possibility of including health benefits in collective bargaining, with these health benefits being exempt from federal taxes. Consequently, the number of Americans who had some type of private health insurance plan increased sharply in the postwar area (from 12 million in 1940 to 76.6 million in 1950) (Hacker, 1998; Gottweis, 2004). Yet from the 1920s until the 1960s, the medical profession in the U.S. successfully blocked any larger health insurance legislation (Gottweis, 2004). This shows two things: Firstly, health care and public health remained institutionally separated, as health care remained attached to the market. Secondly, doctors were a much stronger veto group than they were in Germany, for example, in terms of political activism.

As was mentioned before, the importance of medical care policy increased considerably during the interwar period. Nonetheless, population health and disease prevention still constituted an important element of health policy, especially before and during the Second World War.

During the 1920s, public health officials realized that diagnoses were becoming easier, particularly of infectious diseases such as tuberculosis, because of the increasing size of bacteriological laboratories and public health divisions at the local and state levels, but this was not so for cure and prevention. Consequently, public health officials began to promote changes of individual behavior and created educational public health campaigns. Instead of distributing free milk for babies, public health reformers advocated proper methods of child care; instead of attacking working conditions in sweatshops, nurses visited tuberculosis patients to warn against spitting, because the disease transmitted in this way.

However, this change in the public health strategy was because reformers hoped for better health outcomes. Yet, another reason was that the medical profession was very suspicious of the provision of any measures resembling medical care by departments of public health. In contrast, doctors supported education measures such as the distribution of information regarding diseases (Fee, 1994, 201-202).

The AMA opposed further public health measures, as it felt threatened by the increasing public power in health matters. The AMA strongly opposed the Sheppard-Towner Act of 1921, which provided federal grants for maternal and child health. Yet the act was abandoned in 1928 due to the opposition of the medical profession. At this time, the most important public institution in health policy was the U.S. Public Health Service, which provided the states with grants and personnel, if needed. For instance, in the case of an unexpected outbreak of an epidemic disease, such as typhoid fever, it would send epidemiologists to analyze the source of the disease and to suggest means for prevention (Lewis, 2003*a*; Fee, 1994, 203).

During the interwar period, the situation of the public health profession changed because for many doctors, private practice became a more lucrative option. What is more, public health practice varied greatly throughout the country. In 1923, a report of the American Public Health Association showed wide variety in public health organizations across the U.S. In some cities and states, public health was well organized and efficient, whereas in others, it was more chaotic and improvised (Fee, 1994, 201). During the Great Depression, public health became a more interesting career option for young doctors because private practice did not pay as well in times of economic crisis (Lewis, 2003*a*).

However, before turning to the impact of the New Deal legislation on the public health sector, it is important to discuss another element of public health in the U.S., namely its strongly international dimension. In 1913, the Rockefeller Foundation was created, and it would subsequently play an important role not only in public health policy in the U.S. but also with regard to its promotion on an international level. The foundation's international health policy board had the goal of exporting American-style public health theory in countries around the world. During the 1920s, the organization was involved in campaigns against hookworm and yellow fever in Mexico (Birn and Solórzano, 1999); it influenced the establishment of a national health policy in Australia and sent experts to the League of Nations Health Organization (Weindling, 2002). However, in some countries, among them Germany, the national medical profession public measures of U.S. origin, either because they were allegedly not effective or even dangerous, since there had been accidents with immunization programs, for instance those against TB (Weindling, 2002). In Germany, members of the Rockefeller Foundation were going to meet the same opposition after the Second World War, when it attempted to establish a national school of public health (Ellerbrock, 2002; Ellerbrock, 2004).

With the discussed New Deal and Social Security Act of 1935, the state played a stronger role in public health. The law provided new grants for the states to develop public health services (As a consequence, municipal public health services more than

tripled between 1934 and 1942, from 541 to 1828, and declined again to 1322 after the war), federal funds for health education programs by the states, and federal regulations for minimum public health qualifications for personnel employed with federal grants. As a consequence, state universities offered more public health programs, as there was a high demand for public health education because private practice had become increasingly difficult during the economic crisis of the 1930s. The programs, which were based on federal funds, enormously increased the capacity to deliver public health measures (Fee, 1994).[2] Although compulsory health insurance was not included in the New Deal Act of 1935, the program established grants for aids, which the United States Public Health Service (USPHS) used to establish local health departments (Porter, 1999; Medicine, 1988, 287).

In addition, other national institutions were created during the 1930s and were potentially beneficial for public health policy. Specifically, these were the National Institutes of Health, later the National Science Foundation and the National Cancer Institute, in 1937 (Gottweis, 2004).

Before and during the Second World War, prevention against infectious diseases continued to play an important role in public health policy. In 1938, federal grants for the control of venereal diseases were set up. During the Second World War, national health policy received another expansionary move. Policymakers understood that in order to win the war, it is necessary to have a healthy population (Fee, 1994, 204). In 1940, the USPHS greatly expanded its grant program to states and counties and sent personnel to very needy areas. What followed was the largest public health survey ever conducted in the U.S. The Selective Service Board examined 16 million young men and found 40 percent to be physically or mentally ill. Although mortality rates from infectious diseases had declined since the beginning of the century, morbidity levels remained high. Mobilization efforts required the creation of large training campuses and industry plants, which, in turn, needed infrastructure and workers. These facilities were often placed in Southern areas, where sewage and canalization were inadequate for such large industrial complexes. To counteract malaria, a Center for Controlling Malaria was established in the war areas. After the war, these facilities were transformed into Centers for Disease Control, which later on became important institutions for public health (Fee, 1994, 205-206).

To sum up, during the interwar and Second World War periods, health care and public health remained institutionally separated. There were more and new public health policies, such as programs by the state public health departments, with regard to infections and health education. On the side of health care, policymakers equally created new policies, such as federal funding for child and maternal care. However, comprehensive health insurance, which was on the table during the New Deal debate, did not find a majority in Congress. Consequently, both fields remained institutionally separated because the mar-

[2] 1. development of programs that control specific diseases and services that are targeted at specific population groups; 2. increase in local health departments; 3. more training of personnel; 4. attribution of some areas of medical care with the health departments. The categorical approach was popular, especially welfare services to children. For instance federal grants for maternal and child health services, as well as crippled children (1935) (Fee, 1994, 204).

ket governed most parts of the health care sector, whereas public health remained in the hands of the state.

9.2.2 Conflicts between health care and public health

My discussion on the distinctiveness between policy sectors also showed some insights on the responsiveness between policy sectors. Firstly, during the period of the economic crisis, I did not find any major conflicts between the interest groups and professions of both sectors that were due to the crisis, but rather, in times of economic hardship, the public health sector provided interesting career opportunities for doctors who did not dare to enter private practice, for example. Secondly, conflicts occurred, however, with regard to other problems. For example, doctors opposed any state intervention in the area of medical care. Above all, this entailed a fierce opposition against the proposed health insurance that was supposed to be included in the New Deal. On the other hand, the medical profession also opposed any policies, even if they just seemed to transgress in their discretion, such as measures of individual prevention, such as the distribution of milk or other services. Yet, they did not oppose measures of health education and promotion.

Responsiveness occurred with regard to the exchange of professional members between public health schools and medical schools. Candidates from both fields occupied jobs in the public health sector and implemented the discussed public health measures. What is more, contrary to its opposition to national health insurance, the medical profession did not oppose public health measures concerning infectious diseases, and it participated in and supported the training of new public health personnel as well as the establishment of new public health departments during the New Deal legislation.

As mentioned before, the medical profession fiercely opposed in every way the establishment of national compulsory health insurance. The reason for this opposition is the slow but continuous increase in the competences of the state health departments. Since the late nineteenth century, doctors have resisted the provision of health care services by state public health departments. Plans by local health departments to provide treatment for general diseases have especially received strong opposition. Generally, throughout the entire twentieth century, the medical profession was successful in obstructing these efforts, and personal health care services by the public health departments extended especially to areas in which private physicians were either not competent (TB, sexually transmitted diseases), not interested (certain routine exams), or not available (remote areas) (Jonas, Goldsteen and Goldsteen, 2007).

After the second decade of the twentieth century, however, professional conflicts arose among non-medical public health professionals and doctors. Yet at this moment, only sanitary engineers were strong enough to challenge the dominance of physicians. They contributed a lot to the reduction of infectious disease. At this time, they strongly complained about the medical monopoly in public health, yet physicians were willing to concede responsibility for public sanitation and water supplies but not much else (Fee, 1994, 199). However, during the expansion of public health activities in the early twentieth

century, health departments began to pursue activities beyond urban and sanitary reform - for instance, activities involving the control of infectious disease. The medical profession felt competition and shifted from strong support to criticism of and open hostility toward public health policies. Public health officers understood that cooperation was necessary and took into account occasional conflicts among the clinicians and public health officers. Often, they were afraid and avoided conflicts (Fee, 1994, 200).

However, during the 1930s, the relationship between the medical profession and public health officers became increasingly conflictive. During this period, the economic crisis limited possibilities for private practice because an increasing number of physicians could no longer afford living off out-of-pocket fees from patients. Consequently, support for a national health insurance scheme and a national health service increased. As we have seen before, the former failed and was excluded from the New Deal legislation in 1935. However, in the decade between 1935 and 1945, the USPHS supported the creation of a national health service. In 1938, a conference took place in Washington, D.C., which united representatives on labor as well as farmers and public health professionals. The results of the conference became the basis for a bill that failed in 1939 but re-emerged in the 1943 Wagner-Murray-Dingel Bill proposing a national program for the provision and financing of health care. Although the bill of 1943 failed again, the results of the conference became the substance of the battles between the AMA and the PHS over the introduction of state control in medical care (Mullan, 1989, 109-110)(Porter, 1999, 287).

To sum up, the two decades of the interwar period were highly contentious with regard to health policy, as the medical profession vigorously opposed any public interventions by the state in the field of health care policy, whereas public health reformers demanded more public health interventions (Fee, 1994; Skocpol, 1995). Therefore, responsiveness between the two sectors was mostly absent. On the other hand, public health professionalization continued to establish a separate profession that was concerned with population health matters, which was different from the medical profession (Starr, 2009). Although both groups competed for research money and the attention of policymakers, medical organizations also supported population-based health policies, as long as they did not touch their core competencies, such as free individual practice.

What do these results imply for my hypotheses? I have contended that health care and public health should be loosely coupled or de-coupled. On the one hand, there should be institutional separation because government is rather fragmented. On the other hand, there is high professionalism, which is a good context for sectorial responsiveness. Yet the contextual condition at the time changed, and the economic crisis should have led to conflicts between the two fields. My results confirm these hypotheses. Although there were legal proposals to integrate health care and public health, the respective laws failed in Congress, not the least due to the opposition of the medical profession, which particularly opposed a national health insurance law but also any other law it suspected of diminishing free practice. On the other hand, the medical profession was politically very active. It supported public health policies that did not interfere with the material interests of its

members, such as actions against infections, but it opposed the intervention in its core business. The post-crisis period did not spark opposition against public health generally, but at the time, the number of proposed laws that demanded more integration of health care and public health increased, and so did conflicts between the two sectors, for example, between the AMA and the USPHS.

9.3 Dominance of health care in the shadow of loose coupling (1945-1980)

In this section, I will turn to the co-evolution of the health care and public health sectors during the interwar period. Based on the discussion on the contextual conditions, there should be a de-coupling of health care and public health even though professionalism is low. The reasons for this are that the demands changed, and public health problems were much less virulent than they were in the two preceding time periods.

9.3.1 Towards more institutional integration

In the U.S., after the Second World War, there were many different health care policy reforms. During the war, attempts to introduce a comprehensive national health service, which would have combined public health and health care, failed among others due to the opposition of the medical profession and the conservative majority consisting of Republicans and Southern Democrats in Congress, as I discussed before. In 1946, Congress passed the Hill-Burton Act (Hospital Survey and Construction Act). The law had the goal of constructing hospitals in rural areas and bringing medical care to everyone. Under the act, the federal government paid one-third of the expenditure for hospitals (USD 75 million yearly for the first five years), and it became the most popular health program in the U.S. The law met the demand for nationwide health care without touching the prerogatives of the medical profession. Some authors, such as Fee, argued that the creation of local public health departments could have been achieved with a fraction of the cost, yet public health advocates lacked a strong lobby, and health care gained most of the available public resources (Fee, 1994, 208).

Whereas the AMA supported the construction of the hospitals under the Hill-Burton Act, as the law did not touch upon its prerogatives, it did not change its opinion regarding support for health insurance legislation. After his re-election in 1948, President Harry Truman proposed health insurance reform; however, the bill did not pass in Congress because the same coalition of Republicans and conservative Democrats as in 1935 opposed the law. Although Truman had strong support from organized labor, the campaign for comprehensive health insurance faced opposition not only in Congress but also by the AMA, which invested several million dollars in public relations (PR) campaigns against the proposal that linked national health insurance to socialism. To the contrary, Congress passed the hospital bill and invested large amounts of money in medical research and education especially during the 1950s, which increased the capacity of clinical medicine in

the U.S. even further (Hacker, 1998).

The main reform in American health insurance policy occurred in the 1960s. The establishment of Medicare and Medicaid, in 1965, was part of a new wave of social policy lead by the then President Lyndon B. Johnson and that was entitled the "War against Poverty" (Schild, 2003). However, the reform did not introduce the type of encompassing health insurance that reformers had demanded in previous decades, but rather, it proposed limited insurance for hospitalization for pensioners and the disabled (Medicare) and for some parts of the impoverished population (Medicaid). The passage of this law is significant for health policy in the U.S. in several ways. Firstly, it is the result of reaction by advocates for Social Security to the failure to introduce comprehensive health insurance in the second part of Truman's term in office. Looking back on the failed proposals to establish comprehensive health insurance in the 1930s and 1940s, supporters of the reform introduced a proposal that extended health insurance coverage to more indigent groups - in this case, the elderly, poor, and disabled. Secondly, they ended a long ideological battle concerning the need for government to create health insurance, by creating this exact legislation for a segment of the population. However, this reform was, again, an incremental increase of health insurance coverage, which fits into the pattern of previous social policy legislation that had especially been extended to indigent groups. Further reforms to extend the coverage of health insurance failed, however - for instance, in 1993, a reform attempt under President Bill Clinton (Hacker, 1998; Marmor and McKissick, 2012).

The introduction of Medicaid and Medicare can generally be regarded as a large defeat for the powerful American Medical Association. Yet it is important to mention that the AMA itself changed during the 1960s because it became more diversified. For instance, in 1961, the American Medical Political Action Committee was founded, and later on, many different medical organizations were set up. Subsequently, the medical profession was no longer a homogenous organization (Gottweis, 2004). If we put Medicare and Medicaid into perspective, the law can be regarded as a turning point in American health policy; however, the law entailed less universal coverage than in the Canadian case and placed greater emphasis on private health insurance (Tuohy, 1999).

With regard to the coupling of health care and public health, the reform of 1965 reduced the institutional distinctiveness of the health care and public health sectors. The legislation concerning Medicare and Medicaid underlined once more that the U.S. had taken a different course concerning health insurance policy, as the majority of its welfare state policies, including health insurance, were privately organized. At the same time, several public programs provided health care for the indigent. However, in contrast to the UK, the U.S. did not cover groups of the lower, working, and middle classes, which entailed the majority of the population and were very important for the economy (Hacker, 1998). However, for these cohorts, health care insurance was largely provided as employer-based schemes of health insurance, which are part of the private health care system (Seeleib-Kaiser, 1993).

During the 1970s, when the disease pattern changed, because the problem of chronic

disease became more pressing, a new skepticism toward medicine emerged. This came along with a change in the international debate on health policy, and it shifted the focus of decision makers to population health and prevention, as has been underlined by the Lalonde report, which demanded more public health policies. In countries where universal health insurance had been achieved, such as Britain, Canada, France, Sweden, or Germany, reforms of this national health insurance moved to include more preventive exams and population health policies in the existing health systems (although in very different ways and with different implications for public health policymaking in general). For instance, in Australia, during this period, a national health service had been established.

Interestingly, in the U.S, this development had a different effect. Particularly, the arguments that had been put forward in favor of more public health policy in other countries had the opposite effect in the U.S.-American context. In the U.S., the criticism of medicine and the cost pressure on the health care system became a forceful argument against universal health insurance. Rather than continuing to suggest the introduction of comprehensive health insurance, the majority of health professionals, policymakers, corporate executives, and labor officials proposed that the state make more efforts to reduce environmental hazards as well as behavior that was bad for health, rather than investing in the financing of individual health care. The appearance of these arguments pushed universal health insurance off of the political agenda. Consequently, the shift toward more preventive health policies in the 1970s had different consequences in the U.S. than it did in other developed democracies where universal health insurance was already in place (Marmor and Weale, 2012; Marmor, 2012). This became even clearer when in 1974, President Richard Nixon proposed the introduction of national health insurance. Specifically, he suggested that the federal state take over the costs of employers' share of a national health insurance plan that would be voluntary. However, the National Association of Manufacturers managed to stop this reform (Starr, 1982; Gottweis, 2004).

In the U.S., public health policy underwent significant changes in the postwar period. As in other countries, the context of health policy changed significantly. In 1900, tuberculosis and pneumonia were the major causes of death. In 1946, the major causes were heart disease, cancer, and accidents. The problems of urgent chronic diseases had already been known since the 1930s; however, during the Second World War, all of the focus was on the prevention of infectious diseases, and no one knew how to prevent communicable diseases. More importantly, public health did not take credit for controlling infectious diseases, but the credit for this achievement went to medicine and biomedical research (Fee, 1994, 209). It was only in the 1970s that the critical literature, which was critical of medical dominance, remembered the achievements of public health policy (McKeown, 1979).

In the U.S., due to changes in the political context, during the immediate postwar era, public health policy had particular problems with politically organizing its supporters and voicing its demands. A further problem was the magnitude of activities that needed its attention, such as chronic disease rehabilitation, mental health, industrial health, accident prevention, and environmental issues. Many public health departments had few ideas

about what to do and continued to run the same programs as before the war. Exceptions for this were New York, Virginia, and Minnesota, where the states ran research laboratories for the prevention and treatment of chronic disease. Mostly, public health programs focused on screening and the early detection of disease than on actual preventive measures. According to Fee, the field lost its social orientation and "seemed to be merging with clinical preventive medicine" (Fee, 1994, 209-10). Yet health departments implemented some measures, such as the fluoridation of water supplies to protect children's teeth. Although scientific authorities and professional organizations almost unanimously supported these measures, the political climate at the time was extremely unfavorable to these kinds of policies. The political right especially denounced public health policies as socialist and communist interventions, and the measures were halted. One great success of the 1950s was the development and mass-scale implementation of the polio vaccination. Yet this occurred due to massive private funding and a huge PR campaign by the Foundation of Infantile Paralysis (Fee, 1994, 210) rather than a coordinated public health initiative by the state. At the time, completely new health problems arose. However, public health officers were charged with many tasks, such as visiting child health stations, tuberculosis clinics, and venereal disease clinics; operating immunization sessions; and completing communicable disease diagnoses. Thus, they did not have time for community health education, the study of health problems, diabetes and cancer control, rheumatic fever prophylaxis, nutrition education, and radiation control. As a consequence, positions often remained vacant and could not be filled, and medical practitioners provided these services on the side (Fee, 1994, 206-211).

In 1955, in the context of the annual meeting of the American Public Health Association, the international vice-president of the United Auto Workers criticized public health departments for the malfunctioning of their services. He held that state health services were completely underfinanced and that occupational health did not work (Fee, 1994, 211). One year later, the Senate Committee on Labor and Public Welfare of the U.S. Congress found that the annual number of public health trainees had dropped dramatically in the past ten years. Subsequently, it authorized a new training program for public health officials (Fee, 1994, 211). In 1958, over 2500 vacancies still existed in professional public health categories. About 20 000 public health officials lacked specialized public health training. During the first national conference on public health training, the matter was considered an important factor of public defense. George Rosen, one of the leading figures, demanded beginning education about public health by making students think politically. During the 1960s, public health schools increased their programs on family planning, international health, and the administration of medical care. They created programs in medical care organization, hospital administration, mental health, family planning, population control, and international and environmental health. Between 1958 and 1973, enrollment quadrupled. However, public health schools trained personnel for federal and international health agencies rather than for local and state departments, and the financial support for the schools came from the federal government, which increased their programs

but also made them vulnerable to political shifts (Fee, 1994, 211-215).

However, not all accounts are as critical of U.S. public health policy as the one by Fee, who claimed that the role of public health policy nonetheless remained important in the postwar era and that investments in public health policy also increased with the establishment of new sections in the National Institute for Health (Pratico, 2001). In a book on the history of the USPHS, Mullan insisted that in the postwar area, the USPHS played an important role in national health policy. Particularly under President Dwight Eisenhower, when the Federal Security Agency (FSA) was replaced by a ministry of health and education, which had an impact on the USPHS because the Surgeon General now reported to the new minister. Moreover, this author underlined the allegedly important role of the U.S. public health service in the polio vaccination campaign and the considerable public criticism of them because of accidents with the vaccine, which caused some children to die. Consequently, it was hard to defend the need for more public health policies, and the support of private actors for the immunization campaign was extremely important (Mullan, 1989).

During the 1970s, further public health reforms were put into place in the U.S. The Occupational Safety and Health Act of 1970 aimed to improve health and working conditions for workers in general (Morey, 1975). At the community level, the public remained the most important provider of classical public health services, such as the supply of pure water, sanitary sewage disposal, inspection of food and drugs, and control of communicable diseases (i.e., immunization and the control of sexually transmitted diseases) as well as health statistics and the protection and regulation of the environment. Some of these functions were provided in conjunction with private actors, such as the American Cancer Society and the American Heart Association, which were active in public health education, whereas others had an important role concerning health science education and research. The Sierra Club and the Natural Resources Defense Council participated in environmental protection (Jonas, Goldsteen and Goldsteen, 2007).

Concerning smoking, non-governmental organizations played an important role in the provision of smoking control policies. Particularly, these were smokers' rights groups, which advocated tobacco control policies, especially those policies that would protect citizens from smoke. From the outset, public opinion was rather favorable for smoking bans in order to protect non-smokers. The argument that smokers would place other individuals at risk allowed the movement to bypass accusations of being paternalistic and to demand a "Nanny State." Consequently, the first successful public health policies did already pass during the 1970s. In 1973, seats of smokers and non-smokers were separated on domestic flights. In 1974, the Interstate Commerce Commission decided that 20 percent of the seats on interstate busses had to be smoke-free. In 1977, Berkeley was the first community in California to limit smoking in restaurants and at other public places (Bayer and Colgrove, 2004).

To sum up, health care and public health were institutionally separated during the postwar period. The state was responsible for public health policies, notably the sub-

governments, whereas the national government was in charge of health care for the indigent. On the other hand, health care was privately governed for the majority of the population. However, there has been an evolution of both sectors toward more integration. Specifically, the state assumed a stronger role in institutionalizing individual health care than had been the case during the previous time period, most notably with the Medicare and Medicaid legislation. Nonetheless, the majority of the population had private or employer-based health care plans, which left both sectors largely independent institutionally.

9.3.2 Responsiveness and subordination

After the war, many public health reformers hoped to now unite medical care and public health, as this was appropriate for combatting chronic diseases under the conduct of health departments. Thereby, the reformers forgot the strong resistance of the medical profession against any intervention of the state in curative medicine. Social medicine was also regarded as another possibility for combatting chronic disease and integrating curative medicine and public health. Some in the profession, however, were cautious and warned of the widespread anti-state attitude in the U.S., when it came to medical care. At the same time, a new specialty in public health arose, which was placed between public health and clinical specialties. Its representatives were private practitioners who conducted clinical prevention, such as providing screening tests and advice on the individual level. In order to increase their influence, they wanted public health departments to refrain from preventive action against chronic diseases, such as cancer, diabetes, and cardiovascular disease. On the other hand, public health officers had no unanimous position: Some favored tax-financed medical care, whereas others were more loyal to the medical profession and held that the combination of health care and public health services would disturb the already existing structures of medical care. At the same time, the American Hospital Association and the American Medical Association strongly pushed for legislation to support the building of hospitals (Fee, 1994, 206-208).

During the 1950s, the subordination of public health with respect to the health care sector increased. Theoretically, social medicine proposed efficient and viable alternatives to the sole focus on clinical cures. Yet these ideas were not translated into actual health policies, as public health departments lacked budgets and political support. In contrast, during the post-war period, there was massive investment in biomedical research, hospital construction, and the payment of health care by private insurance providers, whereas public health services were neglected. The reasons for this were that basic sciences and clinical medicine established the research priorities, whereas public and social services caused immediate suspicion of creeping socialism or even communism. In this context, the integration of public health and health care, as envisioned by social medicine, was perceived as a threat (Fee, 1994, 208).

The creation of Medicare and Medicaid legislation shifted public health into the direction of individual care. It covered medical costs and social security for the poor but

failed to provide adequate preventive services. The programs were built on the coordination with private providers of medical care and increased the costs for medical treatment. Programs, such as the anti-poverty programs that were intended to encourage community participation, were seen as competition with private interests and did not function as well (Fee, 1994, 214). At the same time, there was an institutional evolution of the public health service. During the debates on Medicare, the USPHS was bypassed and not included. The USPHS and the local health departments did not receive additional resources, but the grants in aid were offered by the Office of Economic Opportunity to fund new neighborhood health centers. When Medicaid and Medicare were put into legislation in 1965, the Department of Health Education and Welfare assumed the responsibility of administering the acts (Porter, 1999; Medicine, 1988, 288).

The reforms in the U.S. upheld the central principle of the health care financing system, which was the market. Like governments in other countries, the U.S. needed to save health care costs in the 1970s and 1980s. Yet other than in the more statist systems in GB and Canada, the U.S. government faced much more difficulties with establishing second-level-agency relationships, such as with the professional standards review organizations. The 1960s were characterized by the War on Poverty and the growing urban power of the civil rights movement and riots: Anti-poverty efforts as well as other social policy reforms passed by the Johnson administration focused on medical care, i.e., access and hospitalization, especially for the elderly. Many of the social and health programs of the 1960s bypassed public health departments and set up new agencies mediating between the FG and the local communities, as state governments were seen as too conservative to deal with the problems in an egalitarian and progressive manner. In addition, neighborhood health centers and community-based mental health services were established without reference to public health agencies. Environmental issues that attracted political concerns in the 1970s were organized in an Environmental Protection Agency at the federal level. Mental health was, again, included in a different program. As a consequence, "Public health further lost visibility and clarity of definition" (Fee, 1994, 214-215).

However, health care and public health in the U.S. was still very responsive compared to that in other countries. Specifically, there was a successful public health coalition with regard to tobacco control policy, the connection of fluoride to dental caries, and the argument that physical exercise prevents coronary heart disease. However, the context of health policy had shifted its focus toward individual health care. Particularly, public health was not prepared for the relative disappearance of infectious diseases and the advent of non-communicable disease. At the same time, federal expenditures on medical research increased from USD 28 million in 1947 to USD 186 million ten years later. Of this money, most was spent on clinical and laboratory research and little on epidemiology. The schools of public health had not dealt adequately with the arriving chronic diseases and followed the research guidelines of the National Institutes of Health, which had little interest in the practical problems of public health departments (Fee, 1994, 212-213).

In other fields, the USPHS and particularly the Surgeon General continued to make

important contributions to public health policy. This occurred especially based on the reports by the Surgeon General that focused on certain health problems, in the U.S. For instance, in 1964, the Surgeon General published the report *Smoking and Health: Report of the Advisory Committee of the Surgeon General of the Public Health Service*, which sparked a huge debate on tobacco control policy and was the onset for more public health policies.[3]

The publication of the Surgeon General's report on smoking and health had immediate policy implications. The federal commission of trade, which had been prepared for it, immediately released regulations concerning warning labels on cigarette packs and restrictions on tobacco advertising. However, the opposition in Congress and opposing interest groups blocked the adoption of a national ban on tobacco control policy (Bayer and Colgrove, 2004). Yet the Surgeon General's contributions continued to emphasize the need for more tobacco control policy. Historically, the agricultural committee in Congress controlled tobacco control policy in the U.S. The U.S. Department of Agriculture (USDA) and some interest groups closed the sub-system. This was the dominant iron triangle in the first half of the twentieth century, but it changed thereafter through reports by the Surgeon General in 1964 and following reports in 1986 and 1988 in the sense that the medical profession became one of the strongest advocates of tobacco control policy (Bayer and Colgrove, 2004). One policy consequence was the strengthening of warning languages in 1970, 1985, and 1996; the Federal Cigarette Labeling and Advertising Act; and the fact that health warnings on billboard ads became mandatory (Worsham, 2006).

To sum up, during the interwar period, there was responsiveness between health care and public health. Above all, this becomes apparent with regard to the connection of both sectors in education and the participation of doctors in public health research. Yet, as in other countries, health policymaking moved toward more subordination of health care under public health, which means that most health policies focused on individuals rather than on population health. In Australia, the situation was similar, but I found more evidence there of political activity by the medical profession, which participated in a large public health coalition that advocated more population health policies. In the U.S., I did not find such strong evidence of political responsiveness.

What do these results imply for my argument? I have held that in the U.S., there should be a de-coupling of health care and public health because the context changed in the sense that demands for public health policies were reduced. My analysis confirms this hypothesis, at least to some degree. Overall, health care and public health remained

[3]In the following years, the Surgeon General published reports on the health of the nation. These reports focus mostly on the consequences of smoking but also on the effect of certain medical technologies, such as radiation and smog. Other reports evaluate health promotion efforts (1979). Again, another group of reports focused on special diseases, such as chronic lung disease (1984), or the needs of indigent groups, such as kids (1987). More recent reports have been focusing on AIDS and nutrition and health (1988) as well as physical activity (1996). Most importantly are, however, the repeated contributions concerning smoking and health, as the latest report shows (2014: *The Health Consequences of Smoking50 Years of Progress: A Report of the Surgeon General.* All reports are available here: `<//www.surgeongeneral.gov/library/reports/>`. Last accessed 19.11.2014.

institutionally separate. The reason for this was that the federal government did not succeed in passing comprehensive national health insurance, which had been on the political agendas at least of the Truman, Johnson, and Nixon administrations. In each case, however, the combination of a politically active medical profession and no political majority in Congress blocked such a reform. However, there were some incremental reforms. The addition of Medicaid and Medicare in 1965 shifted the relationship of health care and public health toward more institutional integration. Concerning professionalism, there has been no strong responsiveness between health care and public health. Doctors and public health officers did not openly forge a public health coalition, but on the other hand, the medical profession did not oppose new public health policies, such as tobacco control measures. The political activity in that field mostly came from public health officials themselves.

9.4 Towards integration of health care and public health (1980-2010)

During t3, the contextual condition for the co-evolution of health care and public health changed. Demands for more public health policies increased because non-communicable diseases, such as diabetes and cancer, became more prevalent. At the same time, new infectious diseases, such as HIV, appeared. These developments should draw more attention of policymakers to public health and lead to responsiveness between health care and public health in the U.S.

9.4.1 Towards institutional integration

During the 1980s, health care policy in the U.S. underwent similar changes as in other countries, namely an increased demand for more cost containment and reforms to make the provision of health care more efficient. Demands for universal health care, which had been prevalent in the debate in the U.S. since the 1930s, calmed down. During the presidencies of Ronald Reagan and George Bush Senior, deficits in the health care sector dominated the political debate. Reform suggestions mostly concerned the realignment of the bureaucracy in order to rationalize the provision of Medicare and to introduce DRG payments in hospitals (Marmor, 2012).[4] On the other hand, the reforms of the American health care system in the 1980s came with the rise of health maintenance organizations (HMOs), which are profitable organizations in health care (Gottweis, 2004, 15)

During the 1980s, the federal government changed the grant structure of state funding by introducing block grants, and it left the budget cuts to the states. In this phase, state health departments had to manage budget cuts along with Medicaid programs, emergency health services, and a growing poor population with problems including alcoholism, drug abuse, teenage pregnancy, and family violence (Fee, 1994, 216). Health insurance in the U.S. had been dominated by employer-based insurance schemes because attempts

[4] Originating in the U.S., hospital DRGs spread in many industrialized countries (Gilardi, Füglister and Luyet, 2009).

to introduce health insurance legislation failed in the 1930s and thereafter. The company health insurance plans worked as long as workers were young and healthy. However, during the 1960s, most of the beneficiaries had already become older and needier, and health care expenses for companies increased. For instance, in 1965, the spending of American businesses on health benefits increased from 2.2 to 8.3 percent of salary costs and from 8.4 to 56.4 percent of pre-tax profits (Porter, 1999, 262). Since the 1970s, this development began to have negative effects on the competitiveness of American firms, and they began to induce measures to save money - for instance, by shifting costs to older employees, dropping coverage, imposing managed care through HMOs, and stopping the hiring of employees with known medical conditions (Porter, 1999, 262). In addition, companies had cross-subsidized contributions for the low-insured or the underinsured. This changed after the end of the postwar economic growth, and the new jobs that were created in the 1970s and thereafter allowed for no fringe benefits (Tuohy, 1999).

In this context of reduced coverage regarding medical care and the politics of rationalization, the cost of health care in the U.S. continued to rise during the 1980s. In contrast to other countries in the OECD, which kept health expenditure at a stable level (around or slightly above 10 percent of the gross domestic product (GDP)), the U.S. was the only country in which expenditure for health - mostly for individual health care - rose above 15 percent of the GDP after 2000 (OECD, 2013). Consequently, Medicare costs became subjected to debates about budgetary issues. During the 1980s, coverage for private health care insurance and Medicare for services per capita reduced, but at the same time, out-of-pocket payments for health care exploded, shifting the cost for Medicare to the private sector and consequently to consumers (Marmor and McKissick, 2012).

The reform that was most important in the American system during the 1980s was not to negotiate the relationship of midlevel agencies but to adopt a new payment scheme under Medicare that limited the payment per case. Nonetheless, the expenses at hospitals for public and private payers were different: Private payers spent considerably more, and only after 1992 did this divergence begin to decline. Market instruments that belonged to private entrepreneurs drove the reform of the market in the U.S. Public and private payers became more aware of their costs and shifted them toward limited payments. Health care provision was mostly in the hands of profitable firms, which were accountable to shareholders and largely not constrained by professional commitments. They often replaced the HMOs and the collegial networks that belonged to them (Tuohy, 1999).

During the early 1990s, the early Clinton government sought once again to introduce comprehensive health insurance and to nationalize health policy. In 1993, a reform proposal by Clinton failed due to the lacking middle class coalition on the matter and the fact that it had fallen to a lower position on the list of priorities of federal policy issues. What is more, the Health Insurance Association of America (HIAA) and the Republican Party were against it. It is, however, important to consider that the AMA was in favor of the legislation but was not strong enough to win decisive support (Porter, 1999, 265-67). The opposition of the health insurers stemmed from the fact that the reform planned to set up

a National Health Board that would have had serious competences in enacting the prices of health insurance policies. Consequently, the American government failed to finish a reform that would have segmented the insurance market and introduced a similar reform as that in Switzerland in 1994 (Tuohy, 1999; Uhlmann and Braun, 2011).[5]

The consequences of the failed health insurance reform are that health care remained to a large extent private and different from public health. The main problem that remained was the continuing lack of health insurance coverage. There were, however, attempts to increase health insurance coverage at the state level, which were though not to be very successful, in addition to the mentioned cost-containment reforms (Marmor, 2012).

Parallel to the private health care sector, there is a public health care system that is institutionally distinct at all three levels of government. Each of these levels operates certain programs. For example, the federal government is in charge of the hospital system for veterans, mental hospitals operate at the state level, and local government is in charge of public hospitals. The most important institution at the national level is the Department of Health and Human Services. It holds the responsibility for state-run public assistance programs as well as the major national programs in biomedical research, regulation, financing, and public health. The department plays an important role in the allocation of money and the delegation of authority to many other public and private entities in the country. However, certain functions related to public health are the responsibility of other departments. For instance, occupational health and safety is in the hands of the Department of Labor, and nutritional standards are set by the Department of Agriculture together with the Health Department (Jonas, Goldsteen and Goldsteen, 2007).

It was only during the recent financial and economic crisis that the U.S. government passed a major overhaul of its health care system, the Patient Protection and Affordable Care Act of 2011. The law intended to include almost universal health care coverage by sharing responsibilities for this between employers and employees, improve fairness and affordability, improve the value of health care, make the system more accountable, increase access to primary health care, and make better investments in public health by expanding investments in the community as well as preventive care (Rosenbaum, 2011; Beaussier, 2012).

Strictly speaking, this moved the U.S. toward more institutional integration, as health care and public health are organized under the same institutional umbrella. However, the fact that the U.S. (until 2011) did not have universal - or close to universal - health care distinguishes it from other industrialized countries and makes private health care distinct from public health and public health care, such as Medicaid and Medicare schemes. Those schemes were organized early on under the same institutional umbrella as public health, at least in many states. On the other hand, the private sector remains important and distinct from the public health / public health care sector (Jonas, Goldsteen and Goldsteen, 2007; Marmor, 2012).

[5]For a longer discussion of the American health insurance reform attempt of the Clinton administration in all its facets, see: (Barer, Marmor and Morrison, 1995).

Therefore, this reform is important for the purpose of this thesis in two ways. Firstly, it regulates the insurance market and shifts health care into public governance, thereby reducing distinctiveness between the policy sectors. Secondly, it integrates health care and public health by focusing on more community investments and preventive health care.

From the perspective of public health, the period since the 1980s has been one of cost containment and restriction as well as the continuing encroachment of individual health care along with the increasing integration of the two sectors. The institutional combination of preventive programs with health care or social welfare policies threatened original public health programs, which focused on prevention of diseases. During the 1970s, for instance, state and local public health programs began to provide individual care to uninsured patients and those who were rejected by private practitioners (Fee, 1994, 214). During the 1980s, public health policy in the U.S. faced new challenges. On the one hand, the appearance of AIDS shifted the focus of policymakers again to the problem of infectious diseases. The public health community agreed that a coordinated national effort to educate on and prevent these diseases was needed. On the other hand, public health departments also became a part of the cost-containment debates of the 1980s and had to defend their expenditure. At the same time, public health departments became institutions that were oriented toward the poor and the needy, with the challenge of providing care for these groups. At the time, public health officials did not manage to effectively lobby for encompassing public health programs and policies at the national level in order to jump the high hurdles of veto players for national policies. By 1988, more than two-thirds of the budgets of state and local health departments went to personal health services; medical care absorbed more and more of the resources of the health departments. Legislators preferred meeting needy people's urgent care needs over having a basic infrastructure of public health (Fee, 1994, 215-217).

The 1990s also saw some dynamics with regard to the relationship of public health and public health care programs. Currently, health policy is under the control of the Department of Health and Human Services (DHHS). Aside from the Department of Veterans Affairs and the Department of Defense, it is responsible for a lot of public health-related programs. In addition, the Department of Agriculture, the Environmental Protection Agency, and the Department of Labor (Occupational Health and Safety) hold health related responsibilities. Within the DHHS are eleven divisions that are responsible for health; eight among them are under the supervision of the USPHS. The others are the centers for Medicare and Medicaid, the Administration for Children and Families, and the Administration on Aging (Jonas, Goldsteen and Goldsteen, 2007).

With regard to concrete policy issues in the field of public health, the U.S. faced new challenges during the 1980s. On the one hand, the appearance of AIDS shifted the focus of policymakers again to the problem of infectious diseases (Avery, 2004). The public health community agreed that a coordinated national effort to educate on and prevent these diseases was needed, but the money mostly went to research and medical initiatives rather than prevention and education. It seems that at the political level, it was easier

to find money for research than for programs that deal directly with problems of the impoverished middle class; politicians seem likely to avoid very emotional issues such as drug use and AIDS (Fee, 1994, 215-16). The USPHS was revived in the wake of the AIDS epidemic. Surgeon General Everett C. Kopp demanded that Reagan publicly recognize the disease, which turned the attention of the public back to the service. Before that, the USPHS was largely preoccupied with health care issues within medical care provision and only partially focused on environmental health (Mullan, 1989; Porter, 1999, 288).

With regard to tobacco control policy, the U.S. is a very active country. As mentioned before, tobacco control policymaking emerged at the national and, more importantly, the subnational level in the 1960s and the 1970s. From thereon, regulations in the field gradually changed: For instance, the warning languages on tobacco products or billboard ads became necessary. At the same time, there was a large coalition of health care and public health actors who supported public health action on tobacco control. However, the tobacco industry managed to organize strong opposition to it. It was only when state governments sued tobacco companies for causing too high of a cost of health care was there a shift in the policy, which led to the Master Settlement Agreement between the tobacco companies and the state governments regarding compensation payments as well as the disclosure of information concerning industry lobbying activities (Sung, Hu, Ong, Keeler and Sheu, 2005; Clegg Smith, Wakefield and Nichter, 2003; Schroeder, 2004). However, restrictions on smoking in public buildings and restaurants as well as youth access to tobacco had already been passed at the municipal and state levels in the 1970s and thereafter (Shipan and Volden, 2008). The smoking ban legislation at the national level (for buildings of the federal government) followed in 1998, when the Master Settlement Agreement between the tobacco industry and the American states was reached (Gilardi, Giovanoli, Shipan and Wüest, 2014). Interestingly, the support of the public for non-smoking policies had already been high before that. In 1983, a Gallup Poll revealed that over 80 percent of non-smokers supported antismoking policies, whereas over 60 percent of smokers were in favor of these policies (Bayer and Colgrove, 2004).

To sum up, in the U.S., health care policy after the 1980s was similar to that of the UK in the sense that a strong public health coalition existed. However, the lack of powerful public health institutions at the national level as well more veto points against public health policies (Mayes and Oliver, 2012) did not lead to the same institutional integration of both sectors but rather the continuation of institutional separation and a strong interaction of actor groups. Not until the establishment of the national health insurance legislation, in 2011 did the institutional distinctiveness of health care and public health vanish and the U.S. fulfill the criteria of the institutional integration of health care and public health.

9.4.2 Responsiveness regarding HIV and tobacco

Regarding responsiveness between health care and public health, there was interaction between both sectors. First of all, concerning infectious diseases, such as AIDS, there was

a large coalition of actors and public health officials as well as doctors and medical organizations, which demanded a coordinated approach to responding to the disease. What is more, the Surgeon General played an important role in underlining the need for a public health intervention.

AIDS appeared as a clinical condition in 1983. Consequently, debates arose concerning how the response to the disease should be. On the one hand, gay leaders, civil libertarians, physicians, and public health officials argued that the disease needed to be dealt with in an exceptional way and were against using the classical public health approach, which would entail a tight control of the disease and those infected with it. However, the opinion of medical organizations changed during the 1980s, and they demanded recognizing HIV as an infectious disease that can be sexually transmitted (Bayer, 1991).

Generally speaking, the debate about AIDS in the U.S. was conflictual with regard to screening, testing, needle exchange, and research on drugs and treatment. Yet eventually, the policy was made by those who were in charge of health policy during the prior half century in the country. Despite the typical rhetorical debates in the U.S. regarding this type of interventionist policy, there was a certain agreement that a comprehensive reaction to the sickness was necessary. Interestingly, Surgeon General Everett C. Kopp was appointed with the support of the political right although he insisted on a progressive AIDS policy despite his political and religious beliefs (Fox and Klein, 2012). In spite of these rhetorical differences, there was a large public health coalition supporting AIDS policy, which consisted of the medical profession, public health doctors and members of the public health administration, underling the responsiveness of health care and public health in the matter.

The same had occurred with regard to tobacco advertising during the 1980s. In 1985, the AMA publicly demanded a complete ban of tobacco advertising and the Surgeon General agreed publicly. Other public health actors such as the American Heart Association and the American Lung Association joined in on this issue. In public statements, the organizations underlined that the ban of tobacco advertising was a very important step in reducing smoking prevalence (Bayer and Colgrove, 2004). With regard to policies, restrictions on tobacco advertising had been in effect concerning advertising on TV since the 1950s and 60s. However, it was only after the Master Settlement Agreement of 1998 that outdoor and billboard advertising was banned in 46 states (Bayer and Colgrove, 2004).

Despite mutual suspicions of the American Medical Association and the public health services, both sectors joined in and argued in favor of political activity concerning the most important public health issues (Medicine, 1988). The responsiveness of the two sectors is also underlined and cultivated by the inclusion of different professions in the USPHS, which employs doctors, engineers, and other professional actors in order to broadly attack public health issues.

These two examples show that health care and public health responded to each other on the level of actors. Apart from responsiveness with respect to specific policy problems, such as HIV and tobacco, this also led to demands for a more general integration of health

care and public health policies. For example, one suggestion entailed creating health trusts to provide individual medical care and to implement it in tandem with population-based health policies (Chernichovsky and Leibowitz, 2010). However, the main problem with this is that formal policy integration and far-reaching reforms are difficult in the U.S.-American political system, which is also valid for the area of public health. Therefore, policy integration - across all states but also in between different policy sectors - should occur by stealth, as in the area of tobacco control. This means that there is a more informal network of organization and cooperation that coordinates public health policies as much as possible (Studlar, 2014).

To sum up, there has been responsiveness between the health care and the public health sectors since the 1980s in the U.S. Notably, regarding HIV and tobacco, actors from the health care and public health sectors were politically active in supporting an encompassing public health strategy with regard to these problems but also concerning a more encompassing strategy for connecting both fields. Of course, this did not happen without differences in opinions, but there was no general disagreement or ignorance of public health problems on the side of the medical profession. This coalition also demanded more policy integration for public health, but such reforms are difficult to implement due to the political constraints at the national level.

What do these results imply for my hypotheses that I discussed for the U.S. case before? I have hypothesized that in the U.S., there should be a loose coupling of health care and public health because government is fragmented and professionalism is high. What is more, the contextual condition was positive for sectorial responsiveness and the integration of both sectors. The results of my analysis confirm these expectations for the most part. Until 2011, health care and public health were institutionally separated because all attempts to create comprehensive national health insurance failed. During the financial and economic crisis, the Obama government succeeded at passing health care reform despite the magnitude of institutional veto points in the country. Since then, health care and public health have been institutionally integrated. With regard to responsiveness, I find politically active professions in the health care and the public health sector, which have commonly advocated important policies, such as those concerning tobacco control and HIV. Globally speaking, actors from the health care and public health sectors worked together. Concerning policy integration, there were concepts and suggestions to better connect both fields. However, to actually implement these plans in more coordinated policy programs proved difficult, given the mentioned veto structures.

9.5 Discussion

In this chapter, I analyzed the co-evolution of health care and public health in the U.S. I will now review these results and discuss them comparatively with regard to my hypotheses. Overall, the coupling of health care and public health co-evolved from the loose coupling of health care and public health toward the tight coupling of the two sectors.

Most notable is the increasingly important role of the state in the organization, financing, and provision of individual health care throughout the course of the twentieth century. In the first time period under observation, both sectors were institutionally separated: Health care was largely in private hands, whereas the state focused on the provision of public health. At the same time, there was responsiveness between both sectors in the sense that the medical profession and the public health profession commonly supported public health policies. During the interwar period, the aforementioned institutional separation was retained, as was the responsiveness of health care and public health on the professional level. However, conflicts between the USPHS and the AMA increased with regard to a universal health service and compulsory health insurance. Whereas the former demanded both, the latter opposed any large role of the state in individual health care. In that period, the relationship of both sectors shifted from the loose coupling to the de-coupling of health care and public health.

In the postwar time period, health care and public health remained institutionally distinctive. There was an increasing focus on health policy toward individual health care, which led to a strengthening of private health care but also an increasing role of the state in individual health care with the establishment of Medicaid and Medicare. Yet, in contrast to Australia, this did not result in the establishment of national compulsory health insurance. On the contrary, in the 1970s, when the context for health policy turned once again to population-based health policies, compulsory health insurance dropped off of the political agenda, and the state public health departments had to deal with increasing demands for Medicaid and Medicare services. It was only during the global financial and economic crisis when national health insurance passed. With regard to public health issues, such as tobacco use and HIV, the medical and public health profession played an important role in the sense that they both advocated more state activity in the matter. This was more unanimous with regard to tobacco, whereas there were some conflicts concerning how the HIV epidemic should be responded to. Overall, however, my results give the impression that a large coalition of actors from health care and public health support public health issues.

9.5.1 Unified government and professionalism in the U.S.

What do my results imply for my hypotheses? I had hypothesized that I was expecting to find the loose coupling of health care and public health because of a fragmented government and high professionalism, given that the contextual condition is favorable to responsiveness between both sectors.

Concerning a fragmented government, my results turned out as expected. In the U.S., as there are many more veto possibilities at the national level, the institutions of both sectors remained separate from each other until 2011. Health care, notably individual health insurance, was privately governed. Throughout the twentieth century, there had been many attempts to introduce compulsory health insurance, but these projects often failed in Congress. Nonetheless, there had been an incremental growth of publicly funded

Table 9.1: Co-evolution of health care and public health in the U.S.

Time / Country	1850-1918 *(t0)*	1918-1945 *(t1)*	1945-1980 *(t2)*	1980-2010 *(t3)*
Coupling	*Loose coupling:* Separation of sectors at the national level and between the national government and the states (Public - private); responsiveness between professions and interest groups	*De-coupling (Loose coupling):* Separation of sectors at the national level and between the national government and the states (Public - private); responsiveness between professions concerning health education	*Loose coupling (De-coupling):* Separation of sectors at the national level and between the national government and the states (Public - private); more integration due to Medicare; Responsiveness between professions with regard to public health issues	*Loose coupling (Tight coupling):* National health insurance legislation 2011 → institutional integration; responsiveness between professions with regard to public health issues
Professionalism	Politically active and powerful medical organization and public health profession	Medical profession successfully opposes compulsory health insurance; supports public health policies as long as they do not interfere with its original interests; conflicts with public health profession regarding a national health service	Medical profession and public health actors support public health despite dominance of individual health care; AMA against mandatory health insurance	Medical profession opposes and supports compulsory health insurance; large public health coalition
Unified government	Decentralization and many veto points in the presidential democracy; considerable influence of interest groups	Decentralization and many veto points in presidential democracy; AMA successfully mobilizes opposition in parliament	Decentralization and many veto points in presidential democracy; considerable influence of interest groups	Decentralization and many veto points in presidential democracy; considerable influence of interest groups → Supreme Court supports health insurance legislation
Context	Infectious diseases; progressive movement; state-building	Impact of the first World War; Second World War	Success of prior public health policies; pharmaceutical advancement; turn towards individual health care	Non-communicable diseases; risk factors; return of infectious diseases; international public health paradigm

health care schemes that focused on indigent groups. On the side of public health, however, the role of the national government remained stronger. Yet the sectors had been inherently fragmented due to the distribution of legislative competences between the states and as well as municipal governments.

Regarding professionalism, I found strong evidence for politically active professions and proof that this can lead to political responsiveness between the health care and public health sectors. Most importantly in that regard is the professional organization of doctors, the AMA, which successfully opposed the implementation of a national health insurance system and defended the freedom of practice for its members. At the same time, however, it supported public health activities, such as sanitary measures in the late nineteenth century, health promotion actions in the 1920s, and tobacco control policies as well as a coordinated response to HIV, especially after the 1980s. However, at the same time, it jealously guarded the rights and privileges of its members, notably the doctoral monopoly on medical practice and individual health care. Consequently, there were also conflicts with public health reformers, especially during the interwar period, about the question of whether a comprehensive public health service should be created or not. During the postwar period, when the first new public health issues appeared on the agendas of policymakers, the most prominent advocates of these measures were public health reformers but not the medical profession.

The context played an important role in the co-evolution of the health care and public health sectors in the U.S. As I had expected it theoretically, responsiveness between actors of the health care and public health sectors occurred the most when the contextual conditions were favorable for it. This was the case in t0, in the late nineteenth century, when the demand for public health policies was high. However, I also find evidence for this during t3, which is the period after 1980s, when non-communicable diseases and new infections led to the demand for public health regulation.

9.5.2 Competing explanations

In addition to the mentioned explanatory factors, I referred to other theoretical elements in the previous case studies, which came out as potentially important findings. In the remainder of this section, I will discuss these elements for the U.S. before I present a comparative discussion in the concluding chapter.

1. *Complementarity*: In the U.S., health care and public health co-evolved toward complementarity during the time periods under observation in this report. This is empirically visible with regard to the demands for more policy integration in the post-1980 period. However, in some ways, the two sectors were compatible before this period, because health care and public health were largely complementing one another in the sense that the market governed individual health care and the state public health and population-based health policies. During the course of the twentieth century, the state absorbed more and more bad risks in that it provided health

care policies for indigent groups. In other words, it compensated for the externalities of the private health care system. At first, these measures only applied to mothers and children, then also to the elderly and handicapped (Medicare and Medicaid, 1965), until the national government created a universal national health insurance guarantee in 2011. However, actual health strategies that combined elements of prevention and cure with regard to specific health problems had existed long before universal health care, since the 1980s.

2. *Policy learning*: The results of this case study confirm to a certain extent my additional result of the other case studies that responsiveness between health care and public health comes with a learning process - firstly, in the broad sense that professions and interest groups learn from one another, notably the public health and the medical care profession. More narrowly, I found evidence for policy learning, namely that the political activity of the medical profession has an impact on putting public health topics in the political agendas of policymakers. However, this did not always lead to reforms because the U.S. political system makes it difficult to transfer the result of these learning processes into actual policy outputs.

In contrast to some of the other case studies, I did not find evidence for partisan differences regarding the relationship of the health care and public health sectors. Notably, there were conflicts between parties regarding the introduction of a universal health insurance plan but not concerning the direct relationship of the two sectors under observation in this chapter.

9.6 Summary

I selected the U.S. as a case study because it allowed me to examine the configuration of a fragmented government and low professionalism, if the contextual conditions were favorable. My results largely confirm these hypotheses. Due to the many veto points and the decentralization of the political system, health care and public health were institutionally separated for a long time, compared to other countries in this sample. At the same time, the strong professionalism in the U.S. transferred into politically active health professions, notably the medical profession. This resulted in the common political activism of interest groups and professions from the health care and public health sectors - for example, regarding health promotion and tobacco control policy. However, this also led to conflicts, especially regarding the distribution of resources and competences, such as the right of doctors to free practice.

Chapter 10

Comparison

In the preceding chapters, I analyzed the co-evolution of the health care and the public health sectors in five countries, from the perspective of single case studies. I selected Australia, Germany, Switzerland, the UK and the U.S. because I expected to find different degrees of coupling of the health care and the public health sectors in these countries. Based on the literatures of federalism, political constraints and veto players on the one hand and professionalism on the other hand, I hypothesized that health care and public health would be tightly coupled in the UK and Australia, loosely coupled in the U.S., non-coupled in Germany and de-coupled in Switzerland. What is more, I expected that a favorable contextual condition should especially lead to responsiveness (common political advocacy) between health care and public health actors. The results of my analysis partially confirmed my hypotheses. So far, however, I only discussed them separately for each country.

In this chapter, I will compare the results of my case studies and connect them to the theoretical links and the main argument I made in the theoretical section. I will begin with a comparison of the coupling of policy sectors in the five countries. Then, I am going to turn to my main hypothesis and discuss a revised theoretical model, one which includes some of the additional theoretical findings. To conclude, I will present three forms of sectorial co-evolution that could be transferred to other countries and the configuration of other policy sectors.

10.1 Overview: Coupling of health care and public health in five countries

Table 9.1 shows the results of the co-evolution of the health care and the public health sectors for the five countries under observation. Clearly there are not only differences between the countries but also across the different time periods. Most striking is that there are discrepancies between English-speaking countriesAustralia, UK and the U.S.on the one hand, because they co-evolved from non-coupling and loose coupling to tight coupling of health care and public health. On the other hand, in non-English-speaking

Germany and Switzerland, health care and public health are rather de-coupled.

However, there are differences within these two groups. Concerning institutional distinctiveness, in the UK, health care and public health were integrated early on; in Australia, integration occurred in the mid-twentieth century; in the U.S., institutional separation remained until the early 21st century. In Australia, health care and public health were institutionally separated in colonial times and coevolved toward more tight coupling in the interwar and the postwar period. This is because the national government took more and more responsibilities for health care; in 1921, the National Ministry for Health was founded; in 1944, the Pharmaceutical Benefits Scheme; and in 1974, the National Health Service. In the U.S., health care and public health were separated into the public health sector and the health care sector, which was based on private health care organization and provision. However, at the same time, there were primary health care services for indigent groups. At first, these were only for soldiers and mothers, but with the introduction of Medicare and Medicaid in 1965, these services increased to pensioners and the poor. This development came along with institutional drift in the sense that the state public health departments had to implement primary care instead of doing preventive health policies. At the same time, the USPHS was subordinated under a new department of health. However, I am considering the U.S. to have an absence of sectorial integration, after a national health insurance legislation was established in 2011. Until then private health care still played a very important role. In the UK, institutional integration of both sectors occurred in the early twentieth century after the establishment of a national health insurance, which was the means for the national government to control individual health care as well as public health. At the latest, with the establishment of the NHS, health care and public health were institutionally integrated in 1946.

Whereas the degree of institutional distinctiveness varies between Australia, the UK and the U.S., the responsiveness of health care and public health has been a rather constant element in the relations of both sectors in all three countries, except for the interwar period. Doctors and other actors responded to one another with regard to the professionalization of public health in the late nineteenth and early twentieth centuries, as well as with regard to the politicization of public health issues in the sense that the professions in both sectors supported public health policies. In the interwar period, there were conflicts between social hygienists who demanded the creation of national health services to combine matters of population health and prevention, as well as individual health care. These struggles occurred in all three countries. In Australia and the U.S., they were connected to the opposition of the medical profession against compulsory health insurance, whereas in the UK, the BMA sought to keep its prerogatives under the existing health care legislation and (successfully) opposed a national health service according to the style proposed by social hygienists. During the postwar period, individual health care became more prominent in health policy due to the changes in contextual factors. Yet, in all three countries the medical profession and public health professionals advocated further public health action, for instance with regard to immunization campaigns, cancer screening, or tobacco and

Table 10.1: Co-evolution of health care and public health in five countries

Time/ Country	1880-1918 *(t0)*	1918-1945 *(t1)*	1945-1980 *(t2)*	1980-2010 *(t3)*
Australia	*Loose coupling:* Colonial and sectorial distinctiveness; responsiveness with regard to professionalization and "politicization" of public health	*De-coupling (Loose coupling):* Sectorial distinctiveness; mostly conflicts, but also cooperation between health professions and interest groups	*Loose coupling (Tight coupling):* Sectorial integration as of 1974; responsiveness of professions with regard to 'politicization' of public health, despite dominance of health care	*Tight coupling:* Sectorial integration; responsiveness of professions with regard to 'politicization' of public health
Germany	*De-coupling:* Distinctiveness at three levels of government; no responsiveness with regard to professionalization and 'politicization' of public health	*De-coupling (Tight coupling):* Distinctiveness at three levels of government; integration after 1933; conflicts regarding a public health service; responsiveness of professions with regard to public health (After 1933)	*De-coupling:* Distinctiveness at three levels of government; no responsiveness of professions with regard to 'politicization' of public health	*De-coupling (Non-coupling):* More horizontal integration; no responsiveness of professions with regard to 'politicization' of public health
Switzerland	*De-coupling:* Distinctiveness at different levels of government; no responsiveness with regard to professionalization and 'politicization' of public health	*De-coupling:* Distinctiveness at different levels of government; No responsiveness with regard to professionalization and 'politicization' of public health; responsiveness of cantons	*De-coupling:* Distinctiveness at different levels of government; no responsiveness with regard to professionalization and 'politicization' of public health; some responsiveness of cantons	*De-coupling (Non-coupling):* Integration at the national level after 2003, but little responsiveness; Coordination rather between cantons
UK	*Non-coupling (Tight coupling):* Sectorial integration; conflicts of politicized health care and public health professions dominated; general agreement that public health policies are necessary	*Non-coupling (Tight coupling):* Conflict and cooperation between health professions and interest groups	*Tight coupling (Non-coupling):* Sectorial integration; responsiveness of professions with regard to 'politicization' of public health, despite dominance of health care; conflicts regarding NHS	*Tight coupling:* Sectorial integration; responsiveness of professions with regard to 'politicization' of public health
U.S.	*Loose coupling:* Distinctiveness between sectors and levels of government; responsiveness with regard to professionalization and 'politicization' of public health	*De-coupling (Loose coupling):* Sectorial distinctiveness and between levels of government;	*Loose coupling (De-coupling):* Sectorial distinctiveness, but drift towards integration; responsiveness of professions with regard to public health	*Loose coupling (Tight coupling):* Sectorial integration (after 2011 especially); responsiveness of professions with regard to 'politicization' of public health

alcohol control policies, as well as obesity prevention. This dynamic has remained an important element of the relationship between the two sectors since the 1980s.

On the other hand, for Germany and Switzerland the results are different. In Germany, health care and public health have been institutionally separated since the emergence of both sectors. This situation only changed during the Nazi period, when public health was especially more integrated at the national level. However, after the Second World War, policymakers in the FDR restored the old separation of health care as the main paradigm for health policy at the national level and public health at the subnational and municipal level. At the national level, public health was mostly in the hands of the BZfGA, which is a subordinate agency to the National Ministry of Health. Similarly, in Switzerland, health care and public health were de-coupled at the national level from the outset because the national health insurance administration was in the ministry of social insurance, whereas prevention and public health were a responsibility of the Federal Office for Public Health, which was, however, under the supervision of the Department of Domestic Affairs. This sectorial distinction at the national level remained until 2003, when the national health insurance law was transferred to the Federal Office for Public Health. In Switzerland, health care and public health are separated between the national and the subnational level of government. Specifically, the cantons enjoy many competences in the areas of health policy, concerning health care as well as public health.

Regarding the responsiveness between health professions, Germany and Switzerland are similar to one another and different from Australia, the UK and the U.S. I did not find significant responsiveness between both sectors during the late nineteenth century in Germany with regard to the professionalization of public health, but I particularly did not find any concerning the politicization of public health issues. This changed in the interwar period, as there were conflicts between social hygienists and the medical profession concerning the creation of a national public health service, which would have combined health care and public health. The conflict was resolved with the expulsion and incarceration of many members of the public health profession after 1933 and the continuing empowerment of the medical profession. Doctors and the "leftovers" of the health profession took the responsibility for public health, but the new public health legislation fostered racist public health policies. After the war, health policy in Germany turned toward individual health care, as in many countries, but there were barely any public health stakeholders to whom the medical profession could have responded in order to politicize health policy as a public health issue; and the profession itself eventually did not see the necessity to do so. This situation has remained prevalent until today, although the public health profession, as well as related stakeholders, has become more politically active in Germany since the 1980s. The federal government even included leading public health researchers in its expert committee on health policy issues *(Sachverständigenrat)*. Yet, this did not have the same impact as a politically active professional organization in health policy.

In Switzerland, the absence of responsiveness occurred in a different way. In the

late nineteenth century, there was no strong public health profession but rather occasional activities of interested individuals and cantonal health foundations as opposed to organized pressure groups. At the same time, the medical profession did not play a significant role in the politicization and professionalization of public health topics. It was only during the 1960s that public health was professionalized nationally, but even through today there has been little responsiveness between the medical profession and the public health profession concerning public health issues. This became even clearer with regard to the development of a national response to HIV, in which the main national doctoral organizations played no substantial role as political stakeholders. Since the cantonal governments are important for public health policy, they took some action to put the issue on the national political agenda and coordinated some public health responses in the CDP. At the same time, they became an important agenda setter for public health at the national level, as opposed to the medical and public health professions.

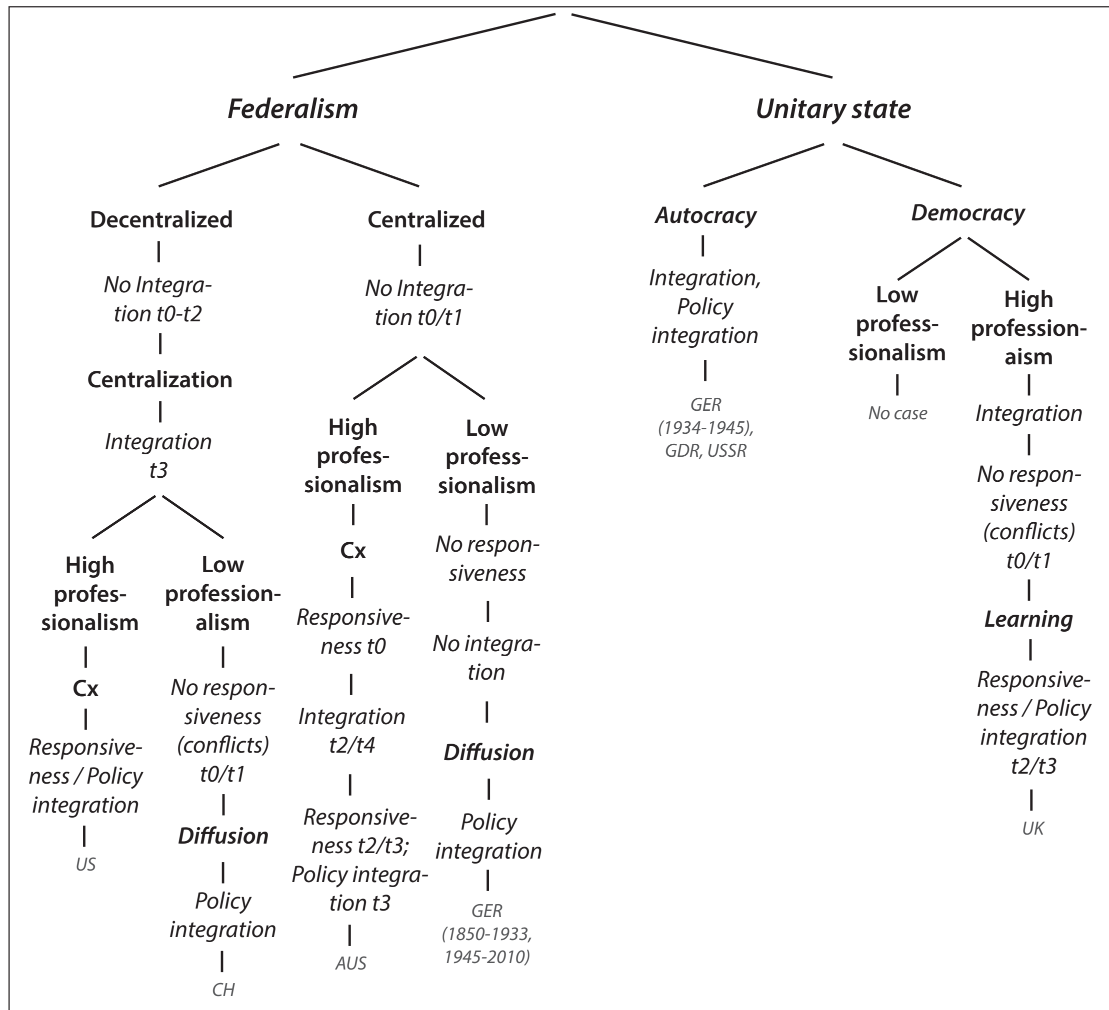
Despite the mentioned differences, there are two similarities between all countries. The first is the absence of responsiveness during the interwar and Second World War period. This was due to conflicts between health policymakers about the role of the state in health policies in general. In all countries, public health reformers proposed to create national health services, which would have combined public health and health care. But in all countries in this sample, the medical profession successfully opposed these proposals. However, responsiveness in the Anglo-Saxon countries between both fields continued in the shadow of this development. The second similarity between the five countries is the increasing policy integration of health care and public health, which began especially after 1980. Again, Australia, the U.S. and the UK were forerunners, but also in Germany and recently in Switzerland the governments created national health strategies that combine preventive and curative instruments for certain diseases.

10.2 Causal pathways of the co-evolution of policy sectors

How do these results fit with the hypotheses I presented in the theoretical section? In the following, I present causal pathways of the co-evolution of the health care and the public health sectors, which result from empirical analysis of the five countries. Thereby, I adapt the argument I made previously. Specifically, I take into more explicit consideration the temporal dimension and the impact of additional explanatory factors, such as regime types, policy learning and diffusion.

Figure 10.1 shows the causal pathways of the co-evolution of policy sectors in the five countries under consideration in this thesis. The results change the theoretical model I presented previously. Notably, I changed the variable "unified government," which I used to combine elements of federalism and veto points, respectively, into veto players. In the revised theoretical model, I focus on the distinction between federal and unitary states, which made an important difference in the co-evolution of the two sectors. In addition, I added the regime type dimension (democracyautocracy), diffusion and policy learning.

Figure 10.1: Causal pathways: Co-evolution of policy sectors



The model explicitly accounts for temporal factors and suggests some interaction between different elements of the dependent variable over time, namely institutional integration, responsiveness and policy integration.

In a nutshell, my argument regarding the impact of professionalism can be upheld. In countries with high professionalism, there was responsiveness between health care and public health professions and interest groups in the political arena if the context was favorable. In cases in which the federation was centralized, this led to an earlier institutional integration of health care and public health than in decentralized federations. On the other hand, I cannot uphold my hypothesis regarding unified government, as I need to refine it with a better focus on the federalist dimension. The fact that subnational governments have distinctive legislative competences had an important impact on the co-evolution of policy sectors.

On a technical note: The figure distinguishes between "integration," which refers to institutional integration, and "policy integration," which describes the connection between the two policies. In the following, I discuss the implications of my findings for theory in more detail.

10.2.1 Unified government, professionalism and context

In this subsection, I focus on the three theories upon which I had based my argument, namely unified government, professionalism and contextual elements. For each of these factors, I review my original hypotheses and discuss the extent to which they need to be revised.

Federalism counts, not unified government

Originally, I argued that unified government should lead to institutional integration. I defined a country as having a unified government either when there were little veto points or players at the national level (Lijphart, 2012; Tsebelis, 2002) or when the country was a centralized federation (Hueglin and Fenna, 2006; Watts, 1996). To the contrary, decentralized federations and many veto points were instances of fragmented government.

My results showed it was necessary to revise this assumption. Above all, the difference between federal and unitary states was important for the co-evolution of policy sectors. The fact that subnational governments are sovereign units (different from municipalities) (Hueglin and Fenna, 2006, 30-33) and possess legislative competences in health policy had an impact on the co-evolution of policy sectors, especially in the early time periods. This came along with the absence of institutional integration, especially until the interwar period. Also, my results showed it was necessary to distinguish centralized from decentralized federations with regard to the institutional co-evolution. Both Australia and Germany are centralized federations, and in the two countries there was no integration at t0 or t,1 as in the other two federal countries, but in the following time periods this changed, along with differences in professionalism. On the other hand, decentralized federations, in this case Switzerland and the U.S., slowly coevolved toward institutional integration, independently of high or low professionalism. This is no surprise, as there has been an evolution toward more national legal frameworks in many federal states. Regarding the co-evolution of policy sectors, this implies there should be a development toward institutional integration in all federal countries. Yet, such a dynamic does not necessarily need to accompany an absolute centralization of powers. Even if there is a new national framework, subnational governments might retain considerable powers in implementation or gain legislative competences in other areas.

The presence of a unitary state led to institutional integration of the two sectors, because another level of government was lacking. My results showed that, in this case, the governments tended to integrate policy sectors. However, it is important to keep in mind that my results are based on the health care and public health sectors, which are two

fields that are very close with regard to their origin and actor constellations. The extent to which this finding is valid for other cases, such as energy policy, for example, remains to be seen. What is more, my only control case for a unitary government was autocratic Germany between 1934 and 1945, when the *Länder* were legally abolished. However, in this instance there was indeed a change from institutional separation to integration.

Professional activism, context and the politicization of health

The second part of my argument entailed the assumption that high professionalism would lead to political activism and, consequently, the responsiveness of professions and interest groups of the health care and the public health sectors. High professionalism means that belonging to a profession is a considerable advantage because it makes it more likely for individuals to receive a well-paid job compared to only having a general educational degree and vocational training (Freidson, 1983, 23-26)(Macdonald, 1995, 30). Consequently, in countries where the membership in a profession is important for the individual in economic terms, professional organizations are more politically active. First of all, they aim at protecting the income of their members. However, I have argued that a side effect of their political activity might be that they politicize relevant problems in coordination with other policy sectors, in my case the health care and the public health sectors. Since strong professional organizations are prone to conflicts, it depends on the context whether there will be responsiveness between the two sectors.

Overall, my results confirmed my hypothesis that strong professionalism led to politically active professions and in turn to responsiveness between the health care and the public health sectors. In the countries in my sample where professionalism was high - Australia, the UK and the U.S. - professions were politically active and responded to one another with regard to health policy problems, notably public health issues. The medical profession, understood as GPs and the medical organizations, were active in politicizing important problems together with actors from the health care sector. Notably, these included issues such as tobacco and HIV, as well as health education. On the other hand, professions in Germany and Switzerland were not very active politically, especially not with regard to agenda setting of issues. Other than in the countries with high professionalism, doctors did not play an important role in publicly politicizing problems of the public health sector. In these two countries, the medical profession focused only on scientific exchange, not on political activism.

High professionalism and responsiveness came along with policy integration of health care and public health. Due to the large coalition of actors in health policy that comprised the health care and public health professions and interest groups, governments were more likely to integrate policies from both fields - even though I also found policy integration of health care and public health in countries where professionalism was low. But this I will explain in one of the following sections. In addition to policy integration, high professionalism contributed to the institutional integration of health care and public health in Australia. Due to the political activity of the medical profession as well as the general

tendency to centralize, health policy had been a high priority for the national government since the foundation of the commonwealth. The medical profession successfully opposed national health insurance legislation and was partly responsible for the fact that this reform was only created during the 1970s. Nonetheless, the consequence of its political activism was a strong national health policy, which included the NHMRC, the PBS and a centralized coordination of the commonwealth and state governments.

However, my findings regarding the impact of professionalism on responsiveness need to be qualified in at least two ways. Firstly, contextual elements played an important role in some countries. Especially in the U.S., the responsiveness of health care and public health actors was most visible during t0 and t3, which means it correlated highly with the contextual conditions. In times when the context was favorable to responsiveness and there was a demand for integration of both sectors, interest groups and professions from health care and the public health sector commonly advocated public health issues, but not in times when the context changed. Secondly, the earlier there was institutional integration and broad legislation of the state in matters of health care and public health, the more conflicts occurred between the health care and the public health sectors, which were resolved by learning over the course of time. This mechanism crystallized in the UK. Although professionalism was high, there were above all conflicts between medical and public health doctors about posts and responsibilities in the public health services and the national health insurance scope of coverage, even when contextual conditions were favorable to sectorial integration (t0). Other than in the U.S., professions and interest groups from both sectors did not demand more state action but fought for resources. This changed in a gradual and linear manner throughout the twentieth century because there was responsiveness regarding new public health problems in t3.

On the other hand, the situation in Germany and Switzerland was different. In these countries, low professionalism led to less politicization of the medical profession compared to the U.S., Australia and the UK. In 1883, the German national government introduced a national health insurance which it delegated its powers in health policy to interest groups that administered this in an corporatist manner. The medical doctors and the health insurance organization were part of this. The power of the medical profession especially increased continuously in the administration of the health insurance. In Switzerland, the situation was different, though with a similar outcome for the professionalization of the medical profession. In the late nineteenth century, health insurance was locally organized and only compensated for income losses; patients paid for treatment themselves. In the course of the twentieth century, health insurance was organized more regionally, and wage agreements were closed between doctors and health insurance carriers. During this process, the medical profession considerably improved its position compared to the health insurance. At the national level, a health insurance law passed, however, only in 1994. Due to this inclusion of doctors in administrative matters of health insurance, the medical profession was less politicized, and consequently, public health did not have its

political support.[1]

These differences in political activism of health professions essentially reveal differences in the boundaries between the state and society. In their essay on health care and its political boundaries, Paul Starr and Ellen Immergut referred back to Karl Mannheim's idea that bureaucracies "tend to turn all problems of politics into problems of public administration." Consequently, they contend that issues of health care have moved from the private into the public sphere and from the technical into the political domain. Thereby, resistance occurred against this dynamic based on two arguments: (1) that medicine and health care should be resolved privately or (2) that they are technical matters that need to be dealt with by professionals in the form of scientific criteria or interest groups in negotiations sponsored by the state (Mannheim, 1946; Starr and Immergut, 1987, 223). In Germany and Switzerland, health professions and interest groups, above all the medical profession, became part of the administration. Therefore, they did not politicize problems beyond their immediate interests, as did the professional organizations in Australia, the UK and the U.S. In the latter three countries, professional organizations played an important role in politicizing problems because they were not part of the administration. The reason for this is the important role of professionalism in general; its consequences are that private actors play an even more important role in the politicization of a common good.

The examination of professionalism and its impact on the politicization of health care and public health issues reveals interesting insights about political parties. I had argued that if the political activism of professions was low, partisan differences would play a more important role. My results showed this has been especially the case for policies connecting health care and public health, or public health policies as such, because a politically active medical profession can forge alliances across political parties. This is particularly important for public health problems, such as tobacco, because among the target groups or negatively affected beneficiaries of this policy are often powerful corporate interest groups, which mobilize especially liberal and conservative parties in their interests and oppose such policies. This mechanism became clear with regard to Germany and Switzerland, where professions are weak and therefore parties are split regarding health policy, whereas this was the other way around in Australia and the UK. However, this does not mean there have been no party conflicts regarding the relationship of health care and public health in these countries. In Australia and the UK, there have been conflicts regarding policy integration of both sectors and public health policymaking. Yet, there is a basic consensus that these issues are important, not in the least due to the support by the medical profession for regulative public health policies. To the contrary, conservative and liberal parties in Germany and Switzerland have successfully opposed broad public health laws for a long time because they have argued that the health care system as it is can provide sufficient prevention and public health and that the state does need to intervene any further in this

[1](Lengwiler and Rothenbühler, 2004; Muheim, 2000; Uhlmann and Braun, 2011). See also: "www.geschichtedersozialensicherheit.ch/institutionen/krankenkassen". Last accessed June 20, 2015.

matter.

I had also argued that responsiveness between professions depends on contextual elements, notably if there is a demand for responsiveness and integration of health care and public health due to pressing health problems or ideas. Specifically, I assumed that in the postWorld War I and the interwar period as well as after the Second World War demands for integration should have been low. My results partially confirmed this theory. In the U.S., contextual elements mostly had the expected effect, as they did to a lesser extent in Australia. To the contrary, in the UK, the responsiveness of health care and public health did not seem to follow the business cycle of public health. The reason for this is that the state controlled health policy already early on in this country, which put the focus of professions and interest groups on political fights for the distribution of resources rather than on political cooperation for public health matters. On the other hand, the results in Germany and Switzerland turned out as expected; there was no responsiveness due to the absence of professionalism. To the contrary, the changing context influenced the health policy agenda by diffusion and learning from others.

10.2.2 Regime type, diffusion and policy learning

During my analysis, a number of theoretical elements I had not discussed in the theoretical section appeared as important factors. Especially, these included the regime type, policy learning and diffusion effects. In the following, I explain the impact of these elements on the co-evolution of health care and public health.

1. *Regime type*: Figure 10.1 shows that the presence of an autocratic regime had an impact on the integration of the health care and the public health sectors. Among the countries under observation in this thesis, there is one unitary state: the UK. However, during its time under the Nazi regime, Germany was also a unitary state with strict centralization of legislative and administrative competences. This had an impact on the institutional integration of both sectors. During that time, a national public health service was created and administrated together with the national health insurance. What is more, there were common policies connecting health care and public health, namely the racist health policies aimed at excluding "inferior races" (above all, Jews). Whether there was responsiveness is difficult to say because political advocacy was not possible like it was in democratic times. Doctors supported public health issues, but I did not analyze whether their majority was only afraid of negative consequences for opposition or truly adhered to Nazi ideas. However, in the USSR and in the GDR, which were both autocratic regimes, there was an integration of the health care and the public health sectors. However, it remains open whether there was responsiveness between professions and interest groups. I would assume this was not the case due to the lack of democratic structures. However, this hypothesis needs to be confirmed by further empirical analyses.

2. *Diffusion and policy learning*: A second element that came out as important is

the role of learning and diffusion. My argument about the political importance of professions and the differences they make for the coupling of policy sectors implicitly includes an assumption about policy learning: namely, that if doctoral professional organizations are political active, they will not only take note of new public health problems and policies as part of the scientific debate but also help to put them on the agenda of policymakers - unless they are not against their own interests. Therefore, a highly politicized medical profession had an important impact on the politicization of innovations in the field of health policy, including public health, and contributed to the connection of both sectors.

Policy diffusion is another important element. I had hypothesized that in countries where professionalization is low so should be the political activism of the medical profession. Therefore, it should be unlikely that policies of health care and public health are integrated. However, my analysis showed the governments learned about policy integration from other countries. For example, although health care and public health were de-coupled and non-coupled, the German government introduced comprehensive health strategies that combined care and prevention because it had learned from other governments, notably those of English-speaking countries.

10.2.3 Complementarity and co-evolution of policy sectors

In addition to professionalism, unified government, regime type and policy learning, my analysis entailed another important theoretical lesson, especially for the analysis of comparative public policy. Specifically, it concerned institutional development over time and the relationship with other fields of social policy. My results showed a pattern of drift and layering with regard to the institutional change of health care and public health over time, as well asand this is an interesting findinga pattern of co-evolution toward complementarity independent of the type of coupling. What is more, my results revealed that non-coupling and de-coupling of health care and public health accompanied "tight coupling" to other institutions of the welfare state.

Learning and complementarity in the co-evolution of policy sectors

The first part of my results regarding complementarity referred to the temporal dimension. In the theoretical chapter (chapter 2) I discussed the literature and presented an innovative argument to explain the coupling between policy sectors by referring to configurations of professionalism and unified government. I framed this argument as a complement to some of the hypotheses based on theories of historical institutionalism and institutional complementarity. Based on my case studies, I showed how political activism of professions and federalism led to the coupling of policy sectors. However, my results also showed the co-evolution of policy sectors partly confirmed and partly refuted some of the hypotheses in the historical institutionalism literature.

Firstly, the co-evolution of health care and public health is a story of institutional drift and layering. Jacob Hacker argued that institutional drift occurred with regard to retrenchment in health policy. This means costs were cut by changing existing policies rather than through formal "legislative reform" (Hacker, 2004*a*; Hacker, 2004*b*, 723). I find such dynamics also with regard to the co-evolution of the health care and the public health sectors. For example, in Germany, and much later in Switzerland, national health insurance had been the guiding principle of health policy. Consequently, policymakers integrated prevention and public health into the national health insurance when the demand for such policies increased. The consequence was that preventive health policies focused above all on individuals. Similarly in the U.S., policy drift took a different form. Once medical services for the elderly and the poor were established in the 1960s, the state public health services had the task of implementing these reformsalthough their original mission was to provide preventive and population-based health services. Yet, there have also been instances of layering, which refers to formal legislative reforms in the health sector. Notably, the introduction of the NHS in Australia in 1964 and the Patient Protection and Affordable Care Act of 2011 in the U.S. were instances of layering because new health care policies were placed onto existing legal arrangements. Although the latter shows that health policy reform does not only happen through mechanisms of drift, these results are not surprising theoretically because the findings remain largely similar to what previous papers have argued.

A second finding relates to the literature on institutional complementarity, but it is theoretically more interesting for the comparative public policy literature. My results showed there has been a co-evolution of the health care and the public health sectors toward more complementarity, independent of the type of coupling between the two sectors. In the literature on institutional complementarity, some authors have put forward the hypothesis that capitalist institutions emerge randomly and that they coevolve toward complementarity under historical and political constraints of their time (Crouch et al., 2005, 364-366). In that sense, complementarity means an improvement of the two sectors' common output due to coordination (Boyer, 2005).

In all of the countries I analyzed in this thesis, there has been a co-evolution of health care and public health toward complementarity, however, in different ways. During t0, the institutions of the health care and the public health sectors emerged regarding the demands and the specific situation of each country. The guiding principles that impacted the relationship of the two sectors were centralized government and professionalism, as I explained previously. During t1 conflicts dominated, and during t2 individual health care was most important. Yet, in t3, complementarity of health care and public health appeared because there were policies that combined both sectors. Since the late 1970s and early 1980s, health policies have emerged combining prevention and cure into common health policies. This entailed strategies to improve population health in general but also policies and strategies against specific diseases, such as cancer or diabetes, or risk factors, like smoking or drinking. There was no planned "grand design" (Crouch et al., 2005, 364-366)

that created complementary institutions, which in turn combined health care and public health. Instead, the institutions of the health care and the public health sectors emerged uncoordinated and coevolved toward complementarity.

To some extent, the only exceptions were autocratic regimes, where the national government sought to create complementary institutions to improve population health, especially in Germany. Among the democratic states, the UK was the closest to this ideal, but it also showed a pattern of co-evolution toward complementarity. First, the government put into place a national public health policy and then a national health care policy (1911 a national health insurance and the NHS in 1946) in order to respond to the most pressing health problems. Although policymakers integrated both sectors quickly, there were a lot of conflicts between professions and interest groups of the two sectors, particularly about resources during t0 and t1. Only in the post - World War II period did actors from both sectors begin to learn from one another and to cooperate, for example regarding health inequalities, tobacco and HIV. This learning process was part of the co-evolution toward complementarity.

Overall, I found that in all the countries of this sample health care and public health coevolved toward complementarity, though in very different ways, depending on the coupling of the health care and the public health sectors. In Australia and the UK, where both sectors mostly have been more tightly coupled, co-evolution occurred in an integrated way. Due to the rather centralized government and high professionalism, the governments put into place complementary policies in an encompassing way and with regard to many fields. Especially in the UK, many conflicts between the health care and the public health sectors accompanied this process and resulted in mutual learning. In the U.S., the two sectors coevolved independent from one another because until 2011 there was, in principle, no universal health care system, although a significant share of the population had access to Medicare and/or Medicaid or employer-paid health care plans. Particularly, the share of the latter decreased, especially during the 1980s, and the number of dependents in the public health care services increased. Nonetheless, the national and the state governments created health strategies that combined health care and public health, which resulted in the creation of a global health strategy. In Germany and Switzerland, the co-evolution of health care and public health toward complementarity was different because the two sectors were de-coupled or non-coupled due to the lack of actor responsiveness. In these countries, public health remained subordinate to individual health care because there was less responsiveness between the two sectors. Nonetheless, the governments in Germany and Switzerland also implemented complementary health policies due to diffusion processes, such as direct and indirect EU pressure and policy learning from other countries.

Coupling of health care and public health with other institutions

A second finding related to complementarity deals with the coupling of health care and public health with other institutions of the welfare state. In short, in countries where health care and public health were tightly or loosely coupled, health care was de-coupled

from other institutions of the welfare state. At the same time, in countries where health care and public health were de-coupled or non-coupled, health care was tightly or loosely coupled with other institutions of the welfare state, such as unemployment or retirement insurance.

As I explained before, coupling has traditionally been understood with regard to the connection of institutions in general and, more specifically, with regard to political economies (Benz, 2013; Hall and Soskice, 2001; Mayntz and Scharpf, 1995), European politics (Jachtenfuchs, 2001; Papadopoulos, 2007) and welfare states (Hemerijck and van Kersbergen, 1999). These authors have distinguished mostly a dichotomy between loosely and tightly coupled welfare states, institutions or political economies. To the contrary, I have used coupling in a more fine-grained way in order to also analyze the relationship between the sectors at the microlevel, such as the responsiveness between professions and interest groups. In a nutshell, my findings are that in Australia, the UK and the U.S., health care and public health have been tightly and loosely coupled, whereas in Germany and Switzerland the two sectors have been de-coupled and non-coupled, respectively.

However, my results are also interesting regarding the broader level of coupling, namely the connection of health to larger institutions. In Australia, the UK and the U.S., health care and public health were tightly and loosely coupled. This was the case even though Australia and the UK have a national health insurance and a national health service and the U.S. had, until 2011, a mostly private health care system (Wendt, Frisina and Rothgang, 2009; Böhm et al., 2013). In all the countries public health was a public matter, and the control of the state over health care policy increased continuously in the course of the twentieth century, although this process went faster in the UK than in Australia and the U.S. lagged behind. In these countries, health was a "benefit in kind" (Barr, 2012), which means the state took a crucial role in providing it. The U.S. was slightly different, but the principle remains the same. Consequently, health care and public health were tightly or loosely coupled, and the common policy output of the two sectors is high in the sense that policy integration appeared early on and in an encompassing way. At the same time, both countries have a liberal welfare state (Esping-Andersen, 1990) and a liberal market economy (Hall and Soskice, 2001). This entailed a de-coupling or non-coupling of health care from other social insurance pillars, which are organized as cash transfers, but in a very limited way compared to other political economies.

To the contrary, in Germany and Switzerland, which are conservative welfare states and liberal market economies, originally health insurance was part of the cash transfer system of social policies. In Germany and Switzerland, the founding principles of health policy was health insurance, which originally provided sickness benefits but did not pay for treatment. This changed considerably, of course, over the course of the twentieth century. Today, health insurance carriers pay above all for the treatment of sicknesses, and in Switzerland sickness benefits are even privatized. However, as a consequence, health care and health insurance were coupled with other social policiessuch as unemployment and accidental insurance, which also provide cash benefitsbut de-coupled from public health.

I explained this outcome by referring to the microlevel, arguing that the politicization of doctors in Germany was low and that they did not object to the introduction of a national health insurance but rather regarded this as an advantage. In Switzerland, although the medical profession resisted national legislation in the field of health insurance, it was involved in the voluntary and cantonal governance of health insurance. Consequently, the state made a deal with the medical profession and other interest groups, which then took the responsibility for health in general. The state withdrew from health policy, except for issues of public security, such as epidemics. Yet, the professions and interest groups involved in health care governance did not have the competences or interests to create health policy as a public health policy in the sense I defined it in chapter two (prevention and population focused). This had negative consequences for the political support of public health because the medical profession was mostly focused on individual health care. The extension of public responsibility in health care occurred as an expansion of individual health care.

10.3 Three types of co-evolution

Based on the discussion in this chapter, I conclude by defining three forms of co-evolution of policy sectors, which combine different configurations of the variables I examined in this thesis. These three forms of co-evolution are: integration, independence and subordination. It is important to note that these categories are analytical but do not imply a normative preference for the relationship between the two sectors or findings about the actual policy outcome of the sectorial co-evolution. The three conditions are not different in all the dimensions I presented here but, rather, have some overlaps, especially integration and independence. Nonetheless, the distinction between these three forms is important because they uncover important notions, especially the divide between private and public actors and the integrating function professions can have between the two.

Table 10.2 shows the distinction of the three forms of co-evolution. I constructed them based on the main variables I used in the theoretical and empirical analysis of this project. The first form of co-evolution is institutional integration and is based on my analysis of Australia and the UK. It entails a strong role of the state in the sense that health care and public health have been institutionally merged because health care regulation and financing are a public responsibility. The fact that in these countries the governments are rather centralized helped this development, although Australia lagged behind. The medical profession has been a strong private actor in the sense of the framework discussed in the theoretical section (Knoepfel, Larrue and Varone, 2011). Yet, due to the high professionalism, it was also very active politically and contributed to politicizing policy integration of health care and public health. However, there were also conflicts between professions and interest groups of the two sectors, especially about resources. The relationships between health and other institutions of the welfare state, such as unemployment or retirement insurance, have been de-coupled.

Table 10.2: Three types of co-evolution applied to health care and public health

Dimensions	Integration	Independence	Subordination
Empirical examples	*Australia, UK*	*U.S.*	*Germany, Switzerland*
Health insurance type	National Health Service, National Health Insurance	Private Health Insurance	Social Health Insurance
Actor triangle	Medical profession private actor	Medical profession private actor, strong public health profession	Medical profession politico-administrative actor
Coupling of HC and PH	Tight coupling (Loose coupling)	Loose coupling	De-coupling; Non-coupling
Policy integration on agenda due to	Responsiveness between sectors	Responsiveness between sectors	Policy diffusion
Professionalism	High → Politically active professions	High → Politically active professions	Low → Professions administratively active
Government	Unitary government, Centralized federalism	decentralized federation	centralized federalism, decentralized federalism
Coupling to other institutions in social policy	De-coupled	De-coupled (Loosely coupled)	Tightly or loosely coupled

Independence is the second type of co-evolution. It is different from integration because the role of the state is much weaker with regard to the regulation, provision and financing of health care, and the competences for policymaking are decentralized. At the same time, the medical profession can also be considered a private actor and politically active, which implies that it plays an important role in politicizing the integration of the two sectors at the policy level. However, in the case of the U.S., this did not lead to immediate policy integration due to the many veto points at the national level. What is more, the connection between health and other institutions of the welfare state was limited, although it is possible to argue that the limited cash transfers of the liberal welfare state were similar to the presence of a private health care insurance. However, along with the increase of publicly funded and provided health care, the coupling of health care and public health became tighter.

The third form of co-evolution is subordination. In short, this form entails the relationship between the two sectors occurs in a different way, which disconnects health care from public health and establishes the governance of a national health policy from the idea of transferring cash to compensate for income losses and pay for treatment rather than providing health as a benefiteither individual care or population-focused prevention, which was the case particularly in countries with integrated co-evolution. In these countries, social health insurance was established, but, especially in Germany, the medical profession became part of the politico-administrative group in the actor triangle because,

together with other interest groups, it participated in the autonomous rule making on the regulation and financing of health care. Consequently, it did not act as a private pressure group that defended its own material interests and advocated public health activities. I made the point that this inactivity had its roots in the low professionalism in these countries. Concerning the relationship with other institutions of the welfare state, in these countries health care has been coupled with the principle of other social insurance pillars but de-coupled from public health.

Again, this distinction is in a way ideally typical and extracts dominant forms of the relationship between the two sectors. However, overlaps are possible in the empirical reality, but based on my empirical analysis, I was able to extract a dominant form of co-evolution in each of the case studies I conducted. These findings are important theoretically and make a contribution to the institutionalist literature, as well as to the research on comparative public policy. What is more, these types of co-evolution are a programmatic statement for further research and could be applied to different problems and contexts for the coordination of policy sectors. This, as well as other issues, will be discussed in the following and concluding chapter.

Chapter 11

Conclusion

This thesis project combined the analysis of an important theoretical and empirical problem. To begin with the latter, I looked at the co-evolution of health care and public health, which are two sectors whose coordination is important for many current health problems, such as infections and non-communicable diseases, but also the relation of inequality and health. To approach complex health problems, it is important to connect individual health care and population-based preventive health policies because they provide interventions at different points in time of the course of the disease. In political science, individual health care received a lot attention, particularly from a comparative perspective (Böhm et al., 2013; Blank and Burau, 2007; Freeman and Moran, 2000; Freeman and Rothgang, 2010; Moran, 1992; Moran, 1999; Rothgang, 2010; Tuohy, 1999). However, the connection of individual health care to preventive health policy has been neglected. Interestingly, several authors have argued that there is a demand for a more political science-oriented approach to the study of public health, including prevention and health promotion (Bernier and Clavier, 2011; Mayes and Oliver, 2012; Clavier and de Leeuw, 2013). Since these two sectors focus on a similar goal, namely to provide health, they are a good example to analyze the theoretical problem in which I am interested, which is the co-evolution of policy sectors.

The theoretical problem on which I have been focusing is the co-evolution of policy sectors, including its micro-foundation, and especially the role of professions. For quite some time, researchers have demanded that it is important to generate more coordination between policy sectors (Peters, 1998). This is true, because cross-sectorial and "wicked" policy problems need more coordination between existing policy sectors, such as health, domestic security, energy and environmental regulations. Recent developments in the literature have approached these problems conceptually (6, 2004; Jochim and May, 2010; Varone et al., 2013). However, two main issues remained. First, comparative analyses of the coordination of policy sectors are lacking. Second, the historical dimension of the coordination of policy sectors merits better analysis in order to understand how policy sectors co-evolved and whether or not the temporal dimension contains any lessons for the coordination of the two sectors. Yet, to grasp the co-evolution of policy sectors, it

is important to look at the micro-foundation of the relation between the two fields and combine them with an analysis of their historical development.

To conceptualize my argument, I used theories from comparative public policy analysis, educational science, sociology of professions and federalism. I argued that the relationship between policy sectors can be described by a different form of coupling, especially four forms of coupling: Tight coupling, loose coupling, de-coupling and non-coupling. In short, these are different configurations of distinctiveness or integration between the institutions of the two sectors and the responsiveness between actors and interest groups, as well as policies. I argued that the type of coupling depends on unified government and professionalism, as well as contextual elements. My comparative analysis of five countries showed that high professionalism leads to the coordination and common advocacy of professions and interest groups, whereas unitary government and a centralized version of federalism cause more institutional integration of the two sectors. Tight and loose coupling coincide with more policy integration of health care and public health, due to common policy advocacy. However, in countries without a politically active medical profession, policymakers adopted ideas about policy integration from other countries. Eventually, the last findings imply that the health care and the public health sector co-evolved toward complementarity (i.e. policy integration), similar to other institutions, independent of the coupling between the two sectors.

In this section, I will focus on the limits and the general lessons for political science research, as well as policy outputs and outcomes. In the following section, I start with an elaboration of the limitations of my approach. Then I will turn to a discussion of my thesis' contributions to political science research in general before concluding with an analysis of policy outputs and outcomes including a reflection on the optimal combination of health care and public health.

11.1 Limitations of the approach

Like any other research project, this project has limitations and shortcomings that need to be addressed before proceeding with the lessons that we learned in general from this analysis for political science research. First, the ambition of this research project, in terms of the scope of the empirical analysis, is vast. An analysis of five countries over a very long time period is a lot and shortcomings arise in the detail of the analysis. This is not surprising and must be done with respect to many research projects in political science. However, for this project, it is necessary to discuss this problem. There are two main shortcomings in particular that need to be addressed:

1. The unit of analysis are policy sectors, namely health care and public health. Each sector assembles a number of policies, such as health insurance matters, pharmaceutical policy and hospital construction and maintenance on the side of health care; concerning public health, these include food safety and immunizations, but also HIV and tobacco control policy. I then analyzed the co-evolution of the two

sectors between 1850 and 2010, focusing on the main developments in each of these sectors and their coupling. My analysis explicitly entailed an examination of actor responsiveness and policy integration between the two fields. Such a research design and strategy for the empirical analysis is unusual for comparative public policy analyses because these approaches normally focus on one specific policy and compare it in different countries or even focus on comparing different policies in similar countries. Thereby, authors provide a detailed and focused analysis of the actor constellations and decision-making processes (Dodds, 2012; Knoepfel, Larrue and Varone, 2011; Kübler and de Maillard, 2009; Rose, 2004). In contrast to this type of analysis, my examination of the co-evolution of the health care and the public health sector is much more reductionistic and focuses more on macro-developments, very similar to analyses in comparative politics (Boix and Stokes, 2007; Caramani, 2011). Since my definition of a policy sector is very broad, I focus on the key development in each field. Regarding health care, this is mostly, but not only, health insurance policy and, with regard to public health general health policy legislation, tobacco and HIV, as well as policies that integrate both policy sectors, such as strategies against cancer, for example. Due to the rather large definition of my subject, my analysis does not have the same depth as other studies of comparative public policy. Nonetheless, it provides interesting insights for the political science literature in general, which I will discuss in the following section.

2. The second shortcoming is a methodological one. Since my analysis covers the co-evolution of policy sectors in five countries over a long time period based on interviews, documents and secondary literature, there is a significant asymmetry of information available between countries and time frames. First, I only have interviews for three countries - Australia, Germany and Switzerland. Second, the interviews cover, above all, the most recent time period (after 1980), at most until the World War II. I have less material on the pre-World War II period because I have to rely on secondary literature since it is difficult to research sources that are lacking online, which was possible for the post-World War period. Nonetheless, I performed an encompassing search for the secondary literature and I had access to the necessary references by interlibrary loan for the European and U.S. titles. Regarding Australia, it was more difficult to access the main books, but I was able to read them during a research stay at the National Library of Australia in Canberra. These restrictions on my empirical research must be considered when interpreting the results.

11.2 Implications for political science research

Despite the mentioned limitations, my analysis contributes to the political science literature in a more general way beyond the co-evolution of health care and public health.

Notably, there are two important points: First, my results show that the political activism of professions is important for the emergence and co-evolution of institutions. Second, I propose an analytical framework for the comparative analysis of the coordination of policy sectors.

11.2.1 Professional activism

The first general contribution of my results to the political science literature concerns the impact of political activity of professions on the development on institutions. In the historical institutionalist literature, the authors have put their focus on the historical dimension of the emergence and evolution of institutions for 25 years or more. Mostly, the focus of these studies either had to do with reactive sequences of institutional development (Skocpol, 1979; Mahoney, 2000), or increasing returns (Pierson, 2000; Pierson, 2004). More recent contributions to the historical institutionalist literature have been focusing on the continuous changes of institutions and their determinants (Streeck and Thelen, 2005; Mahoney and Thelen, 2010), or even have been referring to an evolutionary process of single institutions (Thelen, 2004), or entire states (Steinmo, 2010). Another strand of the institutionalist literature has focused on institutional complementarities (Crouch et al., 2005) and the co-evolution of different institutional configurations (Trampusch, 2010; Thelen, 2014). However, these works primarily focus on the dimension of political economies and often review certain institutions and the development without contextualizing them with other institutions that provide the same good, but in a fundamentally different way.

From a historical institutionalist point of view, this project is innovative because it improves our understanding of the micro-foundations of the theory. Specifically, my analysis connects the development of institutions and policies to the preference and the political activism of the medical and the public health professions and their relation. Rather than underlining differences in the specialization of health professionals (Döhler, 1993), my analysis takes into consideration to what extent the professionalism impacts the coupling of institutions. In other words, I showed that, in countries where the membership in a profession, it is important for individuals to achieve recognition and economic security (Freidson, 1983, 23-26)(Rueschemeyer, 1973*a*, 63-122) because a vocational training system is lacking (Hall and Soskice, 2001).

Therefore, professional organizations are politically more active in these countries because they advocate the needs of their members. What is more, they play an important role for the way in which institutions emerge and relate to other sectors. For example, my analysis shows that countries with high professionalism are resistant to the medical profession against universal health care - especially in Australia and the U.S. and support thereof in the UK, but at the same time, they advocated public health policies and demanded more state action in health-related areas. Consequently, professions played an important role for more public responsibility in these countries, which have a liberal welfare state and a liberal market economy. To the contrary, in countries with low professionalism, professional organizations were less politically active and, rather, played an administrative

role, whereas political parties were more important for politicizing problems.

What is more, in countries with high professionalism, professional organizations have played an important role for the adaptation of institutions and policies to new problems. Due to the scientific background, they have been sensitive to new problems and innovative solutions to them, such as, for example, if they are based on research. Politically active professions have been more inclined to absorb these ideas not only scientifically, but have also made them a part of their political agenda. Therefore, they have contributed to the change and adaptation of political institutions or its absence, as I showed concerning the return of public health policies in the 1980s in countries with high professionalism.

Therefore, my arguments add a more actor-centered dimension to the historical institutionalist literature. Specifically, my analysis shows how professions had an impact on the politicization of important problems in health policy. Whereas my analysis underlined, above all, the importance of the medical profession and its role in relation to the state for the co-evolution of health care and public health, it would be interesting to conduct similar studies for other professions, such as the legal sector, (Surdez, 2005) from a comparative perspective. This would greatly improve our understanding of the emergence and evolution of modern states.

On the other hand, my results contribute to the literature on professions and the sociology of professions (Abbott, 1988; Abbott, 2005; Barber, 1963; Carline and Patterson, 2003; Dingwall and Lewis, 1983; Döhler, 1993; Heinz and Laumann, 1978; Macdonald, 1995; Rodwin, 2011; Rueschemeyer, 1973*b*; Saks, 1995; Surdez, 2005; Dingwall and Lewis, 1983) with an analysis that shows how professional organizations contributed in an active way to creating public policies. Rather than focusing only on the conflicts of interest of doctors between public and private interests (Rodwin, 2011) or the evolution of the struggle of the medical profession and the state (Hassenteufel, 1997), I showed that doctors' political activism had a positive effect on public health policymaking. I demonstrated that, in countries where the economy is more liberalized and cash transfers of the welfare state are weak, doctors play an important role for advocating more state action. Put in the words of the literature on the sociology of professions, in Australia, the UK and the U.S., the liberal economy came along with "free professions" that had protected, but free, labor markets, whereas in Germany and Switzerland, there were "professions of office" in a more coordinated market economy (Rodwin, 2011, 321). My results show that free professions were politically more active and played an important role for how policies and institutions were especially connected with one another, whereas in the latter countries this was less the case.

11.2.2 Coupling of policy sectors

The second contribution of this thesis to political science research is to public policy analysis, especially by presenting a concept to compare the coordination of policy sectors. Harkening back to the work by Karl Weick (Orton and Weick, 1990), I proposed different degrees of sectorial coupling. Particularly, I distinguished loose coupling, which refers to

the presence of sectorial distinctiveness, such as institutional integration, and at the same time responsiveness between actors and policies. Tight coupling referred to the absence of distinctiveness but the presence of responsiveness. On the other hand, policy sectors are de-coupled when there is a presence of distinctiveness and an absence of responsiveness, whereas they are non-coupled when there is no distinctiveness and no responsiveness. I used this distinction to understand the co-evolution of the health care and the public health sector.

Apart from its contribution to the analysis of health care, coupling can be used for the comparative analysis of horizontal relations between policy sectors in other contexts. Recent theoretical contributions emphasized that the connection of policy sectors can take the form of regimes, specifically boundary-spanning-policy regimes, which entail a certain strength and durability concerning the integration of different fields. They are comprised of issues such as drug policy, pollution abatement or the aforementioned homeland security example (Jochim and May, 2010). More recently, the concept of functional regulatory spaces built on this problem and added a territorial, as well as a federal, dimension, arguing that we need to understand public policymaking in a three-dimensional space combining different policy sectors, different levels of government and territories (Varone et al., 2013). However, this literature falls short on describing different degrees in the connection on policy sectors, and their changes over time. For instance, in decentralized countries there should be a different type of boundary-spanning policy regime than in centralized nations. The concept of coupling could amend these concepts and use them in a comparative manner.

With regard to the empirical applicability, coupling could be used with regard to other examples where the connection of policy sectors is necessary in order to provide a certain good. To do this, it is always necessary to start from a specific problem; in the case of this thesis, it was health, but it might be less obvious when it comes to the coupling of different sectors. In the following, I will discuss two examples in which the concept of coupling, as well as the historical perspective, could be used in a fruitful way:

1. Firstly, homeland security and politics of domestic security have become an important issue of the domestic political agendas and for research in political science. The problem has been researched with regard to various countries, in case studies (May, Sapotichne and Workman, 2009; May, Jochim and Sapotichne, 2011; Wolf and Pfohl, 2014) as well as in cross-national studies (Wenzelburger, 2013). Homeland security involves various types of policy sectors that can possibly be involved. For instance, in the case of the U.S., these are various sectors or subsystems, which take part in the provision of homeland security (May, Jochim and Sapotichne, 2011). A comparative study of countries and the degrees of coupling between involved policy sectors, as well as the levels of government, could contribute to our understanding of the presence or absence of institutional cohesiveness on the one hand and the responsiveness and interaction between actors on the other.

2. A second issue that could benefit from the study of the coupling of policy sectors is environmental policy. Environmental policy is a largely studied issue with regard to the integration of policy sectors (Lenschow, 2002), as well as coordination (Lafferty and Hovden, 2003; Jordan and Lenschow, 2010) between policy sectors; respectively, the levels of governments and countries (Varone et al., 2013). In that sense, coupling could advance our understanding of environmental policies because it would help to shed light on the distinctiveness of policy sectors that are included in environmental policymaking, as well as levels of government. What is more, it could provide more insights on the relevant dimensions of integration, such as institutional distinctiveness and actor - as well as policy - responsiveness in environmental policy. However, this is a task for future research.

In addition to coupling, this thesis contributed the idea of co-evolution to the comparative public policy literature. My analysis demonstrated that two policy sectors, which emerged randomly, co-evolved toward complementarity; that is, the coordination of both fields to improve the common output, similar to the way in which the literature on institutional complementarity had demonstrated it regarding capitalist institutions (Boyer, 2005; Crouch et al., 2005). Transferring the idea of co-evolution to other policy sectors would be an important contribution to comparing the long-term dynamics in comparative public policy in general.

11.3 Policy implications

So far, my analysis has focused on the long-term development of health care and public health institutions and actor constellations, especially the political activity of professions, as well as policy integration. In the following section, I will summarize my results concerning policy integration and then turn to more policy output for public health and health care, as well as health outcomes, in order to analyze whether the coupling of the two sectors makes a difference for population health. I will conclude with a discussion about challenges for the combination of the two sectors.

11.3.1 Policy output

So far, my analysis comprised of the coupling of health care and public health and public health from an institutional- and actor-centered perspective. This analysis included policy integration of the two sectors. In the following, I will revise my findings concerning policy integration and then scrutinize more policy outputs in the public health and the health care sectors. Concerning public health, I will examine tobacco control, immunization and cancer screening. On the side of health care, I am going to take into account the number of practicing physicians and hospital beds.

Policy integration: My results on policy integration have shown that there are differences between the countries. On the one hand, for Australia, UK and U.S., I found

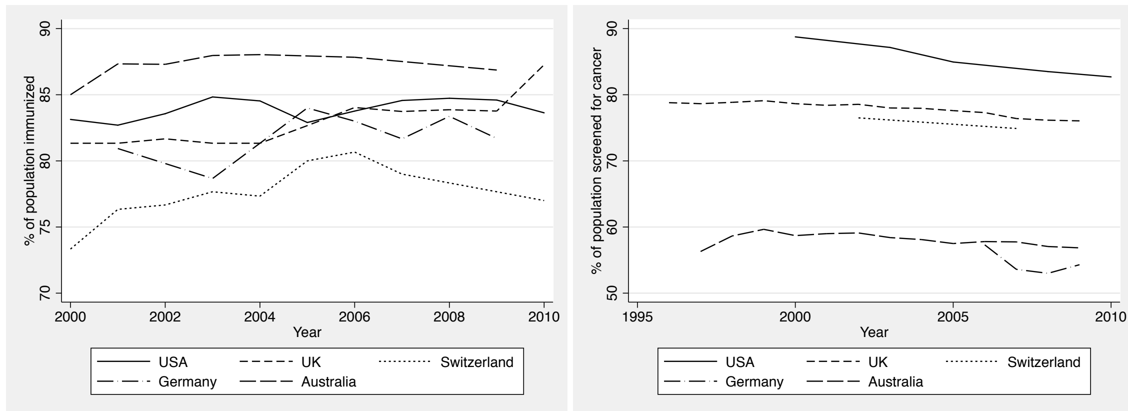
more evidence for policy integration due to responsiveness between actors and interest groups; however, the results between the countries differ. Especially in Australia, the national and the state governments adopted a wide array of strategies that integrated prevention and individual care, such as for cancer and diabetes, but also risk factors such as tobacco and alcohol. What is more, in 2009, the national government passed an Australian preventive health strategy that focused more on preventive health. In the UK, the government had already implemented public health strategies in the 1980s, but actual policy integration occurred especially after 1997, when the Blair government was elected and emphasized the relation of inequality and health, which entailed measures to prevent and cure diseases. In the U.S., the situation was different, in that the national government has also adopted strategies to improve public health, but that its means to implement them have remained limited in comparison to the UK and Australia. The reason for this is that, until 2011, it did not have the power to regulate and pay for universal health care - it could only do so for indigent groups. Concerning all policies, the division of government at the national level created problems in passing more encompassing health policies. Yet, professional activism has remained high and medical and public health professionals have demanded more policy integration. On the contrary, in Germany and Switzerland, policy integration occurred by means of diffusion. In Germany, the subnational governments adopted the first strategies during the 1990s, which aimed at specific health problems, and the national government followed. Other than in Australia, the UK and the U.S., these reforms were the consequence of a diffusion and a learning process from other countries. On the other hand, in Switzerland health policy is much more decentralized and national health strategies have only recently been produced that combine measures of cure and prevention. In this process, the coordination of the cantonal and the national government played an important role.

In order to provide more information on policy output, I will now turn to some specific policies in the area of health care and public health. Concerning public health, I am focusing on three specific policy areas that are important for public health policy. First, tobacco control policy, which aims to change individual behaviors and lifestyle; second, control and prevention of infectious diseases, by looking at immunization rates and third, secondary prevention, especially cancer screening (Allin et al., 2004). In addition, I complement the information by showing differences in health care policy outputs, namely doctors and hospital beds. The information concerning tobacco control policies comes from the comparative tobacco control scale for the EU members (Raw and Joossens, 2010*a*; Raw and Joossens, 2010*b*; Raw and Joossens, 2006) and from secondary literature for the case of Australia and the U.S. For the other policy areas, the information is taken from the OECD database on health policy (OECD, 2013). Thereby, this analysis is not a test of a hypothesis, but rather the connection of differences in sectorial coupling to policy outputs in the five countries under observation in this thesis. The discussion of the results are, rather, more hypothesis-generating than testing in nature, and it will be necessary to do further analyses on this problem based on more data and other countries.

According to the aforementioned case studies, I am assuming that countries that have tight coupling of health care and public health should be more successful regarding public health policymaking than countries where public health and health care are de-coupled or non-coupled. In the former, the domestic coalition of professions is more open to public health regulation. With regard to loose coupling of health care and public health, there should also be a positive effect on public health policymaking. Similar to countries with tight coupling of the two sectors, interest groups and professions are politically active. However, there are many veto possibilities at the national level, which could have a negative impact on health policy output.

Tobacco control: The first area of public health policy on which I am focusing is tobacco control. In order to compare the countries that are under observation in this thesis, I am taking information from the comparative tobacco control scale that has been published by Raw and Joosens (Raw and Joossens, 2010*a*; Raw and Joossens, 2010*b*; Raw and Joossens, 2006). The report contains a ranking of tobacco control policies in European countries, based on advertisement restrictions, compliance with smoke-free legislation, labeling restrictions, budget for tobacco control, cigarette prices and the treatment of tobacco addiction. The information was collected based on an expert survey in each country. The results of the 2013 sample place the UK in the number one position (2010: 1; 2007: 1; 2005: 2; 2004: 2), Switzerland in the 18th position (2010: 11; 2007: 18; 2005: 24; 2004: 21), and Germany in the 33rd position (2010: 26; 2007: 27; 2005: 22; 2004: 21) out of 34 countries (Raw and Joossens, 2010*a*; Raw and Joossens, 2010*b*; Raw and Joossens, 2006). The scale does not contain information on Australia, but the country has one of the strictest anti-smoking regimes in the world, entailing a ban of printed advertisement since 1992, plain packaging legislation, and very high tobacco prices. This indicates that the country should be ranked similarly to the UK (WHO, 2012). With regard to the U.S., the evaluation is more difficult, as tobacco control policy evolved bottom-up, from the cities to the state and, from there, on to the national government (Shipan and Volden, 2008). However, more recent research shows that there is coordination of the cantonal tobacco control policies, due to the advocacy of professional organizations and interests groups (Studlar, 2014). Consequently, the U.S. has a less restrictive tobacco control regime than the UK and Australia, but is ranked above Switzerland and Germany. Switzerland received good evaluations of its tobacco control regime, but the main difference from the U.S. is that the professional support is lacking and, therefore, there is no lasting pressure on policymakers. The results on tobacco control policymaking supports my hypothesis that, in countries with tight and loose coupling of health care and public health, it is more likely that public health policies are passed.

Immunization and screening: The second dimension of public health policymaking refers to immunization and screening. Figure 11.1 shows information on two other areas of public health policy, namely action against infectious diseases and screening for cancer. Based on OECD data, the figure on the left side shows the average immunization rates



(a) % of the population immunized (b) % of the population screened for cancer

Figure 11.1: Immunization and screening

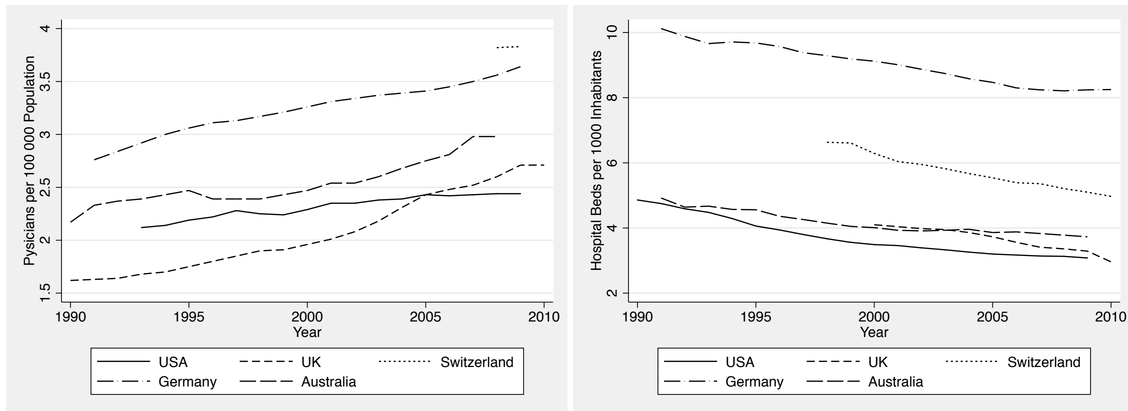
for childhood disease, measles and influenza (OECD, 2013).[1] Again, differences become apparent between the countries. Australia has the highest share of the immunized population, followed by the U.S. and the UK. In Germany, immunization rates are just a little bit lower than in the UK, whereas much less people are immunized in Switzerland.

This pattern is somewhat similar to tobacco control policy and confirms my hypothesis regarding the impact of sectorial co-evolution on public health policymaking: Countries with tight or loose coupling of health care and public health perform better with regard to public health policy outputs than countries where health care and public health are de-coupled. However, the differences are not as clear, as in the case of tobacco control policy. This makes sense because these are more medicalized public health policies than tobacco control or alcohol policies. In Germany and Switzerland, where both sectors are de-coupled, public health policies are difficult to implement if they are less related to medical issues such as tobacco and alcohol policy. With regard to screening, the picture is slightly different. Here the graph shows the average percentage of mammography screening and screening for cervical cancer.[2] The results show a slightly different picture. The U.S. and the UK are again on top, followed by Switzerland, whereas Germany and Australia have lower degrees of cancer screening. The difference between the UK and the U.S. on the one hand and Germany on the other hand seems to follow the hypothesis that I outlined before, but in this instance, the Swiss case performs considerably better than Germany and Australia. In Germany, there has been an ongoing debate about the impact of mammography screening programs.[3] Similarly, in Australia, screening programs had been established early on, but their frequency had been reduced after doubts had been cast on their effectiveness (Int-AUS-12).

Health care resources: In the theoretical section, I have been arguing that tight

[1]The graph contains the average of children immunized against Diphteria, Tetanus and Pertussis, the percent of children immunized against measles, as well as the percentage of the population over 65 immunized against Influenza.

[2]The graph contains the average of 50-69 who underwent mammography screening and women between 20 and 69 who were examined for cervical cancer. Though for Germany, the information for cervical cancer



(a) Physicians per 100 000 inhabitants

(b) Hospital beds per 1000 inhabitants

Figure 11.2: Number of doctors and hospital capacities

coupling of health care and public health comes along with more output in public health policymaking. This argument implies that, on the contrary, in countries with a de-coupling of the health care and the public health sector, there should be more health care policy output. To illustrate this point, I will now discuss the policy output of the health care sector, namely the number of practicing physicians and hospital beds, because these are the most basic functions of the health care sector and, therefore, are an important indicator. Figure 11.2 shows the policies in the health care sector, namely the number of doctors and hospital beds, based on OECD data (OECD, 2013). On the left side of figure 11.2 there is the number of physicians in the population from 1990 to 2010. For Switzerland, there is not much data available in the OECD database. The graph shows a clear pattern, namely that Germany and Switzerland have more doctors than Australia, UK and the U.S. The right side of the figure confirms this finding, showing data for the distribution of hospital beds, which reveals a similar pattern of differences between Germany and Switzerland on the one hand, and Australia, UK and the U.S. on the other. In the light of the argument I made before, this evaluation supports my hypothesis because it shows that a de-coupling of health care and public health leads to more health care policy output. Of course the analysis presented here is only a first indication and needs to be confirmed by using more cases and more formal methods, such as econometric analysis of time-series data.

This brief overview of policy output in different countries supports my hypothesis that there is a connection between the coupling of the health care and the public health sector, as well as the respective policy output. The review of three different fields of health policy shows that there is a pattern of public health policymaking that occurs along with the differences of institutional co-evolution of the health care and the public health sector. Overall, Australia, the UK and the U.S. perform better with regard to public health policymaking, whereas Germany and Switzerland are less active in this area. On the other hand, in Germany and Switzerland, where health care and public health

screening is missing, as is the information regarding mammography screening in Switzerland.

[3]FAZ March 12, April 30, May 05, May 29, July 21, 2014.

are de-coupled, there are more doctors and hospital beds available, which highlights the dominance of health care. These findings support my hypothesis regarding policy output of the coupling of health care and public health and encourage further analysis with regard to this dimension.

11.3.2 Challenges and possibilities for the coordination of health care and public health

In the beginning of this thesis, I started with the statement that health care and public health are two important dimensions in health policy, which somehow need to work together in order to provide health in an optimal way. After reviewing the co-evolution of these two sectors in five countries, I am now taking a moment to pose the question of whether there is an optimal combination of health care and public health. Based on the analysis I did in this thesis, it is neither possible to discuss the ideal combination with regard to the best health outcomes nor determine which is the best cost-efficient solution. However, it is possible to draw some conclusions concerning conditions that need to be reached in order to fulfill the most necessary functions of both sectors.

In order to develop these conditions, I need to take into consideration two different scenarios, namely the issue of infectious diseases on the one hand and non-communicable diseases on the other. The former refers to bacteria or viruses, which spread quickly and lead to sickness and possibly a quick death. On the other hand, there are non-communicable diseases, such as heart attack, cancer and diabetes, which occur either by genetic disposition or by increased risk factors, such as age and education, but also behavioral elements, as the consumption of tobacco, alcohol and too much fat and sugar. In the theoretical section, I discussed pure and overlapping dimensions of the health care and public health sector. Table 2.1 presents health care and public health understood as a two-by-two table, which distinguishes an individual-based and population-based dimension, as well as a curative and preventive dimension of health care and public health. Consequently, I identified pure health care (individual and sickness focused) and public health (population and health-hazard focused) and overlapping dimensions, specifically population-wide treatments and individual health counseling. In order to determine existing combinations of health care and public health, I refer back to these two dimensions. Table 11.1 shows the conditions that need to be fulfilled in order to respond to non-communicable and infectious diseases. Under each line, I am presenting the expected performance for each of the discussed configurations of the health care and the public health sector.

In the presentation of the table, it becomes clear that there are differences with regard to the expected provision of different functions with respect to the balance of health care and public health in different systems. In the upper-left field, I am evaluating the conditions that need to be fulfilled in order to provide the health care function in a good way. Beginning with infectious diseases (2.1), I am arguing that, in order to provide this function, it is necessary to have a network of doctors, nurses and health care facilities, as well as the availability of the necessary pharmaceutical technology and affordable health

Table 11.1: Challenges and possibilities for the coordination of health care and public health

	Sickness	**Health-hazard**
Individual-based	**1.1** *Infectious diseases:* Network of doctors, nurses and hospitals; medical and pharmaceutical technology; financing and availability of health care services	**2.1** *Infectious diseases:* Provision of immunization services; Health counseling either by doctors or public health officers
Order of hypothetical fit	*Well established in all systems*	*(Theoretically) well established in all systems*
	1.2 *Non-communicable diseases:* Network of doctors, nurses and hospitals; medical and pharmaceutical technology; financing and availability of health care services	**2.2** *Non-communicable diseases:* More possibilities for doctors and other health professionals to bill preventive activity; incentives for patients to follow them, financially or ideally; coordination of medical doctors and non-medical approaches
Order of hypothetical fit	*(1) De-coupling; (2) loose coupling; (3) tight coupling*	*Problematic in all systems - (1) Tight coupling; (2) loose coupling; (3) de-coupling*
Population-based	**3.1** *Infectious diseases:* Coordination of private, public and not-for-profit health care facilities; Coordination between levels of government and regions; professionalized and well trained health professionals; functioning public administration; national epidemic legislation; coordination of units on a national level	**4.1** *Infectious diseases:* National public health laws regarding food safety, waste disposal, quarantine; immunization programs; coordinated national response units in case of epidemics; coordinated national response centers
Order of hypothetical fit	*(1) Tight coupling; (2) loose coupling; (3) de-coupling*	*(Theoretically) well established in all systems*
	3.2 *Non-communicable diseases:* Wide availability of sophisticated medication and technology to treat complex health conditions, such as cancers or diabetes on a population level; problems of equity become important	**4.2** *Non-communicable diseases:* Laws and education concerning risk factors (alcohol, tobacco, malnutrition); regulations of companies; availability and promotion of non-medical elements of health education and policy on a population wide dimension
Order of hypothetical fit	*(1) De-coupling; (2) tight coupling; (3) loose coupling*	*(1) Tight coupling; (2) loose coupling; (3) de-coupling*

care services. Based on the analysis I performed, I am concluding that, in the countries I analyzed, I am expecting to find good performance with regard to the provision of health care. The same holds for the prevention of infectious disease at an individual level (2.1), although there are different ways, in which this function would be provided. On the one hand, it could be done by medical doctors; another way would be health education by public health officers. With regard to the treatment of non-communicable diseases, such as cancer or diabetes, which basically need the same facilities and structures (in the way they are discussed here) as the treatment of infectious diseases, although treatments in this case are much more expensive. Therefore, I am expecting better performance with regard to the treatment-side in countries where health care and public health are de-coupled than in those countries where both sectors are loosely or tightly coupled because there public health gets more attention. On the other hand, however, prevention and treatment are closely linked with regard to non-communicable diseases. For instance, the treatment of a cancer should be connected to activities to prevent further metastasis, but in order to do something like this ideally there should be a possibility for doctors to prescribe and perform preventive activities for the patient. Possibilities for such measures would be managed care programs, which already exist in some countries, whereas in others they are more difficult to implement (i.e., Switzerland). Judging from the general historical analysis that I performed, I would expect to find the coordination of prevention and cure in order to prevent non-communicable diseases, especially in countries with tight and loose coupling of public health, because in those cases there is more interaction of both sectors at the level of actors and professions.

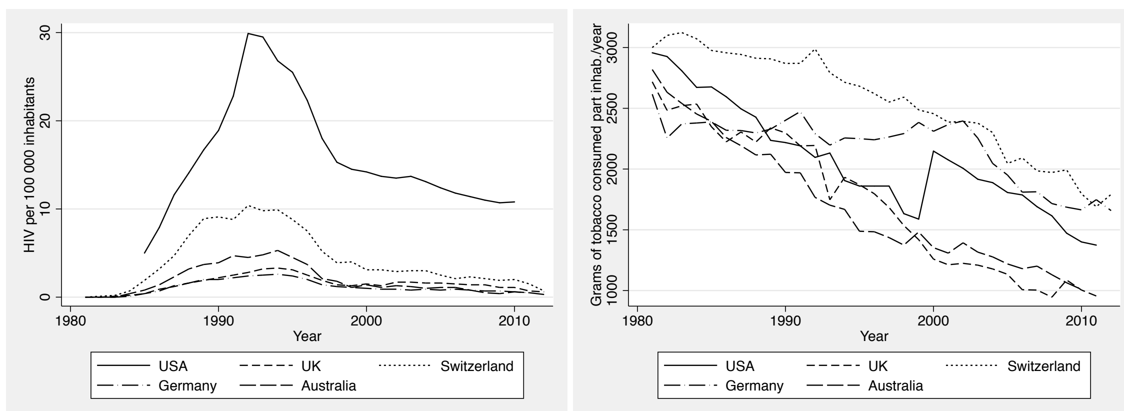
Quadrants three and four refer to population-based policies, distinguishing again activities that are sickness-based and those that are health-hazard related for the two types of diseases that I distinguished. With regard to the treatment of infectious diseases on a population level, it is necessary to coordinate public, private as well as not-for-profit actors in order to achieve the treatment of groups or even populations on a certain territory. What is more, it is necessary to have professionalized and well trained doctors and public health professionals who can deal with the challenges of such diseases and do not make mistakes, which may have serious consequences for the health of an entire population. Based on the historical analysis in this thesis, I am expecting to find the best performance with regard to this problem in countries where health care and public health are tightly coupled because institutional integration between both sectors should be established and, at the same time, there is interaction between professions in the sense that they both are able and willing to work towards public health services. In the second place, I put loose coupling of both sectors, because this entails professional interaction but institutional separation. However, I am supposing that in this case coordination is nonetheless easy, especially if the problem pressure gets very high, because these actors are willing and able to perform a coordinating function. On the contrary, in countries with de-coupling of health care and public health, it is not only the lack of institutional integration, but also the relation of actors in both sectors, that is undeveloped. As a consequence, the coordination for the

provision of population-wide treatment is rather problematic. However, in none of the countries that are under review in this thesis was there the need to react to coordinate population-wide treatment of an epidemic with several thousand patients - apart from HIV. Yet from the disease's outbreak in the early 1980s until the late 1990s, treatment was only possible through the containment of the virus because effective antiretroviral medication was not available before the late 1990s (Piot, 2011). Field 4.1 refers to the prevention of infectious diseases on a population level. As I showed in the case studies, the necessary conditions to provide this function are national public health laws regarding food safety, waste disposal, quarantine and immunization. What is more, it is necessary to have coordinated national response units that are able to isolate infected individuals early on in order to avoid the spread of the disease. The prevention function should be well developed in all of the countries under review; however, the more institutionally separated both sectors are and the less they respond on the actor level, the more complicated it gets with regard to coordinating preventive activities if necessary.

The second example that I introduced in this chapter concerns non-communicable diseases. When referring to the treatment of this problem at a population-wide level (3.2), it is necessary to have the elements outlined in section 1.2, yet, in addition, it becomes important to provide them on a population-wide level. At this moment, questions of equity become very important, namely in the sense of who has access to services of treatment and who will not be able to get them (Braun and Uhlmann, 2009). If we look only at the treatment side, de-coupling of health care and public health should be sufficient to perform the function in the sense that it works better than tight and loose coupling of the health care and the public health sector. However, with regard to the prevention of non-communicable diseases (4.2) I am expecting differences with regard to the performance. The necessary functions in that regard would be the presence of laws and education regarding risk factors (tobacco, alcohol and malnutrition), as well as regulation of companies producing "health endangering" goods. What is more, it would be necessary to have population-wide promotions of non-medical elements of health promotion, such as encouragement to eat better and move more. With regard to the models of coupling of health care and public health, I am expecting that tight and loose coupling perform better, due to professional responsiveness, whereas in the case of sectorial de-coupling this should function considerably worse.

11.3.3 Policy outcomes

Apart from the policy output, another interesting question concerns health outcomes, especially if different forms of sectorial coupling have led to different outcomes regarding population health. In the following, I will focus on some figures that describe the state of the population's health at the national level. I am especially focusing on HIV infections and tobacco consumption as well as cancer mortality and overall mortality. I chose these indicators because they are related to the policies that I discussed before or give an overall impression of the state of the population's health. Tobacco and HIV were two of the



(a) HIV incidences per 100 000 inhabitants (b) Grams of tobacco consumed part inhab./year

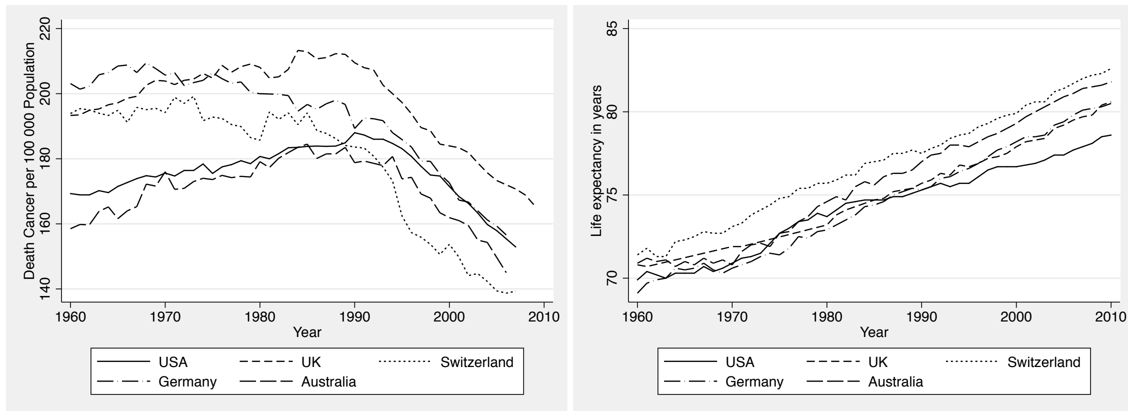
Figure 11.3: HIV incidences and tobacco consumption

examples that I used in the text to explain responsiveness between professions and interest groups of the two sectors. On the other hand, cancer mortality shows a key health problem and overall life expectancy takes into account the general state of longevity in a country.[4]

The results concerning HIV and tobacco show that the countries in this sample do not entirely follow the pattern of coupling that I outlined before. Beginning with the AIDS epidemic, the figure shows that, in all countries the governments sought to reduce the rate of infection. The main difference between the countries is that the U.S. had the highest rate of infections, followed by Switzerland, Australia, the UK and Germany. This shows that, in all countries, the reduction and control of the epidemic could be controlled, although the share of infections has remained almost ten times as high in the U.S. than in the other countries. Regarding tobacco control policy, there is a different picture. Here Switzerland is the country with the highest consumption rate, followed by Germany (particularly after the 1990s). On the contrary, in the UK and in Australia, the smoking prevalence could be reduced significantly. In the U.S., tobacco consumption has been reduced drastically, but there is a break in the OECD data in 1999. However, this does not change the basic results. The findings regarding tobacco control are interesting and reflect, to a certain degree, the differences between the countries. Tight coupling and more policy integration come along with a reduction in tobacco consumption compared to countries where both sectors are de-coupled and non-coupled.

However, when we take a look at mortality rates - cancer specific and general mortality - the picture is different. In this case, my results show that, in Switzerland, cancer mortality has been reduced the most, and that life expectancy has been the highest, though there was a change concerning cancer mortality since the 1960s. Between 1960 and 1990, cancer mortality was the highest in Germany, the UK and Switzerland, whereas Australia and the U.S. lagged behind. This changed around the 1990s. Then, in all countries, the death rates

[4]The data is based on OECD figures (OECD, 2013). I could have also referred to other problems, such as morbidity, but the problem with this indicator is that cultural values and ideas might highly influence the way in which individuals report the state of their health.



(a) Death of cancer per 100 000 inhabitants

(b) Life expectancy in years at birth

Figure 11.4: Cancer and life expectancy

from cancer were considerably reduced, especially in Switzerland, but also in Australia. On the other hand, in the UK, mortality from cancer remained high. These results do not give a clear indication regarding the impact of the coupling of health care and public health on policy outcomes. On the one hand, in countries where both sectors are decoupled or non-coupled, mortality rates are low, especially in Switzerland and to a lesser extent in Germany. Both countries were very successful in reducing the number of deaths from cancer, which indicates that the wide access to health care and the focus on this creates slightly better health outcomes. However, Australia, which has significant policy integration, and the U.S., where private health care has dominated for long, have similar or better outcomes concerning cancer mortality. The UK is an outlier concerning this statistic. Here, death rates from tumors remain high, despite the tight coupling of health care and public health. Regarding overall mortality, the picture is somewhat similar. On the one hand, Switzerland performs very well, especially compared to the U.S. Australia has the second-best increase in life expectancy, although it has a tight coupling of health care and public health and policy integration, which shows that this configuration also coincides with a long life expectancy. On the contrary, the U.S. has the lowest overall life expectancy in this sample.

To explain these differences between health outcomes, the coupling of policy sectors and especially policy integration is a task for further research. A possible pathway would be to look at the type of the health care system (Böhm et al., 2013) or income inequalities (Plümper and Neumayer, 2014) and the impact they have on life expectancy in combination with the coupling of policy sectors.

Appendices

Appendix A

Summary statistics secondary datasets

For the analysis I did in this thesis project, I used datasets that were collected by other scholars. These were OECD health data as well as datasets on the political institutions of the countries under observation. In this appendix, I will briefly show some summary statistics for the variables I employed and discuss missing events in the OECD health data. Table A1 summarizes the variable on political constraints from a large dataset that was collected under the direction of Henisz in order to show a connection between political institutions and economic growth. I mobilize this data to show that there are relatively small differences in the political constraints, above all between the federal states, in chapter three. The summary statistic shows that except for the UK, on average, these countries are situated close to the maximum of this indicator (Henisz, 2000). I did not include the summary statistics on the historical GDP data and the statistics I used to analyze policy outputs, because in these cases I do not use mean values.

Table A.1: Summary variables, POLCONV dataset

Variable	**Obs.**	**Mean**	**Std. Dev.**	**Min.**	**Max.**
Political constraints	8172	.3192256	.3328162	0	.89432

Table A.2: Summary variables, OECD health database

Variable	**Obs.**	**Mean**	**Std. Dev.**	**Min.**	**Max.**
Exp. Public Health p.c. in USD	583	52.12317	50.80537	.137	303.202
Exp. Health Care p.c. in USD	497	1205.638	786.6181	43.83	5278.778

Table A.3: Missings OECD health database

Country	**Data for Health Care Expenditure**	**Data for Public Health Expenditure**
Australia	1960, 1963, 1966, 1969, 1971-2009	1960, 1963, 1966, 1969, 1971-2009
Austria	1990-2009	1990-2009
Belgium	2003-2009	2003-2009
Canada	1975-2009	1960-2009
Czech Republic	2000-2009	1999-2009
Denmark	1998-2009	1998-2009
Estonia	1999-2009	1999-2009
Canada	1960-2009	1975-2009
Federal Republic of Germany	1970-1990; 1992-2009	1970-1990; 1992-2009
Finland	1995-2009	1995-2009
France	1960, 1965, 1970, 1975, 1980, 1985, 1990-2009	1960, 1965, 1970, 1975, 1980, 1985, 1990-2009
Hungary	1998-2009	1998-2009
Iceland	1990-2009	1990-2009
Israel	1994-2007	1995-2007
Italy	–	1988-2009
Japan	1995-2008	1995-2008
Korea	1980-2009	1980-2009
Luxembourg	1999-2008	1999-2008
Netherlands	1972-2009	1972-2009
New Zealand	2004-2009	2004-2009
Norway	2002-2009	2002-2009
Poland	2002-2009	2002-2009
Portugal	2000-2008	2000-2008
Slovak Republic	2004-2009	1999-2009
Slovenia	2002-2009	2002-2009
Spain	1991-2009	1995-2009
Sweden	2001-2009	2001-2009
Switzerland	1995-2009	1985-2009
Turkey	1999-2000	1999-2000
UK	1999	1999
USA	1960-2009	1960-2009

Appendix B

List of Interviews

Three of the case studies in this Ph.D. are based on interviews with experts and stakeholders in health policy and above all public health policy. I conducted the interviews as part the mentioned research project which the Swiss National Science Foundation (SNSF) supported generously. I conducted most of the interviews together with my colleagues Wally Achtermann, Dorte Hering and Björn Uhlmann. Without her help in tracking down interview partners it would have been difficult for me to complete this project in the way it is now. We tried to find interview partners according to three categories: Experts, interest groups and politicians from different parties in order to have different voices. The selection of interview partners occurred according to the research design of the SNSF project, which aimed at understanding the coordination of actors in tobacco control policy and pharmaceutical policy, in Australia, Germany and Switzerland. The interviews were conducted as semi-structured interviews, according to the following broad guidelines:

1. Legal basis for public health
2. Main actors in public health (state and non-state)
3. Coordination of interest groups with parties; coordination between levels of government
4. Timing in the institutionalization of health care and public health
5. Connection of health care system and public health policymaking in general
6. Opposition to public health, i.e. tobacco industry
7. Laws to connect health care and public health, i.e. diabetes, cancer, HIV etc.
8. Institutional relation of health care and public health
9. Actor connection of health care and public health with regard to political activity as well as professionalization
10. Learning between health care and public health actors

11. Relation of professions in health care and public health

12. International dimension of public health policy

B.1 Interviews Australia

1. Int-AUS-1: Senator, Liberal Party, Melbourne, Melbourne, October 17, 2011.

2. Int-AUS-2: Former Minister of Health of South Australia, Canberra, October 5, 2011.

3. Int-AUS-3: Senior Tobacco Policy Officer, Tasmanian Dept. of Health, Tasmania, May 13, 2011.

4. Int-AUS-4: Associate Professor, LaTrobe University, Skype Interview, August 2011.

5. Int-AUS-5: Associate Professor, LaTrobe University, Melbourne, October 18, 2011.

6. Int-AUS-6: Professor of Health Prevention, Cancer-Council Victoria and University of Melbourne, Melbourne, October 13, 2011.

7. Int-AUS-7: Former Prime Minister Victoria, Melbourne, October 18, 2011.

8. Int-AUS-8: Principal Policy Officer at South Australian Department of Health Demographic, South Australia.

9. Int-AUS-9: Professor of Public Health, University of Sydney, Sydney, October, 7, 2011.

10. Int-AUS-10: Former Head of ACoSH, Skype Interview, April, 28, 2011.

11. Int-AUS-11: Professor of Public Health, University of Sydney, Sydney, October, 19, 2011.

12. Int-AUS-12: Former Director, Cancer-Council Victoria, Melbourne, October, 17, 2011.

13. Int-AUS-13: Director of ASH, Skype Interview, May 3, 2011.

14. Int-AUS-14: Director of ASH, Sydney, October 7, 2011.

15. Int-AUS-15: Professor of Public Health, Skype Interview, May 13, 2011.

16. Int-AUS-16: Professor of Public Health, Geneva, August 25, 2011.

17. Int-AUS-17: MP, Liberal Party, Skype Interview, September 12, 2011.

18. Int-AUS-18: Former Commonwealth Minister (Defense/Education, Science and Training) former president of the AMA, Skype Interview, October 28, 2011.

19. Int-AUS-19: CEO of Cancer Council Australia, Skype Interview, April 18, 2011.

20. Int-AUS-20: CEO of Cancer Council Australia, Skype Interview, September 12, 2011.

21. Int-AUS-21: Acting Director, Drug Policy and Population Health Division, South Australia, Skype Interview, May 27, 2011.

22. Int-AUS-23: Researcher, Cancer Council Victoria, Melbourne, October 12, 2011.

23. Int-AUS-24: Former CEO Australian National Preventive Health Agency; Former Policy Advisor Commonwealth Minister of Health, Canberra, October, 6, 2011.

24. Int-AUS-25: Researcher, Heart Foundation Western Australia, Skype Interview, May 5, 2011.

25. Int-AUS-26: Researcher, Heart Foundation Western Australia, Skype Interview, September 08, 2011.

26. Int-AUS-27: Professor of Public Health, University of New South Wales, Skype Interview, May 3, 2011.

27. Int-AUS-28: Professor of Public Health, University of New South Wales, Sydney, October 19, 2011.

28. Int-AUS-29: Former Commonwealth Minister for Health, Sydney, October 20, 2011.

B.2 Interviews Germany

1. Int-GER-1: Professor of Health Policy, University of Braunschweig, Skype Interview, October 9, 2012.

2. Int-GER-2: Professor Public Health, University of Fulda, Skype Interview, October 3, 2012.

3. Int-GER-3: MP of CDU, Berlin, November 27, 2012.

4. Int-GER-4: Professor of Public Health, University of Kiel, Skype Interview, September 28, 2012.

5. Int-GER-5: Professor of Public Health, Hertie School of Governance, Skype Interview, September 16, 2012.

6. Int-GER-6: Researcher, Law School, University of Hamburg, Skype Interview, November 13, 2012.

7. Int-GER-7: Professor of Health Policy, University of Bielefeld, Skype Interview, November 5, 2012.

8. Int-GER-8: MP Social Democratic Party, Berlin, December 10, 2012.
9. Int-GER-9: Employee Society for Health Promotion, Skye Interview, October 2, 2012.
10. Int-GER-10: Professor of Political Science, University of Siegen, Skype Interview, October 22, 2012.
11. Int-GER-11: Lobby Control Germany, Skype Interview, October 26, 2012.
12. Int-GER-12: Adviser of former Federal Minister for Health, Berlin, October 2012.
13. Int-GER-13: Head of the Non-Smoker's Initiative in Germany, Skype Interview, October 22, 2012.
14. Int-GER-14: Professor of Public Policy, University of Hannover, Hannover, October 2012.
15. Int-GER-15: Professor of Health Policy, University of Braunschweig, Skype Interview, Braunschweig, September, 2012.
16. Int-GER-16: Researcher DKFZ (German Cancer Research Centre), Skype Interview, October 8, 2012.
17. Int-GER-17: Head of federal Organization for Health Promotion and Prevention, Skype Interview, October 10, 2012.
18. Int-GER-18: Professor of Public Health, WZB, Skype Interview, October 9, 2012.
19. Int-GER-19: Professor of Health Policy, University of Bremen, Bremen, October 2012.
20. Int-GER-20: Professor of Medicine, Helmholtz Research Centre for Health and Environment, University of Munich, Skype Interview, October 9, 2012.
21. Int-GER-21: MP Social Democratic Party, Skype Interview, December 2012.
22. Int-GER-22: MP Social Democratic Party, Heidelberg, December 3, 2012.
23. Int-GER-23: Former Employee Municipal Public Health Service, Berlin, Skype Interview, October 19, 2012.
24. Int-GER-24: Organization of German Health Insurers, Berlin, October 2012.

B.3 Interviews Switzerland

1. Int-CH-1: Former Secretary of the CDP, Bern, November 24, 2011.

2. Int-CH-2: Former Head of the Federal Office for Public Health, Bern, December 15, 2011.
3. Int-CH-3: Health Policy Lobbyist, Bern, December 22, 2012.
4. Int-CH-4: Member of the Federal Office for Public Health, Bern, January 17, 2012.
5. Int-CH-5: Head of Oxy-Romandie, Geneva, January 26, 2012.
6. Int-CH-6: Head of the Swiss Working Group on Tobacco Prevention, Lausanne, February 9, 2012.
7. Int-CH-7: MP Liberal Party, Bern, Februrary 2, 2012.
8. Int-CH-8: Law Division Federal Office of Public Health, Bern, January 25, 2012.
9. Int-CH-9: Member Federal Office of Public Health, Bern, February 3, 2012.
10. Int-CH-10: Member of Federal Commission on Addictive Substances, Skype Interview, February 13, 2012.
11. Int-CH-11: Member of Federal Commission on Addictive Substances, Zurich, February 7, 2012.
12. Int-CH-12: MP Cantonal Parliament Bern, February 24, 2012.
13. Int-CH-13: Former Professor of Public Health University of Bern, Lausanne, March 3, 2012.
14. Int-CH-14: Member of Department of Health, Canton of Argau.
15. Int-CH-15: Former Head of the Swiss Working Group on Tobacco Prevention, Lausanne, March 3, 2012.
16. Int-CH-16: MP Liberal Party, Bern, February 21, 2012.
17. Int-CH-17: Head of Cantonal Office of Public Health Lucerne, Skype Interview, February 17 2012.
18. Int-CH-18: Head of Cantonal Office of Public Health Geneva, Skype Interview, February 17, 2012.
19. Int-CH-19: Former Head of the Federal Department of Domestic Affairs, Martigny, March 19, 2012.
20. Int-CH-20: Members of the Cantonal Office of Public Health of the Canton de Vaud, Lausanne, March 20, 2012.
21. Int-CH-21: Head of Cantonal Office of Public Health St. Gall, Winterthur, March 30, 2012.

22. Int-CH-22: Former Member of the Law Division, Federal Office of Public Health, Lausanne, March 22, 2012.

23. Int-CH-24: Head of Cantonal Government of Thurgau, Frauenfeld, March 26, 2012.

24. Int-CH-25: Former Head of Cantonal Office of Public Health St. Gall, Geneva, March 8, 2012.

25. Int-CH-26: Minister of Health Canton of Zurich, Zurich, April 5, 2012.

26. Int-CH-27: Health Economist Zurich, Skype Interview, March 14, 2012.

27. Int-CH-28: Former Deputy Secretary General of Federal Office of Domestic Affairs, Bern, April 4, 2012.

28. Int-CH-29: Former MP Social Democratic Party, Geneva, June 6, 2012.

29. Int-CH-30: Professor of Health Economics, University of Neuchatel, Skype Interview, February 27, 2012.

30. Int-CH-32: Health Economist, Bern, March 28, 2012.

31. Int-CH-33: Head of Swiss Cancer League, Bern, March 23, 2012.

32. Int-CH-34: Member Federal Office for Public Health, Bern, June 28, 2012.

Appendix C

Institutional Development

C.1 Institutional Development Australia

- 1847: Public Health Act (English Act) **(Public Health)**
- 1853: VIC English Act (Created a Central Board of Health) **(Public Health)**
- 1871: QUE Health Board (Temporary Board if a formidable epidemic was threatening, caused by smallpox in NZ, VIC, NSW) **(Public Health)**
- 1871: VIC Medical treatment for the cure of alcohol and drug addicts introduced **(Health Care)**
- 1880: NSW Infectious Diseases Supervision Act **(Public Health)**
- 1882: VIC Amendment of Public Health Act (Notification of malignant, infectious or contagious diseases) **(Public Health)**
- 1883: QUE and SA Public Health Act **(Public Health)**
- 1884: TAS Public Health Act **(Public Health)**
- 1885: WA Public Health (Reaction to the bad sanitary conditions in Perth) Act **(Public Health)**
- 1885: NSW Dairies Supervision Act **(Public Health)**
- 1889/1900: Legislation to treat alcohol problems all over Australia **(Health Care)**
- 1896: NSW Comprehensive Public Health Act **Public Health)**
- 1897: Public Health Laboratory in the Department of Bacteriology at the Melbourne University **(Public Health)**
- 1897: NSW Microbiological Lab **(Public Health)**
- 1898: NSW First sanitary courses started **(Public Health)**

- 1900: First Royal Sanitary Examination and VIC Meet Supervision Act **(Public Health)**
- 1905: VIC Pure Food Act and Dairy Supervision Act **(Public Health)**
- 1906: Start of Diploma in PH at the University in Melbourne **(Public Health)**
- 1907: Medical inspections of school children in Sydney and Newcastle **(Public Health and Health Care)**
- 1908: NSW Pure Food Act **(Public Health)**
- 1909: SA Food and Drug's Act **(Public Health)**
- 1910: TAS Food and Drug's Act **(Public Health)**
- 1910: Start of Diploma in PH at the University in Sydney **(Public Health)**
- 1911: QUE General Health Act regarding the control of quality and purity of food **(Public Health)**
- 1911: WA Health Act (Establishment of Advisory Committee for questions of health) **(Public Health)**
- 1915: WA Establishment of compulsory notification of venereal diseases Reaction to the CW urging the states to do that) **(Public Health)**
- 1919: Repatriation Pharmaceutical Benefit Scheme (RPBS). Arrangement between Repatriation Commission and various Australian pharmaceutical societies concerning medication for veterans of the First World War and the Boer War **(Health Care)**
- 1921: Commonwealth Department of Health **(Public Health and Health Care)**
- 1926: Federal Health Council **(Public Health and Health Care)**
- 1930: School of Public Health at the University of Sydney **(Public Health)**
- 1938: Enactment of National Health and Pensions Insurance Bill **(Health Care)**
- 1941: Plan for National Health Service. A NHMRC Sub-committe report proposed the establishment of a national system of hospitals and clinics, which is staffed by salaried doctors and officially supervises preventive work of private practitioners. **(Public Health and Health Care)**
- 1944: Pharmaceutical Benefits Act **(Health Care)**
- 1945 /1948: National campaign against tuberculosis **(Public Health)**
- 1947-1948: Hospital Benefits Act (Coverage for pensioners) **(Health Care)**

- 1947: Pharmaceutical Benefits Act (Coverage for pensioners; small fee of charge for elderly) **(Health Care)**
- 1952: Hospital Benefits Scheme (Co-payment for wage earners) **(Health Care)**
- 1953: National Health Act (Immunization) **(Public Health)**
- 1956: Begin of mass vaccinations against Poliomelytis **(Public Health)**
- 1956: Foundation for Research and Treatment of Alcoholism and Drug Dependence of NSW **(Health Care)**
- 1959: Langton Clinic Sydney created (Treat alcoholism) **(Health Care)**
- 1960: PBS reform (Expanded range of drugs for the general public, and the introduction of a patient contribution (or co-payment)) **(Health Care)**
- 1960s/70s: ACCV ran several campaigns against skin cancer in Victoria **(Public Health)**
- 1970s: First local and state tobacco control policies **(Public Health)**
- 1973: Tobacco advertisement on TVs begun to be phased out **(Public Health)**
- 1963: South Australian Foundation on Alcoholism and Drug Dependence **(Health Care)**
- 1965: Wacol Clinic in Brisbane opened (Treat alcoholism) **(Health Care)**
- 1968: St. Anthony's hospital Adelaide opened (Treat alcoholism) **(Health Care)**
- mid 1970s: Federal Body on Alcohol and Drug Dependence **(Health Care)**
- 1971: First Community Health Centre opened **(Public Health and Health Care)**
- 1971/1972: Introduction of compulsory use of seat belts; VIC first, other MS followed within a year **(Public Health)**
- 1974: Medibank **(Health Care)**
- 1975: Free hospital services introduced (Coordination of CG with states) **(Health Care)**
- 1978/1979: Dismantling of Medibank (Liberal Fraser Government) **(Health Care)**
- 1980: Warnings on cigarette packs (Liberal Government) **(Public Health)**
- 1980-1988: Slip-Slop-Slap Campaign Against Skin Cancer **(Public Health)**
- 1984: Resurrection of Medibank Scheme **(Health Care)**

- 1984: National Campaign against Drug Abuse (NCADA) **(Public Health)**
- 1986: Better Health Commission (Response to WHOs Health for All 2000 Policy) **(Public Health and Health Care)**
- 1986: Prohibition of Smoking on all domestic aircraft flights; Health Ministers agree to introduce stronger Health Warnings **(Public Health)**
- 1987 : Transfer of the public health functions of the National School of Public Health to the University of Sydneys Faculty of Medicine: Australian Institute on Health became a statutory authority **(Public Health and Health Care)**
- 1987: First Health Promotion Foundation created (VIC, other states followed) **(Public Health)**
- 1988-2001: Sun-Smart Program Against Skin Cancer **(Public Health)**
- 1991-1995: National AIDS Strategy **(Public Health and Health Care)**
- 1992: Tobacco Advertising Prohibition Act (CW) **(Public Health)**
- 1992: National Drug Strategy (NDS) **(Public Health and Health Care)**
- 1996: NPHP created (National Partnership for Public Health) **(Public Health)**
- 1997: Strategic Plan against Obesity **(Public Health and Health Care)**
- since 1999: National Tobacco Strategy (Coordination of national and state tobacco policies as well as coordination of various policy instruments) **(Public Health and Health Care)**
- 2001-2010: National Road Safety Strategy **(Public Health)**
- 2006: NHMRC becomes independent (Independent statutory agency within the portfolio of the Australian Government Minister for Health and Ageing) **(Public Health)**
- 2006: AHPC (Australian Health Protection Committee) and APHDPC (Australian Population Health Development Principal Committee) replace NPHP **(Public Health)**
- 2007: Indoor Smoking bans begin to be introduced **(Public Health)**
- 2007: Integration of National Institute of Clinical Studies into the NHMRC **(Public Health and Health Care)**
- 2009: National Preventive Health Strategy **(Public Health)**
- 2011: ANPHA Australian National Preventive Health Agency **(Public Health)**
- 2011: National Cancer Strategy **(Public Health and Health Care)**

Sources: (Palmer and Short, 2010; Lewis, 2003*a*; Lewis, 2003*b*; Lewis, 2008; Montague, Borland and Sinclair, 2001)

C.2 Institutional Development Germany

- 1860s: Cities, such as Berlin and Munich begin to construct sewages **(Public Health)**
- 1869: Liberalization of medical occupations, in Prussia. Everyone could medical services **(Health Care)**
- 1871: Factory inspection became compulsory **(Public Health)**
- 1873: Foundation of the National Society for Public Health **(Public Health)**
- 1876: Legalization of local, voluntary health insurances **(Health Care)**
- 1883: Creation of Public Health Insurance **(Health Care)**
- 1884: Creation of Accident Insurance **(Health Care)**
- 1889: Creation of Invalidity and Retirement Insurance
- 1899: Full time employment for public health doctors (*Kreisärzte*) **(Public Health)**
- 1899: Extension of public health doctors (*Kreisärzte*) competencies to medical and sanitary oversight **(Public Health)**
- 1911: Unification of existing Social Insurances **(Health Care)**
- 1913: Health insurances loose discretion in the appointment of doctors **(Health Care)**
- 1914: Non-doctors cannot be reimbursed by the health insurance anymore **(Health Care)**
- 1925: Preventive measures become part of the Public Health Insurance **(Public Health)**
- 1931: Public health insurances are transferred into statutory organizations **(Health Care)**
- 1933: Sterilization law **(Public Health)**
- 1934: Unification of the municipal and state level public health services **(Public Health)**
- 1935: Marriage health legislation **(Public Health)**

- 1938: Jewish Doctors lose their right to practice
- 1951: Central Health Administration created (GDR) **(Public Health and Health Care)**
- 1953: Law regarding the protection of infectious diseases **(Public Health)**
- 1954: Increase of health care expenditures **(Health Care)**
- 1955: Strengthening of panel doctors **(Health Care)**
- 1956: Failed attempt to introduce a federal law regarding preventive health **(Public Health)**
- 1958-61: Failed attempt to introduce a federal law regarding cost containment in the health insurance sector **(Health Care)**
- 1960: Federal law regarding epidemics passed **(Public Health)**
- 1958-61: Failed attempt to introduce a federal law regarding co-payments in the health care sector **(Health Care)**
- 1964: Failed attempt to introduce a federal law regarding dental care for kids **(Public Health)**
- 1968: First university professorship in workplace medicine established **(Public Health)**
- 1969: Ministry of Health Established **(Public Health)**
- 1972: Preventive exams in national health insurance **(Public Health)**
- 1972: Changes in hospital financing legislation **(Health Care)**
- 1974: Law on workplace security passed **(Public Health)**
- 1976: Cost containment legislation in the health care sector
- 1977: Coordination body in the health care sector established (*Koordinierte Aktion im Gesundheitswesen*) **(Health Care)**
- 1989: Competences of the national health insurances concerning preventive exams extended **(Public Health)**
- 1991: Cost containment legislation in the health care sector **(Health Care)**
- 1993: Reform of health insurance legislation **(Health Care)**
- 1996: Prevention transferred to accident insurances away from health insurances, which came along with a drastically reduction in non medical preventive services **(Public Health)**

- 1998: Failed attempt to introduce a national smoking ban **(Public Health)**
- 1996-2000: Restructuring of public health insurances **(Health Care)**
- 2000: DRGs for hospital payments established **(Health Care)**
- 2000: Prevention reintroduced in the public health insurances **(Health Care)**
- 2000: National strategy regarding diabetes **(Public Health and Health Care)**
- 2003: National strategy regarding breast cancer **(Public Health and Health Care)**
- 2003: National strategy regarding tobacco control **(Public Health and Health Care)**
- 2003/2010: National strategy regarding healthy education, stress reduction, health nutrition and movement **(Public Health and Health Care)**
- 2005: Failed attempt to introduce a national smoking ban **(Public Health)**
- 2003/2011: National strategy regarding improvement of patient competencies **(Public Health)**
- 2005: Failed attempt to introduce a federal law regarding preventive health **(Public Health)**
- 2006: National strategy regarding depressions **(Public Health and Health Care)**
- 2007: Primary prevention reintroduced in the public health insurances **(Health Care)**
- 2007: National smoking ban introduced (In the areas where such legislation by FG is possible; MS followed) **(Public Health)**
- 2007: Strengthening of competition amongst the health insurances **(Health Care)**
- 2008: Occupational and public health insurances merged
- 2012: National strategy regarding healthy aging **(Public Health and Health Care)**

C.3 Institutional Development Switzerland

- 1877: Federal law regarding work safety in factories **(Public Health)**
- 1887: National law on epidemics **(Public Health)**
- 1893: Creation of the federal office for public health **(Public Health)**

- 1900: Unified health insurance failed in referendum **(Health Care)**
- 1911: Federal law on health insurances **(Health Care)**
- 1914: Second law on workplace regulation **(Public Health)**
- 1918: SUVA founded **(Public Health and Health Care)**
- 1919: Foundation of the CDP **(Public Health and Health Care)**
- 1924 Foundation of the Centre antican cereux romand (CACR), Lausanne
- 1928: National law regarding TB **(Public Health)**
- 1935: National law to control alcohol **(Public Health)**
- 1948: Creation of AHV (retirement insurance) **(Welfare)**
- 1949: Law to implement mandatory TB exams failed **(Public Health)**
- 1951: Creation of the federal law on narcotics **(Public Health)**
- 1959: Creation of the invalidity insurance **(Health Care)**
- 1962: Federal legislation on the counteraction of rheumatism **(Health Care)**
- 1964: Revision of the national health insurance law **(Health Care)**
- 1969: "Giftgesetz" - National law regarding drugs and toxic substances **(Health Care)**
- 1974: Opening of the rehabilitation clinic in Bellikon **(Health Care)**
- 1976: "Sezione sanataria" was created in Ticino **(Public Health)**
- 1978: Proposal for a national ban of tobacco and alcohol advertisement failed in referendum **(Public Health)**
- 1979: In St. Gallen, a office for preventive health was created **(Public Health)**
- 1981: Revision of the national health insurance by creating a separate accidental insurance **(Health Care)**
- 1984: Law regarding prevention failed **(Public Health)**
- 1985: National Program to prevent AIDS **(Public Health)**
- 1986: Foundation for public health created **(Public Health)**
- 1990: First HMO in Europe opens in Zurich **(Health Care)**
- 1992: Proposal for a national ban of tobacco and alcohol advertisement failed in referendum **(Public Health)**

- 1993: Drug-prevention law **(Public Health)**
- 1994: National health insurance law **(Health Care)**
- 1995: Federal law on narcotics **(Public Health)**
- 1995: National Program for tobacco prevention **(Public Health)**
- 1997: National Program for alcohol prevention **(Public Health)**
- 1998 - 2004: 13 cantons renewed their legislation on health (The term prevention has mostly been used in the cantons of Western Switzerland, whereas the German-speaking constituencies prefer to "Gesundheitsschutz") **(Public Health and Health Care)**
- 1999: Start of influenza immunization campaigns **(Public Health)**
- 2001: Revision of the national health insurance law. Substitution with generics are allowed **(Health Care)**
- 2003: Creation of the tobacco prevention fund **(Public Health)**
- 2004: Creation of the dialog on a national health policy, replacing the informal consultations between cantons and the federal government **(Public Health and Health Care)**
- 2004: First national cancer program **(Public Health)**
- 2007: Unified health insurance failed in referendum **(Health Care)**
- 2010: National law on smoking bans (exceptions possible) **(Public Health)**
- 2012: National law on prevention failed in parliament **(Public Health)**
- 2012: Managed care project failed in referendum **(Health Care)**
- 2014: Unified health insurance failed in referendum **(Health Care)**

C.4 Institutional Development UK

- 1848: Nuisances Removal and Disease Prevention Act **(Public Health)**
- 1848: City of London Sewers Act **(Public Health)**
- 1848: Metropolitan Sewers Act **(Public Health)**
- 1950: Lodging Houses Act **(Public Health)**
- 1851: Common Lodging Houses Act **(Public Health)**

- 1853: Vaccination Act **(Public Health)**
- 1854: General Board of Health Act **(Public Health)**
- 1855: Disease Prevention Act **(Public Health)**
- 1855: Metropolis Local Management Act **(Public Health)**
- 1860: Nuisances Removal Act **(Public Health)**
- 1861: Vaccination Act **(Public Health)**
- 1863: Nuisance Removal Act **(Public Health)**
- 1865: Sewage Utilisation Act **(Public Health)**
- 1866: Nuisance Removal Act **(Public Health)**
- 1866: Sanitary Act **(Public Health)**
- 1867: Sewage Utilisation Act **(Public Health)**
- 1867: New Vaccination Act **(Public Health)**
- 1868: Sanitary Act **(Public Health)**
- 1871: Government Act **(Public Health)**
- 1872: Public Health Act **(Public Health)**
- 1906: Local health authorities received the rights to feed children **(Public Health)**
- 1907: Education Act granted local health authorities powers to perform medical inspections **(Public Health)**
- 1911: Health Insurance Act **(Health Care)**
- 1918: The Education Act of 1918 made treatment of certain diseases, i.e. skin problems and dental disease in schoolchildren mandatory **(Health Care)**
- 1919: National Ministry of Health established **(Public Health and Health Care)**
- 1923-1924: In 1923 and 1924, legislation permitted subsidies to facilitate improvements in the housing stock, in 1923 and 1924 that permitted subsidies to improve Housing Public health policies **(Public Health)**
- 1929: Creation of national assistance scheme, which was a medical-tested welfare scheme **(Health Care)**
- 1942: Beveridge Plan **(Public Health)**
- 1946: National Health Service **(Public Health and Health Care)**

- 1974: NHS Reorganization **(Public Health and Health Care)**
- 1982: NHS reform: District health authorities (DHA) replaced area health authorities (AHA) **(Public Health and Health Care)**
- 1984: Public Health: Liverpool produced one of Britains first regional reports of public health **(Public Health and Health Care)**
- 1992: Health of the Nation Strategy (1992-1997) **(Public Health and Health Care)**
- 1997: Minister for public health **(Public Health)**
- 1999: New national strategy for health in England published: Saving Lives: Our Healthier Nation **(Public Health)**
- 2000: Health Development Agency **(Public Health and Health Care)**
- 2001: National targets on health inequalities published **(Public Health and Health Care)**
- 2002: Wanless Report published on future health trends and resources required **(Public Health and Health Care)**

C.5 Institutional Development US

- As of 1866, sanitary bureau in the state of New York, as well as laboratories; Similar development in other Eastern cities such as Newark, Chicago, Louisville (Kentucky), Cleveland (Ohio) and St. Louis (Public Health)
- 1879: National Board of Health, which put the task to control public health acts in the states. Repealed in 1883 (Public Health)
- 1900: Public Health Expedition to Cuba (Public Health)
- 1909: Creation of the Rockefeller Sanitary Commission (Public Health)
- 1912: Congress passed a measure that transferred the Marine Hospital Service into the United States Public health Service (Public Health)
- 1919: School of Hygiene and Public Health at the Rockefeller School of Public Health had been established (Public Health)
- 1921: Sheppard-Towner Act, which provided federal grants for maternal and child health. Repealed in 1929 (Public Health)
- 1935: New Deal Legislation (Public Health and Welfare)
- 1938: Federal Grants for the control of venereal disease (Public Health)

- 1940: USPHS greatly expanded its program of grants to states and counties (Public Health)
- 1944: Federal Grants for the control of tuberculosis (Public Health)
- 1946: Hill-Burton Act (Hospital Survey and Construction Act) **(Health Care)**
- 1950s: Polio vaccination campaign was the development and mass scale implementation of polio vaccination (Public Health)
- 1964: Surgeon General Report on Smoking and Health (Public Health)
- 1965: Medicare and Medicaid **(Health Care)**
- 1970: Occupational Health legislation (Public Health)
- 1983: HMO become prominent **(Health Care)**
- 1994: National health insurance reform failed **(Health Care)**
- 2011: Patient Protection and Affordable Care Act **(Health Care)**

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