Nudging for individual health? New perspectives on health care policies

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Abstract

Health care systems are in motion. If we browse through different health systems in Europe, we find similar challenges: demographic change and technological progress both causing high fiscal pressure. Although there are similar causes for problems, the consequences, institutional solutions and reform options differ. Medical treatments are expensive and therefore policies to avoid „cost explosion“ very attractive to governments. As political scientists have already observed with regard to labour market policies (e.g. Trampusch, 2009), the exhaustion of welfare states is obvious, enhances the “marketization” of social risks and brings on new forms of regulation. Literature on European health care systems identifies a trend of “marketization”, or shows that market elements find their way into health systems (e.g. Saltman, 2003; Segall 2000; Schmid & Götze, 2009; Ter Meulen & Jotterand, 2008). There is no reason to question this general trend, but what is needed is to specify the underlying characteristics of this process in much greater detail. More and more the ideas of behavioural economists and psychologists (e.g. „Nudge“ from Thaler & Sunstein or the work of Daniel Kahnemann) seem to find their way into the political sphere. Governments in the several countries are actively seeking advice from behavioural economists to design new policies especially with regard to their health care systems. „Better regulation“, „new policies to address new (and old!) risks“ appear as catchwords in that debate. Marketization and approaches based on behavioural economics (e.g. “Nudging”) seem to go hand in hand and focus on strengthening individual health rather than offering a broad spectrum of benefits. As public health and health economy literature already started to analyze these developments, political science research on health care systems so far concentrates on institutions and actors dealing with benefits. This theoretical paper addresses the question how the debates and insights of neighbouring disciplines can be applied to political sciences and help to develop a new conceptualization of health care policies.

1. Introduction: Public health and risk regulation versus established ways of nalyzing health care systems

Health[1] is an important good – this commonplace statement is accepted by most Europeans (similar to job security) as surveys regularly show (e.g. European Social Survey, National Surveys). One could assume that politicians would register the high priority and take it into consideration when designing health policy. But of course, everybody's personal health is not only dependent on many variables, and specific health or consumer policies could only partly contribute to a "healthy" life. Furthermore it is difficult to define, what "personal health" or a "healthy life" means, as it depends on each individual's assessment. Nevertheless in different policies we can observe the growing effort at least to protect people from health risks and remarkable efforts to find (new) instruments targeting health prevention.

Empirically, studying health policy and the very regulatory fields with an impact on individual health, like product regulation, occupational safety, life-style regulation and the like reveals interesting trends and new fields of political activity – irrespective of whether it can be effective or not (as this is to a lesser extent a question of political science[2]). Examples in different countries (e.g. France, UK, USA, Australia) show how health policy is no longer limited to cases of illness but more and more expanding to promote individual health, concentrating on risk regulation and merging with other policies. That is interesting, because these developments could (in a medium- or long-term perspective) complement or even substitute the benefits of the "traditional" state-run health care sector – particularly in times of high cost-pressure. If it is possible to activate people to take (most of the) responsibility for their individual health this "behavioural turn" might have an impact on health **care** policy. Whereas such a perspective on *activating* social policies and *problem-solving approaches* gained acceptance in labour market studies and allows for theoretically driven empirical findings, it still seems to be ignored in studies on health care policy.

Theoretical and methodological approaches to health (care) policies differ from empirical observations. Health promotion and prevention are often neglected as a pillar of health (care) policy. Literature on welfare states and its typologies mainly concentrates on social policies

[1] In this paper the term „health" is used as contrary to „illness", respectively disease. Despite the implications of sociological debates regarding „health/illness" (see Schnell, 2006), in this context it is not relevant if we see health as a social construct.

[2] In Anglo-Saxon academia we find research in law, trying to evaluate new regulation (e.g. Galle, 2014). Political economists also calculate the potential success of „paternalist" or „nudging" policies and doubt the effectivity (e.g. Schnellenbach, 2012).

and security systems with regard to the „classical" risks and risk compensation schemes: unemployment, age, and illness (seminal: Esping-Andersen, 1990 and 1996; Bonoli, 1997). This traditional triad of risks is closely linked to an underlying assumption in a labour society: as essentially everybody is dependent on a personal income, the loss of income in cases of unemployment, age or illness should be compensated – at least partially or temporarily. Developed countries not only provide for the loss of income but for medical treatments. Institutions for sick payments and services for ill people are broadly analyzed. From a political economy's perspective the conflict between capital and labour plays *the* important role and has an impact on social budgets and distribution.

Interestingly enough, both expressions, „labour market policy" and „health care policy", might suggest that these policies go beyond unemployment and illness. Under the label of "active social policies" (for an overview see Deeming, 2015) a broad spectrum of research shows that labour market policies are more than the distribution of money (benefits, payments) for people losing their jobs. At least during the last ten years most of the European countries also concentrate their labour market policies on activation, regulation and de-regulation, as well as on instruments deployed to the successful placement of the unemployed via employment agencies et al (Heyes & Lewis, 2014 for Europe; Trampusch, 2009; Fleckenstein, 2008 for Germany)[3].

Whilst activation-policies and political measures shifting responsibilities onto the individual are well-known and analysed in labour market policy, it might surprise that the political science literature on health (care) policy is mainly concerned with medical treatments in case of illness. So far there is less attention for policies focussing on health promotion – sometimes this aspect of health policy is even dismissed as completely marginal (maybe as it is not mainly about distributing money). On the other hand Breton and de Leeuw have shown, that political science only "made little inroads in health promotion policy research" and public health analysts widely ignore or poorly adhere the conceptualization of policy and are rarely influenced by political science (Breton & de Leeuw, 2010, 87f.).

In my paper I suggest a new way of dealing with health care policies. First, I will show that common political research on welfare states and therein health (care) policy first and foremost concentrates on illness. Thinking in typologies or "families of countries" makes it even more difficult to systematically include the health care system. It is not surprising that

[3] Of course, the downside of these developments should not be disregarded: meanwhile several studies diagnose a rising sector of working-poor, non-standard employment and a growing social gap (for example: Heyes & Lewis, 2014).

there is no comprehensive policy perspective focusing on health prevention (Breton & de Leeuw, 2010, 88f.). Theoretically, I shall argue, that the well-known frameworks and approaches in social policy (welfare regimes, institutionalism etc.) are not appropriate to analyse health promoting policies. The chapter ends surveying the blind spots in the literature on health care regimes that excludes essential aspects of prevention and health promotion. Empirically, the perspective on „health" and the preservation of health gradually gains weight in the political debate and produces results in public policy, as will be shown. Therefore I shall illustrate how neighbouring disciplines deal with health care and prevention in a comprehensive manner and focus on maintaining good health and risk regulation (instead of just caring for illnesses). Hence the paper should answer the question: How can debates and insights of neighbouring disciplines be applied to political sciences and help to develop a new conceptualization of health care policies?

2. Taking care of health or taken care of illness?

Welfare state research concentrates on risk-compensation-schemes for age, illness and unemployment. As I have mentioned research concentrates on security systems providing for sick payments and medical treatment (Immergut, 1992; Alber & Bernardi-Schenkluhn, 1992; Döhler, 1999; Bandelow, 1998)[4]. The main systematic focus is on *being ill* instead of *not getting ill/stay healthy*. Thus, if we look for insights into activation policy, risk regulation or prevention with regard to health care policy as a part of social policy, until now we will not be satisfied. Although there is empirical evidence (as I will show below) that governments and international organisations have systematically started to implement new tools of governance for activation and self-regulation with regard to life-style and health prevention, the respective literature does not consider these developments. This is surprising, as we find such a debate in neighbouring fields of social policy for quite some time.

If we want to understand how social policies are designed to focus of risk prevention – instead of or additional to risk-compensation – we might have a look at labour market policy. While especially in the post-war period, labour market policy was primarily concerned with equipping the system of transfer payments, in the 1980s (and to a lesser priority with job placement for the unemployed) such a perspective was no longer adequate. Rising unemployment rates and a low activity rates challenged existing policies and had a severe

[4] In their encyclopaedic compendium on German health care policy ("Gesundheitspolitik") Gerlinger and Rosenbrock (2012) dedicate a large chapter to prevention policy. To a large extend their explanations are based on public-health research.

impact on the corresponding security regimes. Insurance schemes suffer from a smaller number of contributors and tax-based systems register similar problems with regard to the tax base. Research on labour market policy demonstrates e.g. for Germany how new paradigms, like activation and the shifting of responsibilities onto the individual, were established and forced institutional change (Trampusch, 2009; Fleckenstein, 2008). Thus the main focus moved from *"being unemployed"* to *"staying employed/quickly becoming re-employed"*. These findings also analyse, how the political process changed. Several studies are dedicated to the role of experts as (new) actors (e.g. the "Hartz-Kommission" in Germany). Furthermore, research on changing labour-market- and pension-policy points out, to what extent new explanations e.g. policy-learning or Europeanization shall be used. Such a perspective would be necessary when it comes to risk-regulation schemes focussing on individual health and health prevention strategies that go beyond the national scope.

In pension policy we observe a similar institutional and policy change. Of course, it is not possible to prevent the „risk" of being old (age), but a high cost pressure forced political actors to reform the systems. The „new" pension policies introduced or strengthened the individual private pillar for provisions and shifted the retirement age (for Germany: Bode & Wilke, 2014, Petring 2010). All in all welfare state research no longer considers a „frozen welfare state landscape" but provides evidence for serious reform processes (Esping-Andersen, 1996, 24). The huge transformations of welfare states – which are sometimes judged as an erosion of the welfare state – are subject to a broad spectrum of studies (e.g. the comprehensive study of Hemerijk, 2013). What we can learn with regard to the focus of my paper is that we see a "marketization of social policy". Referring to this I agree with Nullmeier who for the purpose of systematisation describes three dimensions of marketization taking place in welfare states (Nullmeier, 2004, 495): internal marketization by fostering welfare-markets (Taylor-Gooby 1999); external marketization by the competition of welfare states (Höpner & Schäfer 2008); subject-based marketization or market-education (Nullmeier 2004, 495). The third dimension regards each person individually. Social policy increasingly seeks to foster the subject-based marketization and to allocate new roles to state and the individual. Besides that, the realisation of the first two dimensions of marketization is depending on everybody's market-education. The "market based self-regulation" implies that each person individually and independently copes with any personal risk (Nullmeier, 2004, 497). Various studies prove how this marketization proceeds in labour market- and pensions policy. Future research should broaden this perspective to health prevention and risk regulation as a pillar of health policy. In doing so,

the impacts on the individual citizen as well as on market actors would play a role and should be object of future studies.

Maybe it is not surprising that studies on marketization in welfare states are labour market centred. Anyway, the perception might also be extended to the pension system, since retirement payments could be seen as part of the individual's labour-market biography as they depend on a preceding employment relationship. Health (care) policy seems to be at odds with these perspectives on labour-centred welfare states: If we study the seminal typologies of Esping-Andersen or Bonoli, we realize that health care policy and budgets do not fit with their findings and general assumptions (Esping-Andersen, 1990 and 1996, Bonoli, 1997). As Bambra summarizes, health care policy "has been a significant and notable omission from the broader welfare state literature and particularly the regimes debate" (Bambra, 2005, 196). She underlines, that "it is a strong example of welfare state inconsistency in the provision of cash benefits and welfare services" (ibid). Approaches integrating health care policies typically focus on the following institutional structures that can only partly be explained in the logic of welfare-state typologies: the funding of hospitals, and medical services (incl. physicians, therapists, pharmacies etc.), medical treatments (pharmaceutical products, medical devices etc.), and the funding of statutory sick pay, and perhaps – with small attention – public health policies dedicated to cases of pandemia, epidemia or the regulation of toxic substances. To sum up: it is all about patient-centred care in cases of illness. The health care system (understood as provision of medical infrastructure) is only partly organized analogical to unemployment- or retirement-payments, and therefore not fitting well with the established typologies (e.g. the alleged "liberal" social policy of the UK with the non-liberal National Health Service).

In western health care systems we can already identify how the effects of socio-economic developments (demographical change, unemployment etc.) and rising costs for medical treatments squeeze the relevant budgets for medical care (e.g. Huster, 2011, 29) and start to question the existing systems. This might be the reason why we can consider (empirically) a growing interest in marketization with regard to health care as well. However, in the literature we find an astonishing distance between the awareness and knowledge of "classical" social policy within the scope of welfare state research, its constraints and challenges on the one hand and those public-health research which is integrating findings of behavioural research but without a political science focus on the other hand (Raphael & Bryant, 2006). Political science to a large extent and even actual politics do not (fully) recognize if and how socio-economic determinants have an impact on public health, and

which factors in- and outside the health care systems are relevant and how new policies of health promotion and prevention are designed. Bambra et al (2005) and de Leeuw (2010) empirically show where and why public health is underdeveloped. The demand for public policy analysis in health research ("healthy policy") is deeply rooted in the fact that "public policies both inside and outside the health domain have a significant impact on population health and health inequalities" (Bernier & Clavier, 2011, 109).

Hitherto the debate on welfare states and their health care systems is very much nationally focussed. In the "classical" perspective of tax-based or contribution financed health care systems the national level essentially facilitate an appropriate infrastructure to cure people (cases of illness). Consequently research on these systems deals with it in a national perspective or a comparison of national systems. So far, actors on a supranational level are rarely considered. But when focussing on health prevention, health promotion and risk regulation, the supranational level comes into play and research should take it into account: the European Union and its institutions as well as the World Health Organization are strong agenda setters, as we will see below.

From a political studies point of view, we do not know much about how policies are designed caring for the health of people (instead of illness) or nudging them to live a "healthy" life and making them take responsibility for several health risks – although meanwhile health politicians started to follow such new paths. Increasingly political scientists point to the deficits in public health research, as – how Bernier and Clavier put it – "the bulk of policy analysis un public health research (including health promotion) is largely concerned with measuring and evaluating policy impacts and outcomes and pays little attention to the policy-making process" (Bernier & Clavier, 2011, 110) and "neglect of politics, power and ideology in the HPP [healthy public policy, note from the author] literature" (Raphael, 2014, 381).

To summarize, these are the most important blind spots that cannot be understood if looking through the glasses of welfare state research:

- We do not know to what extent governments turn to risk regulation and other (soft) paternalistic instruments to influence the health status of their citizens.
- We do not understand how political ideologies influence the policy-making process with regard to health promotion (incl. risk regulation and paternalistic instruments).
- We just have a first impression of which new instruments are at disposal?
- We do not know how the policy-making process for health promotion evolves.

- We just have an idea, how institutional structures might frame the process, when we look through the glasses of welfare state research.
- We have not systematically analysed, what impact European or international influences have (mainly European Union, OECD and WHO).
- We are not fully aware of how and which political actors are involved and how they do behave in relevant policy-making. This is also true for the role of experts and the media in the political process.
- We do not know, how product and service markets are affected by new "healthy policies" what it means to market actors.

3. A new political agenda: Individual health as a goal or a tool of health policy?

As opposed to the view on health care policy with the focus on curative care, we need a new approach to analyse policies aiming on the (supposed) "good health" of the citizens ("healthy policy"). Claiming that a new (or at least additional) dependent variable must be analysed means that the focus of health care policy should be expanded or shifted to the following question as a new research agenda: "Under which circumstances do governments establish policies aiming at regulation of health risks?" On a theoretical level I have shown, that this perspective is not yet considered in the political science view on social policy and welfare states. The result of this is a theoretical and conceptual deficit that future research could compensate. Below I will unfold why this question is also empirically relevant and why it is important to understand if and how policies are designed to intervene in those individual lifestyle decisions that affect health and wellbeing.

There are three crucial empirical aspects in the context of the dependent variable: a) *what* is the *object of prevention* and risk-regulating policy? b) *which instruments* are used? c) *when and under which circumstances* are preventing- and risk-regulating policies established? As I have just begun to do research on these question, I shall only present an overview of noteworthy developments in developed welfare states with regard to these questions.

a) If we ask for the *object of prevention* and risk-regulating policy (sometimes called "healthy policy") in developed countries[5], we mostly find examples in the following fields:

- Prevention of chronic diseases (non-communicable diseases): main focus on obesity caused by malnutrition or bad nutrition, physical inactivity (Rütten et al, 2013) and the

[5] Much more areas must be integrated if we open the perspective on non-developed or developing countries (e.g. unclean water, underfeeding…).

like (aiming at individual behaviour as well as product markets, like sugar, sweets etc.; for an overview see Geneau et al, 2010). In this context Pratt (2014) asks for a "new health regulation" regarding the "excessive use of substances".[6]

- Drugs, substances and behaviours causing addiction: main focus on tobacco, but also alcohol (with major differences between national policies and a still rather low level of regulation), gambling, cannabis etc.
- Flu and other communicable diseases: vaccination, prevention- and educating programs, hygiene requirements[7].

Examples:

In the UK we can learn from several reports of the "Behavioural Insights Team" about their fields of activities. With regard to the health area, their reports show that they focus on smoking cessation, organ donation, and hygiene factors in public restaurants and canteens as well as weight loss. Regardless if the measures taken can be considered as "nudges", the policies taken are part of a broader policy. A concrete example in the UK is the "Responsibility Deal" aiming primarily on nutrition (launched in 2011) as a public-private-NG partnership[8]. In the USA there are several examples in the field of fighting obesity. For instance, US-government largely introduced calorific information as it considers this strategy to be effective in the fight against obesity. There are ongoing debates in the US "over calorie count information [that] provide some insights into the challenges of crafting legislation that promotes (what some may define as) nudges" (Oliver & Ubel, 2014, 339). In Germany we cannot register any concrete objects or visible results of the new group for "Wirksames Regieren" around Chancellor Merkel. In 2015 the government introduced a bill specifically for health prevention and health promotion ("Präventionsgesetz"). The bill largely covers aspects of healthy life style, especially the fighting of non-communicable diseases[9].

[6] "In today's world, most preventable diseases and deaths are attributable to broader behavioural risk factors and ecological factors. The goal of reducing preventable disease and death leads proponents of the "new" public health to suggest that public health law be used to reduced behavioural risk factors, including tobacco, alcohol, and drug use; unhealthy diet and activity patterns, and risky sexual behaviours." (Pratt, 2014 reffering to Lawrence O. Gostin: Fast and Supersized: is the Answer to Diet by Fiat? 35 Hastings Center Rep 11, 11, (2005).

[7] This could be categorized as "old public health policy" as it does not focus primarily on individual behaviour but is part of a "traditional" responsibility of the state

[8] Whereas the UK Government seems to claim, that it has "achieved more, faster and cheaper, than regulation". Panjwani and Caraher argue that the collaborative and voluntary practices have hindered the success (Panjwani & Caraher, 2014, 171).

[9] In fact, it is not the first attempt to establish such a specific bill (during the last decade all parties tried an implementation). But there are two differences compared with previous attemps: On the one hand the current bill might be implied as it should not be blocked by the Bundesrat. On the other hand there are substantive

We could add several examples of other countries (e.g. Australia, Mexica) that implement new strategies of fighting especially obesity and physical inactivity. The case of non-communicable diseases seems to be promising if we want to understand healthy policy and analyse it from a political science perspective.

b) Classical typologies on *instruments* are helpful to understand different ways of policy-making which focus on individual health (and therefore risk avoidance) (e.g. Salamon, 2002). Hence, policy-instruments shall be distinguished according to the respective mechanism as shown in Table 1.

Table 1: Policy-instruments in health policy focussing on individual health

Mechanism	**Example of health policy (risk avoidance)**
Regulation (by law: bans / imperatives)	Smoking ban / Helmet obligatory (motorcycles)
Market (introduction of market mechanisms, economic incentives, negative incentives)	Private contributions for medical treatments (e.g. dental protheses), privatisation of health insurances, (partly) reimbursements for training courses, exclusion of certain insurance benefits / contributions
Procedural (specific policy-agenda etc.)	e.g. Germany: "Nationale Diabetes Strategie" (national diabetes strategy)
Provision of public goods and services	Vaccination[10], public health service
Cooperation (voluntary commitments or agreements, round tables, dialog boards)	Germany: www.gesundheitsziele.de UK: "Nudge Unit"
Persuasion (provision, preperation and mediation of (risk)information)	Awareness campaigns (e.g. in schools, postings, information in the public sphere) Labelling ("Food pyramid", "ChooseMyPlate" etc.)

(By author adapting Böcher & Töller, 2012, 75)

Health promotion and prevention policy often combines two or more mechanisms (e.g. immunisation, see fn. 7). In developed welfare states we see that the question how to introduce and how to merge (new) instruments is often answered by experts. So called "evidence-based"-strategies are becoming more and more important as examples from different countries show.

differences regarding the content as it now very much focusses on individual responsibility and considers findings from behavioural economics (e.g. feeding at school or in day-care) (Bundestag Drs. 18/4282).

[10] First and foremost a target-oriented information policy is important to prepare for and to implement effective vaccination (e.g. by public health services) (Spiecker Döhmann & Kurzenhäuser, 2005). The example of vaccination shows, how different instruments must be combined (Provision of vaccines and immunisation and the effective exchange of information).

Examples

Literature from different disciplines (mainly from public health, law and economics) refer to developments in the USA and the UK (later also in Germany) where behavioural economists are hired as experts. This is especially the United Kingdom tries to find new instruments, that are mainly inspired by behavioural economics: "[M]ost of the world's leading behavioural economists live in the United States, but in terms of applying insights from this discipline to government policy initiatives, the United Kingdom is currently at the forefront internationally" (Oliver & Ubel, 2014, 332). They show that Prime Minister Cameron appointed one of the authors of the book on "Nudging", the economist Richard Thaler, as an official advisor in his "Behavioural Insights Team". US-president Obama nominated the lawyer Cass Sunstein, the second author of "Nudge", as the administrator of the "White House Office of Information and Regulatory Affairs" in 2009. The German example shows in the early 2000s, how and to what extend government sought advice from experts (labour market: Hartz-Commission, pension system: Rürup- and Riester-Commission) and how these developments are intertwined with a paradigm shift (from corporatism to pluralism, shift in policies etc.). Nevertheless, compared to other countries Germany was "late bloomer" with regard to "nudging" or other findings of behavioural economics. Though, the German Chancellor Angela Merkel quite recently (in 2014) followed the trend and initialised a group for "Wirksames Regieren" (translation: "efficacious governance") and postulates "Bessere Rechtsetzung" (translation: better legislation) as a working agenda under the explicit reference to behavioural economics (e.g. Smeddinck, 2014, 245).

The above mentioned examples roughly give a first overview, which actors are involved and concerned, and how a health prevention or risk-regulation-strategy tackles the interests of producers and market actors. For the US it points to political conflict, as Republicans often vote against Nudging-Strategies or policies that interfere in every-day-life. However, if at all research or first reports on these developments partly point to important political tools, policies, and sometimes proves the (potential or actual) effects of that policies. But we still do not comprehensively and systematically learn about the policy-making in health prevention policy from a theoretically driven perspective in political sciences. Future research on health promotion and prevention should analyse the significance of the specific instruments and show why and how they are merged strategically.

c) To answer the question *when and under what circumstances* a new health policy agenda is implemented further research is needed. We can find some hints as will be shown in the next chapter. If political actors deal with risk regulation aiming at health prevention and promotion, they must rely on scientific experience and develop evidence-based policies[11]. As Strassheim and Kettunen stated, we do not know much in comparative research on the embeddedness of evidence and expertise in policies (Strassheim & Kettunen, 2014, 3). In their paper Strassheim and Kettunen ask for the conditions under which evidence-based policy turns into policy-based evidence making.

We might have a look at "Nudging" (Thaler & Sunstein, 2009) to illustrate the recent attempts of policies relying on scientific experience or at least expertise. The boom of "Nudging" is an interesting example of policy-intervention into every-day-life with the motive of effective health care or rather prevention. Research on Nudging tries to answer the question, why such strategies are so popular nowadays: "interestingly, the rise in the policy influence of neoclassical economists occurred over the same time period that saw behavioural economics become a more accepted subfield of economics." (Oliver & Ubel, 2014, 339). Some authors claim that at least since the financial crisis (approx. since 2007/2008) political actors started to abandon the idea of rational choice and searched for new ideas to understand social and economic behaviour.

For a first compilation of motives, why especially the nudge approach is so popular in capitalist societies I shall follow Oliver and Ubler (2014). They try to explain under which circumstances the new (healthy) policies are implemented: "Thaler and Sunstein have been active and effective in **marketing their ideas**, and **politicians looking for cheap, non-regulatory methods** to change behaviour have been receptive to them. Moreover, the 2008 **financial crisis somewhat dented the credibility of the standard, neoclassical economic approach** (at least in the short term), and there was a **window of receptivity** to alternative economic ideas. Behavioural economics, in terms of policy applications, has thus far been to some extent captured by those who continue to place an **emphasis on personal responsibility**. Philosophically, there is not too much that separates standard and behavioural economics: both approaches accept that the concept of rationality – i.e., that there are choices that people could make that they would deliberatively recognise as 'optimal' for them – exists, but behavioural economics recognises that people often fail to make these choices." (Oliver & Ubel, 2014, 340).

[11] My perspective on an individually focused health policy follows this view but does not ask about the normative aspects of evidence-based policy-making.

4. Surveying healthy policies: influences, actors and open questions

The previous chapter already relied on the findings in neighboring disciplines to give an overview over empirical aspects. Surveying research in law, economics, history and public health underlines the relevance of "healthy policies".

Generally speaking, Chinitz (2013) proves how an interdisciplinary perspective of institutional economics could integrate the findings of behavioural economics in health policy. He calls for strengthening "the contribution of institutional economics to interdisciplinarity in health policy analysis" (Chinitz, 2013, 394f.), but considers that this is a challenge for future research. Historical studies trace the roots of prevention policy: Lengwiler shows, how European countries developed public health strategies that more and more focus on individual practices for health prevention (Lengwiler, 2008, 521). He diagnoses a convergence of the capacities of what he calls "prevention regimes", although the structures are different in European comparison (ibid.). Although I very much argue for an approach that explicitly comes from political studies and that is theoretically funded, a deeper look into these studies might help to understand at least the roots of the booming "healthy policies".

Reviewing the broad spectrum of studies in law, economics, and public health gives an impression how these disciplines ask questions for political sciences. With regard to influences on policy-making, authors see a growing *significance and consideration of "experts"* mainly coming from behavioural economics. Other than the traditional focus on health care policies, public health experts observe the *multi-dimensionality of influences* on individual health inside and outside the health sector (for an overview see Assmuth et al, 2009). From public-health perspective research often claims health policy being ineffective. Authors ask how policy-making could be inspired or the critically question the thresholds of "healthy policy-making": Rütten et al. argue that individual health problems (e.g. resulting from physical inactivity) should be framed as a policy-problem (Rütten et al 2013) and consider such a perspective to be missing. We also do not now today, how mighty those *technological developments* could be, that might help political actors to follow new strategies in policy-making: the boom of "wearables" for example and smart watches recording every step and daily diet could be used in a public health strategy. From a law perspective, Alemanno raised the question on *control mechanisms* that could be established in policy-making (Alemanno, 2014, 22). Policy-making could also integrate understandings of consumer preferences (Foster et al., 2010). As far as "soft paternalism" and new

instruments are concerned, the role and success of *social marketing* is at question (Crawshaw, 2013).

As suggested above, healthy policy-making involves (*new) actors beyond the national level*. We find some evidence, that new actors are important when it comes to healthy policies: Several authors underline the role of the *EU*. They register the dimension of European involvement in regulation and its influences on national (risk) governance with a strong focus on individual health (e.g. Alemanno, 2014; Assmuth et al, 2009; Demeritt et al, 2015). Several strategies are adopted by the *WHO*, e.g. WHO's "Global Strategy on diet, Physical Activity and Health" from 2004. Due to the micro-foundation of healthy policies (focus on individuals) the regional or even community level is addressed. Healthy policy-making itself (incl. risk regulation) does not only influence markets, but thus it provokes *market actors and interest group power* (e.g. Demeritt et al., 2015, 387). The *lobbying* of powerful actors is predictable when products are regulated that might cause harm as we could see with the example of tobacco regulation (e.g. Brownell & Warner, 2009).

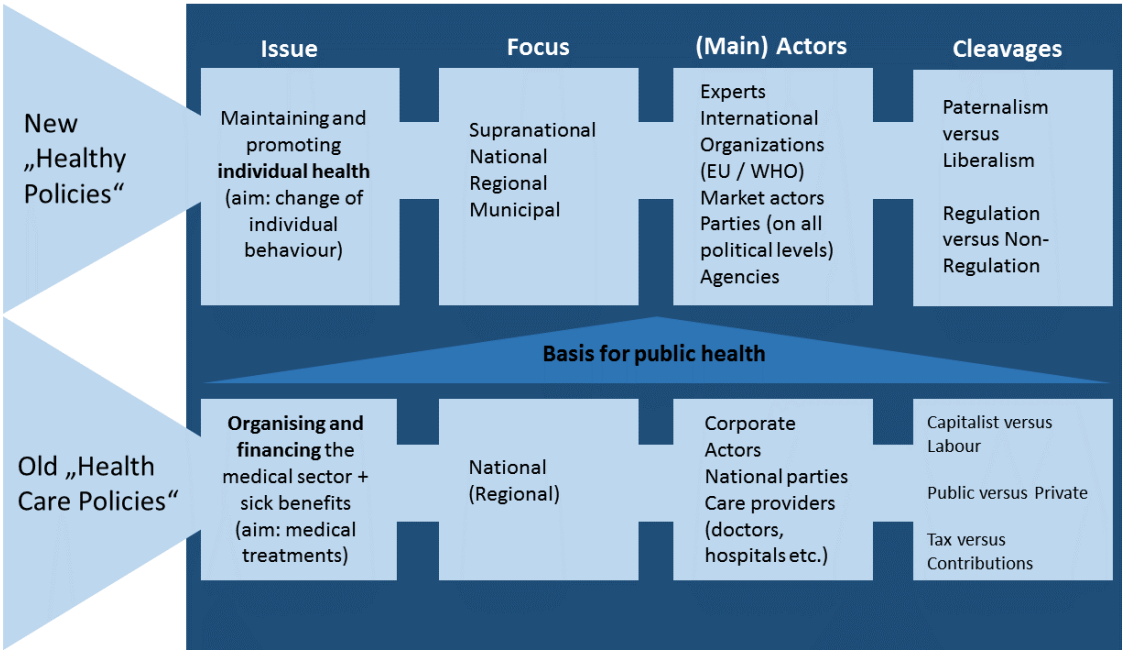
If research on healthy policy is very much influenced by behavioural economics, ethical and normative questions should be raised (Wikler, 2002, but: see fn. 10). For a comprehensive research program such a view might also be inspiring and inevitable, though, this might exceed a perspective on policy-making. With the example of New York City portion cap on sodas and sugary drinks, Pratt generally questions *legitimacy* when it comes to bans or strict regulation of products (Pratt, 2004). As "nudging" and those new instruments that use insights of behavioural economics might be subtle and influence individuals without being noticed we could ask about *legitimation* (e.g. Smeddinck, 2014, 246; Alemanno, 2014) and *accountability* (Demeritt et al., 2015). Analysis in policy-making might try to *control of contextual factors* as the *social determinants of health* are important when it comes to health prevention and promotion (Fröhlich, 2013; for a socio-structural perspective see Townsend, 2009).

5. Conclusion

This paper presented a spectrum of related questions and subfields when dealing with "new health care policy" (healthy policy). It was inspired by several neighbouring disciplines. I shall now present how to bridge the gap between traditional views on health care policies (illness) and the new perspective on healthy policy.

In these early stages of research I suggest a first conceptualization of new health care policies using my findings. Thinking about health care policy focusing on illness and therefore medical treatments on the one hand and health promotion and prevention policy on the other hand results in an integrated approach.

Figure 1: Conceptualizing Health Care Policies



(Original illustration, KL 2015)

Social policy for the health care sector is hardly imaginable without the institutions for medical treatments. Therefore I conceptualize it as the foundation of health care policy that influences the new "healthy policies" as well. However, the focus, actors, and cleavages of "new healthy policies" differ and require a different focus. This first conceptualization might give an outlook for future research: Other than in classical welfare state analysis we need policy-studies that go beyond institutional analysis, that see the interaction of factors, and – above all – that think "out of the box" and ask new questions (see chapter 2). The crucial differences to traditional views on health care policies are a) the role of new – maybe untypical – actors that are not institutionalized or incorporated, b) the role of the market and the interdependencies between regulators and market actors, c) the need for new policy

instruments, especially to analyse the significance of activation policies (marketization incl. nudging). We need such a new approach to identify and explain interdependencies with other policies (market policy, consumer policy, agricultural policy). As seen above it might be fruitful to pursue a systematic comparison of countries as we observe similar transnational trends ("nudging"). In doing so we might register and interpret paradigm changes that are undetected if only funding schemes and the organization of care institutions are analyzed.

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