

# T17aP06 / Conference in a Conference: Comparative Health Policy & Health Politics

**Topic :** T17a / Sectorial Policy - Health

**Chair :** Kieke Okma (Catholic University Leuven)

**Second Chair :** Amardeep Thind (Western University )

## GENERAL OBJECTIVES, RESEARCH QUESTIONS AND SCIENTIFIC RELEVANCE

This Conference in a Conference will host several sessions sponsored by RC 25 on comparative health policy and health politics. It will start with a session especially for young scholars and participants who present a paper for the first time. This will allow for a discussion of both the substance of the papers as well as the presentation itself. Next, it includes a session to discuss issues of methodology regarding comparison in the field. Other sessions focus on expanding health care access and health care insurance in Asia and elsewhere. While the very term universal coverage has become widespread, it is not always well defined. It includes both the coverage of health care financing through general taxation or health insurance, both public and private, and universal access to actual health care services. Discussing both policy intentions and the outcomes of policies across countries will improve the understanding of this point.

Finally, one or more sessions, depending on the interest, will discuss current policy topics in the field, including, for example, the development of regional health networks, health care manpower, aging and health care, medical ethical issues, gender issues and other.

The new format of the Conference in a Conference sponsored by RC 25 thus links the general issues of methodology with the application in the field. It supports young scholars and first time presenters as well as experienced ones, and encourages collaboration between scholars. The format allows for more flexibility in allocating time to certain sessions and topics, depending on the number of participants and their interest. We hope that it will draw many participants!!

## CALL FOR PAPERS

The Conference in a Conference sponsored by RC 25 welcomes papers and proposals for discussion in the field of comparative health policy and health politics.

It will start with a session for young scholars and first timer presenters.

The next session will focus on methodological issues of comparison, addressing questions like: Why do we look at the experience of other nations, what can we learn from that experience? How do we characterize or categorize health care arrangements and policies? What theoretical approaches or models have proven useful as analytical tools for comparing health care policies across countries?

The third major theme is universal coverage of health insurance and health care. This has become a major policy issue across the world, and comparative studies show a wide range of policy directions and outcomes. We especially welcome papers that discuss experiences of Asian countries. In other parts of the world, too, there has been much change in current arrangements of the financing and delivery of health care, aimed to expand coverage or to improve the quality or efficiency or organization of care. Some change took place in nations that already had universal coverage of their population, others are seeking to expand that coverage to reach universal health insurance and health care.

Four, we welcome papers that address current topics in health policy and health politics, in particular addressed with a comparative perspective. Examples of such issues are the development of regional health networks, gender issues, health care manpower, aging and health care, medical ethical issues, and other. Depending on the interest and papers, we will organize one or more sessions to discuss those papers.

We hope the new format of e Conference in a Conference will attract many participants. We would like to emphasize the comparative perspective of RC 25, and encourage collaboration between scholars across borders!

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## Session 1

Friday, June 30th 08:15 to 10:15 (Manasseh Meyer MM 3 - 5)

### **Compensated Kidney Donation: a 30 years policy in Iran, its lessons for Asia and reservations for the United States**

Mehdi Nayeypour (George Mason University)

Compensated kidney donation has been legally practiced in Iran for three decades. The result of this policy has been a system which provides quick access to kidney transplantation for End Stage Renal Disease (ESRD) patients. Iran is the only country in the world which allows kidney sale within a heavily regulated market. In contrast to this policy, the United States does not allow any form of compensation for kidney donation and it only recognizes altruistic or cadaver donation. Currently there are about hundred thousand ESRD patients in the US waiting to receive a kidney, from which 13 die every day. Many models have been explored to solve this problem in the US and Asian countries. This paper compares kidney donation policies in Iran, the US, and the rest of Asia and shows that certain socio-economic characters in Iran's culture and society allows for such model to be successful without exploiting the poor, while the US does not have such characteristics. Certain values and networks like family, social stigmas, status consciousness, religion, single payer health system, and poverty are mutually shared between Iran and several developing Asian countries, which makes them a potentially fertile region for successfully implementing this policy and advancing kidney transplantation within ethical boundaries.

### **Integrating health and social care: could England learn from the Japanese experience? A comparative health policy analysis**

Jimmy Jimmy

Michele Castelli (Università degli Studi di Milano-Bicocca)

Developed countries across the globe are facing a crisis in elderly care. A longer life-expectancy and a rise in multiple, lifelong non-communicable diseases such as diabetes and dementia mean that health and social care systems are coming under severe capacity and fiscal pressures. These conditions typically do not require the traditional hospital-based 'cures' for which many countries' healthcare systems have been historically set up but instead need frequent, low-intensity care, often community-based, to minimise the impacts of conditions and prevent deterioration and additional complications. The care system in England continues to undergo reforms attempting to bring health and social care systems into alignment, yet, for historical, cultural and organisational reasons, the systems remain resolutely separate. Integration between health and social care is crucial to properly address elderly patients' needs, treat them in the most appropriate setting, improve the quality of care provided and make the best possible use of increasingly limited resources. With many countries facing similar problems, comparative health policy analysis offers the opportunity to learn from the experiences of others. Japan, and its Long-Term Care Insurance (LTCI) programme, provides an example of a system that has created a broadly successful integrated care model for long-term care. This study aims to make a comparative analysis in the light of both historical and cultural factors so as to better understand the evolution of health and social care integration in two countries and identify whether there are lessons to be learnt for the English care system from the Japanese experience of integration.

Several studies have mainly focused on differences between countries in the content of health care policies or the performance of care systems in terms of outputs and outcomes. This study argues that lessons can better be learned by also considering three factors: the cultural differences (the history and the context), the role and power of actors within the systems and the different processes put in place to develop integration in

Japan compared to England. An analysis of all these factors can help to shed light on why and how the systems have developed in different ways, what the possibilities are for further integration of care systems, and what lessons can be learned.

This study has been developed through a narrative review of academic papers and grey literature. Because this topic concerns the wider context of change, the analysis of grey literature and media reports is crucial in addition to the review of academic literature.

The policy triangle model developed by Walt & Gilson Policy has been used as reference framework in order to explore the development of health and social care in England and Japan and, in particular, what lessons could be learnt from the Japanese model.

Findings from this study attempt to highlight how these sectors work in the two countries, how and why they differ and offers some insights to improve the integration of health and social care in England, providing new ground for further empirical research on this topic.

### **Mapping the introduction of health technology assessment in Romania**

Alin Preda (University of Medicine and Pharmacy „Carol Davila”)

Alexandru Rusu (Utrecht University, WHO Collaborating Centre for Pharmaceutical Policy and Regulation)

#### **Background:**

Health technology assessment (HTA), the multidisciplinary evaluation of “value for money” of health care treatments, is recognized as a key tool in the pathway to Universal Health Coverage (UHC). In this respect HTA is actively promoted by public and private consultancies as well as organizations such as the World Health Organization, the World Bank and the European Union. Although the need to develop HTA in Romania was identified as early as 1992, an HTA unit was introduced inside the Ministry of Health only in 2012 and frequent changes to the policy followed.

#### **Research questions:**

The current literature on health technology assessment in Romania tends to focus on the developments since the policy adoption by law and thus ignores the previous stages of the policy process. Our objective is to fill in this literature gap and offer a comprehensive picture of this policy process. We map the introduction of HTA via a visual timeline and identify trends, lessons learned and future research questions.

#### **Methods:**

The aim of this text is to map the introduction of health technology assessment in Romania and fill in the current gaps. In the first part we take stock of the academic literature and identify the missing parts. We then fill in these gaps via in-depth, semi-structured expert/elite interviews. Review of grey literature serve as primary sources to complement interview data and allow for triangulation.

#### **How the paper fits with the panel topic (T17aP06):**

- Comparative health policy –We make use of a comparative perspective by presenting side-by-side the various steps in the introduction of HTA to their results in practice.
- Discuss current policy topics in the field - Health technology assessment (HTA) has been attracting considerable attention within health policy debate in the last thirty years.
- Encourages collaboration between scholars – this research project looks to bridge the gap between social and life sciences by bringing together two PhD students from different fields (clinical medicine and public policy).

### **Health systems organization and the production of trust in medicinal transactions in sub-Saharan Africa: a comparative analysis of the health systems in Ghana and Tanzania**

Michele Castelli (Università degli Studi di Milano-Bicocca)

Medicines are at the centre of a major global public health crisis. Widespread counterfeiting and unprecedented global traffic of pharmaceuticals have created significant trust problems for the patients with serious risks for individual and public health.

At the same time, many countries have made concrete steps towards universal health coverage, developing

policies, plans and programmes aimed at increasing the number of people covered and at extending the range of services available to the population.

This paper is aimed at understanding how health systems arrangements could influence people's decisions and foster the production of trust in medicinal transactions in sub-Saharan Africa.

Trust in fact appears to be a key factor to make plans to increase health coverage happen in practice.

A health systems analysis has been developed (based on a narrative review of academic papers and grey literature, documentary analysis and interviews with some key local stakeholders) in order to present and compare the health systems (formal and informal) in Ghana and Tanzania, with a particular focus on the issue of access to health services and on the assessment of their paths towards universal coverage.

This comparison, highlighting key strengths and weaknesses of the two health systems, attempts to identify potential contextual and system factors involved in the trust decisions-making process.

The paper is basically aimed at addressing the following questions: which (contextual) factors could effectively enable the path towards universal health coverage on the ground? Which health systems factors could help to build trust between patients and health care professionals in the two countries?

This analysis is one strand of a larger funded research project designed to investigate how, under conditions of uncertainty and informational asymmetry, actors come to trust and distrust particular medicines.

Its comparative approach could help to shed a light on specific contextual factors able to facilitate or hinder the implementation of policies in practice, providing useful insights to understand the complexity associated with universal health coverage and people's behaviour.

The paper's findings could offer a contribution to assess the impact of health systems' organization on the properly-informed medication decision making process and to inform policy/practice in Ghana, Tanzania and potentially across Sub-Saharan Africa.

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## Session 2

Friday, June 30th 10:30 to 12:30 (Manasseh Meyer MM 3 - 5)

### **Continuity of care and its effect on readmissions and mortality for COPD patients: A comparative study of Norway and Germany**

Jayson O. Swanson (University of Oslo)

Chronic conditions, including chronic obstructive pulmonary disease (COPD), pose burdens on healthcare systems globally that have economic, societal and individual implications. Previous studies have shown that hospital admissions for patients diagnosed with chronic conditions are affected by continuity of care. To our knowledge, few, if any, studies have compared countries based on continuity of care measures and furthermore their effect on hospital readmissions and associated mortality rates. Identification of these differences and their impact will be important for international health care policy modification and development.

The Norwegian and German populations have similar life expectancy at birth and estimated percentage of life lived in good health or free of disability, but these countries differ in many aspects of provision and utilization of their health care systems. Germany operates under a social health insurance model, while Norway has a national health service system. On average, German patients frequent physicians much more often and have longer lengths of stay in hospital than Norwegians do. Despite this, costs per hospital stay are lower in Germany than in Norway. Additionally, differences in system characteristics, such as high compliance with patient list registration and the gate-keeping role of physicians in Norway compared to a lack of patient lists or a gate-keeping role of GPs in Germany, likely have an effect on continuity of care for patients. This expected difference in continuity also likely affects associated readmission and mortality rates.

We will compare continuity of care indices commonly used to evaluate registry- and claims-based data for COPD patients in Germany and Norway using insurance claims data from one of the largest insurers in Germany and national register-based data from Norway. Using logistic regression methods, controlling for a range of covariates, including comorbidity indices, we will ultimately analyze the association these likely differences have with readmissions and mortality for patients hospitalized with COPD diagnoses.

### **Comparative political analysis of HIV policy variation in sub-Saharan Africa: Ethnicity and inequality as alternate explanations for attitudes to HIV stigma and policy**

Ashley Fox (Rockefeller College, University at Albany, State University of New York, State University of New York)

HIV is a significant health policy concern globally, but national policy response to HIV has been uneven. Whereas some countries have reacted swiftly, others have lagged in constructing an appropriate response to the epidemic. A long-standing theory in comparative politics explains the divergent global response as a result of ethnic diversity and division. Researchers have argued that national policy responses have been weaker in countries that show higher ethnic fractionalization, that is, a lack of solidarity along linguistic, religious, or other ethnic lines, because societies that are ethnically divided find it difficult to act collectively to adopt HIV policies. To avoid being associated with HIV stigma, ethnic groups in divided societies are more likely to mute their demand for and acceptance of HIV policies. However, this theory has only been tested with macrodata, which does not allow for a deeper exploration of the mechanisms that might explain how or why fractionalization results in failures of collective action. We test the diversity deficit theory using microdata from Demographic and Health Surveys (DHS) for ten sub-Saharan African countries, which contains information about HIV stigma and ethno-linguistic and religious diversity. We apply a multi-level model to examine attitudes to HIV stigma as reported on questions that, among others, ask respondents if

they would keep the HIV status of an infected family member a secret. If the diversity deficit theory is correct, we would expect countries with more ethno-linguistic heterogeneity to exhibit more stigma towards HIV overall, and for dominant groups to stigmatize more when HIV is perceived as a disease more common among minority groups. We also test alternative explanations including how other group attributes, specifically socioeconomic status of group members, account for group attitudes to HIV stigma and might explain cross-national divergence in HIV policy response. We find wide variation in levels of HIV stigma across countries. Examining who holds stigmatizing attitudes within countries, we find that, contrary to arguments based on the political salience of ethnicity, respondents' socioeconomic status predicts stigmatizing attitudes more so than ethnicity on its own. We argue that cross-national health policy variation can depend on socioeconomic divisions that may be more politically salient than ethnic divisions in determining policy response.

This project addresses theory and methods for comparative health policy analysis, focusing on the HIV epidemic in Africa. We not only compare HIV policy response across African countries, but also contrast explanations for variation in policy response. This analysis provides insights into why some countries mount a more successful policy response to a common health threat than other countries do. It enables researchers to consider alternate social and political mechanisms, including theories of collective action, that undergird health policy outcomes and, more broadly, the politics of policy-making.

### **Does it matter if you Opt in or Out: Organ Donation Policy in the UK, US, and Canada**

Marlene Sokolon (Concordia University)

The need for transplantation organs continues to outpace the capacity of procurement. In the United States, which has the best organ donation rates of an opt-in or informed consent system, the median waiting time for kidney transplantation is still over three years. In contrast, countries that use opt-out or presumed consent tend to have higher rates of donation; in Spain, the average waiting time for a kidney transplant is sixteen months. This discrepancy continues to inspire policy debates in opt-in countries to change the procurement policy to opt-out; most recently, Wales has adopted a new opt-out system that came into effect on December 1, 2015. This paper contributes to this on-going debate by examining the policy debate, institutions, and legal precedence in three opt-in systems, Canada, the UK, and US, to assess the relative success of enacting such a policy change. The paper argues that the policy and legal mechanism of procurement, either opt-in or opt-out, proves less relevant than respect for family decision-making concerning the deceased. Thus, the debate should focus on the more proven crucial policy tool of professional procurement teams, such as the American organ procurement organizations, which are tasked with discussing donation with the family. Second, the paper argues that since both opt-in and opt-out are based on a liberal individualistic view of consent, theoretically organ donation policy requires a rethinking of the meaning of consent in health decision-making to include a broader understanding of family consent.

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## Session 3

Friday, June 30th 13:45 to 15:45 (Manasseh Meyer MM 3 - 5)

### **Divergence of Healthcare Policies - By Comparing Medical Professional Groups' Different Influences in UK, USA, and Korea**

HeaKyeong Kim (Korea University)

This study seeks to answer why countries with advanced economies have different tendencies in making healthcare policies in the era of neo-liberalism. This paper explores this topic by analyzing the dispositions of medical profession groups. I compare their characteristics in three countries focusing on two independent variables: the power of medical associations, and the governments' attitudes regarding medical policies. The first is specified by policy orientation and active-reactive inclinations of the government: specialized workers are much more autonomous and influential in coordinative-reactive countries such as USA, in contrast to hierarchical-active countries such as Korea and UK. The second variable is concerned with how classifications and conflicts resulting from discriminative profits given by policies split the medical profession, weakening interest groups. For example, in South Korea, the NHI is more favorable to large corporate hospitals than small private institutions, fragmenting the medical profession. The degree of fragmentation within a field determines the size of groups and the amount of power in each interest group. According to Olson (1965), the number of members within a group determines the effectiveness of its collective action. Therefore, splitting the medical field into many smaller interest groups will eventually enervate them. Also, these variables determine the relations between one group and others - such as peak associations of doctors, health insurance and pharmaceutical companies that struggle to protect their interests in their own field. This results in different groups influencing a country's healthcare policies by different extents, which explains the divergence of policies. Cases of USA, UK, and Korea with Mill's method of agreement and difference bolster my hypothesis.

### **The Impact of Cost Sharing Change on Health Outcomes in Low and Middle Income Countries: a Systematic Review**

Mengqi QIN (Saw Swee Hock School of Public Health, NUS)

#### **Background**

Many health systems in low and middle income countries are facing escalating health expenditure due to increasing burden of non-communicable diseases, population ageing and greater use of costly medical technologies. Since increasing demand for health care due to health, economic, environmental and other reasons, universal health coverage (UHC) as a powerful mechanism is worth implementing for achieving better health and well-being. One of the primary goals of health insurance or a more common term, cost sharing is to improve population health. Cost sharing change would therefore influence healthcare access behavior and health outcomes of the beneficiaries. Despite the wide use of cost sharing in health system internationally, cost sharing policies persist to be highly controversial. The current review aims to look at the effect of cost sharing on health outcomes by synthesizing recent evidence from quasi-experimental studies.

#### **Method**

We conducted a comprehensive literature search for six databases (Medline, Econlit, Scopus, Jstor, World Health Organization Library Database (WHOLIS), World Bank e-library) for published articles in English on the impact of cost sharing change on health outcomes in low and middle income countries from January 1, 1990 to November 30, 2016. Additional literature search was also carried out by appraising references and citations from the studies identified through database search. Only quasi-experimental study design was included: difference-in-difference (DID), propensity score matching (PSM), instrumental variable (IV),

regression discontinuity, interrupted time series (ITS) and any combination of the designs. Study selection and quality assessment were performed by two independent researchers. This study has registered with PROSPERO 2017: CRD42017054737.

## Findings

After identifying for 8459 records, 32 studies met the final inclusion criteria. Using quasi-experimental study designs (thirteen DID, three PSM, three IV, five RD, one ITS-PSM, seven DID-PSM) for assessing the impact of cost sharing change in low and middle income countries (China, India, Thailand, Vietnam, Indonesia, South Africa, Colombia, Nigeria, Ghana, Burkina Faso, Jamaica, Mauritania, Mexico), most studies found health improvement for the beneficiaries using either subjective (13) or objective (19) health indicators. A few studies suggested there were no significant effect on health outcomes. Although our study only looked at impact on health outcomes, it is convincing from some studies that health improvement is closely related to increase access to healthcare services. However, time frame of some studies is not allowed to test for long-term effect on health outcomes and some other studies used subjective health indicators. These may increase the risk of bias based on the Effective Practice and Organization of Care (EPOC) assessment tool criteria.

## Interpretation

Health cost sharing is one of the key dimensions of UHC. The selected studies show a stronger health effect on people in low and middle income countries compared with the outcome from RAND Health Experiment that cost sharing had no adverse effects on participant health except for improvement in some symptoms such as hypertension, dental health and vision etc. Some low and middle income countries have started their cost sharing schemes for less than a decade, hence we need a longer-term observation and research to provide a more robust evidence in this area of research.

## Reviewing Japan's Unfinished Healthcare Reform---Its Problems and Future Directions

Toshiyuki Nishikawa (Surugadai University)

The purpose of this paper is to review the current state of Japan's healthcare reform and to analyze its future directions. Japan's current healthcare system was established more than a half century ago when demographic and economic conditions were quite different. It is now outdated and dysfunctional, not sufficiently meeting the needs of the coming super-aged society. With a quarter of the population now over 65 and with financial difficulties caused by stagnant economic growth, Japan needs an entirely different approach, as well as structural reform. The paper is going to evaluate what the Abe government has done since it took power in December 2012. More than four years have now passed since the Second Abe Cabinet was established, and it is one of the longest-lasting Japanese governments in postwar history. The stable Abe government has given a fair degree of continuity in its policymaking. The purpose of this paper is to evaluate what the Abe government has achieved in Japan's healthcare reform so far and to point out what has been left undone in view of the rapidly aging society, declining birthrate, and changing socioeconomic environment.

In August 2013, the National Council for Social Security System Reform, established by the Japanese government, issued a final report giving recommendations on healthcare reform. Based on these recommendations, the Abe government has been formulating specific reform policies in the various areas of healthcare. It has been pointed out that Japan needs to move away from "hospital-based" healthcare to a more "community-based" healthcare system by integrating "self-help," "mutual (community) help," and "public (government) help."

This paper will analyze and evaluate the policy directions of healthcare reform in the third phase of the Abe government. Whether proposed healthcare reform will be successful will now depend on the success of "Abenomics" as well as effective policy making and implementation. To improve Japan's financial base, the consumption tax was raised from 5% to 8% in April 2014, and it was scheduled to be raised to 10% in April 2017, but it has now been postponed till October 2019.

The Health Care 2035 Panel Report, another government report issued in June 2015, spells out Japan's vision and its goal of becoming a "health-advanced nation" by 2035. It points to a "paradigm shift" that is to take place in the next twenty years. This includes such changes in healthcare as moving from quantitative expansion to qualitative improvement, from healthcare provider-orientation to patient-orientation, from government regulation to self-regulation, from cure-orientation to care-orientation, and from diffusion to integration, among other changes.

Whether Japan can set a leading example for other countries such as China and South Korea facing similar problems remains to be seen. In conclusion, the author will attempt to point out major issues regarding the direction of future healthcare reform in Japan and its implications for other countries, particularly those in Asia.



## **Prevalence and Generosity of Health Insurance Coverage in European Union Member Countries**

Federico Toth (Università di Bologna)

The concept of health insurance coverage can be resolved into two different components: “prevalence” (who is insured), and “generosity” (what is guaranteed) of the insurance.

In this article, we first provide data – also in historical data series – on the prevalence of health insurance, whether public or private, in the 28 EU member countries. At present, residents in EU countries without health insurance amount to almost 10 million (corresponding to 2% of the population).

To appraise the “generosity” of insurance coverage, two indicators are used: out-of-pocket expenditure and self-reported “unmet medical needs”. These two indicators are first analysed separately, then condensed into a generosity index.

There is a positive relationship between prevalence and generosity of health insurance coverage. Health expenditure per capita appears to significantly affect the generosity of coverage, whereas it has less impact on prevalence.