1 Introduction

In recent years, new policy challenges have emerged in the field of health policy. On the one hand, caseloads have increased, such as with cancer and diabetes. On the other hand, infectious diseases have returned, for example, the Ebola epidemic which recently hit countries in Western Africa. Other instances of infectious diseases include resistant influenza viruses (such as H5N1), the MERS (Middle East respiratory syndrome) coronavirus, tuberculosis, and antibiotic-resistant bacteria, all of which have become primary concerns for health policymakers worldwide (WHO, 2013b, 2014). Furthermore, preventing noncommunicable diseases (UN General Assembly, 2010; OECD, 2011; WHO, 2013a), such as cancer and diabetes, has become an important challenge for policymakers around the globe. During the last sixty years, life expectancy and the share of elderly in the population increased in many OECD (Organisation for Economic Co-operation and Development) countries. This poses a new policy challenge for many nations as a larger percentage of older people will come along with higher caseloads of chronic diseases. Consequently, there is a demand for more preventive health policies – in addition to curative interventions. These new health policies will cause additional health expenditure (Russell, 1986, 2009), but will also lead to improved health outcomes (McDaid, Sassi, and Merkur, 2015, xxi–xxiii). At the same time, health expenditures are consuming an increasing share of the national income overall in many countries. For example, in 1960, countries like the United States spent around 5 percent of their GDP on health (care and prevention) whereas in other countries, such as Australia and the United Kingdom, it was a bit less. By 2010, this share had doubled and in the United States, it had more than tripled (Figure 1.1).

To deal with these health policy challenges efficiently, health systems have to manage complex cases of multiple morbidities as well as new threats from resistant viruses and bacteria, which can travel easily in a

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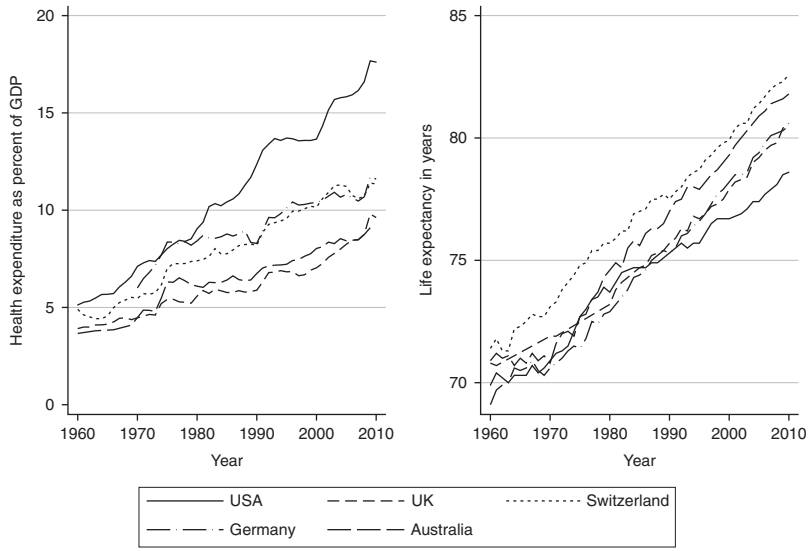

Figure 1.1 Health expenditure and life expectancy.

globalized world, along with increasing pressure for cost containment. It is the goal of this book to analyze how different health systems have dealt with these policy challenges, notably how to coordinate and integrate preventive, curative, individual, and population aspects in health policy from a comparative historical perspective.

Policy responses to the aforementioned challenges can be distinguished according to two dimensions: preventive approaches, which attempt to tackle origins of a disease before it breaks out, and cure, which comprises of policy instruments to regulate, finance, and provide treatment of sick individuals or groups. This book identifies these two approaches as health care and public health. In short, *health care* refers to policies organized along the illness or individual-based principle. Illness-based refers to the moment of intervention against a disease, which occurs when a patient is already suffering from an illness. Individual-based means that health care sector policies are designed to foster treatment of individuals by doctors who cure diseases. *Public health* focuses on policies that take a health hazard or population-based perspective. Health hazard denotes that the moment of intervention is when health is in danger, which is before the outbreak of a disease. Public health interventions are population-based,

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which means that they are designed to affect the entire population, or groups, rather than just individuals (Trein, 2017a).

This distinction of the two policy sectors is ideal-typical, which means that in the real world they must work together effectively to deal with policy challenges that require the coordination of both fields. For example, this is the case with chronic diseases – e.g., cancer or diabetes – which require the combination of individual cures, individual medical screening, and group- or population-focused primary prevention measures (Busse et al., 2010; Nolte, Knai, and Saltman, 2014). Nevertheless, readers should keep in mind that the proposed distinction between health care and public health is ideal-typical and serves as an analytical tool to analyze the relationship of the two principles, but that it does not describe the full range of the term's use among practitioners.

During the twentieth century, health policy has evolved toward a structural and professional dominance of the medical approach (Foucault, 1963) and, as a consequence, most of the health expenditures have gone into the cure of diseases (OECD, 2017). Nevertheless, due to the changing demands on health policymakers – notably the appearance of new infections and chronic diseases – public health (health hazard and population-focused) solutions, such as health promotion, have reappeared on the agenda of policymakers (McQueen et al., 2007). Around the world, health policymakers have dealt with this problem in many different ways to take into account the renewed demand for public health policies (Blank and Burau, 2013; Tulchinsky and Varavikova, 2014). Ideally, health care and public health would appear in a coordinated or even integrated (Chernichovsky and Leibowitz, 2010) manner in order to provide cost-effective focus on the patients' interests. Given the different legal approaches of health care and public health (Gostin, 2014), as well as the professional autonomy and power of the medical profession (Rodwin, 2011), it is not self-evident that coordination and integration of health care and public health will be implemented smoothly and conflicts are likely to occur. Given the variety of health care systems around the world (Böhm et al., 2013), there might be differences among countries regarding the capacity of the country to relate the two sectors and resolve the conflicts between them (Trein, 2017a). For these reasons, we need to know more about the relation of health care and public health and its development over time. Notably, insights from this

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research could help to understand actor coalitions and the capacity to create policies combining health care and public health in different countries.

This research problem ties into a theoretical challenge of the political science literature. Public policies are separated into a large number of policy sectors or subsystems, which govern a part of the political system with a certain autonomy (Howlett, Ramesh, and Pearl, 2009, 81–88). Nonetheless, they interact constantly with one another. This dimension of sectoral interaction has been poorly researched by the political science literature – especially from a comparative perspective. Taking the viewpoint of the public policy and public administration research, Guy Peters referred to the search for the coordination of policy sectors as the "Holy Grail" for policymakers (Peters, 1998, 295). Recent contributions still emphasize the need for more empirical research on this problem (6, 2005; Tosun and Lang, 2017; Trein, Meyer, and Maggetti, 2018). Similarly, there is room for a deeper conceptual inclusion of the concept of institutional and sectoral coevolution in the literature (Pierson, 2000; Cusack, Iversen, and Soskice, 2010; Steinmo, 2010; Trampusch, 2010; Thelen, 2014).

1.1 Concepts and Theoretical Priors in Brief

Starting from these practical and theoretical problems, this book analyzes the institutional and policy relations of health care and public health and their change over time. Therefore, this book uses a number of concepts from the political science and public policy literature, such as policy sectors, coevolution, coupling, distinctiveness, responsiveness, integration, and coordination. Analytically, this book starts from hypotheses that I develop based on secondary literature to provide the conceptual background for the following empirical analysis. In this section, we will go through to the concepts and hypotheses guiding the analysis. The following section will discuss the results of the analysis.

1.1.1 Concepts

This book defines health care and public health as policy sectors. Analog to industrial sectors, policy sectors include specialization and provision of public services, but, next to service delivery, they also have a political component to them. The specialists (Rodwin, 2011) and organized interests participating in the delivery of services reach

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out to decision makers and form subsectors to the overall political system, similar to narrower policy subsystems (Howlett, Ramesh, and Pearl, 2009, 81). In the sense used in this book, policy sectors entail the core elements of public policy analysis, such as "sectoral" policy paradigm (Béland, 2005, 8), actors, policy instruments, and institutions (Howlett, Ramesh, and Pearl, 2009). Given the (relative) autonomy of policy sectors, conflicts between sectors might occur when sectors attempt to coordinate – in our case – population, individual, curative, and preventive elements of health policy to deal with the discussed policy challenges (Trein, 2017a).

To analyze the relation between the health care and the public health sectors and their development over time, this book refers to *coevolution*. According to the literature on evolutionary biology, coevolution is an evolutionary change in one population as a reaction to a condition of a second population, which is followed by a change in the second population (Janzen, 1980, 611). This book transfers coevolution to policy analysis to understand the mutual influence and adaptation of the health care and the public health sectors and the change of the relation between both sectors over time. In the following, I will use coevolution as a metaphor and I do not identify evolutionary theory with political analysis (Ma, 2016, 225), as other authors have proposed (Lewis and Steinmo, 2010). This book refers to coevolution in the same way as research focusing on coevolution of dyads, such as capitalism and systems of political representation (Cusack, Iversen, and Soskice, 2010) or skills and welfare (Trampusch, 2010).[1] Thereby, this book accounts for two analytical dimensions: first, an intersectoral dimension that concerns the connection between the health care and the public health sectors and, second, a temporal dimension that refers to the development of the sectors' relations over time.

To analyze the relationship between policy sectors, I hark back to the concept of coupling (Orton and Weick, 1990; Weick, 1976) and propose four forms of coupling to denote different conditions of the relationship between policy sectors. These are tight coupling, loose coupling, decoupling, and noncoupling. Tight coupling entails the conditions of "no distinctiveness"[2] and "responsiveness" between the two sectors. No distinctiveness contains the presence of formal institutional unification, i.e., the sectors share common structures that intend to set up common organizational elements and policies to merge professional practices and interventions. Responsiveness means that professionals and administrators from the two policy

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sectors formally coordinate political activities because they have "ideas about joint and holistic working" (6 et al., 2002, 33–34) or actors from both policy sectors engage in common discourse coalitions. For example, the medical profession (broadly defined) makes nonmedical public health policies, such as tobacco control, a political priority. Responsiveness entails also policy integration, e.g., policies that actually merge professional practices and interventions of the two sectors (6 et al., 2002, 33–34), which is different from institutional unification which entails only structural preconditions for the integration of policies. An example for political coordination is when medical associations publicly support tobacco control policies. Instances of policy integration are integrated care measures or health strategies that aim at particular diseases. The other forms of coupling follow this logic. Loose coupling combines distinctiveness with the presence of responsiveness. Decoupling includes distinctiveness and the absence of responsiveness and noncoupling refers to the combination of no distinctiveness and the absence of responsiveness (Trein, 2017c).

These four forms of coupling are ideal-typical. To make them applicable to empirical analysis, this book proposes a two-dimensional continuous space with two axes. The vertical axis runs from no responsiveness at the bottom end to full responsiveness at the top end, and the horizontal axis spans from distinctiveness on the left side to no distinctiveness on the right side. The four forms of coupling are placed in the corners of this two-dimensional analytical space: loose coupling is in the upper left corner, tight coupling in the upper right corner, noncoupling in the lower right corner, and decoupling in the lower left corner. In between these extreme points, there are a number of intermediate forms mixing the different forms of coupling (cf. Figures 1.2 and 2.1). I will use this analytical space to map the coupling of health care and public sectors in different countries at different points in time. This strategy allows me to examine the coevolution of the health care and the public health sectors from a comparative perspective (see Chapter 2).

1.1.2 Theoretical Priors and Research Design

This book not only aims to describe the relations of health care and public health over time, but also attempts to explain why the two sectors (potentially) coevolve differently in different countries. Therefore,

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I start the analysis with three hypotheses. My first hypothesis holds that there is no distinctiveness (unification) of health care and public health if government is unified. Unified government means that the national government has a relatively large discretion in changing policies and parts of the formal institutional structure without having to consider the position of many veto players, such as a second parliamentary chamber, subnational governments, or find solutions among several parties in government. Examples of a unified government are centralized federations (Hueglin and Fenna, 2006), countries with few veto points (Tsebelis, 2002), majoritarian democracies (Lijphart, 2012), and strong states (Crouch, 1993; Nathanson, 2007). Countries whose political system resembles these qualities are likely to have institutional unification of the health care and public health policy sectors.

The second hypothesis states that there is responsiveness of health care and public health if professionalism in that country is high (Macdonald, 1995). High professionalism means that professional organizations – for example, the medical and legal associations – are strong and politically independent from the state; in other words, they are "free professions" (Rodwin, 2011, 321). In this instance, professional actors are active political pressure groups who defend their special interests and, in addition, lobby for problems that do not directly concern their own interests but are beneficial for the public good. For example, doctors should be interested in public health matters that concern nonmedical health policies from a professional point of view but not because public health touches on their special interests as a profession. Additionally, in the context of strong professionalism, medical organizations would advocate public health issues because they need political legitimacy clout to attract policymakers' attention. The reason for this is that strong professionalism comes along with interest group pluralism (Macdonald, 1995; Siaroff, 1999), i.e., a situation, in which not all interest groups are included automatically in the political process but need to compete with other interest groups for the access to politicians. Thus, health care actors have an incentive to demonstrate that they care about public health matters and work together with health care actors. Consequently, I expect to find responsiveness between the two sectors. To the contrary, weak (or low) professionalism (Macdonald, 1995) implies that health professions are "professions of office" (Rodwin, 2011, 321). In this case, professional organizations do not consider themselves as pressure groups that need to voice societal problems to

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policymakers. Obviously, professions of office are politically active, but mostly regarding their special interests as they operate in contexts where they do not need to do more, as corporatist structures of interest inclusion guarantee their political participation (Macdonald, 1995; Siaroff, 1999). Therefore, in countries with weak professionalism there should be no responsiveness between the two sectors.

The third hypothesis accounts for contextual elements. I hypothesize that the relation of the health care and public health sectors (coupling) should remain stable over time, as long as the context (most problematic illness, technology) does not change either. However, changes in the context might alter the demand for the coupling of the health care and the public health sectors. My analysis covers the time period from 1880 until 2010. Across this time span, the socioeconomic context has changed considerably and the demands for health policy along with it. In order to consider the mentioned contextual changes, this book focuses on four time periods, each of which has different contextual conditions and therefore varies in its expectations regarding sectorial coupling. The first time period (t1) covers the period from 1880 to 1918. During this period, infectious diseases were the most pressing health problem and medical capacities were limited. This context created high incentives for more responsiveness between professional organizations and policies during that time period. The second period (t2) comprises the time from 1918 to 1945. During this period, infections were still a problem, but less so than before, and medical technology had been improving. Therefore, incentives for responsiveness and policy integration remained present, but should have been weaker than in the previous time period. The third time span (t3) entails the time from 1945 until 1980. During this period, contextual incentives for responsiveness and policy integration were not present because most infections could be cured. Incentives for and unification of policy sectors have returned since the 1980s (t4) because disease patterns have changed as well. Notably, prevalences of noncommunicable diseases have increased and new infections have become a problem, for example, HIV (Baum, 2008; Tulchinsky and Varavikova, 2009).

Starting from these hypotheses, this book analyzes the coevolution of the health care and the public health sectors in five countries, namely Australia, Germany, Switzerland, United Kingdom, and the United States. I selected these countries according to their differences in professionalism and unified government (Table 1.1); other elements,

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Table 1.1. ***Case studies and empirical implications.***

	Strong professionalism	Weak professionalism
Fragmented government	US → *loose coupling*	Switzerland → *decoupling*
Unified government	Australia, UK → *tight coupling*	Germany → *noncoupling*

such as the nations' economic development and levels of democracy, are fairly stable. The only particularity is the United Kingdom, which is not a federal state. It serves as a control case to and allows for testing my hypotheses beyond the realm of classical federations.

My empirical analysis is a historical account of the development of coupling between the health care and the public health sectors from the mid-nineteenth century until 2010. I chose this long time span because it allowed me to trace the relationship between the two sectors from the origins of the modern state until today. I base my analysis on secondary literature, official documents (including Internet sources), and interviews. Based on a review of these sources, I record instances of institutional reforms, responsiveness between the actors, and policies of the health care and the public health sectors. An example of institutional unification is the creation of a national health service. Responsiveness entails a common advocacy between health care and public health actors, such as when the medical profession and health foundations share support for tobacco control policy or health promotion. Conflicts between the professions would also count the absence of responsiveness. An example of policy integration is a policy that combines prevention and cures regarding a certain policy challenge, such as cancer.

1.2 Main Results

The results of my analysis demonstrate that health care and public health coevolved differently between the five countries. In short, health care and public health coevolved from loose to tight coupling in Australia. In the United States, the development was similar, but the institutional distinctiveness between both fields was more pronounced. In the United Kingdom, the two sectors coevolved from noncoupling

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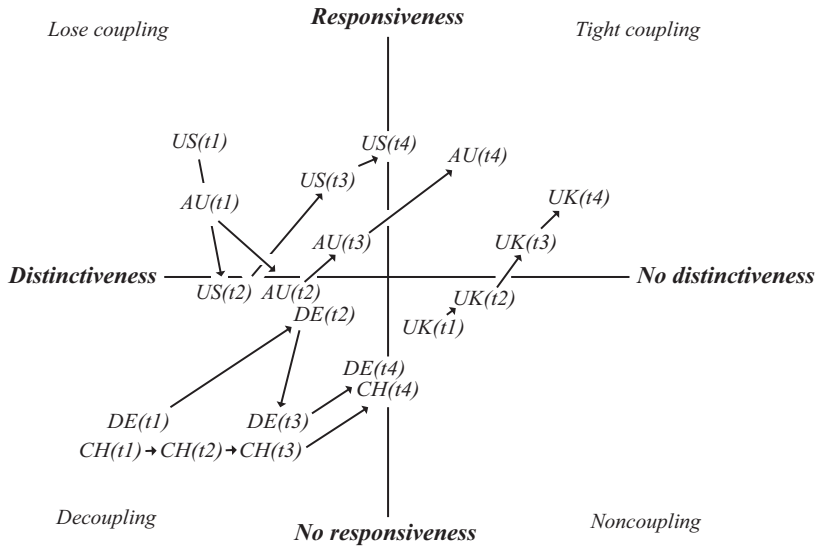

Figure 1.2 Coevolution of health care and public health.

to tight coupling. In Germany and Switzerland, health care and public health coevolved from decoupling to some degree of noncoupling, i.e., both sectors remained relatively distinct institutionally and did not enter a full relationship of noncoupling. An intriguing finding is that the two sectors coevolved toward more responsiveness in all countries in the sample (Figure 1.2).

Concerning the hypotheses that guided the analysis, my results are particularly interesting. The findings 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, taking the role of an important pressure group in these matters. This was especially the case if the issue did not concern the group's original interests, for example, in the case of the merger of universal health care with a public health service. Responsiveness changed according to the context. In the United States, and partly in Australia, responsiveness was strong, but only at times when the most prevalent diseases demanded policy integration of the two sectors. If this was not the case, political conflicts and absence of

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responsiveness remained prevalent. The situation was different in the United Kingdom. The health care and public health sectors were already unified institutionally in the late nineteenth century. During the late nineteenth and the early twentieth centuries, this led to conflicts between the medical profession and public health professionals, mostly about resources. At the same time, in Australia and the United States, there were fewer conflicts, although professionalism was similar to the United Kingdom. Nonetheless, through a mutual learning process, the relationship between the health care and the public health sectors coevolved toward greater responsiveness, in all three countries. 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 other countries; rather, it acted like a member of the administration, i.e., as professions of office, rather than a public interest organization. Consequently, health professions in Germany and Switzerland did not play the same role in the coupling of the two sectors as health professions did in the other countries.

Based on my empirical results, I need to modify my hypothesis on unified government. My analysis shows that federalism has mostly impacted the institutional relationship between the two sectors. In other words, the coevolution of health care and public health proceeded differently in federal states and in unitary states in the sample. Notably, there has been an overall centralization of health policy, which means that in all countries the two sectors coevolved toward less vertical and horizontal institutional distinctiveness and toward more unification of the various institutions. This process was slower in decentralized federations, namely, in Switzerland and the United States, than in Germany, which is a more centralized federation. In Germany, health care and public health were institutionally unified at a later time. In Australia, which has an even more centralized form of federalism, the two sectors were unified earlier at the national level due to the advocacy by health professions, especially doctors. Contrariwise, in the United Kingdom, which is a unitary state, health care and public health coevolved above all in a tightly coupled manner.

Although my analysis targets primarily democratic countries, the results show also that the difference between democratic and autocratic countries has had an impact on the distinctiveness and responsiveness of the two sectors. This book also covers the coevolution of the health care and the public health sectors during

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Nazi rule in Germany. In addition, it contains some preliminary references to the GDR and the USSR. In all of these countries, autocratic government accelerated the institutional unification of health care and public health.

My results also show 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. In other words, independently from the starting point, responsiveness between the policy sectors increased over time (Figure 1.2). Changing contextual elements played an important role in that outcome. Similar to capitalist institutions, policy sectors emerged randomly and coevolved to complementarity (Crouch et al., 2005). 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. For that outcome, changing context played an important role regarding health care and public health. Once contextual conditions changed, i.e., noncommunicable diseases increased and infections returned since the 1980s, governments in all of the countries in this sample passed policies that integrated health care and public health policies, although at different speed. This finding points to the importance of policy learning in the coevolution of policy sectors. I hypothesized that the absence of responsiveness led to less policy integration between the two sectors. However, my results show that in countries with little actor responsiveness (for example, Germany) there was also 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. For that outcome, changing contexts played an important role. Another explanation for this result is that policymakers from both sectors learned from one another over time regarding policy design – even against the backdrop of non-politicized professions. Thus, the increase of policy integration of health care and public health signals policy learning or emulation between the two sectors.

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; Trein, 2017a) and their coordination (Peters, 1998), and I

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apply them to a longitudinal comparative historical analysis of five countries, which is usually done in the qualitative comparative politics literature (Steinmo, 2010; Thelen, 2014). The consequence of this hybrid approach is 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 et al., 2011; Saetren, 2005) across the entire time frame that this book covers. Nevertheless, my approach is innovative and interesting because it researches the historical background of policy sectors – namely their main stakeholders, institutions, and policy instruments – in a clearly comparative perspective. Thereby, this book makes a number of contributions to the political science literature, which will be discussed in the following section.

1.3 Lessons from this Research for the Political Science and Health Policy Literature

Overall, this book contributes to the scholarly literature in three ways. First, this book speaks to the health policy and public health literature in general. The second and third contributions are on theoretical and conceptual elements that are relevant to the political science and public policy literature.

1.3.1 Health Care and Public Health

This book clearly contributes to health policy research. My results are indeed interesting for the literature on both health care and public health because my analysis connects policies from health care, which focus on sickness, to public health policies, which aim at preventing diseases. In the comparative health policy literature, researchers focus often on health care systems and the differences between them (Freeman and Rothgang, 2010; Rothgang, 2010; Böhm et al., 2013) taking a comparative political-economic approach to the study of health policy. On the other hand, the public health literature focuses on public health (population health) problems (Nathanson, 2007) and politics from a broad perspective, which usually includes individual health care into the public health perspective (Tulchinsky and Varavikova, 2014; Baum, 2016). Another line of research that

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has emerged from public health has focused on health promotion (McQueen et al., 2007) and the politics and political science aspects that are relevant to it (Clavier and De Leeuw, 2013).

This book contributes to the health policy and the public health literature by forging an explicit connection between health care and public health from a comparative public policy and a comparative politics perspective. Previous researchers have rarely pursued such an approach to the analysis of health policy (Blank and Burau, 2013). Therefore, this analysis fills a gap in the health policy literature. This book makes a general conceptual contribution to the health policy literature by distinguishing health care and public health as two distinct but overlapping policy sectors. Furthermore, since this book connects an institutionalist approach with a public policy approach to the analysis of health policy, it allows readers to draw some hypotheses that could explain differences in expenditure for health promotion and prevention in general, as well as the adoption of different strategies on integrated health policies (Trein, 2017a). Eventually, this book takes a historical perspective on health policy that starts in the second half of the nineteenth century when modern health policy emerged (Foucault, 1963) and extends until the third public health revolution and its implications in the late twentieth and the early twenty-first centuries (Potvin and McQueen, 2007, 17–18).

1.3.2 Professional Activism and Institutional Evolution

This book also contributes to the (new) institutionalist literature that has become very prominent across the political science literature (DiMaggio and Powell, 1991; Mahoney, 2000; Pierson, 2004; Shepsle, 2006). This literature has analyzed from different theoretical angles how institutional contexts shape the way individuals construct and express their preferences and how mutual understanding and aggregation of these preferences are rendered complicated (Immergut, 1998, 25). For example, from a historical institutionalist perspective, authors have focused on how historical events and contexts affect changes in institutions (Streeck and Thelen, 2005; Thelen, 2004; Mahoney and Thelen, 2010) or the evolution of entire states (Steinmo, 2010). Another strand of the institutionalist literature has focused on different institutional configurations (Crouch et al., 2005) and

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the coevolution of different institutional configurations (Trampusch, 2010; Thelen, 2014).

This book contributes to the historical institutionalist literature by emphasizing the role of professions and their political activity for institutional development. Specifically, my analysis connects the development of institutions and policy innovations to the political activism of professional actors, notably the medical profession. The literature on professions and the sociology of professions (Rueschemeyer, 1973b; Freidson, 1983; Macdonald, 1995; Rodwin, 2011) points out that there is a difference between the political activity of professional actors across countries, since there are variances in how the state governs professional education, training, standards, and its relation to these groups (Rueschemeyer, 1973a, 63–122; Freidson, 1983, 23–26; Rodwin, 2011, 321). This book uses this literature to demonstrate how in the context of "free professions," health professions make nonmedical health policies a political priority, which results in responsiveness of the health care and public health policy sectors. Examples for this finding are Australia, the United Kingdom, and the United States. On the other hand, this book argues that in countries such as Germany and Switzerland, "weak" professionalism or "professions of office" (Rodwin, 2011, 321) result in less responsiveness between the two sectors. Against this backdrop, health professions are included in the political process rather automatically and also through corporatist interest intermediation. They consequently do not need to gain legitimacy clout by advocating publicly on policy problems beyond their special interests, such as public health matters in the case of the medical profession. On the other hand, in countries with strong professionalism and pluralist interest intermediation, health professions are more free from state intervention but need to develop a stronger political profile to defend their special interests. Therefore, it is in their interest to support public health, including non-medical interventions. It is important to note that the political activity of health professions is also related to the broader structure of interest intermediation within a country, given that the countries with "strong" professionalism have a liberal and pluralist interest intermediation (Australia, UK, and the US) whereas the countries with "weak" professionalism (Germany and Switzerland) have relatively more corporatist interest intermediation (Lijphart, 2012).

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1.3.3 Policy Integration, Coupling, and Coevolution of Policy Sectors

This book contributes to the public policy literature, notably on the research that regards coordination and integration of policies and public sector organizations (6, 2004; Christensen and Lægreid, 2007; Peters, 2015; Trein, Meyer, and Maggetti, 2018). More recent theoretical contributions to this literature have emphasized that the connection of policy sectors can take the form of regimes, specifically boundary-spanning policy regimes, which denote the durability of the integration of different fields. Examples for boundary-spanning policy regimes are drug policy, pollution abatement, or homeland security (Jochim and May, 2010). Another concept that researchers have recently elaborated on is functional regulatory spaces, which build on boundary-spanning policy regimes and add 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. Rather than proposing another concept to understand the conceptualization of the institutional relations among different policy fields, this book focuses on comparing the degree to which existing sectors are related. We look at different degrees of coupling between the health care and the public health sectors. The different forms of coupling proposed in this book could be used to compare different boundary-spanning policy regimes or functional regulatory spaces concerning how they are coupled in order to denote to what degree they provide integrated policy solutions (6 et al., 2002, 33–34).

In addition to coupling, this book contributes to the literature on policy integration and public sector coordination by transferring coevolution from the comparative political economy literature to comparative public policy research. Notably, this book shows that despite the presence of different forms of coevolution, health care and public health moved toward complementarity, i.e., more policy coordination, of health care and public health. My analysis demonstrates that the two policy sectors, which have emerged randomly, coevolved toward

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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).

The analytical framework and terminology used in this book can be transferred to the analysis of other new policy challenges that span existing policy sectors; notably I suggest two examples. First, homeland security and politics of domestic security have become important issues of the domestic political agendas and for research in political science. The problem has been researched, covering 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 United States, various sectors or subsystems 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. Second, migration and refugee policy has emerged as a key policy challenge for many governments around the world. To deal with this policy problem, governments will need to at least coordinate or even integrate (Scholten, Collett, and Petrovic, 2016) different policy instruments that are needed to resolve the problem of migration – such as social assistance, employment promotion, and housing – to address the challenge of immigrant integration.

1.4 Outline for this book

In order to pursue the planned analysis of the coevolution of the health care and the public health policy sectors in five countries, this book will proceed in the following manner. Chapter 2 defines health care and public health as two different policy sectors. Notably, I will explain how they differ regarding ideas, actor constellations, policy instruments, and conflicts. Chapter 3 discusses my theoretical priors and develops hypotheses concerning the horizontal relations of health care and public health. I will discuss how both sectors

https://doi.org/10.1017/9781108670883.001 Published online by Cambridge University Press

can be coupled by developing different forms of sectorial coupling. Subsequently, I discuss why I expect differences in sectorial coupling between countries and over time, particularly as a result of differences in the political activity of health professions and fragmentation of government. Contextual elements – namely pressing problems for changes in health policy, i.e., due to new diseases – lead me to expect differences of sectorial coupling over time. Chapter 4 elaborates on the contextual dimension. I discuss how patterns of diseases, the technological development over time, broad ideas, and the economic development create demands for responsiveness between policy sectors. Chapter 4 concludes with 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.

Chapters 5 to 9 comprise the case studies for the five countries. Each case study reviews the coevolution of both sectors, strictly along the two main analytical dimensions (actor–policy responsiveness and institutional distinctiveness), in each of the four time periods. Each chapter concludes with a summary of the results and a discussion of the hypotheses (professionalization, governmental fragmentation, and contextual elements) in light of the empirical analysis' findings. Chapter 10 presents a comparative evaluation of the results. Therein, I summarize my main results, compare the coevolution of the sectors, and present a revised argument with more specific causal pathways in order to account for other theoretical elements as well.

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