Editor's Note

Comparative Health Politics: The United States and the United Kingdom

The enactment of the Patient Protection and Affordable Care Act of 2010 moves the United States closer to the norm of universal insurance coverage embraced by the rest of the industrialized world. To be sure, even with the new legislation, the United States will not have a system of universal insurance coverage: there still will be 15–18 million uninsured, even after the complicated combination of Medicaid expansions, insurance exchanges, federal subsidies, tax credits, mandates, regulations, and fiscal penalties goes into effect in 2014. So while there certainly is a story of convergence (as the United States moves closer to the international norm), there is still a story of divergence (as we discuss next steps to help the remaining uninsured).

A cross-national comparison on insurance coverage is part of a broader set of cross-national comparisons on health systems more generally. Why the emphasis on such comparisons? Is there utility beyond national pride (or shame) when the latest effort to rank health systems is released? Do nations learn from others' experiences? How do we consider cross-national efforts to cope with a common set of problems (rising costs, uneven quality, inefficient delivery systems), while simultaneously acknowledging and accounting for the unique historical, political, cultural, and economic contexts within each nation? Are health systems around the world converging around particular financing or delivery strategies?

One of the leaders in the effort to consider these cross-national issues is Adam Oliver, a health and behavioral economist at the London School

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of Economics (LSE), often working collaboratively with Lawrence D. Brown, a political scientist at the Mailman School of Public Health at Columbia University (and a former *JHPPL* editor). One afternoon over coffee, Adam, Larry, and I decided to propose a collaboration between Columbia and LSE under which faculty from the two institutions would work together to compare and contrast policy in the United States and the United Kingdom over a wide range of health care arenas. We applied for and received generous funding from our host institutions to create the LSE-Columbia Health Policy Group: special thanks to Gus Stewart at LSE and Roxie Smith at Columbia. We then created teams of researchers to work together, convened two conferences (one in London and one in New York), and produced the articles that together constitute this issue of *JHPPL*.

The U.S.-U.K. cross-national tale is, of course, long-standing. Over the (postwar) years, as the United States contemplated reform, England's National Health Service was always a powerful symbol — for the Left of what we ought to do (public authority, public money, and public management) and for the Right of exactly what not to do (socialized medicine). Moreover, the ideological polarity seemed to have empirical parallels: the United States was at one end of the cost continuum, England at the other, at maybe half what the United States spent in GDP terms on health care. England rationed because more is not always better and cost is an object. We Americans derided rationing (for the insured!) because more is always better and cost is no object, or so we assumed. So the question of how are the two nations alike and different has come down in the last few decades in rather tortured and perplexing form.

The issue begins with the article by Howard Glennerster and Robert C. Lieberman, which challenges the assumption that the United States and the United Kingdom represent opposite poles in the health policy arena. To be sure, Glennerster and Lieberman acknowledge the different paths taken after World War II: the United Kingdom enacted the National Health Service, while the United States used the tax code to encourage employers to provide private health insurance to their employees. Similarly, the British nationalized their hospital industry and organized and paid providers quite differently from their American counterparts. The divergence story is thus quite powerful. At the same time, the authors note that over the last twenty years, the British and the Americans have confronted a common set of challenges (the need for cost containment and for delivery reform) and have approached those problems with a range of similar strategies,

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including integrated delivery systems and the use of financial incentives to shape provider behavior.

George France, Chelsea Clinton, and I then consider intergovernmental relations in the United States and the United Kingdom, another arena where divergence has long seemed the defining characteristic: fragmented federalism in a single nation versus centralized leadership in a state of unions. Like Glennerster and Lieberman, however, the argument here is that there is evidence of convergence, as the United States becomes (marginally) less fragmented, with the enactment of the recent health reforms, while the United Kingdom becomes (marginally) less centralized, with the devolution of authority to the member states (Scotland, Wales, and Northern Ireland).

Coeditors Adam Oliver and Larry Brown next delve into a policy arena where there is significant policy overlap and perhaps even some cross-national looking and learning: the use of financial incentives to shape both provider and consumer behavior. For example, both the NHS and the Medicare program have implemented large-scale pay-for-performance initiatives, and the authors offer a speculative typology of when and why such initiatives have the greatest impact. There also are many efforts on both sides of the Atlantic to encourage both simple personal behavioral changes (medication compliance) as well as more ambitious efforts (smoking cessation).

The next two articles consider two trends that are particularly important to policy makers throughout the world: health care for the elderly and the increased use of health technology. In their article, Michael Gusmano and Sara Allin reexamine the long-standing assumption that England rations by age (the painful prescription), while the United States rejects any age-based limits. The authors provide a more current and a more nuanced view: the elderly in England have worse access to certain specialty services (such as coronary bypass surgery), but they have better access to primary care (and so have better managed chronic conditions). Bhaven Sampat and Michael Drummond then examine the use in the two nations of health technology assessment, pointing out the differences between the two and the likely path forward. The United Kingdom, for example, has a public infrastructure (National Institute for Health and Clinical Excellence) that is designed to examine the clinical and cost effectiveness of health technologies, and the NHS uses its (sometimes controversial and unpopular) conclusions to shape coverage policy. In the United States, by contrast, health technology assessment is generally done below the

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radar screen, by private insurers, who then use prior authorization and co-payment tools to implement. The authors conclude that despite the current fascination with technology assessment in the United States, the likelihood of a British-styled strategy is extremely unlikely.

Gwyn Bevan and Katharina Janus then bring us back to a story of convergence: regardless of good evidence and elite consensus that integrated delivery systems (such as Kaiser Permanente and Group Health) work well, neither the United States nor England has moved aggressively to develop and expand the model. There is of course much rhetoric (and even some legislation) designed to encourage such delivery integration, but Bevan and Janus conclude that the established (and quite different) organizational arrangements in the two nations serve as major obstacles, and that each nation needs to focus on hybrids that replicate the successful models now in place, rather than continue the nearly forty-year effort to replicate Kaiser Permanente or Group Health here or abroad.

Tony Barnett and Corinna Sorenson then provide another variation on the divergence/convergence balance: infectious disease surveillance is largely decentralized in the United States and centralized in the United Kingdom, but in both nations evolving trends are pulling toward the middle. One new variable is the globalization of infectious disease (which challenges the American bias toward decentralized surveillance). At the same time, the implementation of devolution in the United Kingdom is providing at least something of a push in the opposite direction (toward a more decentralized model).

The issue concludes with an inquiry of a very different sort: a comparative analysis of the impact of racism on health in the United States and England. Here the evidence reviewed by authors Peter Muennig and Michael Murphy seems rather unclear: blacks are healthier in England than in the United States, but on other measures the evidence seems harder to read. For example, black immigrants live longer in the United States than in England. The authors conclude that many mysteries escape simple explanation, and that perhaps is a good coda for this entire issue: there are various ways in which a U.S.-U.K. comparison illuminates and offers useful lessons, and other ways in which the comparison slips into the murky terrain of national history, politics, demographics, and culture.

Taken together, the eight articles in this issue provide interesting cross-national insights on a range of health policy issues. Enjoy!

Michael S. Sparer

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