Introduction

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Introduction

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The two chapters in this section aim to answer a broad research question from an international perspective: to what extent does integrated healthcare policy reform impact policy design and people's living conditions? Integrated healthcare reforms have aimed at addressing global concerns about the consequences of the demographic and epidemiological transitions, taking into account the increased threat of fragmented healthcare service delivery and mounting healthcare expenditures. Through a comparative lens, the chapters here focus on the Chinese and European welfare states to address why integrated healthcare reform is key, the different reform paths taken, and their policy outcomes. The chapters provide new insight into—and social recognition of—the specific social policy fields that currently affect the directions taken in healthcare policy development globally and the populations at risk for sliding into poverty based on access to healthcare. These issues were already relevant before COVID-19 and have remained so during the pandemic. Together, the two chapters also present deviations regarding the definition of policy integration. The chapter on the "Relationship between Poverty Risk and Access to Healthcare in Germany and China during the COVID-19 Pandemic" focuses on policy integration of healthcare policy and long-term care policy fields, addressing how they are integrated with regard to the risk low-income people face of falling into poverty. The chapter "Comparing Policies and Strategies for Integrated Care Reforms in China and Norway" centers on healthcare policy integration reform at different levels of medical care institutions before COVID-19 and discusses the impact of integrated care reform on policy implementers. Both chapters use an international comparative perspective to compare healthcare policy in China with that in Germany and Norway, respectively.

Comparing Germany with China is particularly significant because the two countries share a similar social insurance regulation system and hold strong cultural values of family solidarity; however, they experienced different policy outcomes in the fight against COVID-19. Germany can learn from the Chinese government's support for a flexible

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healthcare policy scheme that lies within the structured social insurance system. This will be important for facing issues arising in a post-pandemic world. Conversely, China can learn from Germany's effective integration of specific policy fields to support the role of a welfare state in poverty risk prevention. The second comparison, between China and Norway, is also pertinent since both countries have been considered "reluctant reformers" in integrated care reform, which has facilitated and shaped a shift in global healthcare policy practice with pattern deviations. Moreover, both countries have implemented reform at about the same time, the Norwegian Parliament passing a Coordination Reform in 2012, with implementation taking place in the same year, and China unveiling and prioritizing its multi-tier diagnosis and treatment reforms in 2015. The comparative work in this chapter interrogates the policy rhetoric of this transition and examines areas of divergence in reform strategies between China and Norway.

Until now, most available studies on integrated care reform have focused on comparing OECD countries like Germany, the Netherlands, and the UK, to each other. Some studies have sought an understanding of integrated reform in low-to-middle income countries, but these are too diverse and fragmented to provide an overall vision of global health policy processes. Overall, this section of the book argues not only that there is a need for more case studies on integrated care reforms outside Europe and North America, but also that studies that compare the strategies for integrated care reform across high-income countries are particularly valuable. In addition, previous research has frequently proposed service provisions, financing, and the regulation of social policy systems as appropriate analytical dimensions for healthcare systems or long-term care policy. However, few studies have systematically examined the extent to which healthcare systems are linked to the risk of low-income groups of falling into poverty. Furthermore, little is known about the influence of differentiated levels of welfare in healthcare systems on poverty risk conditions in low-income groups (specifically, access to healthcare services and long-term care insurance, as well as the extent of benefits). Therefore, analyzing how a healthcare system contributes to poverty risk prevention in low-income populations helps highlight and explain differing cross-national policy outcomes, especially during the COVID-19 crisis. Against this background, the second study in this section argues that low-income people's hypothetical poverty risk is markedly correlated to the generosity dimensions of a healthcare system and that integration of long-term care insurance has a significant impact on poverty risk. The study introduces an analytical framework to examine the hypothetical poverty risk of low-income people bound by differing healthcare policy dimensions and compares two healthcare systems that practice a similar type of social insurance but are based on different traditions.