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Healthcare Systems in Comparative Perspective: Classification, Convergence, Institutions, Inequalities, and Five Missed Turns

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Abstract

This essay reviews and evaluates recent comparative social science scholarship on healthcare systems. We focus on four of the strongest themes in current research: (1) the development of typologies of healthcare systems, (2) assessment of convergence among healthcare systems, (3) problematization of the shifting boundaries of healthcare systems, and (4) the relationship between healthcare systems and social inequalities. Our discussion seeks to highlight the central debates that animate current scholarship and identify unresolved questions and new opportunities for research. We also identify five currents in contemporary sociology that have not been incorporated as deeply as they might into research on healthcare systems. These five "missed turns" include an emphasis on social relations, culture, postnational theory, institutions, and causal mechanisms. We conclude by highlighting some key challenges for comparative research on healthcare systems.

Keywords

cross-national; health policy; social organization of healthcare

INTRODUCTION

Nearly two decades have passed since the *Annual Review of Sociology* last published an essay on healthcare systems. Mechanic & Rochefort (1996) identified medical care as buffeted by countervailing forces of international convergence on the one hand, and institutional path-dependence on the other. In the seventeen years since, efforts to classify healthcare systems have contributed to the precise assessment of similarities and differences among healthcare systems. Still, the convergence debate has not been resolved, which reflects developments in the sociology of globalization, and provides new opportunities for a closer dialogue between sociological theory and health services research. The institutional boundaries of what constitutes a healthcare system are also up for grabs, as policy innovations in healthcare point toward the integration of healthcare into other fields, the

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devolution of delivery to sub-national organizations, and the development of transnational organizations devoted to healthcare. Another lively area of comparative research on healthcare systems is inequality: inter-governmental organizations, national governments, and well-funded nongovernmental organizations have set an agenda of monitoring and reducing disparities, including disparities in healthcare.

In this essay, we evaluate each of these four research themes – classification, convergence, institutional boundaries, and disparities – within the field of comparative healthcare research, highlighting the central debates that animate current scholarship. We also identify unresolved questions and new opportunities for research. At the outset, we note that we focus on sociological research, but, like healthcare systems themselves, the boundaries of comparative healthcare system research are porous. Sociologists are well represented, but are probably in the minority if health economists, political scientists, health-services researchers, epidemiologists, and public health scholars are also included (as we believe they should be, and as we try to do). Fortunately for the coherence of an essay like this, the problems and debates currently driving research on comparative healthcare systems are themselves inter-disciplinary, as scholars from many fields are engaging them. Unfortunately for sociology, we think, this area has detached somewhat from the discipline’s central theoretical and substantive developments, and so one of our goals is to encourage re-engagement (cf. Beland 2010; Leiber et al. 2010; Light 2004).

Before turning to our evaluation of four of the largest areas of comparative research on healthcare systems, we want to revisit why we should compare in the first place. In healthcare system research, three concerns motivate most work: (1) accurate description, (2) performance assessment, and (3) policy diffusion. The descriptive impulse is strongest in attempts to develop clusters or types of healthcare systems, on the basis of selected measures such as expenditures, performance, and organization. The performance impulse is strongest in the “health production function” tradition of health economists, in rankings of healthcare systems, and in applied policy research on the results of specific policy innovations. The diffusion impulse is strongest in work that identifies lessons from some healthcare systems for other healthcare systems (Light 1997; Mechanic 2008; Ruggie 2011), and in research on globalization and healthcare.

We see a need for more work that would be motivated by general institutionalist theory: comparative healthcare systems research is especially well-positioned to investigate how institutions – the “rules of the game” – have distributional implications and generate winners and losers. That is, healthcare systems shape inequalities within and between societies. Since healthcare institutions vary so greatly across national, trans-national, and sub-national contexts, two central questions for comparative healthcare systems research should be what explains this institutional variation, and how this institutional variation matters for the distribution of population health. In other words, a person’s birth in a place with one healthcare system rather than another can be conceptualized as a sort of natural experiment (Habbema et al. 2012). Given that there is so much debate among health researchers over which aspects of a person’s position in society (e.g. education, wealth, income, class) matters most for health (Mechanic 2007), comparative research across healthcare systems is potentially important for developing new knowledge of how, when, and why such positions matter.

In what follows, we first review and critique four central concerns of comparative research on healthcare systems: classification (which has generated creative typologies of healthcare systems), convergence, institutional boundaries, and disparities. Next, we identify five currents in contemporary sociology that have not been incorporated as deeply as they might into research on healthcare systems. Then, we conclude the essay with a discussion of the practical challenges to comparative research on healthcare systems.

CLASSIFYING HEALTH CARE SYSTEMS

Before considering classifications, it is important to define what the healthcare system is. Quadagno (2010) sees it as "organizations that both deliver care and medical services (hospitals, physicians' practices, clinics) and that arrange for the financing of care (governments, agencies, states, local communities, and private insurance companies)." Many configurations are possible, and the goals of comparative typological research are to reduce the massive amount of data that is available on any given healthcare system, and to identify a reasonably small set of common configurations. Recently, comparative health care researchers have taken this notion seriously and not only attempted to classify nations, but to consider how that can be done in a way that is analytically meaningful and can move our understanding of health care systems across countries forward.

Turning to different classifications, researchers have been interested in comparing health care systems, at least since Anderson (1972) set out to compare the health care systems of the U.S., Sweden and England. Early on, Field (1973) identified four ideal types, mostly based on ownership and doctors' autonomy (the *pluralistic* health system, the health *insurance* system, the health *service* system, and the *socialized* health system). Since then, the appropriate dimensions have been debated by researchers, for example whether it should be focused on the main organizational unit (Terris 1978), the form of state control over the production of medical care and the basis for the eligibility of the population (Frenk & Donabedian 1987) or the functional strength and structural superiority of a specific medical tradition (Lee 1982). Despite the different ways in which a classification is possible, researchers often appear to come back to two key dimensions: funding and ownership (Wendt et al. 2009).

Given the great interest in trying to classify health care systems, many have attempted, although often unsystematically to do so (Wendt et al. 2009). Here, some variation of the three types of the National Health Service system, social insurance system, and private insurance system has been popular within the context of rich democracies. The UK is the classic case of NHS; Germany is the classic case of social insurance; and the US is the classic case of private insurance (Burau & Blank 2006; Schmid et al. 2010). Similarly, when including Eastern European nations, the systems have also been referred to by the name of their founder as the Beveridge, Bismarck, and Semashko health systems (Stevens 2001). The systems differ by organizational configuration and by the role of three principal actors – the medical profession, the state, and the payers. The *Bismarck* model is financed through insurance fee and the role of the state is limited to overseeing a system of contracts among patients, providers, and insurers. The medical profession has the autonomy to make decisions about the provision of services. Countries belonging to this type include Canada, France, Germany, Japan, and the United States. In the *Semashko* model, universal health care is controlled directly be the state that owns facilities, finances them through the state budget, and allocates services to the population. Nations included in this type are Bulgaria, Czech Republic, Hungary, Poland, and Russia. Finally, the *Beveridge* model secures free access to health care in hospitals, but does not require complete state control of all facilities. In addition, the medical profession has higher levels of autonomy, and physicians can opt out of the system. Countries belonging to this system are Italy, New Zealand, Spain, Sweden, and the United Kingdom (Lassey et al. 1997; Stevens 2001).

More recently, and in an attempt to systematically combine the dimensions of funding, service provision, and governance, Moran (1999, 2000) proposed the concept of “healthcare state.” His scheme incorporates consumption, provision and production of health care. There are four families of health care states in his classification: the entrenched command and control state, the supply state, the corporatist state, and the insecure command and control state. In *command and control states*, the state controls all three governing areas. This would be the case in Scandinavian countries and the UK. In *corporate healthcare states*, there is a mix of public law and doctors’ association that control the health care field as is in Germany. Provider interest dominates the *Supply states*, and the US is the clearer example of such a state. Finally, the *insecure command and control states* are different from other NHS types because their nationalized hospital sector coexists with a large private sector. Greece and Portugal provide examples for this type (Moran 2000).

While this framework is the most comprehensive and has the highest level of generalizability, Wendt et al. (2009) argue that it still requires some specification to meaningfully compare a larger number of countries. In order to do so, they develop a classification of 27 distinct types of healthcare systems based on the potential range of variation of financing, service provision and regulation. Focusing more on access regulation than on the balance of state and market, they then identify three ideal types: the *state healthcare system*, the *societal health care system*, and the *private health care system*. There are six mix-typed systems possible under each ideal type, as real health care systems will never confirm exactly to an ideal type (e.g. a system can correspond to a state health care system on two domains, but a societal health care system on one). In one of the first attempts to empirically test how health care systems cluster, Wendt (2009) analyzed 15 European healthcare systems to construct groups of health care systems expenditure, financing, service provision and access regulation in analytically distinctive ways. Using the broad categories of health expenditure and private payment, healthcare provider indices, and institutional indicators, he identifies three distinctive health care types: the *health service provision-oriented type*, the *universal coverage – controlled access type*, and the *low budget – restricted access type*.

Austria, Belgium, France, Germany and Luxembourg belong to the *health service provision-oriented type*. These countries put a high importance on service provision, especially in the outpatient sector. There is a high number of providers and a free choice of medical doctors.

Patients are expected to pay only a modest out-of-pocket copayment. Importantly, and in contrast to the U.S., autonomy of patients and equal access are greatly valued and matter more than on the autonomy of the medical profession. Denmark, Great Britain, Sweden, Italy and Ireland belong to the *universal coverage-controlled access type*. Here, all citizens are covered through universal plans, but access to care is strictly regulated by the state. Finally, Portugal, Spain, and Finland compose the *low budget-restricted access type*. These are the low spenders that restricted use, due to high co-payments, and requirement of going to the same doctor for a long period of time. While this typology is theoretically and empirically ambitious, it still remains to be seen whether this typology generalizes beyond the healthcare systems included in the analysis (Wendt 2009). We also note that efforts to typologize – helpful as they are as a descriptive technique for data reduction – do cut against the grain of research that tries to develop lessons for one healthcare system from others (Rochefort & Donnelly 2012). Such efforts can also be criticized for oversimplifying the differences among healthcare systems (Baldwin 2005).

CONVERGENCE, NEW AND OLD

There are strong pressures for the convergence of healthcare systems, and so there is a robust debate over whether, when, why, and how convergence has taken place (Glennerster & Lieberman 2011; Marmor et al. 2005; Schmid et al. 2010). Most analyses of convergence examine rich democracies (Wilensky 2002), operationalized as the member states of the Organization for Economic Cooperation and Development (OECD), which is among the international organizations that have been identified as potential forces for convergence. Research on the role of international organizations, including the OECD and the World Health Organization, is a prominent part of a wave of “new convergence” research that draws inspiration from the sociology of globalization (Brady et al. 2007; Deleon & Resnick-Terry 1998; Guillen 2001). The Commonwealth Fund is one example of an international non-governmental organization, or INGO, that supports efforts to transfer policies across national borders (Chalkidou et al. 2009). International organizations arguably generate convergence by creating ties among policymakers (Heymann et al. 2010; Slaughter 2005), and by diffusing norms about what constitutes “appropriate” policy (Meyer et al. 1997). The human rights framework is one such set of global norms (Cuadra 2012; Gruskin & Dickens 2006); privatization of health services is another (Holden 2005). The “where” of convergence has largely been overlooked, despite the pronounced regionalization of international organizations (Beckfield 2010; cf. Lovecy 1995). Likewise, the timeframe for convergence – which moments in history generate what sort of convergence and why – remains undertheorized.

Policy diffusion need not be between nation-states; Clavier (2010) identifies instances of cross-border, local-level convergence in healthcare among communities in Denmark and France, which adopted ideas from the social determinants of health framework that has gained international prominence through the efforts of the WHO. Still, most analysis of diffusion examines national-level policy innovations, including what is known as “comparative effectiveness research” in the US, and “health technology assessment” or “evidence-informed policymaking” in other rich democracies (Chalkidou et al. 2009). Schmid et al. (2010) find evidence of convergence across healthcare systems, insofar as many systems are becoming “hybrid” systems through the introduction of policies borrowed from other systems (see also Tuohy 2012). For instance, healthcare systems as disparate as the US, Germany, and the UK have all adopted Diagnostic-Related Groups (DRGs), though these serve different functions in each system. Focusing on the US and the UK, Glennerster & Lieberman (2011) identify elements of “hidden convergence,” as ideas about service delivery and cost containment cross the Atlantic. In a rare global-scope analysis, Weiner et al. (2008) demonstrate that managed-care organization of healthcare has been “exported” from the US to many other healthcare systems, including low-income countries (also see Jasso-Aguilar et al. 2004). Holden (2005) finds that the privatization of healthcare services has been adopted in many healthcare systems, although a global market for healthcare services has not emerged.

The Pan-American Health Organization is another example of an international organization involved in policy diffusion; it started in 1902 as the International Sanitary Bureau, largely under US influence, and is now a regional office of the World Health Organization (Fee & Brown 2002). Latin American “social medicine” is one approach that highlights broad social conditions and social inequalities as important for understanding specific diseases (Krieger et al. 2010, Waitzkin 1998); as such, PAHO is one of the drivers of convergence of healthcare systems in the Americas, as its promotion of social medicine resonates with concerns about social inequalities evident in North American and Canadian policymaking. This regionalization of international health policy diffusion is possible elsewhere too, as the WHO organizes its efforts regionally around the world. The Bamako Initiative for primary care is an example of regional policy in West Africa (Ridde 2011).

While attention to globalization produced a wave of “new convergence” research that emphasized international policy diffusion, the “old convergence” forces of aging populations, economic decline (or at least slower growth in the rich democracies), and maturing welfare states continue to put pressure on healthcare systems (Marmor et al. 2005). The “common pressures” argument for convergence is that because the rich democracies face similar challenges, they will tend to adopt similar responses. For instance, Rice & Smith (2001) note that capitation, which gives a per-capita budget on healthcare spending that is sometimes adjusted for socioeconomic status, is widespread among healthcare systems of various types. High-cost cancer treatments also raise challenges of rationing care for healthcare systems (Faden et al. 2009). Still, while it is certainly true that many healthcare systems face common demographic and economic challenges, healthcare systems are embedded in national sociological and cultural systems that introduce contingency and path-dependence into efforts at policy learning (Marmor et al. 2005). Healthcare systems are also objects of domestic politics, as in the case of the 2007 German reforms (Leiber et al. 2010).

Grignon (2012) notes that if there has been convergence of healthcare systems, any such convergence has been slow. Candidate explanations for the slowness of reform include path dependency, veto points, public opinion, and stakeholder mobilization. Marmor et al. (2005) also blame superficial comparative analysis for the slow rate of policy learning. The development of common regulations has been slow even in the European Union, given the “constitutional asymmetry” between the EU-level drive for a common political economy, and the maintenance of national-level regulatory authority over healthcare (Permanand & Mossialos 2005).

INSTITUTIONAL BOUNDARIES

Where, analytically, is the healthcare system? One of the underlying issues in the convergence debate is that while healthcare systems are national, they are also international, and arguably becoming more international over time as “global health” gains attention and funding (Dickens 2011; Katz et al. 2011; Shaffer et al. 2005; Tarantola 2005), and as patients engage in “medical tourism” (Turner 2010). Even within a nation-state, it is difficult to distinguish the healthcare system from the welfare state (and indeed the provision of healthcare as a citizenship right is a conventional measure of the welfare state). Expenditures on healthcare constitute, in many rich democracies, one of the largest shares of government outlays across policy domains. Furthermore, medical care, which is usually if implicitly seen as the “core” of the healthcare system, is only part of the healthcare system, and “non-medical health policies” (Burau & Blank 2006:67) integrate the healthcare system with other parts of the welfare state. There have also been persistent calls for “health in all policies,” although there is little work comparing the health performance of the healthcare system to the health performance of other policy areas (Parker et al. 2010). Healthcare is delivered at the local level, such that field analyses can capture the multiplicity of actors involved in healthcare (Scott et al. 2000), and caregivers (most often women) face severe constraints when healthcare is delivered in the home (Lilly et al. 2007), or in schools (Silberberg & Cantor 2008). To put it bluntly: we are arguing that the boundedness and coherence of any “healthcare system” should not be taken for granted. Rather, its social ontology should be investigated as a research question.

The variable boundaries of what researchers call healthcare systems are apparent in cases where the organization of the polity structures healthcare systems. In Europe, the largest political change that shapes healthcare systems is arguably the introduction of multilevel governance through European integration (Kohler-Koch 1996). In the US, federalism organizes the healthcare system – some functions are performed by the central government, other functions are performed by local units, and others are a blend (Greer & Jacobson 2010). Sparer et al. (2011) argue that the 2010 Affordable Care Act in the United States, which devolves substantial responsibility for healthcare insurance (already fragmented by state-specific Medicare and Medicaid policies) to the US states, could follow the same path as devolution in the UK in 1999, which has sparked intergovernmental efforts at strengthening government involvement in the healthcare system. We also note that the Affordable Care Act, which marks a real change in the US healthcare system, expressly excludes undocumented immigrants, potentially reinforcing a citizenship-based axis of inequality.

Migration is one significant trend that blurs the institutional boundaries of healthcare systems. Research on migrants is usually focused on documenting disparities (see below), but research on migrants that seeks to explain the evolution of healthcare systems highlights how international migrants experience very different national institutional environments over the life course. This is particularly pronounced in the European Union, where efforts to encourage internal migration arguably blur the boundaries of healthcare systems.

In the US, Schlesinger & Gray (1998) note that managed-care organizations in the 1990s were under pressure to demonstrate a wider “community benefit” (defined in US tax code, demonstrating the connections between the national legal regime and health policy); this is an example of how policy can blur the boundary between healthcare organizations and the community it is embedded in. Such blurring has generated a debate over the role of public vs. private actors in healthcare systems (Gran 2003).

DISPARITIES, INEQUALITIES, INEQUITIES

We note at the outset of this section that although most research on social inequality in healthcare appears under the rubric of “healthcare disparities research,” there is a robust debate over conceptualization (Braveman 2006). Governmental and non-governmental organizations are making efforts toward reducing healthcare disparities, and advocates and researchers are interested in incorporating health inequalities research into policy (Exworthy et al. 2006; Gibbs et al. 2006; Pittman 2006). This is despite the “rule of the thumb” that the healthcare system contributes no more than 10% to overall healthcare disparities; this truism is in line with longstanding work demonstrating that public-health improvements such as basic sanitation have far outweighed medical technology in the lowering of mortality rates across the advanced industrial countries, although critics argue that technology matters more in mortality reduction after 1945. Still, in a comparison of cervical cancer rates in the US and the Netherlands, for instance, Habbema et al. (2012) find little difference in rates of cervical cancer, despite dramatically higher levels of preventative services in the US.

Nevertheless, there is growing interest in the relationship between healthcare disparities and health disparities, particularly in countries that have passed the demographic transition and exhibit higher rates of chronic disease (Wright & Perry 2010). There is also increased need for comparisons of how healthcare systems moderate or exacerbate different kinds of healthcare disparities. For instance, Norredam et al. (2006) and Cuadra (2012) reveal striking cross-national differences in the healthcare rights accorded to migrants in the European Union, and Schnittker & Bhatt (2008) highlight disparities in healthcare by race and income groups in the U.S. and the U.K. However, this issue would benefit from a systematic treatment of how the healthcare system variously shapes race-, gender- and class-based disparities in healthcare.

Link & Phelan’s (1995) now-classic article on “social conditions as fundamental causes of disease” has sparked a strong research tradition on the various “upstream” (cf. Krieger 2008) social conditions that shape disease distribution. Only some of this work has been comparative (Elo 2009). One pressing question is how the healthcare system relates to other broad social conditions that matter for health and disease. King and coauthors (2009), for instance, show that privatization of healthcare systems in the former Soviet states was associated with elevated levels of stress and reduced healthcare resources, but they find little evidence of a strong direct effect of privatization through healthcare. Turning to low-income countries, Croghan et al. (2006) find that targeted improvements to the healthcare system outweigh broader changes like economic development and governance institutions in lowering child mortality.

An alternative, and perhaps currently predominant, approach to measuring healthcare system performance is to quantify “healthy life expectancy” or the average amount of time the average person at a given age can expect to live in good health (Stiefel et al. 2010). The aim of such research is to establish a single number as a policymaker-friendly measure of the performance of healthcare systems. We think this underestimates the capacity of both the policymaker and the healthcare system (Leiber et al. 2010). Clearly policymakers attend to distributional issues, so they would likely attend carefully to measures that included information about the distribution of health across socially meaningful groups. Such an aggregated, summary estimate of a central tendency also potentially underestimates healthcare systems since such systems represent institutions that create winners and losers. For instance, Schuster and coauthors (2005) identify significant gaps between need and healthcare delivery, and they suggest detailed methods for monitoring the quality of health care. We note that monitoring quality and inequality is a forefront area for data collection since current data collection often fails to match the political organization of healthcare delivery (Blewett et al. 2004; Gibbs et al. 2006).

A new controversy surrounding healthcare system “outputs” is the relationship between population-health measures such as healthy life expectancy and measures of inequalities in health (Krieger et al. 2008). On one side of the debate are those who argue that social inequality in health is in part a function of improvements in population health. That is, the very things that improve population health (e.g., basic sanitation, medical technology, and healthy behaviors) are likely to increase health inequalities because those with greater socioeconomic resources will be better positioned to adopt such technologies (Cutler et al. 2006; Glied & Lleras-Muney 2008). Conversely, others argue that advances in mortality and life expectancy will instead be associated with declining inequalities in health because such population health improvements are propelled by enhanced health prospects among previously disadvantaged groups (Siddiqi & Hertzman 2007). Research on this debate has so far been mixed, with studies providing support for both claims. Moreover, some evidence suggests that the relationship between health improvements and health inequalities may differ across nations and social contexts (Krieger et al. 2008). This raises the possibility that healthcare systems play a role in determining the extent to which improvements in population health are accompanied by widening or declining inequalities and suggests a prime opportunity for further cross-national research that explores linkages between population health and health inequalities.

A forefront area for comparative research on healthcare systems is variation in health disparities across nations. Research has established that the association between socioeconomic position and health outcomes varies substantially in different countries (Beckfield & Olafsdottir 2009; Kunst et al. 2005; Stirbu et al. 2010). Mackenbach and colleagues (2008) evaluate this relationship in 22 European countries and report substantial cross-national differences in the extent to which education predicts mortality risk. For example, in Norway, the risk of mortality between the least and most educated men differs by a factor of two, but in Poland, this risk differs by a factor of more than four. Scholars have begun to explore the extent to which healthcare systems can account for such cross-national variation in health inequalities. One line of research uses welfare regime types (e.g., Esping-Andersen 1990) to represent broad differences in the nature of healthcare systems across countries (Bambra 2007; Muntaner et al. 2011). Borrell and colleagues (2009) examine variation in the relationship between education and self-rated health across welfare regime-types in 13 European countries. They find evidence that countries classified as Social Democratic have the lowest health inequalities while reporting minimal variation between other regime-types. Other studies further develop this research (e.g. Bambra et al. 2010b; Beckfield & Olafsdottir 2009; Cavelaars et al. 1998; Eikemo et al. 2008; Espelt et al. 2008; Navarro et al. 2006; Olafsdottir 2007), but a consensus has not yet been reached on the extent to which welfare regimes structure the relationship between socioeconomic position and health outcomes. Underlying this literature is the notion that different welfare regimes are associated with variation in healthcare systems across countries. Although this may be a valid assumption, few scholars have attempted to link particular features of national healthcare systems to cross-national variation in health inequalities. Thus, a promising area for future scholarship is research that moves beyond comparisons of welfare regimes to study how the specific policies that differentiate national healthcare systems help to explain variation in the relationship between socioeconomic position and health across countries.

Finally, healthcare systems also contribute to inequalities between countries. Stuckler (2008) examines the rise of chronic disease rates in low-income countries and argues that health inequality and economic inequality between high-income and low-income populations will grow over time if current trends continue. Other research on cross-national differences in health outcomes uses clustering techniques to identify groups of nations with comparable health outcomes and finds dramatic disparities between such groups (Day et al. 2008; Ruger & Kim 2006). Ruger & Kim (2006) categorize countries based on mortality rates as better-off, mid-level, or worse-off. They find that countries ranked worse-off in child mortality had higher rates of extreme poverty, lower per capita expenditure on healthcare, fewer hospital beds and doctors, and lower rates of access to improved water, sanitation and immunizations (cf. Day et al. 2008). This suggests an important role for healthcare systems in structuring inequalities in health between countries.

FIVE MISSED SOCIOLOGICAL TURNS

Our goal in this section is to suggest some ways that comparative research on healthcare systems can use theoretical developments from other areas of sociology, and to suggest how sociologists working in other areas of inquiry might find healthcare systems of interest for their own purposes. In other words, we want to encourage conversation. How might sociologists incorporate analysis of healthcare systems into their comparative research? One approach is to use healthcare policy as a case of social policy; strong connections to political sociology and the sociology of the welfare state can thus be made. The convergence debate, for instance, has been advanced by welfare-state scholars (Armingeon & Beyeler 2004; Pluemper & Schneider 2009), whose insights suggest a range of new hypotheses and analytical approaches for comparative healthcare system research. A second approach would be to compare healthcare policy to other areas of social policy, perhaps to demonstrate the distinctiveness or similarity of policy fields. This seems to us the road not taken; we have located very few studies that compare the healthcare system to other “systems” (pension systems, employment systems, etc.). Field-analytic studies, for instance, tend to examine the healthcare field as a case to explain its evolution; comparison is thus diachronic. One exception of the tendency to analyze the healthcare system in isolation is Lovecy (1995), who compares the regulation of medicine to the regulation of law. A third approach is to use the comparative analysis of healthcare systems as a way to investigate broader theoretical concerns (Beland 2010; Green-Pedersen & Wilkerson 2006). But whatever the rationale for investigating healthcare systems, there are several currents of contemporary sociological theory that seem not to have emerged as major concerns in understanding healthcare systems in comparative perspective. This may be one reason that the subfield most closely connected to the analysis of healthcare systems – medical sociology – is sociometrically distant from large subfields such as race/ethnicity, economic sociology, political sociology, cultural sociology, and theory (Lin 2013).

The relational turn

The first “missed turn” we want to highlight is the relational turn in sociology (Emirbayer 1997; Mische 2011; Tilly 1999). Sociologists increasingly investigate specific social relations, often through ethnography, such as eviction (Desmond 2012) and social exclusion (Silver 2007). In light of the strong tradition of research on doctor-patient interaction in medical sociology, it is surprising that the analysis of specific relational structures has not made more of a mark on the comparative analysis of healthcare systems. This is probably a function of method, as most of the work we have reviewed is macro-sociological. As Lutfey & Freese (2005) note, the analysis of doctor-patient interaction holds great promise for specifying “fundamental cause” theory. If placed into a comparative framework, such research could reveal the macro-institutional arrangements that condition the utility of SES in chronic disease treatment. That is, are there certain institutional arrangements – specific “rules of the game” – that make class, status, race, citizenship, and gender more or less important in the relations that constitute healthcare systems?

What exactly is comparative healthcare systems research missing, if indeed it can be argued that the field has missed the relational turn? An excellent example can be found in Annette Lareau’s work on how parents’ social class affects the way their children relate to institutions such as the healthcare system (Lareau 2003; Festa 2010). Such research could advance the debate over class and cognition in the effects of healthcare (Mechanic 2007). In missing the relational turn, research on healthcare systems has also missed the pragmatist theorization of social mechanisms (Gross 2009). Such an approach can help to reveal how healthcare systems matter differently for population health in different contexts, given the variable problems that are confronted in different healthcare systems, and the variable habits that actors in different healthcare systems follow.

The cultural turn

An emphasis on social construction and on the importance of meaning contributed to a shift across disciplines where researchers begun to theorize about the social world differently. Geertz’s (1973) redefinition of culture in anthropology was an important step to what is often referred to as the cultural turn (Alexander and Smith 1992; Bonnell and Hunt 1999;

Sewell 1992; Swidler 1986). Steinmetz (1994:1–2) refers to this development as an analysis that emphasizes: "the causal and socially constitutive role of cultural processes and systems of signification." In response and following this development, researchers have reframed the key theoretical and methodological issues in health care utilization research (Olafsdottir & Pescosolido 2009; Pescosolido & Olafsdottir 2010). More specifically, they have considered how the overarching cultural context of a society (or a smaller unit) impact the ways in which individuals respond when confronted with a health problem.

Along similar lines, Furedi (2006:17) has argued that "people's perception of health and illness are shaped by the particular account that their culture offers about how they are expected to cope with life and about the nature of human potential." While multiple factors in society can be understood as "culture", we have argued earlier that the social organization of the welfare state (including the health care system) provides the overarching national culture that citizens have come to expect (Olafsdottir and Beckfield 2011). A serious consideration of the health care system, not only as a political institution, but as a cultural one, helps us understand the expectations citizens hold about the relationship between the state, the market, and medicine. Consequently, it can provide clues to how and why health care systems drastically change or remain the same, as well as important insights into the debate on the convergence or divergence of health care systems around the globe.

Boundaries and construction of exclusion and inclusion regarding the health care systems are key issues that are debated within and across countries. To understand this, it is fruitful to bring to bear notions of cultural categories of worth (Katz 1986, 1989; Patterson 1994; Steensland 2006). Despite health and illness being culturally bound (Angel and Thoits 1991; Kleinman 1988); the threat of illness is universal. Consequently, which individuals and groups are considered worthy of assistance (e.g. universal vs. targeted benefits) provides insights into the broader culture of a society with clear implication of what is expected of the health care system (e.g. how it should provide services and to whom). As an example, an analysis of media discourse surrounding mental illness in the U.S. and Iceland reveals stark differences regarding possible causes and solutions of such illness. In the U.S. discourse, mental illness is viewed as an individual problem with individual solutions, whereas in Iceland the emphasis is on mental illness as a social problem with social solutions (Olafsdottir 2011). These clear cultural differences, grounded in the different social organization of welfare, likely shape mental health policymaking and provision. Therefore, understanding these cultural boundaries and frames across societies can provide a new perspective on the development and future directions of national health care systems.

Cultural sociology has made great progress toward theoretical specificity, distinguishing the concepts of symbolic boundaries, repertoires, frames, and narratives (Lamont & Small 2008). Each of these cultural concepts offers a distinct set of explanations that might resolve puzzles in debates over healthcare system typologies, convergence, institutional boundaries, and disparities. While the social organization of health care is undoubtedly about politics, we argue that culture plays an equally important role as it has a key role in defining the possibilities that are available to policymakers, practitioners and other stakeholders within a given society. An examination of the role culture plays in shaping national health care systems, as well as systematic cross-national comparisons, are likely to generate new insights regarding health care systems in a comparative perspective.

For example, although public-opinion surveys are sometimes included in typologies of healthcare systems (e.g. Wendt 2009), the theory of symbolic boundaries could be extended to the institutionalization of healthcare disparities through the treatment of migrants and ethnic minorities by the healthcare system. Hall & Lamont (2008) illustrate one way to incorporate cultural sociology into the comparative analysis of healthcare systems. Lynch & Gollust (2010) also consider the role of culture as they link current work on moralities to changes in the healthcare system. More specifically, they identify fairness norms as a symbolic resource for US reformers. Similarly, Stone (2006) identifies moral frameworks for state policymakers in the US for policies to reduce racial disparities. Still, morality is receiving sustained theoretical attention from sociologists, arguably as a case of the ongoing development of cultural sociology.

The postnational turn

Wimmer & Glick-Schiller (2002) theorize the practice and problems of what they call “methodological nationalism” – the epistemological premise that the nation-state is the natural unit for comparative research – in social science. An exemplar of how to move beyond methodological nationalism in the comparative analysis of healthcare systems is the work of Julia Lynch (2009), who ratchets down the level of analysis from the nation-state to the region (within Europe). Instead, in privileging the nation-state, most work in this area assumes two things it ought to set out to test: that most of the meaningful variation in healthcare systems is at the national level, and that our theories of how healthcare systems develop and what healthcare systems do apply to de-nationalized (Sassen 2006) healthcare systems.

We think a post-national approach fundamentally re-frames the questions of classification, convergence, institutions, and inequalities that motivate so much research on healthcare systems. Research that classifies healthcare systems rarely incorporates information on the nation-spanning organizations and policies that shape the healthcare system as an institution. Likewise, convergence research is usually oriented to convergence of nationally-organized systems, but what if the nation-state is simply the wrong unit of analysis? And, if the rules of the game that characterize healthcare systems have distributional implications, then surely it would be important to relax the assumption that those rules are somehow inherently national.

The institutional turn

Research on social stratification in sociology has taken an institutional turn, in that the “rules of the game” as formalized in law and enforced by the state has become a central explanation for social inequalities in wages, employment, and poverty (Esping-Andersen 1990, Western 2006, Beckfield 2006, McCall & Percheski 2010, Pettit & Hook 2009). Surprisingly, there is relatively little research on social inequalities in health that relates such inequalities to the healthcare system or other policies (Bambra et al. 2010a; Beckfield & Krieger 2009). One exception is Starfield et al. (2005), who identify primary care as equality-enhancing, relative to inequality-enhancing specialty care. This suggests that healthcare systems with more emphasis on primary care should exhibit more health equality. Another exception is Bambra (2005), who develops an index that measures decommodification in the delivery of healthcare. The *International Digest of Health Legislation*, along with the *Health Policy Monitor*, and online repositories of the World Health Organization, could serve as a useful resource for comparative analysis of health reform, which could be linked to distributional consequences. There is a need for such data for the 50 United States (Burris 2012). Currently, there are several new sources of individual-level data that could be used for cross-national comparison, drawing on the Luxembourg Income Study as a model. Such data sources include the European Health Interview Survey and European Health Examination Survey (Aromaa et al. 2003). These are but a few sources of data that would be useful in developing new insights into how healthcare systems (and related institutions) matter for social inequalities in health.

The healthcare system itself is an object of distributional contestation, e.g. by labor unions in the contemporary US (Gottschalk 2007). Evans (1997) examines distributional coalitions in healthcare systems, and argues that health service providers have a “natural alliance” with high-income citizens that drives the demand for pro-market healthcare policy. A recent review of the literature on inequalities in access to curative care gives some empirical support for this view, finding more class inequality in specialist care, and less class inequality in primary/GP care (Hanratty et al. 2007), across several healthcare systems. In the US, the UK, and the Netherlands, recent reforms of healthcare systems raise a host of new questions about distributional conflicts over healthcare, including unequal relations among stakeholders and other organized interests (Quadagno 2010; Tuohy 2012).

The mechanismic turn

The sociological analysis of mechanisms (or sequences of events that connect causes to effects) has matured to a point that it has a programmatic statement (Hedstrom & Bearman 2009). Theoretical development (the identification of causes) and analytical craft (the careful scrutiny of claims about data) have both benefitted from this mechanismic turn. We think that comparative healthcare systems research could also benefit from such an emphasis. For instance, the analysis of convergence often draws on sociological theories of diffusion, without investigating alternative mechanisms. An exception to this general “black box” tendency is Leiber et al. (2010), who examine the 2007 reform of the German healthcare system (which introduced central government health funds that finance insurance). The German system came to resemble the Dutch system much more closely after 2007, but rather than demonstrating policy learning, Leiber et al. are able to show, through a careful process tracing, how this case demonstrates that changes to the healthcare system resulted from policymakers’ pragmatic attempts to solve political problems (in this case, the problems of the new coalition that took power in Germany in 2005).

The need for an increased emphasis on mechanisms in healthcare systems research is also highlighted by the literature on health disparities. As previously discussed, research on how healthcare systems influence the relationship between social position and health has mostly focused on broad associations between national political regimes and health inequalities

(Muntaner et al. 2011). Moving forward, scholars must provide more detailed explanations of the mechanisms and pathways though which healthcare systems and other social policies affect health disparities. Whitehead et al. (2000) illustrate how such an emphasis can be effectively integrated into research on health inequality with their analysis of single mothers' health in Britain and Sweden. Their project seeks to identify the "entry points" through which policy may influence the relationship between socioeconomic position and health. After initial analyses show health disparities between single and coupled mothers to be similar in both countries, Whitehead and colleagues work to explain the mechanisms driving this association. They demonstrate notable cross-country differences in the pathways leading from single motherhood to health disadvantage, with poverty and joblessness playing a considerably larger role in Britain than in Sweden. This emphasis on the particular pathways linking single motherhood to health status not only provides a strong springboard for future research, but also provides a tangible set of takeaways relevant to social policy.

CONCLUSION

This essay reviews and evaluates recent comparative social science scholarship on healthcare systems. We have focused our essay on four of the strongest themes in current research: (1) the development of typologies of healthcare systems, with the aim of facilitating comparison and reducing the large amount of system-level data that are available; (2) assessment of convergence among healthcare systems, which tests hypotheses drawn from theories of common economic and demographic pressures, and globalization, (3) problematization of the shifting boundaries of healthcare systems, as responsibility for and costs of healthcare are shifted, and (4) the relationship between healthcare systems and social inequalities, as "disparities" have risen to the top of policy and research agendas over the past two decades. We have also identified how comparative research on healthcare systems might better incorporate new work from sociologists in the areas of relational sociology, cultural sociology, postnational sociology, social stratification research that examines political institutions as drivers of inequality, and social mechanisms.

We conclude this essay by highlighting the challenges of comparative research on healthcare systems. A major challenge is data: there is, at the same time, too much data and too little. The *OECD Health Database* is perhaps the canonical source for comparative healthcare system research, and while its utility for typological and convergence research is obvious, it is much less useful for analysis of institutional boundaries or social inequalities, and it is of course limited to rich democracies. To make progress on the most pressing questions in the field, researchers need access to data that is (1) comparable in the conceptualization and measurement of variables, (2) available for a wide range of healthcare systems, to avoid the truncation of institutional variability, and to facilitate assessment of generality, and (3) detailed enough to allow for the examination of specific causal mechanisms. We think the first challenge – comparability – is the highest hurdle. Comparative healthcare systems research, particularly large-N quantitative research, confronts the criticisms that (a) not enough can be known about all the healthcare systems involved to support strong causal inferences, and (b) each healthcare system is so complex and so different from other systems that each should be analyzed *sui generis*. Progress is possible, but requires effort at least as substantial as the Luxembourg Income Study, which sparked a generation of comparative research on income inequality. We think a similar feat is possible for healthcare disparities, and is necessary, lest the variation in healthcare systems (especially healthcare disparities) be massively under-estimated.

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LITERATURE CITED

Alexander, Jeffrey C., Smith, Philip. The discourse of American civil society: A new proposal for cultural studies. Theory and Society. 1993; 22(2):151–207.

Anderson, OW. Health care: can there be equity? The United States, Sweden, and England. New York: Wiley; 1972.

Angel, Ronald, Thoits, Peggy. The impact of culture on the cognitive structure of illness. Culture, Medicine and Psychiatry. 1987; 11(4):465–94.

Armingeon, K., Beyeler, M., editors. The OECD and European Welfare States. Cheltenham, UK: Edward Elgar Publishing; 2004.

Aromaa A, Koponen P, Tafforeau J, Vermeire C, HIS/HES Core Group. Evaluation of health interview surveys and health examination surveys in the European Union. Eur J Public Health. 2003; 13:67–72.

Baldwin, P. Disease and democracy: the industrialized world faces AIDS. Berkeley, CA: University of California Press; 2005.

Bambra C. Worlds of welfare and the health care discrepancy. Soc Policy Society. 2005; 4:31–41.

Bambra C. Going beyond the three worlds of welfare capitalism: regime theory and public health research. J Epidemiol Community Health. 2007; 61:1098–1102. [PubMed: 18000134]

Bambra C, Gibson M, Sowden A, Wright K, Whitehead M, Petticrew M. Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. J Epidemiol Community Health. 2010a; 64:284–91. [PubMed: 19692738]

Bambra C, Netuveli G, Eikemo T. Welfare state regime life courses: the development of Western European welfare state regimes and age-related patterns of educational inequalities in self-reported health. Int J Health Services. 2010b; 40:399–420.

Beckfield J. European integration and income inequality. Am Soc Rev. 2006; 71:964–85.

Beckfield J. The social structure of the world polity. Am J Sociol. 2010; 115:1018–68.

Beckfield J, Krieger N. Epi + demos + cracy: linking political systems and priorities to the magnitude of health inequities—evidence, gaps, and a research agenda. Epidemiol Rev. 2009; 31:152–77. [PubMed: 19474091]

Beckfield J, Olafsdottir S. Empowering health: a comparative political sociology of health disparities. Perspect Eur. 2009; 39:9–12.

Béland D. Policy change and health care research. J of Health Politics Policy Law. 2010; 35:615–41.

Blewett LA, Good MB, Call KT, Davern M. Monitoring the uninsured: a state policy perspective. J Health Politics Policy Law. 2004; 29:107–46.

Bonnell, Victoria E., Hunt, Lynn Avery. Studies on the History of Society and Culture: New Directions Study Society Cult. University of California Press; 1999.

Borrell C, Espelt A, Rodriguez-Sanz M, Burstrom B. Analyzing differences in the magnitude of socioeconomic inequalities in self-perceived health by countries of different political tradition in Europe. Int J Health Services. 2009; 39:321–41.

Brady D, Beckfield J, Zhao W. The consequences of economic globalization for affluent democracies. Annu Rev Sociol. 2007; 33:313–34.

Braveman P. Health disparities and health equity: concepts and measurement. Annu Rev Public Health. 2006; 27:167–94. [PubMed: 16533114]

Burau V, Blank RH. Comparing health policy: an assessment of typologies of health systems. J Comp Policy Anal. 2006; 8:63–76.

Burris S, Mays GP, Douglas Scutchfield F, Ibrahim JK. Moving from intersection to integration: public health law research and public health systems and services research. Milbank Q. 2012; 90:375–408. [PubMed: 22709392]

Cavelaars AEJM, Kunst AE, Geurts JJM, Crialesi R, Grötvedt L, et al. Differences in self reported morbidity by educational level: a comparison of 11 western European countries. J Epidemiol Community Health. 1998; 52:219–27. [PubMed: 9616407]

Chalkidou K, Tunis S, Lopert R, Rochaix L, Sawicki PT, et al. Comparative effectiveness research and evidence-based health policy: experience from four countries. Milbank Q. 2009; 87:339–67. [PubMed: 19523121]

Clavier C. Bottom–up policy convergence: a sociology of the reception of policy transfer in public health policies in Europe. J Comp Policy Anal. 2010; 12:451–66.

Croghan TW, Beatty A, Ron A. Routes to better health for children in four developing countries. Milbank Q. 2006; 84:333–58. [PubMed: 16771821]

Cuadra CB. Right of access to health care for undocumented migrants in EU: a comparative study of national policies. Eur J Public Health. 2012; 22:267–71. [PubMed: 21659389]

Cutler D, Deaton A, Lleras-Muney A. The determinants of mortality. J Econ Perspect. 2006; 20:97–120.

Day P, Pearce J, Dorling D. Twelve worlds: a geo-demographic comparison of global inequalities in mortality. J Epidemiol Community Health. 2008; 62:1002–10. [PubMed: 18854506]

Deleon P, Resnick-Terry P. Comparative policy analysis: déjà vu all over again? J Comp Policy Anal. 1998; 1:9–22.

Desmond M. Eviction and the reproduction of urban poverty. Am J Sociol. 2012; 118:88–133.

Dickens BM. Promoting health near and far. Am J Public Health. 2011; 101:394. [PubMed: 21307372]

Eikemo TA, Huisman M, Bambra C, Kunst AE. Health inequalities according to educational level in different welfare regimes: a comparison of 23 European countries. Sociol Health Illn. 2008; 30:565–82. [PubMed: 18298629]

Elo IT. Social Class Differentials in Health and Mortality: Patterns and Explanations in Comparative Perspective. Annu Rev Sociol. 2009; 35:553–72.

Emirbayer M. Manifesto for a relational sociology. Am J Sociol. 1997; 103:281–317.

Espelt A, Borrell C, Rodríguez-Sanz M, Muntaner C, Pasarín MI, et al. Inequalities in health by social class dimensions in European countries of different political traditions. Int J Epidemiol. 2008; 37:1095–1105. [PubMed: 18339662]

Esping-Andersen, G. The Three Worlds of Welfare Capitalism. Princeton, NJ: Princeton University Press; 1990.

Evans RG. Going for the gold: the redistributive agenda behind market-based health care reform. J Health Politics Policy Law. 1997; 22:427–65.

Exworthy M, Bindman A, Davies H, Washington AE. Evidence into policy and practice? Measuring the progress of U.S and U.K policies to tackle disparities and inequalities in U.S and U.K Health and Health Care. Milbank Q. 2006; 84:75–109. [PubMed: 16529569]

Faden RR, Chalkidou K, Appleby J, Waters HR, Leider JP. Expensive cancer drugs: a comparison between the United States and the United Kingdom. Milbank Q. 2009; 87:789–819. [PubMed: 20021586]

Fee E, Brown TM. 100 Years of the Pan American Health Organization. Am J Public Health. 2002; 92:1888–89. [PubMed: 12453801]

Festa, N. Unpublished BA thesis. Harvard University; 2010. More than Just Class: Understanding How Social Networks Shape Parenting Strategies.

Field MG. The concept of the "health system" at the macrosociological level. Soc Sci Med. 1973; 7:763–85. [PubMed: 4749063]

Frenk J, Donabedian A. State intervention in medical care: types, trends and Variables. Health Policy Plan. 1987; 2:17–31. [PubMed: 10282125]

Furedi, Frank. The end of professional dominance. Society. 2006; 43(6):14–18.

Geertz, Clifford. The interpretation of cultures. New York, NY: Basic Books; 1973.

Gibbs BK, Nsiah-Jefferson L, McHugh MD, Trivedi AN, Prothrow-Stith D. Reducing racial and ethnic health disparities: exploring an outcome-oriented agenda for research and policy. J Health Politics Policy Law. 2006; 31:185–218.

Glennerster H, Lieberman RC. Hidden convergence: toward a historical comparison of U.S. and U.K. health policy. J Health Politics Policy Law. 2011; 36:5–31.

Glied S, Lleras-Muney A. Technological innovation and inequality in health. Demography. 2008; 45:741–61. [PubMed: 18939670]

Gottschalk M. Back to the future? Health benefits, organized labor, and universal health care. J Health Politics Policy Law. 2007; 32:923–70.

Gran B. A second opinion: rethinking the public-private dichotomy for health insurance. Int J Health Services. 2003; 33:283–313.

Green-Pedersen C, Wilkerson J. How agenda-setting attributes shape politics: basic dilemmas, problem attention and health politics developments in Denmark and the US. J Eur Pub Policy. 2006; 13:1039–52.

Greer SL, Jacobson PD. Health care reform and federalism. J Health Politics Policy Law. 2010; 35:203–26.

Grignon M. A democratic responsiveness approach to real reform: an exploration of health care systems’ resilience. J Health Politics Policy Law. 2012; 37:665–76.

Gross N. A pragmatist theory of social mechanisms. Am Sociol Rev. 2009; 74:358–79.

Gruskin S, Dickens B. Human rights and ethics in public health. Am J Public Health. 2006:1903–5. [PubMed: 17018811]

Guillen MF. Is globalization civilizing, destructive or feeble? A critique of five key debates in the social science literature. Annu Rev Sociol. 2001; 27:235–60.

Habbema D, De Kok IMCM, Brown ML. Cervical cancer screening in the United States and the Netherlands: a tale of two countries. Milbank Q. 2012; 90:5–37. [PubMed: 22428690]

Hall, PA., Lamont, M. Successful societies: how institutions and culture affect health. Cambridge, UK: Cambridge University Press; 2009.

Hanratty B, Zhang T, Whitehead M. How close have universal health systems come to achieving equity in use of curative services? A systematic review. Int J Health Services. 2007; 37:89–109.

Hedström, P., Bearman, P., editors. The Oxford Handbook of Analytical Sociology. Oxford, UK: Oxford University Press; 2009.

Heymann J, Rho H, Schmitt J, Earle A. Ensuring a healthy and productive workforce: comparing the generosity of paid sick day and sick leave policies in 22 countries. Int J Health Services. 2010; 40:1–22.

Holden C. Privatization and trade in health services: a review of the evidence. Int J Health Services. 2005; 35:675–89.

Jasso-Aguilar R, Waitzkin H, Landwehr A. Multinational corporations and health care in the United States and Latin America: strategies, actions, and effects. J Health Soc Behav. 2004; 45:136–57. [PubMed: 15779471]

Katz, Michael B. In the Shadow of the Poorhouse: A Social History of Welfare in America. New York: Basic Books; 1986.

Katz, Michael B. The Undeserving Poor: From the War on Poverty to the War on Welfare. New York: Pantheon Books; 1989.

Katz R, Kornblet S, Arnold G, Lief E, Fischer JE. Defining health diplomacy: changing demands in the era of globalization. Milbank Q. 2011; 89:503–23. [PubMed: 21933277]

King L, Hamm P, Stuckler D. Rapid large-scale privatization and death rates in ex-communist countries: an analysis of stress-related and health system mechanisms. Int J Health Services. 2009; 39:461–89.

Kleinman, Arthur. The Illness Narratives: Suffering, Healing, and the Human Condition. Basic Books; 1988.

Kohler-Koch B. Catching up with change: the transformation of governance in the European Union. J Eur Pub Policy. 1996; 3:359–80.

Krieger N, Alegría M, Almeida-Filho N, Barbosa da Silva J, Barreto ML, et al. Who, and what, causes health inequities? Reflections on emerging debates from an exploratory Latin American/North American workshop. J Epidemiol Community Health. 2010; 64:747–49. [PubMed: 20584723]

Krieger N, Rehkopf DH, Chen JT, Waterman PD, Marcelli E, Kennedy M. The fall and rise of US inequities in premature mortality: 1960–2002. PLoS Med. 2008; 5:227–41.

Kunst AE, Bos V, Lahelma E, Bartley M, Lissau I, Regidor E, Mielck A, et al. Trends in socioeconomic inequalities in self-assessed health in 10 European countries. Int J Epidemiol. 2005; 34:295–305. [PubMed: 15563586]

Lamont, M., Small, ML. How culture matters: enriching our understanding of poverty. In: Harris, D., Lin, A., editors. The Colors of Poverty: Why Racial and Ethnic Disparities Persist. Vol. 4. New York: Russell Sage; 2008. p. 76-102.

Lareau, A. Unequal Childhoods: Class, Race and Family Life. Berkeley, CA: University of California Press; 2003.

Lassey, ML., Lassey, WR., Jinks, MJ. Health care systems around the world: characteristics, issues, reforms. Upper Saddle River, NJ: Prentice Hall; 1997.

Lee RPL. Comparative studies of health care systems. Soc Sci Med. 1982; 16:629–42. [PubMed: 7089599]

Leiber S, Greß S, Manouguian MS. Health care system change and the cross-border transfer of ideas: influence of the Dutch model on the 2007 German health reform. J Health Politics Policy Law. 2010; 35:539–68.

Light DW. From managed competition to managed cooperation: theory and lessons from the British experience. Milbank Q. 1997; 75:297–341. [PubMed: 9290632]

Light DW. Introduction: ironies of success: a new history of the American health care “system”. J Health Soc Behav. 2004; 45:1–24.

Lilly MB, Laporte A, Coyte PC. Labor market work and home care’s unpaid caregivers: a systematic review of labor force participation rates, predictors of labor market withdrawal, and hours of work. Milbank Q. 2007; 85:641–90. [PubMed: 18070333]

Lin, KH. ASA section member networks 2011. 2013. http://www.kenhoulin.info/graph, accessed January 2, 2013

Link BG, Phelan J. Social conditions as fundamental causes of disease. J Health Soc Behav. 1995; 35:80–94.

Lovecy J. Global regulatory competition and the single market for professional services: the legal and medical professions in France and Britain. J Eur Pub Policy. 1995; 2:514–34.

Lutfey K, Freese J. Toward some fundamentals of fundamental causality: socioeconomic status and health in the routine clinic visit for diabetes. Am J Sociol. 2005; 110:1326–72.

Lynch J. The political geography of mortaity in Europe. Perspect Eur. 2009; 39:13–17.

Lynch J, Gollust SE. Playing fair: fairness beliefs and health policy preferences in the United States. J Health Politics Policy Law. 2010; 35:849–87.

Mackenbach JP, Stirbu I, Roskam AJR, Schaap MM, Menvielle G, et al. Socioeconomic inequalities in health in 22 European countries. N Engl J Med. 2008; 358:2468–2481. [PubMed: 18525043]

Marmor T, Freeman R, Okma K. Comparative perspectives and policy learning in the world of health care. J Comp Policy Anal. 2005; 7:331–48.

Meyer JW, Boli J, Thomas GM, Ramirez FO. World society and the nation-state. Am J Sociol. 1997; 103:144–81.

McCall L, Percheski C. Income inequality: new trends and research directions. Annu Rev Sociol. 2010; 36:329–47.

Mische, A. Relational sociology, culture, and agency. In: Scott, J., Carrington, PJ., editors. The SAGE Handbook of Social Network Analysis. Vol. 7. London: SAGE Publications, Ltd; 2011. p. 80-97.

Moran, M. Governing the Health Care State: A Comparative Study of the United Kingdom, the United States, and Germany. Manchester: Manchester University Press; 1999.

Moran M. Understanding the welfare state: the case of health care. Brit J Politics Int Rel. 2000; 2:135–60.

Mechanic D. Population health: challenges for science and society. Milbank Q. 2007; 85:533–559. [PubMed: 17718667]

Mechanic D. Rethinking medical professionalism: the role of information technology and practice innovations. Milbank Q. 2008; 86:327–58. [PubMed: 18522615]

Mechanic D, Rochefort DA. Comparative medical systems. Annu Rev Sociol. 1996; 22:239–70.

Muntaner C, Borrell C, Ng E, Chung H, Espelt A, et al. Politics, welfare regimes, and population health: controversies and evidence. Sociol Health Illn. 2011; 33:946–64. [PubMed: 21899562]

Navarro V, Muntaner C, Borrell C, Benach J, Quiroga A, et al. Politics and health outcomes. Lancet. 2006; 368:1033–37. [PubMed: 16980120]

Norredam M, Mygind A, Krasnik A. Access to health care for asylum seekers in the European Union —a comparative study of country policies. Eur J Public Health. 2006; 16:285–89.

Olafsdottir S. Fundamental causes of health disparities: stratification, the welfare state, and health in the United States and Iceland. J Health Soc Behav. 2007; 48:239–53. [PubMed: 17982866]

Olafsdottir, Sigrun. Medicalization and Mental Health: The Critique of Medical Expansion, and a Consideration of how National States, Markets, and Citizens Matter. In: Pilgrim, DavidRogers, Anne, Pescosolido, Bernice A., editors. The SAGE Handbook of Mental Health and Illness. London, England: Sage Publications; 2011. p. 239-60.

Olafsdottir, Sigrun, Beckfield, Jason. Health and the Social Rights of Citizenship: Integrating Welfare State Theory and Medical Sociology. In: Pescosolido, Bernice A.Martin, Jack K.McLeod, Jane D., Rogers, Anne, editors. Handbook of the Sociology of Health, Illness, and Healing: A Blueprint for the 21st Century. New York, NY: Springer; 2011. p. 101-15.

Olafsdottir S, Pescosolido BA. Drawing the Line: The Cultural Cartography of Utilization Recommendations for Mental Health Problems. J Health Soc Behav. 2009; 50:228–44. [PubMed: 19537462]

Parker LA, Lumbreras B, Hernández-Aguado I. Health information and advocacy for “health in all policies”: a research agenda. J Epidemiol Community Health. 2010; 64:114–16. [PubMed: 20056965]

Patterson, James T. America’s Struggle against Poverty, 1900–1994. Cambridge, Mass: Harvard University Press; 1994.

Permanand G, Mossialos E. Constitutional asymmetry and pharmaceutical policy-making in the European Union. J Eur Pub Policy. 2005; 12:687–709.

Pescosolido BA, Olafsdottir S. The Cultural Turn in Sociology: Can It Help Us Resolve an Age-Old Problem in Understanding Decision Making for Health Care? Sociol Forum. 2010; 25:655–76.

Pettit, B., Hook, JL. Gendered Tradeoffs: Family, Social Policy, and Economic Inequality in Twenty-One Countries. New York: Russell Sage Foundation; 2009.

Pittman PM. Beyond the sound of one hand clapping: experiences in six countries using health equity research in policy. J Health Politics Policy Law. 2006; 31:33–50.

Plümper T, Schneider CJ. The analysis of policy convergence, or: how to chase a black cat in a dark room. J Eur Pub Policy. 2009; 16:990–1011.

Quadagno J. Institutions, interest groups, and ideology an agenda for the sociology of health care reform. J Health Soc Behav. 2010; 51:125–36. [PubMed: 20617754]

Rice N, Smith PC. Capitation and risk adjustment in health care financing: an international progress report. Milbank Q. 2001; 79:81–113. [PubMed: 11286097]

Ridde V. Is the Bamako Initiative still relevant for West African health systems? Int J Health Services. 2011; 41:175–84.

Rochefort, D., Donnelly, K. Foreign Remedies: What the Experience of Other Nations Can tell Us About the Next Step in Reforming US Health Care. London: Routledge; 2012.

Ruger JP, Kim HJ. Global health inequalities: an international comparison. J Epidemiol Community Health. 2006; 60:928–36. [PubMed: 17053281]

Ruggie, M. Learning from other countries: comparing experiences and drawing lessons for the United States. In: Pescosolido, BA.Martin, JK.McLeod, JD., Rogers, A., editors. Handbook of the Sociology of Health, Illness, and Healing. Vol. 5. New York: Springer; 2011. p. 85-99.

Sassen, S. Territory, Authority, Rights: From Medieval to Global Assemblages. Princeton, NJ: Princeton University Press; 2006.

Schlesinger M, Gray B. A broader vision for managed care, part 1: measuring the benefit to communities. Health Aff. 1998; 17:152–68.

Schmid A, Cacace M, Götze R, Rothgang H. Explaining health care system change: problem pressure and the emergence of “hybrid” health care systems. J Health Politics Policy Law. 2010; 35:455–86.

Schnittker J, Bhatt M. The role of income and race/ethnicity in experiences with medical care in the United States and United Kingdom. Int J Health Services. 2008; 38:671–95.

Schuster MA, McGlynn EA, Brook RH. How good is the quality of health care in the United States? Milbank Q. 2005; 83:843–95. [PubMed: 16279970]

Scott, WR., Ruef, M., Mendel, PJ., Caronna, CA. Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care. Chicago: University of Chicago Press; 2000.

Sewell, William H. A Theory of Structure: Duality, Agency, and Transformation. American Journal of Sociology. 1992; 98(1):1–29.

Shaffer ER, Waitzkin H, Brenner J, Jasso-Aguilar R. Global trade and public health. Am J Public Health. 2005; 95:23–34. [PubMed: 15623854]

Siddiqi A, Hertzman C. Towards an epidemiological understanding of the effects of long-term institutional changes on population health: acase study of Canada versus the USA. Soc Sci Med. 2007; 64:589–603. [PubMed: 17097790]

Silberberg M, Cantor JC. Making the case for school-based health: where do we stand? J Health Politics Policy Law. 2008; 33:3–37.

Silver H. The process of social exclusion: the dynamics of an evolving concept. SSRN eLibrary CPRC Working Paper. 2007; 95:1–22.

Slaughter, AM. A New World Order. Princeton, NJ: Princeton University Press; 2005.

Sparer MS, France G, Clinton C. Inching toward incrementalism: federalism, devolution, and health policy in the United States and the United Kingdom. J Health Politics Policy Law. 2011; 36:33–57.

Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005; 83:457–502. [PubMed: 16202000]

Steensland, Brian. Cultural Categories and the American Welfare State: The Case of Guaranteed Income Policy. American Journal of Sociology. 2006; 111(5):1273–1326.

Steinmetz, George. State/Culture: State-formation After the Cultural Turn. Ithaca, NY: Cornell University Press; 1999.

Stevens, F. The convergence and divergence of modern health care systems. In: Cockerham, WC., editor. The Blackwell Companion to Medical Sociology. Vol. 20. Malden, MA: Blackwell Publishers Inc; 2001. p. 158-79.

Stiefel MC, Perla RJ, Zell BL. A healthy bottom line: healthy life expectancy as an outcome heasure for health improvement efforts. Milbank Q. 2010; 88:30–53. [PubMed: 20377757]

Stirbu I, Kunst AE, Bopp M, Leinsalu M, Regidor E, Esnaola S, Costa G, et al. Educational inequalities in avoidable mortality in Europe. J Epidemiol Community Health. 2010; 64:913–920. [PubMed: 19833607]

Stone D. Reframing the racial disparities issue for state governments. J Health Politics Policy Law. 2006; 31:127–52.

Stuckler D. Population causes and consequences of leading chronic diseases: a comparative analysis of prevailing explanations. Milbank Q. 2008; 86:273–326. [PubMed: 18522614]

Swidler A. Culture in action: symbols and strategies. Am Sociol Rev. 1986; 51:273–86.

Tarantola D. Global health and national governance. Am J Public Health. 2005; 8

Terris M. The three world systems of medical care: trends and prospects. Am J Public Health. 1978; 68:1125–31. [PubMed: 717620]

Tilly, C. Durable Inequality. Berkeley: University of California Press; 1999.

Tuohy CH. Reform and the politics of hybridization in mature health care states. J Health Politics Policy Law. 2012; 37:611–32.

Turner L. "Medical tourism" and the global marketplace in health services: U.S. patients, international hospitals, and the search for affordable health care. Int J Health Services. 2010; 40:443–67.

Waitzkin H. Is our work dangerous? Should it be? J Health Soc Behav. 1998; 39:7–17. [PubMed: 9575701]

Weiner JP, Famadas JC, Waters HR, Gikic D. Managed care and private health insurance in a global context. J Health Politics Policy Law. 2008; 33:1107–31.

Wendt C. Mapping European healthcare systems: a comparative analysis of financing, service provision and access to healthcare. J Eur Soc Policy. 2009; 19:432–45.

Wendt C, Frisina L, Rothgang H. Healthcare system types: a conceptual framework for comparison. Soc Policy Admin. 2009; 43:70–90.

Western, B. Punishment and Inequality in America. New York: Russell Sage Foundation; 2006.

Whitehead M, Burström B, Diderichsen F. Social policies and the pathways to inequalities in health: a comparative analysis of lone mothers in Britain and Sweden. Soc Sci Med. 2000; 50:255–270. [PubMed: 10619694]

Wilensky, HL. Rich Democracies: Political Economy, Public Policy, and Performance. Berkeley: University of California Press; 2002.

Wimmer A, Glick Schiller N. Methodological nationalism and beyond: nationstate building, migration and the social sciences. Global Networks. 2002; 2:301–34.

Wright ER, Perry BL. Medical sociology and health services research: past accomplishments and future policy challenges. J Health Soc Behav. 2010; 5:S107–S119.

The Luxembourg Income Study as an Exemplar for Comparative Research

The Luxembourg Income Study (see http:lisdatacenter.org), now formally named LIS, has helped to spark original research on the institutional determinants of income inequality. Such research has enabled the development of policy-oriented research as well as the development of institutional theories of economic inequality. LIS makes freely available to the scholarly community individual-level datasets that have been harmonized to facilitate international comparison. Confidentiality concerns are overcome through the use of a remote-analysis protocol that allows LIS to retain possession of the data, as users are able to analyze the data through e-mail access to a remote server. The LIS has also made important theoretical contributions to the study of economic well-being, in its development of a cross-nationally comparable income concept. We view the LIS as a model for what comparative research on healthcare systems could be. Conceptual work is needed, for instance, to defined healthcare disparities in a way that facilitates comparative research. National-, regional-, and organizational-level data could be acquired, harmonized, and made available to the research community for remote analysis. Such an innovation could transform the field of comparative healthcare systems research by sparking institutional theory and thereby generating a new range of hypotheses.

Related Resources

1. World Health Survey: http://www.who.int/healthinfo/survey/en/
2. OECD Health Data: http://www.oecd.org/health/healthpoliciesanddata/oecdhealthdata2012.htm
3. WHO System of Health Accounts: http://www.who.int/nha/sha_revision/en/
4. INDEPTH Network: http://www.indepth-network.org/
5. Ellen Kuhlmann and Ellen Annandale, Editors. *The Palgrave Handbook of Gender and Healthcare*. Palgrave Macmillan: London, 2010.
6. Ellen Kuhlmann and Ellen Annandale, Editors. *Transforming Health Services and Policy: New International Experiences*. *Current Sociology*, June 2012.
7. Robert Blank and Viola Burau. *Comparative Health Policy*. Palgrave Macmillan: London, 2010.

Table 1

Summary of Questions Motivating Current Research on Healthcare Systems

1. Classification
    - **a.** What are the major types of healthcare systems?
    - **b.** Which are the key dimensions that differentiate healthcare systems?
    - **c.** Do the typologies developed for rich democracies generalize?
2. Convergence
    - **a.** Are healthcare systems becoming more similar?
    - **b.** How should variation among healthcare systems be measured?
    - **c.** If there is convergence, what role does globalization play?
3. Institutions
    - **a.** What are the institutional boundaries of healthcare systems?
    - **b.** Are international healthcare systems developing?
    - **c.** How do subnational healthcare systems intersect with national systems?
4. Inequalities
    - **a.** How do healthcare disparities compare across healthcare systems?
    - **b.** How does the healthcare system compare to other “upstream” causes?
    - **c.** What do healthcare systems contribute to global health inequality?
    - **d.** How do inequalities in healthcare relate to average levels of care?