# Books

## Review Essay

**Health Care Systems in Transition.**
**Copenhagen: World Health Organization**
**Regional Office for Europe, 1996–**

This review appraises an ambitious project of the European Observatory on Health Care Systems (the Observatory) of the World Health Organization (WHO) to compare health systems. The project consists of a series of booklets providing information about health care systems and health care reforms in the European region of the WHO. Geographically, that region encompasses a wide range of countries from Iceland in the northwest to Turkmenistan and Kyrgyzstan in the far southeast of the European continent. The series includes Canada as well. The main goal of the *Health Care Systems in Transition* series, or HiTs, is to provide building blocks that can be used to "learn about financing, organization and delivery of health care; . . . describe the process and contents of health reforms and their implementation; . . . highlight common challenges; . . . and provide a tool for dissemination of information on health care systems, and exchange of experience of reform strategies" (European Observatory on Health Care Systems [EOHCS] 1999: 3).

The project started in the early 1990s, with the support or collaboration of the governments of Norway and Spain, the European Investment Bank,

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the World Bank, the London School of Economics and Political Science, and the London School of Hygiene and Tropical Medicine. The HiTs are largely written by country experts and edited by the staff of the WHO. The Observatory aims to update the publications regularly.

The WHO project sets out an elaborate and detailed guide to country portraits. The aim is to maximize comparability (EOHCS 1999: 3) between countries by using a common set of questions to be answered in a specified order.

The project does acknowledge some of the methodological problems involved, such as the lack of information or lack of commonly agreed upon definitions. It seeks to overcome the latter by providing its own definitions. The template contains three main parts (ibid.: 7): the introduction and historical background, the health care system (organizational structure and management, finance and expenditure, and delivery and resource allocation), and health care reforms (determinants and objectives, content of reforms and legislation, and reform implementation). It distinguishes two main models of funding and contracting (the *integrated model* and the *contract model*) and frames three main functions of statutory health care systems: planning, regulation, and management of providers (interestingly, it leaves out the core function of income protection). The lessons learned from each country's experience constitute the conclusions.

There is, however, a fundamental problem with the project's mode of lesson drawing. On the one hand, the template states that the questionnaire does not explicitly deal with policy objectives such as equity, cost containment, or consumer choice as such objectives are not concerned "with one objective of the health care system only." On the other hand, the concluding section is supposed to review the lessons learned from the health care systems and reforms "against the achievement of these objectives" (ibid.). This is a puzzle to which we will return.

The last two decades of the twentieth century witnessed a rapid growth in the number of comparative studies in health policy. There are roughly speaking four main categories of such studies (Okma 2000). The appendix to this review contains an overview of publications in each category. The first group includes comparative studies based on aggregate statistical data, such as the Organisation of Economic Co-operation and Development (OECD) studies of the 1990s. The second category consists, in terms of Rose 1991a, of multiple-country descriptions without concepts or collections of individual country studies without a clear common overriding theme or systematic approach. The third group is made up of coun-

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try studies focused on particular themes and based on a common and explicit theoretical framework that imposes order to the separate chapters. The fourth group comprises theoretical studies that use cross-national evidence to underline certain theoretical assumptions or findings. The HiTs belong to the category of "parallel portraitures" that describe health care systems and health care policies of widely divergent categories of countries in the European region of the WHO.

Between 1996 and the end of 2002, the Observatory published forty-three country descriptions and twelve updates of earlier ones. In terms of volume, this is a remarkable accomplishment. The series now provides comprehensive country data on health care systems across Europe. Or does it? At this stage of the project, it seems appropriate to look back at its original aims and ambitions and to assess its substantial accomplishments. We will start with four general observations, followed by some more specific remarks and a concluding comment.

As a first general comment, we turn to one of the core methodological problems of international comparative studies. Policy learning and lesson drawing across time (from one's own experience) or across space (someone else's experience) start with the framing of concepts that allow for generalizations and categorizations across systems and countries (Rose 1991a; Klein 1995). In other words, we have to distinguish between the processes of *learning about* versus the *learning from* such experience (Marmor 1995). To permit systematic learning, there is a need for common frameworks applicable across systems to describe and understand the anatomy and physiology of health care systems. By anatomy we mean, for example, the funding and contracting structure, what services are available, to whom and why; the formal decision-making systems; the organization, cost, and quality of health care systems. By physiology of health systems we mean what makes the system work; who are the main actors; regulation of the governance structure. Such frameworks also provide a common basis for categorization and for understanding how institutional legacies and stakeholder positions affect the shaping and outcome of (health reform) policies. The past two decades have seen a rapid increase in the number of comparative studies, particularly in the third category of descriptive portraits. But there has been relatively little reflection on the methodological questions mentioned above.

Second, there is ample reason to question the definitions used by the WHO studies. One core concept used throughout the HiTs is *health care reform*, but—like the term *transition*—this term is notably ill-defined. It seems to embrace all actions that aim to change the health care system

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in any direction. As Joe White (1995: 21) observed, "if health care policy includes everything, then it means nothing." That also applies to the loose labeling of all policy change as reform. In this sense, the HiTs lack direction or focus, describing a wide range of health policies. For example, the HiT of Azerbaijan seems to depict mostly policy intentions, while that of the Czech Republic describes a wide range of policies, including privatization, the dismantling of existing regionalized structures (while the Canadian portrait regards regionalization as the core of many provincial reforms), the introduction of state-sponsored health insurance, and shifts from fee-for-service payments to salaried physicians and back to fees for service. The HiTs include both plans and intentions as well as actual policy steps taken. In several cases, they illustrate that policy steps can be reversed. The questions are not always precise. What is the meaning of such topics as "the key proposals and legislation related to the health care system and reforms" or how precise is the injunction to describe the "chronology of the process and content of reforms"? (EOHCS 1999: 37). One problem with such wide definitions of what reform covers makes the comparison across countries all the more problematic.

Third, there is clear tension between the twin ambitions of the project. Describing the contemporary health systems on the one hand (and reforms as well) is taxing enough; interpreting and evaluating those findings is a substantial task in itself. The template's questions reflect the orientation of the WHO staff. They focus more on problems than on possible positive outcomes. So, for example, they emphasize "what old problems persist, and what new problems have developed" (ibid.: 12). In the area of health care benefits, the questions focus on rationing and reduction of benefits, whereas in reality, the past two decades have seen much more expansion. The answers to many questions require subjective judgment, such as "how effective is the planning system in implementing change" and "what is the prevailing thinking on the future development of planning for health and health care" (ibid.: 13). Social policies are usually contested; views and interpretations of the results diverge. When authors of the HiTs are asked to discuss reform results (or the reasons for failure), their answers will reflect their evaluation of the outcomes. How is one to make sense of the answers to "discuss main problems encountered in the process of decentralisation" (ibid.) and "discuss any problems with respect to any of the above issues and plans for reform" (ibid.: 16)? Some questions are too open-ended without guidance: "discuss the level of provision and quality of health care personnel"; "are the levels and geographical distribution

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appropriate?"; or, the "availability of management skills"; or, "what major problems were associated with the organizational aspects of the health care system of earlier years?"; or, "what is the prevailing thinking on the future development of planning for health and health care?" Related to the open-ended nature of such general questions is the lack of instruments to measure: "comment on the quality of services" (ibid.: 24). Do the answers to such questions reflect the individual authors' opinions or the view of the WHO? The general application of categories to widely divergent countries leads to interesting contradictory conclusions — for example, Azerbaijan's HiT concludes that the monopoly position of the state as the sole financier of health care is seen as a weakness of the health care system, whereas in Canada the position of government as the one single payer of health services is seen as a positive strength.

Our fourth general comment regards the selection of countries covered by the HiTs. The European office of the WHO in Copenhagen has a stake in defining Europe as the entire continent (and beyond, even including Canada). It seeks to apply the HiT template to that whole range of countries. Predictably, the HiTs vary greatly in size, detail, and emphasis. The health systems in Eastern European countries have suffered under the fallout of processes of political transformation (hurried shifts toward privatisation, lack of public funding, erosion of existing systems of primary care). They are struggling with the development of new administrative systems of health insurance and contracting health care (systems that in Western Europe took many decades if not centuries to mature). Such problems are quite different from, say, the permanent bickering between health departments and treasuries in Western Europe about the annual budget increase or the annual ritualized fights between physicians' associations and Ministries of Health about the adjustment of the payments (Okma 1999). And of course, the availability of reliable and up-to-date statistical data restricts the possibilities to present comparable data across the continent. Perhaps the heterogeneity of the countries is too large to justify one common framework for all. One framework for all may lead to what Rose (1991b) labeled "false universalism."

We now turn to four specific comments. First, we discuss statistics. The HiTs contain tables with statistics on health care and health expenditure largely derived from the OECD health data bank and the WHO SOURCES statistics. It is interesting to note that, over time, statistical averages gain a normative status. For example, the HiT of the Czech Republic (EOHCS 2000: 25) claims that the share of the gross domestic product spent on health care is seen as "an important economic indictor." Does that mean

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that increasing health expenditure will help to further economic growth? Similarly, the same HiT concludes that there are too few physicians in the country on the grounds that the number of Czech doctors per 100,000 population is lower than the group average. Is that average "right?"

Second, the lengths of publications vary widely. There does not seem to be any correlation between population size and length of the HiTs. The HiT of Latvia (with a population of 2.3 million) contains 93 pages, Norway's HiT (population 4.4 million) has 80 pages, Tajikistan's HiT (population 6 million) has 60 pages, Azerbaijan (with a population of 7.4 million) contains about 10 pages of text, the Czech Republic's (10 million population) has 65 pages, Germany's (population 82 million) has 120 pages, Italy's (population 58 million) has 125 pages, and the United Kingdom's (60 million) has 105 pages.

Third, the series illustrates that it is not easy to update a series of publications. The earliest reports came out as preliminary versions in 1996, but not all of those have seen an update. That also raises the question of authorship, costs, and benefits. Do the HiTs' contents reflect the view of the author, the participating country, or the WHO? Who bears the costs of collecting, updating, and revising data? Is the value of the publication enough to justify its cost for a participating country strained for resources?

Our general conclusion is that while the Observatory staff and other participants have spent much time and effort on the HiT project, they have spent too little time reflecting on the promise and pitfalls of comparative policy analysis. The publications contain varying amounts of information about health care systems, health care policies, and health care reforms in over 50 European countries. The observatory's ambition is "to illuminate policy issues; to analyse trends in health care reforms; and to provide evidence based analysis," but its actual results are mostly descriptive. The template for the country descriptions does not offer an analytical framework that will help to categorize countries; neither does it provide a theory of change or stability nor systematic justifiable conclusions. In particular, its aim to evaluate the results of health care reforms without making explicit the goals of such reforms can hardly be taken seriously. If the WHO wants to play a respectable and central role in the international debate on health reform, it should take its own methodology more seriously.

## Appendix Categorization of International Comparative Studies in Health Care

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The 1980s and 1990s witnessed a rapid growth of comparative studies in health policies and health politics. There has been little effort to characterize or categorize those studies. The sections below distinguish four main groups: first, reports presenting aggregate (macroeconomic) data of a large number of countries; second, parallel reports of individual country descriptions as case studies without much effort to impose a common analytical framework; third, studies seeking to explore a common theme across a selected number of countries; and fourth, a group of more theoretical works that seeks to develop theories or models of change with a limited number of country case studies. The listing is not exhaustive but illustrative of this categorization.

### Statistical Studies

Organisation for Economic Co-operation and Development. 1987. *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries*. Paris: Organisation for Economic Co-operation and Development.

———. 1992. *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries*. Paris: Organisation for Economic Co-operation and Development.

———. 1994. *The Reform of Health Care: A Review of Seventeen OECD Countries*. Paris: Organisation for Economic Co-operation and Development.

Schneider, M., G. Cerniauskas, and L. Murauskiene. 1998. *Gesundheitssysteme im internationalen Vergleich*. Augsburg: Basys.

### Parallel Descriptive Country Studies

Artundo, C., C. Sakellarides, and H. Vuori, eds. 1992. *Health Care Reforms in Europe*. Copenhagen: World Health Organization.

Blue Cross of California and the King's Fund. 1990. *Health Care in the 1990s*. Los Angeles: Blue Cross of California and the King's Fund.

Ham, C., R. Robinson, and M. Benzeval, eds. 1990. *Health Check: Health Care Reforms in an International Context*. London: King's Fund Institute.

Organisation for Economic Co-operation and Development. 1992. *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries*. Paris: Organisation for Economic Co-operation and Development.

———. 1993. *OECD Health Systems,* 2 vols. Health Policy Studies. Paris: Organisation for Economic Co-operation and Development.

———. 1994. *The Reform of Health Care: A Review of Seventeen OECD Countries*. Paris: Organisation for Economic Co-operation and Development.

Saltman, R. B., and C. Von Otter, eds. 1995. *Implementing Planned Markets in Health Care: Balancing Social and Economic Responsibility*. Buckingham, PA: Open University Press.

Van Kemenade, Y. W. 1993. *Health Care in Europe: The Finance and Reimbursement Systems of 18 European Countries*. Zoetermeer: National Council for Public Health.

Williams, R., ed. 1995. *International Developments in Health Care: A Review of Health Care Systems in the 1990s*. London: Royal College of Physicians.

### Individual Country Studies with a Common (Explicit) Framework

Altenstetter, C., and J. W. Bjorkman, eds. 1997. *Health Policy Reform: National Variations and Globalization*. London: MacMillan.

Altenstetter, C., and S. C. Haywood, eds. 1991. *Comparative Health Policy and the New Right: From Rhetoric to Reality*. London: MacMillan.

Jerome-Forget, M., J. White, and J. M. Wiener, eds. 1995. *Health Care Reform through Internal Markets*. Montreal: Institute for Research on Public Policy/Washingon DC: Brookings Institution.

Maioni, A. 1998. *Parting at the Crossroads: The Emergence of Health Insurance in the US and Canada*. Princeton, NJ: Princeton University Press.

Ranade, W., ed. 1998. *Markets and Health Care: A Comparative Analysis*. London: Addison Wesley Longman.

White, J. 1995. *Competing Solutions: American Health Care Proposals and International Experience*. Washington DC: Brookings Institution.

Wilsford, D. 1991. *Doctors and the State: The Politics of Health Care in France and the United States*. Durham NC: Duke University Press.

### Cross-national Studies with a Specific Theme

Feldman, E., and R. Bayer. 1999. *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster*. New York: Oxford University Press.

Freddi, G., and J. W. Bjorkman, eds. 1989. *Controlling Medical Professionals: The Comparative Politics of Health Governance*. London: Sage.

Immergut, E. M. 1992. *Health Politics: Interests and Institutions in Western Europe*. Cambridge Studies in Comparative Studies. Cambridge: Cambridge University Press.

Pierson, P. 1994. *Dismantling the Welfare State? Reagan, Thatcher and the Politics of Retrenchment*. Cambridge: Cambridge University Press.

Tuohy, C. H. 1999. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. Oxford: Oxford University Press.

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*Source*: Okma 2000.

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Klein, Rudolf. 1995. Learning from Others: Shall the Last Be the First Markets? Conference report at the Four Country Conference Amsterdam, 1995. The Hague: Ministry of Health, Welfare and Sports.

Marmor, Theodore. 1995. The Politics of Medical Care Reform in Mature Welfare States: Fact, Fiction and Faction. Conference report at the Four Country Conference 1995, Amsterdam. The Hague: Ministry of Health, Welfare and Sports.

Okma, Kieke G. H. 1999. Review essay of *European Health Care Reform: Analysis of Current Strategies*, by Richard B. Saltman and Josep Figueras (Copenhagen: World Health Organization, 1997). *Journal of Health Politics, Policy and Law* 24:835–840.

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Rose, Richard. 1991a. *Comparing Forms of Comparative Analysis*. Studies in Public Policy, no. 188. Glasgow: Centre for the Study of Public Policy, University of Strathclyde.

———. 1991b. *What Is Lesson-Drawing*? Studies in Public Policy, no 120. Glasgow: Centre for the Study of Public Policy, University of Strathclyde.

White, J. 1995. *Competing Solutions: American Health Care Proposals and International Experience*. Washington DC: Brookings Institution.

**Elianne Riska. *Medical Careers and Feminist Agendas: American, Scandinavian, and Russian Women Physicians.*** Hawthorne, NY: Aldine de Gruyter, 2001. 172 pp. $39.95 cloth; $19.95 paper.

How can we explain the vastly different proportions of women physicians in the United States, the Scandinavian countries (Denmark, Finland, Norway, and Sweden), and Russia? Riska tackles the question with historical accounts of women's entry and advancement in the three types of societies, comparing their similarities and differences. Her analysis also seeks to address feminist and sociological questions about career paths and collective efforts to shape medical practice over time and place. Because the

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history of women in medicine has been studied extensively in the United States, Riska's contribution lies mostly in elucidating developments in Russia and Scandinavia that provide much needed comparative analyses.

Given the theoretical and empirical scholarship on both gender and medicine, differences are expected in the careers of women in medicine in a market economy, in welfare states, and in a society that has undergone dramatic structural change (from a monarchy, to communism, to postcommunism). In 1910, women comprised only 6 percent of all physicians in the United States, 3 percent in Finland, and 10 percent in Russia. By 1950, women remained at only 6 percent in the United States, but had increased to 77 percent in Russia, 21 percent in Finland, and 9–10 percent in the other Scandinavian countries. By 1990, women comprised 17 percent of the profession in the United States, 69 percent in Russia, 42 percent in Finland, 34 percent in Sweden, 26 percent in Denmark, and 23 percent in Norway (p. 38). As medical school enrollments move toward gender parity, it is particularly important to understand how divergent economies and gender systems shape career paths and transformations in the profession of medicine.

In broad brush strokes, Riska highlights women's strategies for gaining access to medical education and practice, power and influence, and gender equity. She places particular emphasis on how women took advantage of national factors, organized feminist activism, and devised strategies for establishing niches. Drawing largely on studies and narrative accounts of the careers of women physicians, Riska attempts to explain patterns of differentiation and change using a wide range of theoretical and conceptual frameworks. The exposition of functionalist, interactionist, neo-Weberian, neo-Marxist, and postmodern and social constructionist perspectives provides an overview of complex bodies of work, but of necessity simplifies the contributions of each. This simplification is sometimes useful, providing a map of research agendas. The range of theories and empirical studies cited, with their complex concepts and arcane jargon, at times overwhelms analytic clarity. This work is, nonetheless, an important step toward systematic assessment of the explanatory power of competing theoretical perspectives and concepts across diverse societies.

The narrative chapters provide interesting accounts of women's entry into medicine in strikingly different societies. Women are portrayed as agents of their own destinies within the changing opportunity structures and constraints of their specific, historical circumstances. In the mid–nineteenth century, internal populist political dissent in the United States and Russia spurred debate over women's suitability to practice medicine.

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Separate women's medical colleges were established first in the United States and then in Russia. In both countries, some women of extraordinary means undertook medical education in Zurich or Paris, the epicenters of the scientific revolution in medicine. In Russia, daughters of civil servants, military officers, and professionals filled the new and far less prestigious women's medical training institutes. In the United States, sectarian schools opened doors to women earlier than did allopathic schools. Scandinavian women, who sought entry into medicine later in the century, were allowed into previously all-male institutions in their respective countries.

In all the countries, women initially entered maternal and child health where claims of special suitability were clearest. Today, women are still clustered in these and related primary care areas and least represented in surgery, the specialty most dominated by male ethos and culture. Women's advancements in policy, administrative, and academic posts vary greatly between countries but prestigious specialties and positions remain male dominated, even in Russia where women have been the majority of practitioners for over half a century.

A striking similarity between countries is women's strategy of making claims of special expertise to gain entry and advancement. Feminist scholars who reject essentialism in favor of gender equity will be particularly interested in the "strategic essentialist" stance used to achieve political ends (134). Examples include U.S. women physicians' efforts to establish a new specialty of women's health generalist and Finnish women pathologists' strategies for transforming a stereotypically male specialty into a gender appropriate field for women.

In Finland, as pathology evolved from mostly stereotypically male autopsy work to microscopy, women have made claims to their special suitability for discerning between normal and abnormal tissue. Riska's qualitative study of Finnish pathologists highlights the visual and scientific elements of pathology, as well as working conditions, attractive to women. Pathologists have greater control over hours and working conditions than most other specialists do. Women continue to make career decisions in relation to family life, even in Scandinavia, where gender equity is ideologically embraced and nominally institutionalized into social policies ranging from maternity and paternity to child care.

To enter pathology, Riska's informants described how women had to overcome initial negative experiences with autopsy work and maintain autopsy skills even when they preferred microscopy. The stereotypes and barriers they overcame included not only the male culture of autopsy work but perceptions of women's intrinsic suitability and preference for direct

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contact with patients. Because pathologists never see patients, just corpses or tissues, women must overcome numerous gender expectations and manage internal gender typing. The Finnish pathologists were commonly assigned autopsies on children and tissue work on both women and children. Their tacit acceptance of this gendered division of labor provides a niche while they make strategic essentialist claims about women's natural superiority for microscopy, emphasizing precision, thoroughness, order, detail, and diligence as female strengths.

Although Riska concludes that some theoretical perspectives best explain patterns of entry and advancement for women physicians, there are few systematic comparisons or weighing of evidence. Analysis of the consequences of different types of organized feminist activism, or lack of it, would also benefit from more systematic treatment. Knowing that the second wave of feminism did not take hold in the Scandinavian countries, except in Denmark, leaves unanswered questions about the contributions or consequences of these differences in either professional careers or medical care for women. While it is interesting to know that feminist activism largely played out through existing political parties and institutions in Scandinavia, a more systematic comparison of results—and failures—would be useful. Similarly, it would be helpful to define the nature of the divide between lay advocacy groups and organized women physicians in the United States, which has led to sometimes competing and at other times complementary feminist agendas. More analytic clarity here would provide a fuller view of the contributions of outside (lay) versus inside (female physician) advocacy groups in changing medical care.

Despite these limitations, Riska provides important insights into developments in Russia and the Scandinavian countries that deserve attention. Comparative data add important perspectives to debates about the future of the medical profession. Two areas that will particularly benefit from cross-national consideration are studies of the feminization and proletarianization of medicine and shifts from central to regional or local control over service provision and funding. Riska emphasizes how in the Soviet era medical work became comparable to that of teachers and other female occupations in terms of autonomy and control over resources. In Russia, she attributes this to a central policy that devalued services and elevated the status and reward systems of industrial investments and endeavors. She also raises questions about the effects of decentralizing medical services in Sweden and Finland, transferring financing and decision making to the local level. With such changes, the equity and standardization that are hallmarks of the welfare states may decline. In the United States, uni-

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versal access to a floor of equity has not been achieved. In both societies, such fiscal and structural changes will shape women's futures in medicine.

Riska concludes that structural forces and ubiquitous gender systems will continue to provide new opportunities and barriers to women physicians. Women will continue to employ a wide range of strategies to advance both individually and collectively, but the structures of medical organizations and gender systems warrant attention. This book should spur on such work.

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