



## Review

## Conceptual frameworks for comparing healthcare politics and policy

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## ABSTRACT

This literature review pursues two main objectives: first, it argues that research on health policy actors and healthcare systems need to be separated more thoroughly. Though there are important interactions between both fields, it is often advisable to separate analytically research on health policy actors and on healthcare systems. Second, concentrating not only on actors and institutions but also on outcomes, we suggest, is theoretically valuable, practically feasible, and policy relevant. Most studies discussed in this review concentrate either on health policy implementation or on healthcare system characteristics. Our emphasis is on extending the understanding about the outcomes of different national healthcare arrangements and whether policy reforms actually deliver their promised results. To do this, more attention to the measurement of success is required.

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## 1. Introduction

Formal healthcare, the work that patients, doctors, nurses, druggists, and hospitals do when facing real or feared illness, is everywhere a topic of concern. The politics of that world – where by politics we mean the role of governmental policy in the financing, delivering, and regulating that care – is among the nations of the OECD of great salience. National (and often international) media report healthcare developments regularly, with attention usually riveted on the costs and quality of the care delivered or denied. In recent decades, the performance of countries other than one's own has gained considerable prominence. Where once policy elites and scholars learned of “foreign” medical care arrangements from books and reports by knowledgeable authors, the range of commentators now is much wider and arguably less knowledgeable. The sources of cross-national commentary include television interviews across borders, quick trips by party leaders to discover what “best practices” can be found abroad,

and thin portraits of national arrangements that international organizations deliver from time to time. The various disciplines – from the social scientists to the biomedical specialists reporting about the medical care practices they know from collegial exchanges – produce bewilderingly diverse portraits of how healthcare works in this or that country.

This essay is about this complicated portraiture, addressing the topic through the lens of comparative, cross-national analysis. Its mode is a literature review. Its approach is two-fold: how to understand the literature addressing the politics and policy processes that shape, sustain or reform the medical care arrangements of any society. What does this literature tell us about the political processes – the interplay of governmental institutions, interest groups, and political ideas – that shape the operations of the medical care world? Such an inquiry is applied political sociology and this literature can, we believe, be approached with the following simple model in mind (Fig. 1).

The second topic is the descriptive and explanatory scholarship about what is conventionally termed “healthcare systems.” How is healthcare financed, provided, and regulated, and what are the outcomes of different national care arrangements? Fig. 2 sets out the

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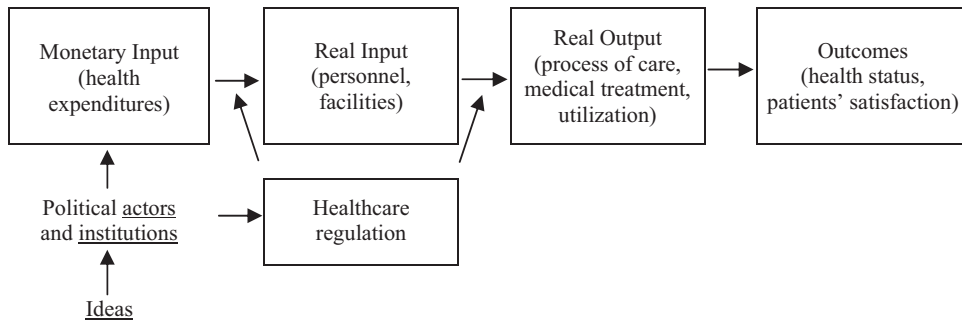


Fig. 1. Ideas, interests, and institutions in healthcare source: adapted from [1: xxv].

typical categories of writing in these areas (see [1] for an overview).

From this perspective, our review addresses the following question: does the analysis concentrate on healthcare politics or on healthcare systems? There are useful studies that combine the analysis of decision-making in healthcare with that of institutional structures [2–4]. This research approach has undoubtedly illuminated the role of political actors in different healthcare arenas. However, we suggest that sharply separating both parts can be analytically helpful. Both the healthcare system and its specific institutional architecture are the results of policy decision-making. Even if studies combine the analysis of health politics and healthcare systems, it is analytically meaningful to reveal the main focus of research.

Comparative studies of health politics and policy can also be classified by whether or not they address substantive outcomes. Healthcare arrangements can be read as the programmatic results of policy decision-making. How health reforms are implemented is a crucial component to the analysis. When comparing healthcare systems, on the other hand, we want to know how they function, what they produce [5]. That means we should attend to the outcomes of healthcare systems for patients, the insured, and citizens. Without performance information, there is no strong evidence with which to design healthcare reform [6].

Defining health policy goals, such as improving cost effectiveness, augmenting population health, and assuring patient safety as well as performance monitoring [6,7], are examples how health policy decision making can be better informed.

We do not address a number of health policy studies. Country reports such as the European Observatory on Health Systems and Policies series provide detailed and increasingly up-to-date country descriptions (health system profiles, or HiTs) and are invaluable sources for comparative analysis. Volumes that collect country reports together with an editorial introduction and summary conclusion, labeled by Marmor et al. [8] as “stapled national case studies,” can also provide important information for cross-border learning (see, for example, the excellent volumes by Altenstetter and Bjorkmann [9] and Okma and Crivelli [10]). Other books address a particular theme in health policy: for example, healthcare financing [11], primary care [12], and decentralization in healthcare [13]. We have not included such studies in this article because we want to concentrate on comparative studies addressing overall healthcare systems. The comparative focus on overall healthcare systems has some disadvantages, of course. Comparing complex arrangements of various countries necessarily requires a broad focus while implementing health policy reform requires knowledge about specific

		Analysis of	
		Political actors & institutions	Healthcare systems
Outcome analysis	No	a) Role of political institutions and actors in healthcare policy	c) Regulation, financing and organization of Healthcare systems
	Yes	b) Health policy actors & health policy results	d) Healthcare systems & outcomes (such as access, quality, equity, satisfaction)

Fig. 2. Actors, institutions, healthcare systems, and outcomes.

programs. However, efficiency gains in one or another feature of healthcare or particular type of hospital does not mean, as US experience demonstrates, higher efficiency for the overall healthcare system [1]. Accordingly, research on the latter topic remains highly relevant.

The following questions focus our review: What purpose is the comparative work – whether its focus is politics or medical care arrangements – meant to serve? Is it simply to give the reader a different perspective through comparison, without policy implications? Is it to understand why policies, or programs, worked reasonably well in some settings and not others? Is the focus on treating other similar national settings as natural experiments for predicting what will happen in the context of interest? Finally, what concepts and methods have been used when comparing broadly healthcare politics and policy? These questions motivated our review, one form of stocktaking.

The following sections review the literature according to the four categories mentioned above (see Fig. 2): (a) the central political institutions and actors in healthcare policy; (b) health policy actors and health policy outcomes; (c) healthcare systems; and (d) healthcare systems and outcomes.

## 2. Conceptual frameworks for comparing healthcare politics and policy

The contemporary literature has placed increasing emphasis on comparative methods. Earlier comparative studies typically concentrated on a very limited number of countries. The aim was to understand in detail the complexities of the healthcare arrangements in question. More recent comparative work has used conceptual frameworks that permit studying a much larger number of countries, often combining both macro and micro levels of analysis.

Drawing policy lessons from the experience of other countries requires, it is commonly and rightly claimed, knowledge about contextual factors [14]. An analytical framework that captures the relevant institutional factors of the political environment on the basis of a standardized set of indicators is one way to satisfy this criterion. At the same time, however, these studies often do not include the results of health policy implementation. Many comparisons of healthcare systems have a similar bias – or feature. They focus on the institutional structure and do not concentrate on outcomes such as health status or health inequalities. If we want to learn more about improved practice in healthcare systems, however, studies need to include outcome measures. And if we want to learn about successful health policy implementation, we need both to define and measure health policy results.

### 2.1. The role of political institutions and actors in healthcare policy

This has been a particularly rich field of scholarship. Ellen Immergut is one of the seminal scholars. Her 1992 study [15] of Swiss, Swedish, and French health policy analyzed what shaped the power of the major interest groups in healthcare policymaking. She demonstrated that

veto opportunities – ones arising from specific features of national political institutions – crucially influenced what policies were adopted. Physicians' organizations, for example, had less influence on the health policy process than generally believed. Immergut's hypothesis, that veto points in the political system are more important than veto groups within society, has prompted other scholarship. For example, Döhler and Manow [16] have illustrated how the influence of medical provider groups is further weakened when financial resources are sharply reduced. According to this literature, retrenchment reduces the power of physician groups, but the degree to which that takes place varies with the institutional context.

The institutionalist perspective was carried to something of an extreme by Steinmo and Watts in their 1995 article [17], "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America." That article concentrated on an American institutional setting in which legislative stalemate is common, and on a reform episode in 1993–1994 that was over-determined.

The importance of historical legacies for health policy development is part of this line of scholarly argument. Hacker's 1998 study [18] of the historical sequence and timing of health policy change in Britain, Canada, and the United States is illustrative. Hacker identified three conditions that arguably influenced the health policy path of these countries. The achievement of universal health insurance, he stipulates, is less likely when (1) a sizable part of the population has physician-dominated private health insurance before national health insurance is on the political agenda; (2) public insurance reform targets residual populations from the outset; and (3) medical care was a substantial industry before the idea of universal health insurance became politically salient. Hacker wants to explain the enduring American conflicts over universal health insurance as the result of the United States' satisfying all three conditions. Using path-dependency, Wilsford [19] explored the timing and scope of healthcare reform in Germany, France, Great Britain, and the United States. Large-scale policy change is highly unusual, he rightly argues. But some institutional structures are more conducive to big-bang reforms than others. Wilsford correctly asserts that both the British and German structures are institutionally more open to large-scale reform than is the US political structure.

A second stream in the literature concentrates on what issues and with what resources the state addresses healthcare [2–4]. Tuohy [3,20] provided one of the most theoretical approaches for analyzing models of governance in the healthcare arena. Concentrating on the question of accountability in healthcare, Tuohy [20] argued that the dominant model has shifted from an agency to a contract one. In the trust-based principal-agent relationship, the state (the principal) delegates authority for regulating and distributing healthcare to the medical profession (the agent). According to Tuohy [20], this system, which placed the physician at the center of the decision-making process of healthcare provision, dominated medical care – at least in Canada, the US, and UK – until the end of the 20th century. New information technology, Tuohy contends, has provided governments with much

better information, reducing the information asymmetry between state actors and physicians. This strengthened another governance model, the contract model, in which the state both finances and purchases healthcare. According to Tuohy, the medical profession, from the late 1980s on, lost some of its earlier power not so much because of increased cost pressures as because of the state's superior access to relevant medical information.

Typologies represent a third cluster of writing in the field of health politics. Such work is more expansive in geographic scope, with more than three or four countries studied. Like Tuohy, Moran [21] analyzed models of governing healthcare. Instead of focusing on the state-doctor relationship, however, he classified healthcare politics according to three central concepts: "consumption," "provision," and "production." The "consumption" dimension describes the basis of eligibility for patients to access healthcare and the funding mechanisms that allocate financial resources to healthcare. The "provision" dimension describes who controls and regulates hospitals and doctors. And the "production" (or technology) dimension encompasses mechanisms that regulate medical innovation (see also [22]). Using these dimensions as analytic tools, Moran identified four ideal types of healthcare politics: (1) the "entrenched command-and-control state," represented by the Scandinavian countries and Great Britain; (2) the "supply state," illustrated by the US; (3) the "corporatist state," represented by Germany; and (4) the "insecure command-and-control state," exemplified by Greece and Portugal. The typology is meant to illuminate which actors dominate these four types of healthcare states. In "supply states," provider interests dominate in all three dimensions, while in "command-and-control states," the government is central in all three areas. In "corporatist healthcare states," public-law bodies and doctors' associations are the most powerful. "Insecure command-and-control states" are problematic. Formally, the state is dominant. In fact, such states "lack the administrative capacities for guaranteeing universal coverage and equal access to healthcare services, principles that have characterized the healthcare systems of the Nordic countries and Great Britain for many decades" [1: xix].

Another typology was advanced by Wendt et al. in 2009 [23]. They distinguished healthcare arrangements by the role state-, non-governmental (societal)-, and private actors have in the financing, provision, and regulation of healthcare. The result is a classificatory scheme of 27 types of healthcare politics, three of which are ideal types. In "state healthcare systems," financing, service provision, and regulation are carried out by political actors. In "societal healthcare systems," by definition societal actors dominate all three dimensions. And in "private healthcare systems," private for-profit actors dominate all three dimensions. For each ideal-type, there are six mixed combinations in which state-, societal-, or private actors dominate two dimensions. Six further combinations do not approach any of the three ideal-types. This methodological framework allows one to identify more fine-grained differences in healthcare politics as well as changes over time. Germany, for instance, is not identified as an ideal-typical corporatist healthcare state, as suggested by

Moran. Rather, it is a mixed, more complicated type in which corporate actors control the financing and regulation while provision is dominated by private actors. Central and Eastern European countries (CEE) provide another illustration of complexity. Formally speaking, they replaced their former socialist arrangements with social health insurance schemes. But according to Wendt et al.'s methodological framework, these countries are correctly classified as state-based systems because social insurance and corporate actors are, in fact, weak and healthcare services are largely provided in public institutions.

This framework also suggests a classificatory basis for understanding policy transformations. There is (1) "system change," such as a shift from a societal-based to a state-based healthcare system, which is expected "to arise only in exceptional instance in which drastic turns in policy goals meet high public acceptance" [23: 83]; (2) an "internal system change," which occurs for instance if the provision of healthcare services becomes dominated by private instead of state actors while financing and regulation remain in state hands; and (3) an "internal change of levels," in which changes can be identified on one or more dimensions but without a transformation of the dominant mode of healthcare financing, provision, or regulation. Due to the difficult measurement of regulation, however, typologies of health policy decision making have so far not been used for empirically analyzing country differences and changes in healthcare politics.

## 2.2. Health policy actors and institutions and health policy outcomes

The comparative analyses of governance institutions and constellations of political actors provide a better understanding of the possible results of healthcare politics, but often do not measure them. The results of health policy decision-making include cost-containment, priority setting and rationing, coverage, and solidarity – among other possibilities [24]. A number of studies take up these topics. Most either focus on single countries [e.g., 25,26] or analyze outcomes without specifying the governance structures and actor constellations that produced or shaped the results [e.g., 11,27]. Looking forward, we would hope that consistent criteria for measuring policy change and health policy outcomes in a larger number of countries will become more common. But, as Pierson suggests,

there is probably no substitute for investigations that pay attention to fairly detailed dimensions of policy change [...]. Rigorously applying consistent criteria to even a small subset of affluent democracies is a time-consuming and expertise-taxing enterprise. Carrying out such research for the affluent democracies as a whole would require the efforts of a large and well-funded team. So far no one has carried it out [28: 421]

The European Observatory on Health Systems and Policies provides a platform for collecting relevant information on a number of countries. In this context, Kutzin [29] has suggested a methodological approach for comparing health policy results. Lessons from the implementation of healthcare financing reforms, according to Kutzin, can first

be drawn by using a common set of explicit health policy objectives as criteria for assessing the reform processes. The second suggestion is a “function-based framework” for capturing the existing healthcare financing system. The third suggestion involves identifying and analyzing the key contextual factors that have major implications for particular reform options and the related outcomes. Using this framework, Kutzin et al. [30] characterized the implementation of health policy reforms in Central and Eastern European transition countries over twenty years. Their main conclusion about the reform experience in transition countries is rather general: “Coherent and successfully implemented reform strategies require clear identification of specific policy objectives, based on analysis of critical health system performance problems, and careful choice of a combination of well-aligned policy instruments that respond to the identified problems” [30: 384].

Wendt and Kohl [31] analyzed the impact of public policies on the transformation of financial resources into healthcare provision in 22 OECD countries. Countries with a higher share of public health expenditure, they suggest, are more successful in controlling healthcare costs. Financial resources are not, however, linearly transferred into healthcare provision. Countries with a strong share of private health insurance have high costs and low levels of healthcare provision. Countries with strong corporate actors (e.g., Austria, Belgium, France, and Germany) that invest above-average levels of financial resources in healthcare also achieve above-average levels of healthcare provision. Strong states, on the other hand, such as Denmark and Great Britain, have healthcare expenditure levels below the OECD average, but their levels of healthcare provision are also lower. Only a few countries, such as Finland and Luxembourg, achieve above-average healthcare provision with financial resources below the OECD mean. But Wendt and Kohl do not provide in-depth information about the role of health policy actors in achieving such a favorable combination.

Few comparative studies have concentrated on health policy results other than health expenditures or levels of healthcare provision. But contemporary policy conflicts go far beyond this narrow focus. Universal access to medical care, patients’ choice, and equity and solidarity are all issues on the health policy agenda [1,24]. Comparing Belgium, Germany, and the Netherlands, Maarse and Paulus [32] argue that the political culture of European welfare states remains powerful. Market principles, they contend, have not sharply reduced solidarity. Analyzing the dimensions of “risk solidarity,” “income solidarity,” and “scope,” Maarse and Paulus found evidence that solidarity has even increased and remains a key principle in European social health insurance. Addressing earlier British and Swedish health policy reform, Saltman [33] showed that state regulation increased to safeguard solidarity in healthcare systems in which market principles appeared to gain importance.

The comparative studies discussed so far have contributed innovative methodological frameworks and some new understandings of the results of health policy reforms. They have not, however, contributed frameworks for assessing the role of health policy actors within the reform

processes. Hassenteufel et al. [34], however, do offer an actor-centered approach to health policy change. They propose that “we... pay close attention to precisely who defends a particular reform program and how idea formulation links to specific policy decisions in a given case. Once we know who and how, we must not forget to ask why” [34: 528]. They conclude that programmatic actors are decisive in explaining particular health policy results. Specific actors transform available health policy instruments into health reform programs. That is why it is so crucial to know who presses for particular policies and how those are related to institutional and economic contexts.

### 2.3. Healthcare systems

We now turn to comparing systems of healthcare provision and in particular to how they are organized and financed. This field includes comparative studies with a fundamental theoretical orientation that take into account the healthcare’s high level of complexity. These are typically studies of similarities and differences in a limited number of countries. A larger number of countries can be included in the analysis when the comparison is based on few, pre-selected criteria.

There are, of course, numerous studies of comparative financing and expenditure [e.g., 35–40] and of healthcare provision [e.g., 4,41–42]. Very few comparative studies cover the overall arrangements for funding, delivering, and regulating healthcare. A good example of the latter is Blank and Burau’s [43] textbook on comparative health policy. It introduces scholars and students to the complexity of health policy and medical care and describes how healthcare is delivered, financed, and regulated in different countries. Another recent textbook is by Gauld [44], who compares the healthcare programs of New Zealand, Great Britain, and the United States. His analysis is guided by the theoretical assumption that healthcare has moved from a “neoliberal” to a “social-democratic” era in health policy. Gauld argues that healthcare quality improvement is firmly planted on the health policy agenda in New Zealand, Great Britain, and the United States. There is, Gauld contends, greater alertness to coordinated and patient-centered care in the three national settings he studied, and he emphasizes that healthcare information technology has changed the relationship between policy makers, funders, healthcare providers, and patients, all of whom have been empowered via better access to information. Interestingly, the tax-funded British NHS seems to be particularly innovative with regard to information technology. Patients are provided with better information and therefore power in the care-giving process, most visibly in Great Britain and New Zealand. Gauld [44] sees this as a social-democratic response to preceding neoliberal arrangements. The US healthcare system, on the other hand, is by comparison not only an example of market failures [1] but also of a system with relatively low levels of patient information and involvement and public satisfaction [44].

Typologies group healthcare systems by using a few pre-selected criteria. The OECD study “Financing and Delivering Health Care,” prepared by Schieber in 1987 [45], distinguished healthcare arrangements on the following



three dimensions: (1) access to healthcare measured by the degree of population coverage; (2) the sources of financing, such as general taxation, social insurance, or private insurance; and (3) the public–private mix of healthcare provision. For Schieber, there were three basic healthcare arrangements: (1) a national health service model with universal coverage, tax funding, and public ownership of healthcare provision (e.g., Sweden, Great Britain); (2) a social insurance model with universal coverage, social insurance financing, and public or private ownership of facilities for provision (e.g., Germany); and (3) a private insurance model with private coverage, financing, and ownership of provision (e.g., the United States) [45]. The OECD concept combined modes of governance and healthcare system characteristics such as the degree of coverage. Later typologies concentrated even more on different modes of governance and therefore on the role of political actors in the healthcare arena [see above; in particular, 3,21–24].

Only recently have typologies with a focus on patients and in particular on patients' access to healthcare emerged [46,47]. According to Reibling [47:5], "putting access at the centre of a health typology strengthens a patients' perspective and thereby the impact of health services on individual health." The patient-oriented typologies aim to understand better the relationships among healthcare systems, access to healthcare services, and health outcomes. They do not, however, directly measure the effects of healthcare systems on health status or other outcomes (see below).

Wendt [46] used the following eight criteria for classifying healthcare systems: total healthcare expenditure, the public–private mix of healthcare financing, private out-of-pocket payment, out-patient healthcare provision, in-patient healthcare provision, entitlement to healthcare, remuneration of medical doctors, and patients' access to healthcare providers. Based on these criteria, he identified three types of healthcare organization: (1) a "health service provision-oriented type" characterized by a high number of healthcare providers and free access for patients to medical doctors (Austria, Belgium, France, Germany, and Luxembourg); (2) a "universal coverage – controlled access type" in which healthcare is a right of citizenship and equal access to healthcare is more important than freedom of choice (Denmark, Great Britain, Sweden, Italy, and Ireland); and (3) a "low budget – restricted access type" with limited financial resources for healthcare and in which patients' access to healthcare is restricted by high co-payments and the regulation that patients be on a general practitioner's (GPs) list for extended periods (Finland, Portugal, and Spain).

Reibling [47] focused even more on patients' access to the supply of healthcare services, using the criteria of gatekeeping, cost-sharing, provider density (GPs, specialists, and nurses), and medical technology (magnetic resonance imaging units/MRI, computed tomography scanners/CT). Classifying European healthcare systems by these criteria yields the following four types: (1) "financial incentives states" that regulate patients' access to medical doctors mainly by cost-sharing (Austria, Belgium, France, Sweden, and Switzerland); (2) "strong gatekeeping and low supply states" with no cost-sharing but extensive

gatekeeping arrangements for doctor's visits and a low numbers of healthcare providers and relatively little medical technology (Denmark, the Netherlands, Poland, Spain, and Great Britain); (3) "weakly regulated and high supply states" with weak gatekeeping and a high supply of healthcare providers (the Czech Republic, Germany, and Greece); and (4) "mixed regulation states" that combine gatekeeping and cost-sharing arrangements (Finland, Italy, and Portugal).

None of the comparative studies reviewed in this section directly measures the outcomes of healthcare systems. By outcomes, we mean the utilization of healthcare services, people's perception of healthcare systems, and their health statuses.

#### 2.4. Healthcare systems and outcomes

One influential study on health outcomes is that by Nolte and McKee [48]. They describe healthcare systems as complex institutions serving multiple functions. To relate population health outcomes to healthcare, Nolte and McKee used the concept of "amenable mortality." By that they mean "deaths from certain causes that should not occur in the presence of timely and effective health care" [48,59]. They found that "amenable mortality" accounted for about 23% of total mortality in males and about 32% in females in 2002/03, with huge country variation. Between 1998 and 2002/03, the "amenable mortality gap" among countries widened since ischemic heart disease mortality was reduced by more than 20% in some countries (France, Great Britain) while remaining almost at the same level in the United States. Even if healthcare is not measured directly, the concept of "amenable mortality" can be used to draw conclusions about medical care areas where improvements seem particularly needed [see also 5,49,50].

Mackenbach et al. [51] studied differences in health results in 22 European countries to identify some immediate determinants of country variations. They concluded that differences in mortality are strongly related to inequalities in access to healthcare. In this interpretation, differences in mortality that are related to the socio-economic position may well result from conditions amenable to intervention by healthcare providers. This is especially so in Eastern Europe. Since Scandinavian countries show no smaller inequalities in health than the rest of Europe, they suggest "that although a reasonable level of social security and public services may be a necessary condition for smaller inequalities in health, it is not sufficient" [52: 2479].

Neither Nolte and McKee nor Mackenbach et al. directly measured healthcare. Studies on targets and performance measurement could potentially step in but have so far, with few exceptions, concentrated on single countries [52]. Comparative studies on health policy processes could even combine the analysis of healthcare reform, health policy implementation, and healthcare system outcomes. As dimensions for measuring healthcare system performance, Smith et al. [7] suggest "health status," "clinical quality and appropriateness of care," "responsiveness of the healthcare system," "equity," and "productivity." In a comparative study that is based on this work, Smith et al. [6] discuss

health policy targets in various countries but they do not measure outcomes.

Reviewing 45 studies published on health inequities between 1992 and 2008, Beckfield and Krieger [53] contend that researchers on healthcare systems and researchers on health outcomes have rarely communicated directly despite common interests. Only nine out of forty-five studies have concentrated on the effect of the healthcare system itself on health inequities, and none of the nine studies was comparative.

When including macro-indicators in comparative studies on health and health disparities, authors have so far concentrated on welfare state typologies, not healthcare systems. Conley and Springer [54], for example, analyzed the influence of healthcare expenditures and of welfare state regime types on infant mortality. They found that increased investment in healthcare associates with a lower infant mortality rate. However, when analyzing welfare regime types, only the “Corporatist” welfare state showed a positive effect, not the “Social-democratic” or the “Liberal” types. Without directly analyzing the healthcare system effect, the authors concluded that there is “no convincing evidence that the institutional structure of the health care delivery system matters in determining the ‘bang for the buck’ – that is, the impact of state health expenditure” [54: 801].

Focusing on health and health inequalities more generally, Eikemo et al. [55] asked to what extent welfare state typologies can explain the variation of self-perceived health in Europe. Since social transfers and welfare services reduce inequality, they assumed that a developed welfare state should have some bearing on health outcomes as well. Their key finding is that the Scandinavian and Anglo-Saxon welfare states seem to have advantages with respect to population health compared with Southern and East European welfare states, and that welfare state characteristics seem to represent important factors in self-perceived health among European nations. But some 90% of the variation in self-perceived health was at the individual level, and only about 10% was at the country level. Furthermore, from a classic welfare regime perspective, the high performance of Anglo-Saxon countries in Europe is counterintuitive. Eikemo and colleagues therefore assume that the advantage of Anglo-Saxon countries on self-perceived health is related to the national health services in these countries, not the welfare state more generally.

Measuring patients' utilization of healthcare services is another way to analyze outcome variations among countries. The relation between utilization differences among socio-economic groups and healthcare features has been extensively investigated in the equity literature, especially the work of van Doorslaer et al. [60,61]. Differences in healthcare utilization between income groups emerged from several cross-sectional analyses. One general observation is that poorer people use medical services more frequently. This relationship disappears when controls for need are introduced. Van Doorslaer et al. also found that GP visits are characterized by a (slight) pro-poor difference while specialist visits show a strong pro-rich differentiation. Medical specialist visits are unequally distributed in nearly all countries, irrespective of system characteristics.

In addition, the main share of specialist inequity is found when analyzing whether people have seen a specialist at all and not in the conditional number of specialist visits. Van Doorslaer and Masseria [60] conclude that inequity here is rather more patient-initiated than doctor-driven.

In a similar study, Reibling and Wendt [62] introduced healthcare system indicators and asked whether the formal regulation of patients' access to the healthcare system through a gatekeeping system influences differences in healthcare utilization among income and educational groups. They found that the degree of gatekeeping has a significant effect on healthcare utilization among educational groups. Countries with almost no access regulation (e.g., Belgium, France, and Germany) show huge differences in healthcare utilization between those with the highest level of education and with the lowest education level. When patients' access to healthcare providers is strictly regulated through a gatekeeping system (e.g., in Denmark, the Netherlands, and Spain), there are very few differences in the number of specialist visits among educational groups.

“Objective outcomes” need to be distinguished from “subjective outcomes.” “Subjective outcomes” can be measured and compared by portraying how healthcare arrangements are understood by the population. Most studies report high levels of public support for European healthcare systems [56–58]. This also bolsters the hypothesis that universal welfare state institutions covering the middle classes are likely to receive strong public support [28]. According to Gelissen [57], the healthcare arena enjoys a high level of solidarity, and public support seems largely independent of social class or income level. When analyzing the importance of macro-level indicators, Wendt et al. [59] found that the level of public healthcare expenditure and the amount of private out-of-pocket payment are both positively related to public support of a strong role of the state. Furthermore, the higher the level of public healthcare expenditure is, the higher the level of satisfaction with the overall healthcare system is. The level of out-of-pocket payment is not related to satisfaction. There is also no correlation between the level of satisfaction and whether patients have a free choice of doctors or whether formal access to doctors is regulated through gatekeeping. The findings suggest that both a high number of service providers in the out-patient sector and especially the availability of general practitioners are of great importance.

### 3. Conclusion

Our reading of the comparative literature on health politics and healthcare systems documents considerable theoretical and methodological research. We already have substantial evidence of health policy change, relevant health policy actors, and the main institutional characteristics of healthcare systems. At the same time, the reviewed literature shows considerable heterogeneity. However, it is not plausible to search for “the overarching method” in comparative healthcare research. There is no “canon of the scientific literature” in health policy – that is, a research agenda for comparative studies that relies on a common set of theoretical and empirical approaches [1].

Our literature review took up two main objectives: first, we argued that research on health policy actors and healthcare systems needed to be separated more thoroughly. Though there are important interactions between both fields, it is often advisable to separate research on health policy actors and on healthcare systems analytically. This becomes obvious when our second objective comes into play. Concentrating not only on actors and institutions but also on outcomes may combine the strengths of different disciplines and is theoretically valuable, practically feasible, and policy relevant. Exploring feedback loops from policy outcomes may inform the study of policy processes. Outcome research may show, moreover, that the political determinants of health inequities are alterable [5,53]. Furthermore, healthcare systems themselves are the outcomes of health policy decisions, which demonstrates the inter-relationship between health policy actors and healthcare systems.

For both areas of research, there is often a trade-off between theoretical depth and the number of countries included in the comparative analysis since a single author, or few authors, can only assess very few of these highly complex institutions in detail [8]. When comparing a larger number of countries, it is necessary to pre-select a feasible set of dimensions that are analyzed in precisely the same way for all countries included.

Rothgang et al. [63], for instance, suggested using the dimensions of “regulation,” “financing,” and “provision” for analyzing the changing role of the state in healthcare. In addition to funding and organization, Gauld [44] used the dimensions of “healthcare quality” and “information technology”. The selection of appropriate dimensions and the interpretation of the results require a broad knowledge of the healthcare systems investigated and a theoretical framework justifying the selection of indicators and dimensions.

The reviewed studies have indicated that the ideal-typical method may represent a useful tool for measuring changes in the role of health policy actors and also for identifying most-similar and most-different cases for detailed comparisons of healthcare politics and policy. Typologies have the advantage that they allow for the inclusion of a larger number of countries in the analysis. Typologies may also provide a basis for bridging the macro-micro link in comparative studies in such instances as when analyzing the outcomes of certain health policy constellations. Typologies of health policy actors have concentrated on governance concepts [3,30], and Moran has applied the governing concepts “consumption,” “provision,” and “production” to contrasting four healthcare states. Wendt et al. [23] classified healthcare politics by asking for the role of governmental-, societal-, and private actors in healthcare provision, financing, and regulation. Both typologies provide methodological frameworks that, however, have so far not been analyzed empirically, a shortcoming related to the difficult measurement of regulation.

Typologies of healthcare systems have gone one step further and have classified healthcare systems on the basis of empirical information. Reibling [47] has used the dimensions of “gatekeeping,” “cost-sharing,” “provider density,” and “medical technology,” and Wendt [46] has classified

healthcare systems by using the dimensions of “healthcare expenditure,” “public-private mix of financing,” “private co-payments,” “level of healthcare provision,” “entitlement to healthcare,” “remuneration of medical doctors,” and “patients’ access to healthcare providers.” Both typologies focus on the supply side as well as on the demand side of healthcare provision. So far, however, healthcare system typologies have mainly served descriptive purposes, and outcomes related to healthcare system types remain to be measured.

The challenge of drawing defensible policy lessons from comparative scholarship remains daunting. The problem is not only that findings come from different methodological frameworks but that accurate characterization is a precondition for sensible lesson-drawing. Klein [14: 1269], emphasizes that “the challenge to improving our capacity to learn from the experience of other countries is to deepen our understanding of the respects in which they differ or are similar.” The task of health policy learning has important implications for future comparative research. For instance, by including outcome-measures, we may improve our understanding about what healthcare reforms and the functioning of healthcare systems mean for individual patients. A theory-guided set of dimensions has, we contend, been helpful in analyzing the role of health policy actors, healthcare systems, and health policy outcomes. We need to extend our understanding about the outcomes of different national healthcare arrangements and whether policy reforms actually deliver results. To do this, we need to pay more attention to the measurement of success.

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