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The Convergence and Divergence of Modern Health Care Systems

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Do countries at about the same stage of industrial development adopt the same approach to the organization and management of their health care system? Or are cultural heritages distinctive enough that each society fashions its own political and administrative structure? And to what extent do national and international policies affect and determine the organizational structures located in and emerging from the institution of health care?

A widespread view in reflections on modern health care systems is that they are becoming increasingly similar. This view is based on the fact that modern societies are faced with analogue problems impinging their health care organization. Most importantly are an aging population, technological developments, and rising costs of health care. The percentage of very old people will continue to rise. With this, we see a shift in disease patterns from acute to chronic illnesses. When people are getting older, the chance that they will age in good health decreases. Combined with the growth of science and medical technology, these factors influence public expectations and demands for health care, and consequently result in higher expenditures on health care.

The scope of this chapter is to review developments in health care organization of industrialized societies in the context of the current debate on health care reform, with a specific focus on the structural and cultural context of health services. We argue that the organization of health care in modern societies reflects a wide range of convergencies and divergences. This is illuminated by discussing international trends in health care, and some of the basic health care organization models in three regions: Europe, North America, and Asia.

INTERNATIONAL TRENDS IN HEALTH CARE ORGANIZATION

During the last decades industrialized nations have felt an increasing need to reform health care. This need is due to a general dissatisfaction with overall performance, evidence of inefficiencies in the use of resources, and a lack of responsiveness of services to users. The latter is particularly reflected in attempts to increase patient choice and in demands for more public accountability and participation in the organization and management of services. More and more nations are seeking ways to increase the choices of patients in selecting their general practitioner, specialists, and hospital.

Dissatisfaction is further manifested in attempts to change the balance between public health, prevention, and primary health care on the one side, and secondary care at the other. It has been recognized that in the past too much priority has been given to hospital care at the expense of the development of primary care, community care, and public health. By means of budgetary incentives, health care services are refashioned, for example, with regard to the relation between primary and secondary care provision and with regard to measures to improve continuity of care. New professions come into existence at the interface of nurse and physician, while the content of nursing practice is changing. Particularly in primary health care the role of nursing is expanding.

Another general trend is that the future role of the hospital in health care is increasingly being questioned (Ginzberg 1996). Epidemiological and demographic changes, and new technological developments in the field of diagnosis and treatment have a tremendous impact on the delivery of services. Many services that, until recently, were only delivered in hospitals have found their ways to the home of patients. Typical examples are renal dialysis and diabetes care, where patients and their relatives are taught to deal with low- and high-tech medical equipment (Gallagher 1999). The number of acute beds in hospitals and the average length of stay have dropped substantially in almost all industrialized countries (OECD 2002). This is a direct result of changes in treatment procedures, new diagnostic techniques, the changing role of primary health care, early discharge procedures, and overall cost-containment measures.

With the changing role of hospitals in health care we see that the involvement of health professionals in the management of health services is also changing. By making health professionals responsible for management in health care, professional accountability and cost containment will benefit. It results in a shift of focus of professional norms exclusively aiming at the quality of professional care, to one also focusing on issues of cost containment and service reduction (Leicht and Fennell 1997). A variety of initiatives have been launched. One example is the recent purchaser – provider split in the UK, where groups of general practitioners are held responsible for purchasing hospital services. Groups of primary care physicians receive the allocation for their patients' health care to purchase all services, including hospital care. In other countries, for example in the Netherlands, experiments are going on by giving doctors a greater role in the management of services, notably with regard to the management of hospitals. In the US, shifts in decision-making are taking place as a result

of contract relationships and reimbursement policies. For example, physicians are forming associations to negotiate managed care contracts. But also, as was predicted almost two decades ago, medical work is becoming more and more under bureaucratic control (Starr 1982). The overall impact of these developments on professional autonomy is not clear. Indeed, professionals will lose some of their professional control. But then again, professionals are moving into managerial positions which create new opportunities for control and satisfaction (Zeitz 1984; Stevens, Diederiks, and Philipsen 1992; Warren, Weitz, and Kulis 1998).

The thread through all these developments is a continuing debate on the financing of health care. Dependent on the country under consideration, these debates focus on overall expenditures (for example in the US), on the role of the government in cost containment (for example in Sweden and Canada), and on policies regarding health care coverage restrictions (for example in Germany and the Netherlands). In most countries an increasing interest has been shown in the introduction of competition between providers. This is considered as a reform strategy to tackle inefficiencies and to enlarge the responsiveness of providers to users. Policy makers are trying to find a position in the middle between competition on the one hand and managed care on the other. Countries where competition lies at the heart of service provision, as is the case in the US, are moving toward more regulated and managed care. In countries with a long tradition of governmental planning and regulation like, for example, in Sweden or in the UK, we see a movement in the opposite direction toward more competition on the basis of market mechanisms. Not surprisingly, the overall trend in health care reform is managed competition, being a mixture of competition on the one side and management on the other. But as Saltman and Figueras (1998: 87–8) recently noted in their overview of health care reforms in Europe: "There is no single concept of a market that can be adopted for use within a health care system. Rather, market-style mechanisms include a number of different specific instruments such as consumer sovereignty (patient choice), negotiated contracts and open bidding, which can be introduced on the funding, allocation, or production sub-sectors of the system."

Because of these congruent cross-national patterns and policies seeking an optimal mix of public and individual responsibility, there is a growing interest in the comparison of health care systems. Countries in the process of health care reform seek to adopt suitable financial and organizational solutions, but also try to learn from each other's mistakes. The necessity of making health care available and accessible for whole populations within certain budget restrictions gives rise to dilemmas in priority setting and rationing. Making choices about the allocation of resources has traditionally been considered an almost exclusive part of the jurisdiction of the medical profession. What we see now, however, is that priority setting and rationing are becoming part of the public debate.

Priority setting and rationing are not pure technical operations. The course and direction of these activities are influenced by the dominant belief system of a nation. Many European countries try to find ways to combine the values of equity, efficiency, and autonomy. Equity implies that health care should be

accessible for everyone who is in need of it. It reflects a *collectivist* approach with regard to the equal distribution of health care resources among all strata of the population. The contrasting value of individual autonomy reflects the ability of self-determination and independence in health care. It signifies that people should have a free choice, and preferably would have the means to decide for themselves what they would need from health care, irrespective of the distribution of resources. Efficiency indicates that resources for health care should be spent as economically as possible. In their priority setting, all modern nations try to combine these three values in one way or another. Some nations, however, put more emphasis on the collectivist approach (equity), others on individual autonomy. But for all modern nations efficiency has become the more dominant orientation in the light of the increasing costs of health care.

A major dilemma is whether values of efficiency and self-determination can be sustained without losing principles of equity and solidarity. But as priority setting and rationing in health care have become important policy issues in many countries, the outcomes of the political debate are not spectacular. As Mossialos and King (1999: 131) noted: "Greater relative awareness of rationing and priority setting issues in countries such as the Netherlands, Sweden and the UK, is accompanied by some ambivalence about the actual need for rationing or priority setting." Indeed, in Scandinavian countries and in countries like Israel and the Netherlands, with their long tradition of equity and solidarity principles, governments are rather reluctant to introduce measures to restrict the payment for services (Saltman and Figueras 1997).

HEALTH CARE AS A SOCIETAL SECTOR

While the comparison of health care systems has grown in popularity during recent years, some may have wondered at the quasi-absence of studies relating health care and health care organization to the broader societal and institutional environment. The literature on the comparison of health care systems has strongly been influenced by (neoclassical) economic, managerial, and policy perspectives. These focus on issues of macro-and micro-efficiency, on organizational arrangements conducive to effectiveness, on quality of services, and on measures to improve the continuity and accessibility of care. Many studies try to answer the question how, in the context of changing circumstances, goals and priorities in health care can be reached within the limits of political and legislative boundaries, and using resources economically. In essence, this question regards the *effectiveness* of health care.

For their survival and continuity, however, health care systems also must be assessed on their *legitimacy.* Societies have to solve the problem of how health care goals and priorities can be set and achieved in such a way, that the actions of health care actors and the effects of these actions, intentionally or unintentionally, will be judged as socially acceptable. To evaluate the effectiveness of health care, but in particular its legitimacy, it is important to envisage health care as a societal sector, and to take its societal and institutional environment into consideration.

Societal sectors are defined as collections of actors who are functionally interconnected, who operate in the same domain (for example, health, education, economics, or welfare), and who have a set of similar or interrelated functions (Powell and DiMaggio 1991; Scott and Meyer 1991). Defining health care as a societal sector would imply a focus on the collectivity of actors working within the context of that specific institution. In other words, it comprises of focal organizations, services and functions delivering specific products, but also includes all other organizations, providers, facilities, and services that directly or indirectly influence the core actors. This includes facilities such as hospitals, medical practices, nursing homes, and the health professions (medical and non-medical), their clients, client organizations, funding sources on a national, federal, regional level, local governmental bodies, suppliers of facilities such as the pharmaceutical industry, and so on.

Societal sectors have their primary orientation on one societal core function, in this case, health and illness (Lammers 1993: 321–39). They further have a (social) structure, and a specific pattern of relationships between actors in super/subordinate or egalitarian positions. Societal sectors also have their specific institutional culture. This includes a dominant belief system, a specific system of routines, norms, and values, and specific notions of their "bond." In some sectors, for example in economy, these bindings will be primarily competitive. In health care they are more cooperative.

Analyzing health care systems as societal sectors would also imply the recognition of their distinctive history over time, their specific values and value patterns that go beyond technological requirements, and their commitment to a set of normative standards (Parsons 1951; Selznick 1957). In the comparison of health care systems across nations it may seem that goals do not vary much, but that, over time, variations are primarily found in the implementation of technologies used to reach these goals. Where health care systems vary is in their emphasis on goals and priorities; this is mainly due to long-term cultural and structural developments. Consequently, it can be argued that every health care system is typified by its structure of relations of actors and organizations. Every health care system is typified by its unique pattern of underlying norms, values, and value orientations.

The Structure of Health Care Systems

To conceptualize health care systems as societal sectors indicates a high degree of specialization and vertical integration of system elements (Scott and Meyer 1991). Vertical integration denotes that in a production chain activities are controlled at both ends. The health economist Robert Evans, however, argues that because of their distinctive structure, health care systems are characterized by incomplete vertical integration (Evans 1981). As relative independent subsections are involved, such as hospitals, medical services, drugs prescribers, and so forth, vertical integration is difficult to achieve.

Vertical integration is further complicated by the fact that regulatory authority is for the major part delegated by the government to the suppliers. Also, the

provision of health insurance is directly linked to one or more of the other transactors in health care (Evans 1981). Consumers permit providers to act as their agents. But professional organizations enjoy, to a substantial degree, independence from other actors, which indicates that the integration between first-line providers and consumers is far from complete. This incompleteness also regards the physician – hospital relations. In general, physicians do not own or manage hospitals, although in some countries, like for example in Japan, this is different.

Also the role of the government in health care can vary considerably. In some countries the state has only very limited control of the insurance activities, as is the case, for example, in the US. In other countries, for example in Canada and in the UK, the state is in control of insurance by means of taxation.

Health care systems vary in structural relationships and in formal interactions between system elements. A traditional market structure presupposes bilateral relations between buyers and suppliers. The health care sector differs essentially from the market sector, because interactions between the actors are not organized in bi-directional relations of pairs of producers and consumers. In contrast to these typical market structures, the exchange relations between the actors in health care are much more complex (Evans 1981). Multilateral transactions involve many participants who have limited independence and jurisdictions. The organization of health care, therefore, consists of multidirectional relations within an interacting system of five principle actors. These are the consumers, first-line providers (general practitioners), second-line providers (hospitals), governments, and insurers (Evans 1981). How these five actors are connected reflects the basic structure of a system.

HEALTH CARE MODELS OF EUROPEAN HEALTH CARE SYSTEMS

Although health care systems diverge in their methods of financing, organization, and regulation, certain organizational configurations dominate, dependent on the role and position of the respective (trans)actors. From the relations between these transactors typical health care systems can be modeled: the social insurance system, the centralized system of (former) communist countries, and the UK national health care system (Evans 1981; Hurst 1992; Marrée and Groenewegen 1997). These are found in eastern and western Europe, as well as in America and Asia.

The Bismarck model. The first model is the social insurance or Bismarck model, named after its founder. Typical for the social insurance system, or "Bismarck" model, is that patients pay an insurance premium to the sick fund which has a contract with first-line and second-line providers. The role of the state is limited and is confined to setting the overall conditions of the contracts between patients, providers, and insurers. The social insurance system is funded by premiums paid and controlled by employers and labor unions. These, however, have little inference with the provision of services. This is left to the professions, specifically the medical profession, and to charity organizations (e.g. home nursing, home help). For people with lower-and middle-class salaried

incomes, collective and enforced arrangements are available. This social security model was founded in Germany at the end of the last century, and then almost immediately adopted by Czechoslovakia during the Austrian–Hungarian rule, Austria, Hungary, and Poland. During World War II it was enforced on the Netherlands (1941), and later also adopted by Belgium and France. The social insurance system survived two world wars and national socialism, and essentially still exists in Germany, the Netherlands, Belgium, France, Austria, Switzerland, and Luxembourg (Saltman and Figueras 1997).

The Semashko model. Founded in 1918, the second major European health care model is the centralized communist model or "Semashko model." This model is characterized by a strong position of the state, who guarantees free access to health care for everyone. This is realized by state ownership of health care facilities, by funding from the state budget, and by geographical distribution of services throughout the country. The state dominated Semashko model is funded by taxation. Health services are hierarchically organized. They are provided by state employees, planned by hierarchical provision, and organized as a hierarchy of hospitals, with outpatient clinics (polyclinics) as the lowest levels of entrance. Among the nations that still have a health care system based on the Semashko model are Russia, Belarus, the central-Asian republics of the former USSR, and some countries in central and eastern Europe. Many former soviet republics, however, are now in a process of transition toward a social insurance-based system.

The Beveridge model. The third European model is the UK National Health Services (NHS) or "Beveridge" model. The basic model is virtually similar to the Semashko model. It is also centralized, funded by means of taxation, while the state is responsible for the provision of institution-based care (hospitals). The major difference between the Beveridge model and the Semashko model, however, is that in the former model the medical profession has a more independent position. Further, self-employed general practitioners have an important role as the gatekeepers in primary health care. This implies that before visiting the hospital or a medical specialist it is obligatory to have a referral from a general practitioner. Another difference is that the NHS model has less government regulation, and leaves more room for private medicine.

Through processes of diffusion and adaptation, the Beveridge model was first adopted in Sweden, and then by the other Nordic countries: Denmark, Norway, and Finland. At present, the Beveridge model applies to the United Kingdom, Ireland, Denmark, Norway, Sweden, Finland, and Iceland. Four southern European countries have adopted, or are in the process of adopting the tax-based model. These countries are Spain, Italy, Portugal, and Greece (Saltman and Figueras 1997).

North American Health Care Systems: Canada and the United States

It has been argued that a crucial element of ways in which health care systems are structured, in essence, depends on the relationship between three principal

actors: the medical profession, the state, and the insurers (Johnson, Larkin, and Saks 1995; Tuohy 1999). There is a mix of mechanisms of social control systemizing and legitimizing between these actors. The first is by the market, characterized by voluntary exchange relationships. The second is through a hierarchy, based on a chain of command and on obedience to rules. The third is characterized by collegiality, based on common norms and values and on a common knowledge base. While the National Health Service in the UK is a typical example of the hierarchy model (strong position of the state; rules), the US and Canada reflect the market and the collegiality models (Tuohy 1999). In the United States the logic of the market and enterpreneuralism dominates. Canada relies more on collegial mechanisms.

While during past decades many health care systems underwent major structural reforms, the Canadian health care system remained remarkably stable. There has been continuing public and political support for maintaining a system that provides universal access to medical services, regardless of economic position. In the late sixties, Canada adopted universal hospital and medical care insurance, based on tax financing, while the provision of professional services remained in private hands. Most physicians (about two-thirds) are in private, self-employed, fee-for-service practice. Provincial governments were the exclusive payers for most services, and the allocation of services was negotiated with the medical profession. Prior to the introduction of universal public programs, the financing of hospital and medical care occurred in a mixture of funding modalities. State-provider negotiations promoted enormous discretion for the profession, which explains, in part, why the Canadian health care system ranked among the high-spenders of publicly financed systems. Physicians' fees tended to rise faster than the general income level. In the early seventies Canada broke with this previous trend.

As Evans (1985) notes, the Canadian health care system is quite clearly not "socialized medicine," despite the rhetorics. Only the insurance can be typified as socialized, because it is exclusive, without competition, and superimposed by the government upon a delivery system that is virtually private. For a long period, with this model Canada succeeded in complying to the effectiveness and legitimacy criterion in health care, in providing all the citizens access to all the medically necessary hospital and medical services, without financial barriers, and at a reasonable and acceptable price in terms of share of the national income.

Just like everywhere in the world, however, Canadian physicians favor the use of the power of the state to ensure their professional monopoly without being publicly accountable. Consequently, continuing profession–government tensions and public concerns on rising costs and limited access resulted in several modifications of the Canadian health care system. According to most recent figures (2002), the Canadians spent 9 percent of their Gross Domestic Product (GDP) on health care, which is again quite high. It ranks them among the highest spenders among 29 OECD countries. One of the questions in Canada is whether market competition should be introduced, by permitting private entrepreneurs to provide for-profit services, next to the well-established Canadian Medicare model. On this issue, the Canadian medical profession is

divided, whether to continue to accommodate with the state, or to press for more entrepreneurial freedom. On a provincial level, the accommodation of the state with the medical profession, serving purposes on both sides for more than two decades, has become more and more of an uneasy relationship in the nineties (Tuohy 1999).

While Medicare and Medicaid provide services to the poor and to the elderly, the basic model of the United States health care system is a voluntary reimbursement model, with four actors playing a key role (Hurst 1992). First-level (general practitioners) and second-level providers (hospitals) deliver services to patients who will be reimbursed for their medical bill, in part or in whole. Patients pay a voluntary risk-related premium to voluntary insurers, who reimburse them for medical expenses. In principle, there is no, or minimal interaction between insurer and provider. Only the patient interacts with both parties.

This private reimbursement model has two major drawbacks (Hurst 1992). One is that it does not have built-in incentives to restrict demand and, therefore, is often accompanied by cost sharing. Another drawback is that it does not have built-in mechanisms to prevent inequities. For reasons of profit maximization, private insurers have an incentive to select against poor risks. Moreover, access to voluntary insurance is only open to those who are willing, or can afford to pay. This has enormous consequences for health care insurance coverage in the US. While most OECD countries achieved universal coverage, with only 33 percent the United States had the largest percentage of citizens without government-assured health insurance. According to the most recent estimates, 43 million Americans are uninsured which is about one out of every seven people (US Census 1998; Anderson and Poullier 1999).

US health care spending per capita grew more rapidly in the 1990s, compared to the average industrialized country. From 1990 to 1997 US spending per capita increased 4.3 percent per year, compared to 3.8 percent of the OECD median. In this period, the increase in Canada was only 2.7 percent, and actually leveled off (Anderson and Poullier 1999). In spite of managed care initiatives and of attempts of government regulation, costs kept increasing in the US (Anderson 1997; Anderson and Poullier 1999).

Just like in other industrial societies, health care reforms in the US are essentially focusing on cost containment. Managed care initiatives, for example Health Maintenance Organizations (HMOs) were developed to increase competition, to change methods of payment for medical services, and to curb the power of the medical profession. The fundamental model of the Health Maintenance Organization is to be typified as a voluntary contract model (Hurst 1992). It involves contractual relationships between insurers and independent providers, which give these providers an exclusive right to supply complete services, mainly free of charge. Patients pay a voluntary, risk-related premium to voluntary insurers who have contracts with providers. The difference with the voluntary reimbursement model is that insurers now have contractual relationships with providers. Variations on this voluntary contract model are the Individual Practice Organizations, where insurers are controlled by providers. These managed care models are all aimed at controlling the costs of health care by monitoring the work of doctors and hospitals, and by limiting the visit to

second-level hospital care. In practice, this is often done by means of a "case manager," who, on behalf of the insurer, is authorized to decide whether the care to be rendered is effective and efficient. Another feature is that patients are only allowed to see a specialist after they have visited a general practitioner. This gatekeeper role of the primary care physician to the use of specialist care is similar to the role of GPs in European countries like in Denmark, Norway, Italy, the Netherlands, Portugal, Spain, and the UK (Boerma, Van der Zee, and Fleming 1997).

At present, almost 90 percent of practicing physicians in the US participate in at least one or more managed care organizations (Tuohy 1999). Its share in patient enrollment rose from 12 percent in 1981 to 62 percent in 1997. Therefore, managed care is the most significant development in the US health care arena in the 1990s. But as Tuohy explains, the "competition revolution" in US health care in the 1990s was more driven by the increasing activism of purchasers, than by the supply side (Tuohy 1999). As a result of government efforts to introduce more tight payment schemes under Medicare, hospital providers sought to shift some of their costs from public to private payers. Within the context of changing economic circumstances, this alerted purchasers, and provoked them to play a more substantial role in the organization and management of the use of services. For the medical profession, the increasing importance of bargaining relationships and the contracting with entrepreneurs ultimately led to a dramatic decline of their influence in the private-market-oriented US health care arena.

HEALTH CARE SYSTEMS IN ASIA: THE CASE OF JAPAN

Conceptually, the Japanese health care system can be typified as a social insurance model with mixed public and private providers (Abell-Smith 1996). Japan adopted the Bismarckian health care model of Germany in 1927. It has achieved universal health insurance coverage since 1961, with one insurance program for employees and their dependents (paid by employers and employees), and one national program for all others (paid by taxes). Japan has one of the most equitable health care systems in the world (Ikegami 1991; Ikegami and Campbell 1999). An insured person is free to go to any hospital or clinic, with no differences in costs.

Despite this nationwide insurance scheme, the delivery of services is highly privatized with an overwhelming amount of physicians in solo practices working on a fee-for-service basis (Nakahara 1997). These physicians are essentially general practitioners, similar to European GPs, but prefer to see themselves as more specialized (Nakahara 1997).

The Japanese health care system would benefit from more differentiation and vertical integration. Private practitioners are not allowed to practice medicine in the hospital, just as is the case in several European countries (Garland 1995). But, different from the situation in other countries, there is no referral relation between first-level services of these office-based physicians and second-level services provided in hospitals. As a consequence of the fee structure, office-

based physicians compete with hospitals for patients, and try to keep them in their own practice as much as possible. Hospitals do the same, because they are in the main owned by physicians, who also serve as prescribers and dispensers of medications (Ikegami and Campbell 1999). Also long-term care for the elderly is burdened by the absence of a differentiated and vertical integrated health care system. While the rate of institutionalized elderly does not deviate from figures in other industrialized societies, care is provided in hospitals rather than in nursing homes. A consequence is the extremely high average hospital length of stay (OECD 2002).

Incomplete vertical integration of Japanese health care services is, for an important part, due to the high degree of autonomy of the medical profession in medical practice and in capital expenditures. This is evident in the availability of medical equipment. Japan has the highest rate of CT scanners and MRI equipment in the world, because not only hospitals but also private clinics are allowed to purchase expensive equipment (Anderson and Poullier 1999).

The Japanese medical profession is divided between physicians employed in hospitals and those working in private practice (Nakahara 1997). This weakens their position in relation to the state and other health care actors. The office-based physicians, however, have always been the mainstay of the Japanese Medical Association (Ikegami and Campbell 1999).

While having adopted a basic European health care model, Japan kept many of its typical cultural peculiarities. Traditional medicine continues to be widely practiced in Japan (Anderson, Oscarson, and Yu 1995; Garland 1995). As Anderson et al. have noted, since western medicine was introduced in Japan it has been shaped and molded to fit into the cultural context of East Asian medicine (Anderson, Oscarson, and Yu 1995). Despite the long average intramural length of stay, Japan has the lowest rate of hospital admissions in the world. One reason is the cultural antipathy for invasive procedures and a preference for more conservative treatments. Another is that invasive procedures are discouraged by low fees for physicians to conduct surgery (Ikegami and Campbell 1999).

In recent years, the Japanese health care system has been faced with rising costs, an aging population, and growing consumer consciousness. This has led the government to initiate proposals to reform the system, similar to those in other industrialized countries. However, the necessity of health care reform in Japan should be considered in the circumstance that its health spending is still among the lowest in industrialized societies. There may be more reason to reform because of organizational problems than of financial ones (Ikegami and Campbell 1999).

Culture and Value Orientations in Health Care

Anthropologists have argued that differences between health care systems are imbedded in the values and social structure of the societies involved (Helman 2003). Based on specific histories, traditions, customs, and so on, differences in health care organization reflects the way in which societies define and deal with

issues of health and illness. Health and health care are imbedded in value systems which give explanations why and how, in specific cultures, health problems are handled. For example, in some societies health care is considered as a collective good for the benefit of all citizens. In others, health care is considered more a "commodity" that can be bought or sold on a free market. As Gallagher (1988: 65) notes, "The concept of health care as a calculable resource is an essential feature in its role as a carrier of modernity." The notion of health care as a commodity, however, has not been rooted everywhere. It appears that it has been more established in the essentially market-oriented organization of health care in the US than in Europe or Asia. Nowhere in Europe has it become part of health policy objectives, notwithstanding a wide range of health care reforms in recent years introducing market-oriented approaches with incentives to introduce more competition between providers and to use resources more economically (Saltman and Figueras 1997).

Cultures or nations can vary in value orientations to a considerable degree. For example, values of equity, solidarity, and autonomy may have different significance (Hofstede 1984). As will be discussed, emphasis on hospital care versus home care or care for the elderly, on individual responsibilities or on solidarity between people, reflects general value orientations that have priority in a society (Philipsen 1980; Hofstede 1984; Stevens and Diederiks 1995). The cultural embeddedness of health care in industrialized societies, however, is an often discussed, but rather under-researched topic (Saltman and Figueras 1997; Stevens and Diederiks 1995). There is little research on core values underlying the organization of health care systems in modern societies.

One notable exception is Lynn Payer's *Medicine and Culture* (Payer 1990). She compared medical culture and health practices in Germany, Great Britain, France, and the United States on the basis of her own observations, literature study, and interviews with key persons. Not unexpectedly, she found the largest differences between the US and the European systems. For example, the dominant attitude of doctors in the US is described by her as "aggressive" and "action oriented," in accordance with a kind of "frontier mentality." American doctors appear to favor surgery above drug therapy. But when drug therapy is used, they do it more aggressively than in Europe. European doctors were found to prefer less radical approaches, although the differences between Germany, France, and Great Britain were also substantial, in particular with regard to procedures in diagnosis and treatment (Payer 1990).

Another study is Hofstede's research on international differences in value orientations. For his *Culture's Consequences: International Differences in Work Related Values*, Hofstede (1984) surveyed employees of IBM plants in 40 different nations. He found that national cultures could be classified along four different value orientations: (a) individualism versus collectivism, (b) large versus small power distance, (c) strong versus weak uncertainty avoidance, and (d) masculinity versus femininity.

Individualism/Collectivism refers to whether, in a particular society, the individual opinion and the individual interest is considered as more important than collective opinions and collective interest, or vice versa. It indicates the weight of our own interests versus the weight of the public good. The second dimension,

Power Distance, indicates the extent to which the less powerful members in a society expect and accept that power is unequally distributed. Power distance, therefore, points to the degree of inequality in a society. The third dimension, *Uncertainty Avoidance*, reflects the extent to which members of a society feel threatened by uncertain or unknown situations, and whether people can cope with this. It also indicates whether people are willing to take certain risks in life. Finally, *Masculinity/Femininity* refers to the division of social roles between the sexes and indicates whether achievement, competitiveness (masculine behavior), prevails above "tender" relations and care for others (feminine behavior).

Hofstede's study was not designed to analyze health care systems. But his work goes beyond the settings that were subject to his research, and indeed applies to the organization of health care services (Hofstede 1991). For example, in health care the masculinity/femininity dimension would indicate the importance of rationality, efficiency, justice, and so forth on the one side (masculinity), and solidarity, continuity, importance of care and caring relationships, on the other (femininity). Uncertainty avoidance has been related to the nurse–physician ratio in a country (Hofstede 1984; 1991). When people in a society would have difficulty in dealing with uncertain situations, they will be more likely to consult the doctor (the "expert") rather than a nurse. Consequently, work of physicians is considered as more important than that of nurses. Comparing doctor–nurse ratios in different European countries gives some support for Hofstede's hypothesis. The group of *northern* European countries, consisting of Sweden, Norway, Finland, Denmark, and also the Netherlands, share high scores on femininity and low scores on uncertainty avoidance. These countries are characterized by their long-standing tradition of social democratic policies, and their well-developed systems of social security and health insurance coverage. All have a well-established system of "care" provision with regard to the delivery of home care, mental health care services, and care for the elderly. All these countries also have many more nurses than physicians (Saltman and Figueras 1997: 240; WHO 2001). Alternatively, in the *southern* European countries with high scores on masculinity and on uncertainty avoidance, specifically in Italy and Greece, there are more physicians than nurses.

But there is another inference to be made from these data, which regards the development of professional home care nursing. Because doctors and nurses have different work, it is likely that in countries where the medical profession dominates health care, professional home care provided by the nursing profession is less in existence. Philipsen (1988) hypothesizes that in societies typified by a high degree of *uncertainty avoidance* and a *masculinity* orientation, it is more likely that: (a) "cure" (medical intervention) instead of "care" will prevail; (b) the physician has a dominant position in the health care system; (c) social positions are ascribed according to traditional sex roles.

Philipsen's hypothesis is also consistent with a north–south division in Europe, whereby in southern regions priority would be given to the cure and treatment of health care problems, while care activities would be dealt with more in family relations than by professional nursing (Philipsen 1980; Giarchi 1996). This is supported in an OECD study of the early nineties, showing that the lowest percentages of institutionalized care (nursing home care) were found

in southern Europe (Greece, Italy, Portugal, Spain, Turkey). Most institutional care for the elderly was found in northern Europe (the Netherlands, Finland, Norway, Luxembourg) and in Canada.

However, the absence of institutional care for the elderly is not compensated for by professional home care everywhere. For example, this is the case in the US, Canada, Austria, Germany, Ireland, and Japan. All these countries are considered as masculine societies, but divide on the uncertainty avoidance dimension.

High levels of institutional and professional home care were found in Denmark, Finland, and Norway, while low levels of both types of care were found in southern Europe (Italy, Spain, Portugal). Other countries were somewhat in the middle (Belgium, France, Sweden, UK, the Netherlands). From these data it appears that there is indeed evidence of a north–south division in Europe, whereby institutional care for the elderly in the north is not paralleled by professional home care in the south, but more by family care (Mossialos and Le Grand 1999: 56). This latter conclusion also applies to Japan, that has the highest masculinity score among countries that were under consideration (Hofstede 1984). Also Canada and the US are considered masculine societies, but in contrast to Japan they are low on uncertainty avoidance.

Conclusions: The Convergence and Divergence of Health Care Systems

In this chapter, models of health care organization have been presented within the context of their cultural environment. While these models are the major ones that can be found in industrialized countries in Europe, America, and Asia, since the nineties there is no system that fully complies to one of these. Because of financing problems necessitating cost containment, and through processes of adaptation and diffusion, national health care systems vary. For example, Bismarckian health care systems and the enterpreneurial system of the US were confronted with problems of rising costs in the sixties and seventies. The NHS systems and Semashko-like systems of eastern Europe had problems of neglect, underfunding, and extensive bureaucracy. In some countries this led to more state regulation to curb the costs of health care. In other countries it resulted in less state intervention and in the introduction of experiments with different forms of managed competition. For example, in eastern Europe, after the fall of the Berlin wall, we see the demise of state funding and state provision because of economic deficits. In the countries that have adopted the Bismarck model we see more state regulation in order to introduce more planning and to curb the rising costs of health care. One of the results has been a stronger position of hospitals. In the United Kingdom we have seen a movement toward more decentralization, which was realized by the earlier noted split between purchasers and providers (Saltman and Figueras 1997; Tuohy 1999).

Health care organization, however, is also influenced by cultural circumstances. For example, nations with a strong collective orientation have more state intervention, a small private sector, have a preference for tax rather than

insurance funding, and prefer a comprehensive coverage with universal entitlement based on the notion of rights. In contrast, societies steeped in individualism prefer private enterprise and insurance funding with selective coverage and high responsiveness to consumer demand. In societies which have equity as an important root we see explicit attempts to avoid discrimination and to facilitate public participation.

We have started this chapter with the question whether countries at the same stage of industrial development have the same approach to the organization and management of health care services. Indeed, institutional patterns are converging. There is ample evidence that contingencies like increasing health care costs, an aging population, changing disease patterns, technological developments, growing public demand, and so forth, impose a common logic in terms of institutional performance and in the structuring of modern health care systems. In the literature a wide range of convergencies in health policy and health care organization have been listed (Field 1989; Mechanic and Rochefort 1996; Raffel 1997; Saltman and Figueras 1997). These include (a) the concern of governments to control health care costs while at the same time improving the effectiveness and efficiency of the system; (b) the increasing attention for health promotion and healthy lifestyles such as abstinence from substance use (alcohol, smoking, drugs), and healthy behavior; (c) reduction of health care inequalities and differences in access; (d) the stimulation of primary health care at the expense of cutting-back further medical specialization; (e) the promotion of patient participation and improving patient satisfaction; (f) the reduction of fragmentation of services and the promotion of continuity of care.

The convergence of modern health care systems, however, is not undisputed. Even if societies are faced with similar contingencies, their societal structures have to be consonant with culturally-derived expectations (Lammers and Hickson 1979). Consequently, while there is substantial evidence that modern societies are evolving in the same direction with efficiency equity and utilitarian individualism as core value orientations, differences exist in degree and similarity of these developments. Modern societies still vary considerably in the way they deal with issues of health and illness (Anderson, Oscarson, and Yu 1995). Moreover, while nations may have similar goals, alternative options are available to reach these. National health systems are the outcome of a dialectical tension between universal aspects of technology and medicine on the one hand, and particularistic cultural characteristics of each nation on the other (Field 1989). These particularistic cultural characteristics refer to the historical foundations of health care systems, to the societal and national context, and to specific values and value orientations of societies and health care systems under consideration. According to Pomey and Poullier (1997), health care institutions are still largely country-specific. Such country-specific elements would include the social, economic, institutional, and ideological structures, the dominant belief system, the role of the state versus the market, patterns of health care coverage, and centralization or decentralization of political authority (Saltman and Figueras 1997, 1998). As Saltman and Figueras (1998: 105) note, "Given unbridgeable conceptual differences and divergence in organizational principles, suggestions of convergence among the health care systems of industrialized

countries seem to be misplaced." Whether health care systems and not only policy objectives will converge remains to be seen.

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