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

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Abstract

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

INTRODUCTION

Nearly two decades have passed since the *Annual Review of Sociology* last published a review on healthcare systems. Mechanic & Rochefort (1996) identified medical care as buffeted by countervailing forces of international convergence, on the one hand, and institutional path-dependence, on the other. In the 17 years since, efforts to classify healthcare systems have contributed to the precise assessment of similarities and differences among healthcare systems. Still, the convergence debate has not been resolved, which reflects developments in the sociology of globalization and provides new opportunities for a closer dialogue between sociological theory and health services research. The institutional boundaries of what constitutes a healthcare system are also up for grabs, as policy innovations in health care point toward the integration of health care into other fields, the devolution of delivery to subnational organizations, and the development of transnational organizations devoted to health care. Another lively area of comparative research on healthcare systems is inequality: Intergovernmental organizations, national governments, and well-funded nongovernmental organizations have set an agenda of monitoring and reducing disparities, including disparities in health care.

In this review, we evaluate each of these four research themes—classification, convergence, institutions (specifically, institutional boundaries), and inequalities (often called "disparities" by researchers based in the United States)—within the field of comparative healthcare research, highlighting the central debates that animate current scholarship (see **Table 1**). We also identify unresolved questions and new opportunities for research. At the outset, we note our focus on sociological research, but, like healthcare systems themselves, the boundaries of comparative healthcare systems research are porous. Sociologists are well represented but are probably in the minority if health economists, political scientists, health services researchers, epidemiologists, and public health scholars are also included (as we believe they should be, and as we try to do). Fortunately for the coherence of a review like this, the problems and debates currently driving research on comparative healthcare systems are themselves interdisciplinary, as scholars from many fields are engaging them. Unfortunately for sociology, we think, this area has detached somewhat from the discipline's central theoretical and substantive developments, and so one of our goals is to encourage reengagement (cf. Béland 2010, Leiber et al. 2010, Light 2004).

Table 1 Summary of questions motivating current research on healthcare systems

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

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

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

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

CLASSIFYING HEALTHCARE SYSTEMS

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

Researchers have been interested in comparing healthcare systems at least since Anderson (1972) set out to compare the healthcare systems of the United States, Sweden, and England. Early on, Field (1973) identified four ideal types, based primarily on ownership and doctors' autonomy (the pluralistic health system, the health insurance system, the health service system, and the socialized health system). Since then, the appropriate dimensions of classification have been debated by researchers, including, for example, whether classification should be focused on the main organizational unit

(Terris 1978), the form of state control over the production of medical care and the basis for the eligibility of the population (Frenk & Donabedian 1987), or the functional strength and structural superiority of a specific medical tradition (Lee 1982). Despite the different ways in which a classification is possible, researchers often appear to come back to two key dimensions: funding and ownership (Wendt et al. 2009).

Given the great interest, many have attempted to classify healthcare systems, although often unsystematically (Wendt et al. 2009). In the rich democracies, some variation of the key three types have been popular: a national health service (NHS) system, a social insurance system, and a private insurance system. The United Kingdom is the classic case of a NHS system, Germany of social insurance, and the United States of private insurance (Burau & Blank 2006, Schmid et al. 2010). The systems have also been referred to by the names of their founders, such as the Beveridge (United Kingdom), Bismarck (Germany), and Semashko (Soviet Union) health systems (Stevens 2001). The systems differ by organizational configuration and by the role of three principal actors—the medical profession, the state, and the payers.

- The Bismarck model is financed through insurance fee, and the role of the state is limited to overseeing a system of contracts among patients, providers, and insurers. The medical profession has the autonomy to make decisions about the provision of services. Countries belonging to this type include Canada, France, Germany, Japan, and the United States.
- In the Semashko model, universal health care is controlled directly by the state, which owns facilities, finances them through the state budget, and allocates services to the population. Nations included in this type are Bulgaria, the Czech Republic, Hungary, Poland, and Russia.
- The Beveridge model secures free access to health care in hospitals but does not require complete state control of all facilities. In addition, the medical profession has higher levels of autonomy, and physicians can opt out of the system. Countries belonging to this system are Italy, New Zealand, Spain, Sweden, and the United Kingdom (Lassey et al. 1997, Stevens 2001).

More recently, and in an attempt to systematically combine the dimensions of funding, service provision, and governance, Moran (1999, 2000) proposed the "healthcare state" concept. His scheme incorporates consumption, provision, and production of health care. There are four families of healthcare states in his classification: the entrenched command-and-control state, the supply state, the corporatist state, and the insecure command-and-control state. In command-and-control states, the state controls all three governing areas, as in the Scandinavian countries and the United Kingdom. In corporate healthcare states, a mix of public law and doctors' associations control the healthcare field, as in Germany. Provider interest dominates the supply states, and the United States is a clear example. Finally, the insecure command-and-control states are different from other NHS types because their nationalized hospital sector coexists with a large private sector. Greece and Portugal provide examples for this type (Moran 2000).

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

- Austria, Belgium, France, Germany, and Luxembourg belong to the health service provision–oriented type. These countries put a high importance on service provision, especially in the outpatient sector. There are a high number of providers and a free choice of medical doctors. Patients are expected to pay only a modest out-of-pocket copayment. Importantly, and in contrast to the United States, autonomy of patients and equal access are greatly valued and matter more than the autonomy of the medical profession.
- Denmark, Great Britain, Sweden, Italy, and Ireland belong to the universal coverage–controlled access type. Here, all citizens are covered through universal plans, but access to care is strictly regulated by the state.
- Portugal, Spain, and Finland comprise the low budget–restricted access type. These are the low spenders that restrict use through high copayments and that require patients to use the same doctor for a long period.

Although this typology is theoretically and empirically ambitious, it still remains to be seen whether it generalizes beyond the healthcare systems included in the analysis (Wendt 2009). We also note that efforts to typologize—helpful as they are as descriptive techniques for data reduction—do cut against the grain of research that tries to develop lessons for one healthcare system from others (Rochefort & Donnelly 2012). Such efforts can also be criticized for oversimplifying the differences among healthcare systems (Baldwin 2005).

CONVERGENCE: NEW AND OLD

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

Policy diffusion need not be between nation-states; Clavier (2010) identifies instances of cross-border, local-level convergence in health care among communities in Denmark and

France, which adopted ideas from the social determinants of health framework that gained international prominence through the efforts of the WHO. Still, most analysis of diffusion examines national-level policy innovations, including what is known as comparative effectiveness research in the United States and health technology assessment or evidence-informed policy making in other rich democracies (Chalkidou et al. 2009). Schmid et al. (2010) find evidence of convergence across healthcare systems, insofar as policies borrowed from other systems are leading to hybrid systems (see also Tuohy 2012). For instance, healthcare systems as disparate as the United States, Germany, and the United Kingdom have all adopted diagnostic-related groups, even though they serve different functions in each system. Focusing on the United States and the United Kingdom, Glennerster & Lieberman (2011) identify elements of "hidden convergence" as ideas about service delivery and cost containment cross the Atlantic. In a rare global-scope analysis, Weiner et al. (2008) demonstrate that managed-care organization of health care has been exported from the United States to many other healthcare systems, including low-income countries (also see Jasso-Aguilar et al. 2004). Holden (2005) finds that the privatization of healthcare services has been adopted in many healthcare systems, although a global market for healthcare services has not emerged.

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

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

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

INSTITUTIONAL BOUNDARIES

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

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

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

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

DISPARITIES, INEQUALITIES, INEQUITIES

We note at the outset of this section that although most research on social inequality in health care appears under the rubric of healthcare disparities research, there is a robust debate over conceptualization (Braveman 2006). We refer readers to Bettez (2013) for a critical analysis of the emergence of the disparities concept. Currently, governmental and nongovernmental organizations are making efforts toward reducing healthcare disparities, and advocates and researchers are interested in incorporating health inequalities research into policy (Exworthy et al. 2006, Gibbs et al. 2006, Pittman 2006). This is despite the rule of thumb that the healthcare system contributes no more than 10% to overall healthcare disparities; this truism is in line with longstanding work demonstrating that public health improvements such as basic sanitation have far outweighed medical technology in lowering mortality rates across the advanced industrial countries (although critics argue that technology matters more in mortality reduction after 1945). In a comparison of cervical cancer rates in the United States and the Netherlands, for instance, Habbema et al. (2012) find little difference in rates of cervical cancer, despite dramatically higher levels of preventative services in the United States.

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

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

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

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

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

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

FIVE MISSED SOCIOLOGICAL TURNS

Our goal in this section is to suggest how comparative research on healthcare systems can use theoretical developments from other areas of sociology and how sociologists working in other areas of inquiry might be interested in studying healthcare systems for their own purposes. In other words, we want to encourage conversation. How might sociologists incorporate analysis of healthcare systems into their comparative research? One approach is to use healthcare policy as a case of social policy; strong connections to political sociology and the sociology of the welfare state can thus be made. The convergence debate, for instance, has been advanced by welfare-state scholars (Armingeon & Beyeler 2004, Plümper & Schneider 2009), whose insights suggest a range of new hypotheses and analytical approaches for comparative healthcare systems research. A second approach is to compare healthcare policy to other areas of social policy, perhaps to demonstrate the distinctiveness or similarity of policy fields. This seems to us the road not taken; we have located very few studies that compare the healthcare system to other systems (pension systems, employment systems, etc.). Field-analytic studies, for instance, tend to examine the healthcare field as a case to explain its evolution; comparison is thus diachronic. One exception to the tendency to analyze the healthcare system in isolation is Lovecy (1995), who compares the regulation of medicine to the regulation of law. A third approach is to use the comparative analysis of healthcare systems as a way to investigate broader theoretical concerns (Béland 2010, Green-Pedersen & Wilkerson 2006).

But whatever the rationale for investigating healthcare systems, there are several currents of contemporary sociological theory that seem not to have emerged as major concerns in understanding healthcare systems in comparative perspective. This may be one reason that the subfield most closely connected to the analysis of healthcare systems—medical sociology—is sociometrically distant from large subfields such as race/ethnicity, economic sociology, political sociology, cultural sociology, and theory (Lin 2013).

The Relational Turn

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

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

The Cultural Turn

An emphasis on social construction and on the importance of meaning contributed to a shift across disciplines in which researchers began to theorize about the social world differently. Geertz's (1973) redefinition of culture in anthropology was an important step to what is often referred to as the cultural turn (Alexander & Smith 1993, Bonnell & Hunt 1999, Sewell 1992, Swidler 1986). Steinmetz (1999, pp. 1–2) refers to this development as an analysis that emphasizes "the causal and socially constitutive role of cultural processes and systems of signification." In response and following this development, researchers have reframed the key theoretical and methodological issues in healthcare utilization research (Olafsdottir & Pescosolido 2009, Pescosolido & Olafsdottir 2010). More specifically, they have considered how the overarching cultural context of a society (or a smaller unit) affects how individuals respond when confronted with a health problem.

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

Boundaries and construction of exclusion and inclusion regarding healthcare systems are key issues that are debated within and across countries. To understand these debates, it is fruitful to consider notions of cultural categories of worth (Katz 1986, 1989; Patterson 1994; Steensland 2006). Despite health and illness being culturally bound (Angel & Thoits 1987, Kleinman 1988), the threat of illness is universal. Consequently, observing which individuals and groups are considered worthy of assistance (e.g., universal versus targeted benefits) provides researchers with insight into the broader culture of a society and into what its members expect of their healthcare system (e.g., how it should provide services and to whom). As an example, an analysis of media discourse surrounding mental illness in the United States and Iceland reveals stark differences regarding possible causes and solutions of such illness. In the US discourse, mental illness is viewed as an individual problem with individual solutions, whereas in Iceland the emphasis is on mental illness as a social problem with social solutions (Olafsdottir 2011). These clear cultural differences, grounded in the different social organization of welfare, likely shape mental health policy making and provision. Therefore, understanding these cultural boundaries and frames across societies can provide a new perspective on the development and future directions of national healthcare systems.

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

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

The Postnational Turn

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

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

The Institutional Turn

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

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

THE LUXEMBOURG INCOME STUDY AS AN EXEMPLAR FOR COMPARATIVE RESEARCH

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

The Mechanismic Turn

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

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

CONCLUSION

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

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

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