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Comparative Health Systems: Emerging Convergences and Globalization

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Chapter 28: Comparative Health Systems: Emerging Convergences and Globalization

Introduction

Managed health-care systems in Chile? Preferred provider programs in Bolivia? Herbalists in Indiana? St John's Wort, Cat's Claw, and *Gingko biloba* in Arkansas? Are health-care systems becoming more alike as globalization connects our economic and political systems, e-mail thrusts our communications across continents with speed, accuracy and ease, and people and pathogens fly greater distances with more frequency than ever before? This chapter reviews comparative health system (CHS) research and asks if health systems are converging on a limited number of Western-influenced models of care, or are there new and still emerging 'mosaics' of models stimulated by the conflicting forces of globalization and cultural diversity?

Even a cursory review of the literature on CHS shows a vast array of models, criteria, concepts, and critiques. The lack of standard definitions and comparability of methods in the field of CHS makes cross-cultural comparisons difficult. Some researchers decry the lack of data available for analysis, while others lament the lack of uniform conceptualizations of the units to be measured, the processes to be investigated, and the outcomes to be compared. The field of CHS analysis, traditionally dominated by social scientists such as sociologists, political scientists, anthropologists, economists, and policy and public administration experts, reflects the epistemological and methodological bases of these distinct academic disciplines, as well as the diversity of the subject matter. This very diversity, while difficult to summarize, provides provocative and challenging analyses suggesting future directions of CHS research in a time of global change.

Interest in health system research has skyrocketed since the 1980s, and in particular, interest in health system reform. Much of the early work in CHS research focused on the developed nations of Europe and North America, with little research on the modern health systems of developing nations and even less written by scientists from other countries. In our review of the current CHS research we found some of the most exciting and challenging analysis being written by Latin American social scientists about their own countries' struggles to reform health systems. To compensate for historical oversight and recognize innovative voices emerging from non-European and non-North American sources, we focus our discussion of current CHS research on health-care reform in Latin America.

The descriptive paradigm of ‘systems,’ that formed the basis for CHS analysis from the 1940s through the 1990s is giving way to an emerging paradigm in which the process of health-care delivery is being redefined, reformed, and re-conceptualized. The new models attempt to include diversity, allow for structural pluralism, and identify health-care methods and evaluations appropriate to their cultural context and articulated goals. To understand those changes it is necessary to review the history of CHS research.

As we explore the field of CHS research, it is helpful to remember how Eurocentric systems came to develop, dominate, and influence approaches to health care throughout the world. Until recently, values, vision, and ethics **[p. 441 ↓]** were viewed as nonessential concerns for corporate managers, who viewed them as tangential to the real work of the enterprise (Wheatley 1992). In health-care sectors strict attention to objectivity, close scrutiny, careful measurement, and prescribed care in the search for absolute answers characterized earlier approaches to health-care concerns and practices. The social science focus of CHS studies, coupled with the conceptual break from industrial age rigidities, provides unprecedented opportunities for innovative reform, multiple routes of access to care, fundamental health status improvements, and a rich array of types of multidisciplinary collaboration.

The formal analysis of health-care systems began in the 1970s with the early work of medical sociologists such as Roemer and the Sidels, and other social scientists such as Navarro, Gish, Elling, Kelman, Kleinman, Mechanic, and Waitzkin. Culminating in a conference on social science and medicine held in Washington, DC in the late 1970s, Charles Leslie stimulated a parallel interest in comparative medical systems

(Leslie 1978). The issues they discussed at that time are the same problems that beset CHS analysis today-the lack of shared definitions, methods, concepts, and paradigms. However, the analysis of that period changed the way we think about medical/ health-care systems. Social science has contributed to our increasingly sophisticated understanding of how our own knowledge is shaped by cultural experiences, which in turn, shape our definition of data and infuse our interpretations with values. The field of CHS analysis has moved from a reflection of an uncritical and unquestioning dominance of the biomedical paradigm as 'normal' (using Kuhn's 1970 definition) to a greater awareness of values in defining the research process, the role of funding agencies and mass media in giving substance and direction to our perceptions, the inadequacy of extant models, and the need to focus on articulated goals and processes as a means of comparing health systems.

In this chapter we highlight the research of social scientists who have approached CHS as complex social systems, and using health reform as a focus, we incorporate a brief description of Chile as an example of relational analysis in CHS. In our review of David Mechanic's idea of emerging convergences, we move from a discussion of CHS literature in a period of subtly declining but still pervasive Industrial Age influence, to current analysts who step out of traditional disciplinary confinements to explore their subjects in a postmodern view. The transition from a single way of thinking to one that is receptive to change has been described as the struggle 'between those who try to prop up and preserve industrial society and those who are ready to advance beyond it. This is the super struggle for tomorrow' (Toffler and Toffler 1995: 104). We suggest that CHS analysts are moving beyond the propped up past. Global conditions and trends that stretch beyond national borders increasingly influence the health sector. CHS scientists understand the challenges and opportunities of globalization, and are engaged in cross-national comparisons of health systems, exchanges of information, and provocative debates; their contributions are setting the stage for improved health in a greatly transformed world.

History of Comparative Health Systems Research

Social scientists have long been interested in the organization of health systems: their economic base, structural compartmentalization, service delivery programs, allocation of resources, decision making, and the interactions between physicians, allied health professionals, and the community. Initial research in health systems in the United States began in the 1930s and was motivated by the need to evaluate New Deal social reforms (Roemer 1991). The development of the British National Health Service stimulated comparative research in the 1950s and 1960s, and the health system experiments in Cuba and Nicaragua intrigued social scientists and lay people. The political left in the United States, Europe, and Latin America gave strength and support to social science analyses of the changing structure of health systems. Perhaps in response to the more explicitly polemical writings of the social left, others attempted to write about CHS from a less explicitly political view. Foremost of those writers was Milton Roemer, whose work shaped CHS analysis for 20 years (Roemer 1977, 1985, 1991). Roemer's early work focused particularly on the health systems of Europe and the United States, investigating the relationship between national political structure and health system development. Equally powerful in directing the scope of early CHS analysis were Victor and Ruth Sidel (1974), whose work on non-Western health systems, such as those in China, provided powerful counter-examples to the Western models.

In the late 1960s and early 1970s, the CHS literature focused primarily on the issue of *equity*, concerned with comprehensive healthcare availability for entire populations. The writings of the time reflect both an optimistic view of **[p. 442 ↓]** the future and a willingness to challenge past assumptions that economic advantages would trickle down to the poor, that overall prosperity would improve health conditions for all, and that established government programs and policies were designed to make health for all a realistic goal. The *International Journal for Health Services* epitomized the conceptual changes of the time. It provided a way for the influential social health analysts of that era, such as Vincente Navarro, Oscar Gish, Sander Kelman, Ruth and Victor Sidel, Ray Elling, and Howard Waitzkin, to publish research reports, air opinions, and challenge

established ideas by focusing on class relations, non-capitalist health models, and world economic system analyses.

The hopeful optimism of the early 1970s changed to more guarded realism in social analysis following the worldwide oil crisis in the mid-1970s. Social scientists engaged in CHS research turned away from structural analyses of equity to analyses of health system *cost containment* (Klein 1991; Sidel 1980–81). The Organization for Economic Cooperation and Development (OECD) published a series of comparative health analyses (OECD 1977, 1985, 1987) as part of their overall research on economic management and public expenditure, which consolidated the shift from equity issues to economic issues. The OECD reports also determined the database that structured the parameters of subsequent research by collecting previously unavailable or inaccessible statistical data on which numerous other studies were based (OECD 1977, 1985, 1987, 1990, as cited in Klein 1991). The nature of the data available and the prevailing interests of the OECD in economic indices ensured a continuing focus on cost containment, moving the center of discussion away from issues of equity toward an emphasis on efficiency.

A review of the CHS literature in the late 1970s and well through the middle 1980s demonstrates a clear shift away from a focus on equity to the new economic indices such as spending levels, administrative costs, number of beds, and recuperative costs. The shift was without doubt influenced by the economic hardships of the times and concomitant emphases on accountability, as well as by the data made available by the OECD. During that decade, economists comparing health inputs in economic terms eclipsed the role of social science analysis from sociologists and anthropologists. Klein (1991), in his excellent discussion of the risks and benefits of comparative studies, forcefully argues that while there was 'an inflation of economists in the field of health research' (1991: 281; see also Fox 1990), there was no conspiracy to take over the field. Rather, the influence of economists and statisticians reflected both the availability of statistical and economic data, and '…the famine of other data, notably about the impact of different types of health care systems on the *populations* being served' (Klein 1991: 282 [emphasis added]).

As our example of health-care reform in Chile shows, the draconian cuts in health budgets in the 1980s had negative repercussions on the health status of women and

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children and other at-risk populations. In some cases, this negative consequence precipitated an attempt to mediate between the conflicting goals of cost-cutting and equity in the provision of services. The decade between the middle 1980s and 1990s shows this shift away from cost containment and economic measures to indicators of the 'effectiveness' of various health systems. 'The assumption of the 1990s seems, increasingly, to be that assuring effectiveness – by eliminating unnecessary, redundant, or low-yield forms of treatment – is a necessary condition for reconciling the demands of economy and equity' (Klein 1991: 283). Even the 1990 OECD report moves away from the primacy of economic indices to international comparisons of medical practices and health-care use. However, unlike some economic indices, health service utilization is problematic to define, difficult to measure, and the international data is often unavailable. The lack of internationally shared and mutually understood paradigms and conceptual frameworks complicates and impedes research in this new direction.

This historical review of CHS research highlights how the field has changed in content and focus from system-based comparisons of equity and economic measures, to effectiveness. Concurrently, CHS research has been struggling with questions of methods, models, and conceptual frameworks. While the CHS literature contains examples of many typologies and models, few are explicitly tied to theoretical frameworks. As Klein noted, CHS research tends to be data, not question, driven. As a consequence, there is a proliferation of models, categories, and typologies, with fewer articles that are theory-driven. Too often the data-driven research is difficult to generalize from because of the lack of theory, and the theoretical articles are challenged by lack of cross-cultural data.

Implicit political biases also hamper comparability of CHS research. Roemer (1977, 1985, 1991), perhaps the best known author in the first decades of CHS research, presented a typology in which three types of government planning and control of health systems were tied to three levels of resources in terms of gross national product per capita. According to Roemer, the levels of government planning are **[p. 443 ↓]** as follows: (a) pluralistic or laissez faire, (b) cooperative or welfare states, and (c) socialist or centrally planned. The three resource levels are (a) affluent or industrialized, (b) moderate or developing, and (c) poor or underdeveloped. Thus, nine categories of health systems can be identified by level of government planning and resource base, with the United States representing the affluent pluralistic category, the United Kingdom,

the affluent cooperative, the former USSR, the affluent socialist, and China, the socialist and underdeveloped. These early works by Roemer and others (cf. Roemer 1977; Rostow 1971) reflect the dominant 'modernization' framework common to social policy makers in the 1950s through the 1970s. The modernization framework assumes that all societies desire the same end point – to become 'modernized' – and that while they may move at different speeds and through different paths, through time they will become more similar. A related assumption, although not frequently made explicit, is that there is a hierarchy of desirability in health systems, with the US/UK models of affluence setting the standard and the goal for other less developed health systems to emulate. These ideas implicitly deny the validity of alternative directions in health care, denigrate the role of history and culture in shaping national systems, and ignore the value of structured pluralism.

The modernization approach has been thoroughly critiqued by social scientists from a variety of disciplines and fields of concentration. Ray Elling (1981, 1994) points out that while Roemer has made significant, continual and long-lasting contributions to CHS, his early work in particular reflects an assumption that health systems evolve automatically from diversity and variability, to convergence and conformity, to structures and forms modeled on those from highly industrialized nations. These perspectives of convergence of health systems, along with assumptions of modernization, dominate much of the early writing on CHS in the 1970s (see Field 1967; Fuchs 1974; Mechanic 1975). This view abrogates the role of struggle, particularly class struggle, in the development of systems (Elling 1981). The case study of health systems development in Chile that we include in this chapter provides an example of how context and culture challenge modernizationist assumptions of convergence and conformity to *a priori* models.

While many analysts and researchers have made significant contributions to the field of CHS, three classic studies deserve emphasis. Litman and Robins (1971), while sharing the modernization frame, argued that health systems evolve through social, cultural, political, and economic influences both internal to the country and external (in response to those similar influences from outside of the country). However, they make explicit the need for longitudinal studies that capture change over time. Much of the CHS research, they note, is cross-sectional and fails to demonstrate how variables influence one another. Litman and Robins articulate a previously identified (De Geyndt

1968, cited in Litman and Robins) but often ignored recognition of bias: that research is commissioned and undertaken for political results, providing the appearance but not the reality of 'scientific objectivity.,' This watershed article marks the beginning of a serious interest in, and almost domination of, politics in CHS research.

In 1976, Kohn and White brought together population-based surveys from seven countries in an ambitious and problematic study. The study was aimed at addressing problems of '… health services administrators, and investigators, planners and policy makers, as well as scholars in the disciplines of epidemiology, sociology, psychology, economics, and medicine, elements of all of these fields of endeavor combined in the design and execution of the study' (1976: 1). The result was a complex and unwieldy document, difficult to apply to real-life situations. Their contribution brought together data from seven countries for comparison; their failure was the inability to draw meaningful and stimulating conclusions from the research, perhaps due to the unwieldiness and complexity of the data.

The third major study marking these developmental years of CHS research was the examination of 144 studies by van Atteveld et al. (1987). The authors note that the most '… striking conclusions are that there is very little connection between the stated objective of a given study and what is actually described, and that special attention is paid in international comparative research to the organisation and financing of health care, in particular to the subject of cost control' (1987: 105). Atteveld et al. reviewed the literature during the period when economic themes dominated, but concerns about inadequate data and lack of appropriate conceptual frameworks that were sounded then are still resonant throughout CHS research today.

While CHS research remains methodologically and theoretically diverse, and the applications of its results problematic, social scientists continue to make significant contributions to the field. Social scientists are influencing the move away from the modernist paradigm by focusing attention on the validity of data, the methods of analysis appropriate for various applications, identification of observer biases, and the nature, **[p. 444 ↓]** purpose, and most appropriate methods of comparison.

Roemer (1991) identifies six reasons for comparing health systems: (1) for the observers to gain perspective; (2) to learn through observation of other systems, with

the intent to improve; (3) to achieve equity; (4) to improve efficiency; (5) to investigate how health-care systems impact health status; (6) to develop generalizations across system types. Other CHS analysts suggest that research can reduce ethnocentrism through the demonstration of similarities across systems (Fox 1986; Klein 1991; Marmor and Thomas 1972) and can sharpen our understanding of problems within our own health systems by providing information to guide constructive change (Sidel 1980–81).

Others argue that comparisons are elusive at best, and fallacious at worse (Hsiao 1992; Illsley 1990). One of the difficulties, as previously noted by Sidel (1980–81), is that too often the nature and purpose of the comparison are not made explicit from the outset. This can result in comparisons between entities that are similar superficially, but whose purpose and function are distinctive. Hsiao (1992) identifies three conceptual struggles in the development of CHS research. The first is the view that a health-care system is a means to an end, and that the ends (and means) must be agreed upon and clearly articulated within the system. This often is not the case; frequently nations fail to reach a consensus about either health system goals or means, let alone a shared, agreed understanding of them both. An additional barrier to effective comparison is the ideological debate between those favoring free enterprise and those who support government health-care planning (demand-side versus supply-side economics). The third obstacle is the lack of empirical data. Klein (1991) disagrees with Hsiao's contention that what CHS lacks is data, and argues instead that the problem with CHS research is that it is driven by the data which are available instead of by research questions. According to Klein, one of the costs of using available data to compare systems is that those data reflect particular national agendas, and may not be the most appropriate basis for cross-cultural comparisons of equity, economy, or efficiency.

The history of CHS is shaped by concern for conceptual and methodological rigor, political sophistication, and application. Social scientists, such as those whose work we have reviewed, have contributed to the struggle to define appropriate measures to be employed in the analysis and comparisons of health systems. The ongoing critiques and challenges to the methodologies, theories, and conceptual frameworks incorporated in CHS research come in large part from social scientists. We turn next to the emerging issues in health-care reform and the effect of globalization on health-care systems.

Emerging Issues in Chs: Health Sector Reform

Findings and determinations of major social trends, such as those just presented, are essential for identifying and clarifying issues for later analysts to incorporate into the next levels of discourse. Concern for methodological and conceptual rigor, political sophistication, and appropriate applications continue to characterize the work done by successive CHS analysts, but the approach and content increasingly correspond to changing epistemological shifts that distinguish modern views from those that are postmodern. Modern theorists devised systems for classifying and compartmentalizing; postmodern theorists tend to veer away from prior patterns of organization and provide open-ended explorations of situations that do not always lead to clear-cut conclusions.

In continuing interrogations of modern systems and limits, globalization or postmodernism calls into question the bases of Western (Eurocentric) modes of thinking, ordering, and constructing. Familiar values are in the process of deconstruction, exploration, and testing as new possibilities emerge. The texts reviewed earlier illustrate a drive toward 'totalization and finite and closed knowledge' (Hutcheon 1988: 75), or what might be described as corporate centralization and the pursuit of the definitive. In both subtle and substantive ways, more recent CHS research demonstrates a change in direction as the impact of globalism has led social scientists to move from past restrictions to new explorations and possibilities concerning the shape and structure of international health care.

Beginning in the 1960s with the social movements accompanying desegregation, the Peace Corps, and the war in Vietnam, increasing in the 1970s with the end of the Cold War, the women's movement, and the collapse of the Berlin Wall, and intensifying in the 1980s and 1990s, with the war in Bosnia, the genocide in Rwanda, and the availability of these images through cable television, inhabitants of Western or Eurocentric societies have come to recognize that old ideologies and views of the world order are undergoing widespread upheaval and transformation. The long-standing and familiar packaging of an industrialized society looming authoritatively over marginalized **[p. 445**

↓] nations rutted in 'developing' configurations no longer works; it is in the process of entropy.

Worldwide changes in politics, internationalization, civil rights for women and other groups, political correctness, empowerment efforts by marginalized groups, and postmodern art and literature represent a radical departure from modernist views about the world, its people, and societies. These currents of change spread throughout the academic world to generate debates about new conditions, social movements, post-colonial studies, 'orbital' currencies, and speeded-up information sources.

In this section our focus centers on the comparative study of health sector reform within the evolving context of global change. First, we consider why globalism serves as an unavoidable impetus for health system reform, and then we review options for the comparison of health sector reform within the emerging global context.

Globalization as Impetus for Health Systems Reform

The influence of postmodernism can be seen in art and architecture with the debates, for instance, about the Pompidou Museum and the Pei Pyramide in Paris, as well as in the social and natural sciences. The force of postmodernism on academic conceptualizations in the late twentieth century is pervasive. That influence is also reflected in the writings about health-care reform, as social scientists borrow the 'mosaic' concept to discuss how disparate entities form coherent interconnections. A mosaic seems an appropriate image in a time of amorphous boundaries – geopolitical, cultural, personal, and perceptual – and unfamiliar landscapes.

Major transitions or paradigm shifts relating to fundamental ways of seeing and interpreting do not occur without discord and strong reaction; when the dynamics of globalism become local, difficulties relating primarily to power and control produce considerable degrees of tension and conflict. Innovation can occur when different ideas, perceptions, and ways of processing and judging information collide, and so too can

dissolution and conflict. The study of comparative health systems, itself a reflection of academic interests, is in the process of reinventing itself in a global context.

Blurring of national borders, another feature of globalism, produces mixed signals for analysts who optimistically envision collaborative improvement of basic human conditions. Concern is expressed about concentrations of power and control by the World Bank and International Monetary Fund, and about trade agreements negotiated under GATT, APEC, and NAFTA that severely limit development of strong national and independent governments. The needs for economic support and cooperation, on the one hand, and for independence and autonomy, on the other, appear to be in conflict (Korten 1995: 87–8). Consolidation of the world's national markets into seamless global economies by powerful mega-corporations, whose view of reality may be dominated by financial incentives (Korten 1995: 37), poses complex social, political, and economic concerns.

Health System Reform as a Result of Globalization

What may have appeared contained and controlled in the past has exploded into strange, unrecognizable formations as a result of electronic simulacra, new technologies, and complex patterns of human migration and dislocation. Old management structures and techniques are increasingly irrelevant.

In the past, health-care workers, for example, under the auspices of bureaucratic organizations, were able to organize immunization campaigns and other programs for fairly static populations in developing countries. However, in recent decades those programs and others have been disrupted by large numbers of people migrating from native homelands to resettle in London, Frankfurt, Miami, Marseilles, Caracas, La Paz, Buenos Aires, and other world cities. Migrations like these overturn traditional assumptions about health-care needs of populations and frustrate established management expectations and norms. Moreover, because migrations bring diverse populations together and raise compelling new concerns about health-care issues, future health-care systems must be prepared to respond quickly and innovatively to

global shifts. Continued use of earlier policies and approaches to health care often prove to be outdated, inappropriate, costly, and useless.

An increasingly visualized world reveals financial differences and the concomitant social inequalities that characterize groups in society and increase claims for equity and social redistribution (Kleinman and Kleinman 1997). What might have been unknown, overlooked, or ignored by audiences in industrialized nations before, now becomes an unavoidable reality. Today, the focus is immediate and sustained: the entire world turns on the television set or logs on to the Internet to receive powerfully portrayed accounts of world events. A wired world **[p. 446 ↓]** that has forged connections and links between formerly disparate populations has consequences for social tension and unrest, and also for social improvement.

Emerging Convergences

Through media exposure, the integration of economies in worldwide markets, and technological information resources, globalization's impact on health has been fast-tracked. In an important discussion of comparative health systems, Mechanic and Rochefort (1996: 242) described threads of connection derived from global shifts, or what they call 'emerging convergences,' that are creating cross-national and cross-dependent imperatives for cost containment, expansion of access to care, financing of care, government roles, and patient choice. Underscoring the importance of 'exogenous' or non-health-specific factors contributing to common burdens on systems throughout the world, the authors note that the 'strength of these factors is not identical from one country to another… they occur at varying rates and interact in different ways. Nonetheless, they provide an excellent window through which to monitor and evaluate the evolution of medical care in its principal outlines' (1996: 266). The recognition of non-health specific factors becomes a central ingredient for reform collaborators in what is termed 'shared learning experiences' (Gonzalez-Block 1997: 190) and 'networks of communities' (Frenk et al. 1997: 1404), and has set the tone for recent discourse. Intent on promoting meaningful and sustained health sector reform, a critical mass of proponents has begun to assemble overlapping matrices out of diverse and oddly shaped building tool concepts.

Contemporary CHS analysts recognize a trend in health sector reform moving toward goal-related outcomes that include cost containment, while reviving attention to the equity and effectiveness concerns raised by earlier scientists. Within a strengthened environment of collaboration, analysts are proposing a full review of available options in order to imagine and design ‘planned, purposeful, and positive health-care transformations and a consistent basis for delivery services, policy, action, and research’ (Frenk 1994: 20). Implicit in the identification of options is the need to specify main components of current health systems and their relational elements and structures (Frenk 1994: 24). Having little interest in historical patterns of incremental reform, CHS analysts are calling for re-articulated reform and synthesizing levels of reform, for producing achievable goals, commitment to and support of those agreed-upon

Comparative health system research is crucial for shared learning, providing fundamental explanations of current health system structure, function, and change, and generating new health sector models (Gonzalez-Block 1997: 200). Comprehensive research allows analysts to examine *all* key factors rather than just those related to the innately more measurable financial considerations historically central to prior research studies. The emerging relational model signals a shift from bureaucratic and hierarchical structures to more flexible and fluid arrangements that invite new approaches and understandings about multiple perspectives, process, professional discourse, and review. Rather than imposing a single direction or determination, such as cost containment, the emphasis is on complex variables defining multiple dimensions of human beings and their health. Frenk (1994: 23), Nixon (1997: 244), and Wheatley (1992: 10) use the word ‘relational’ to describe an emerging context in which twentieth century modernism is giving way to postmodernism, its epistemological successor. Frenk (1994: 32) and Gonzalez-Block (1997: 189), for example, argue that traditional comparative health system research has become mired in inflexible, bureaucratic categories generated by past research and financial demands and are encouraged by the opportunities inherent in the evolving context of transformation. In her considerations of change, Wheatley notes the need for ‘courage to let go of the old world, to relinquish most of what we have cherished, to abandon interpretations about what does and does not work’ (1992: 5).

In a time marked by opportunities for healthcare reform, CHS research needs to remain open to innovation, inclusion, and flexibility so that ‘prisoners of the past [can] imagine

and design alternative paths to the future' (Frenk 1994: 20). Accordingly, it is necessary, for instance, to 'conduct experiments and demonstrations that introduce, on a small scale, innovations in the financing and delivery of services' (1994: 32), and early evaluations of those efforts before moving to broader implementation. In his advocacy of shared knowledge and 'diffusion of innovations' among health system planners and analysts, Gonzalez-Block proposes a minimum data set to process and compare international **[p. 447 ↓]** information for assessing the advantages and limitations of each situation (Gonzalez-Block 1997: 189). The purpose and scope of health reform, he argues, depends on shared understandings of current conditions, practices, and processes (1997: 205).

Encrusted economies and obsolete institutions symbolized by the banking industry, General Motors, communication networks, and health care are being reshaped by a chaotic kineticism generating an entirely new, relational landscape of complexities in which connections – previously overlooked or ignored in earlier studies-are identified and explored. Health systems have been 'defined as a mere list of the different organizations or persons that participate in producing health services, without requiring that such components be coordinated or integrated' (Frenk et al. 1997: 23). The recent transformations in social, economic, and cultural orientations shift toward an increased recognition of disparate and formerly separated entities, so that current interpretations of 'system,' include not only traditionally scrutinized components or units, but also the interrelations that are slippery and not easily packaged into manageable units. For many, the transformed frontier is unfamiliar and strange; others, however, have accepted the challenge of change and are exploring multiple, conflicting, and overlapping spheres of meaning.

Not unlike AT&T, banks, and other large corporations of influence and power, the UN and WHO have been challenged by revisionists who believe that well-intentioned, but mired 'systems' of health care typically have difficulty responding to a new world order comprised of evaporating borders and the commingling of goods, services, people, values, and lifestyles (Frenk et al. 1997: 1404). More than 50 years old, those organizations and others have been constrained by traditional and often paternalistic organizational structures and approaches to problems. Some may be incapable of reinventing themselves and competing with forces seeking a 'code of mutual existence' in which difference is respected and hostilities relating to intolerance and desperation

are reduced (Frenk et al. 1997: 1405). Caught between cross-currents of a disappearing past and an alternative future, many reformers (Frenk et al. 1997: 1404) are moving away from established patterns of service to re-articulations of what health can become in the future. ‘Current international health agencies… were designed for a different world, where few problems need global action…. Today the world is a different place…. [Their] efficacy… has been diminished by lack of coordination, overlapping mandates, and the duplication of efforts' (Frenk et al. 1997: 1405).

Health-care needs are greater than available resources, causing cost-containment and cost-effectiveness measurements to be relevant topics in the general reform dialogue. While reiterating this global concern, discussions by analysts increasingly incorporate wider ranges of more complex factors in their analytical investigations. Hammer and Berman (1995: 30), speaking from a World Bank perspective, suggest that past strategies for health sector reform were molded out of a preference for clear and simple rules (1995: 30). The complexity of health care's varied factors, however, ranging from behavior to risk sharing plans, does not allow for the formation of definitive rules and conclusions. Like other writers in this section, Hammer and Berman propose the development of multiple goals based on community values, and note how information between providers and patients, for example, has become an important area of research in regards to allocation determinations.

In the emerging context of change, many CHS researchers have begun to focus on what Frenk calls ‘the repertoire of options’ (1994: 19). Given the cost of research, comparative research and policy analysis is crucial for evaluating innovative approaches to health care and recommending broader applications. Other postmodern tools for improving interactive data collection for CHS use are now available through Internet capabilities and the European Union's ability to collect and share cross-national data (Gonzalez-Block 1997: 191). Use of informational-age tools and an exploration of relational configurations suggest a powerful potential for collaborative studies in future phases of CHS research and analysis, one that clearly reflects the passage from modernism to postmodernism – and globalization.

Governments in Transition

With the collapse of authoritarian rule, conditions for the establishment of new, more participatory governmental forms have improved along with the forecast for market development and economic vitality. Advancements in technology, health care, knowledge, and global linkages generate corresponding tensions caused by glaring disparities between the affluent and the poor: internal wars in Eastern Europe and Africa, marginalization of groups of people in Latin America; continued threats to a fragile and seriously damaged environment; intractable corporate powers. Legitimate concerns about threats to developing countries by global powers with self-serving goals challenge the vision posed by social scientists who seek broad social improvements. **[p. 448 ↓]** In an age of neoliberal reforms, there is grave concern about the potential for consolidation of control by 'consequential institutions of global governance: the United Nations, International Monetary Fund, the World Bank, and the General Agreement on Tariffs and Trade' (Korten 1995: 18). The concern reflects an earlier statement that these institutions are a poor fit for the expanded, cross-boundary mosaic of the future.

Intervention, amelioration, and arrangement of currently disparate health sector pieces into multidimensional entities – without concern for overlaps or extensions beyond traditional framing techniques and expectations – is critical. Because a paradigm shift has revitalized the level of interest and creative momentum, encouraged analysts are focusing on open forums centered around the achievement of productive ends, specifically, how health care can be assembled so that equity, quality, and efficiency can promote improved health status outcomes.

Analysts acknowledge that government support for the development and funding of a basic health package comprising essential interventions and resources can achieve improved health status (Chernichovsky 1995: 83; Frenk 1995: 270; Hecht and Musgrove 1993: 7). Challenges to this goal are formidable and include various protagonists: providers, financing entities, university and research centers, private corporations, NGOs, governments, and populations served by implementation of the goal. Even though the enormity of resistance is formidable, the following passage by Toffler provides an encouraging outlook:

> In probing the future… we must do more than identify major trends. Difficult as it may be, we must resist the temptation to be seduced by straight lines. Most people… conceive of tomorrow as a mere extension of today, forgetting that trends, no matter how seemingly powerful, do not merely continue in a linear fashion. They reach tipping points at which they explode into new phenomena. They reverse direction. The future is fluid, not frozen. It is constructed by our shifting and changing daily decisions, and each event influences all others. (Toffler 1990: 145)

In the following section, we briefly review health-care reform in Chile as an example of the type of analysis being called for in current CHS literature. In spite of, or perhaps due to, its tumultuous political history, Chile is beginning to exhibit signs of postmodern relationality in its present struggle for health-care improvements. Such developments correspond to trends discussed by social scientists: the profoundly political process of health-care reform in national and global arenas (Frenk et al. 1997; Reich 1995), historical and cultural structured pluralism (Londono and Frenk 1997), the consequence of changing health-care goals as they affect process (Frenk 1994), and the direction toward the development of a mosaic response to changing conditions.

Case Study of Chile

In 1975, David Mechanic introduced the concept of health system convergence. Since then, there has been on-going discussion concerning whether health systems are becoming more similar to one another. According to Mechanic, the convergence in health-care systems is generated by similar conditions such as similar health problems (for instance, the increased number of countries facing populations with chronic health problems such as heart disease, diabetes, stroke). Other contributors include similar international pressures (such as global competition and international monetary policy), and shared analytic models and conceptual trends for health-care systems research (such as the continued emphasis on cost-containment policies).

While some forces exist that cause health-care systems to become more uniform and similar to one another cross-culturally, such as global economic pressures, similar health conditions, and shared health policy goals, there are also important differences

that give individuality and identity to the shape and form of health-care systems. Cultural systems, while influenced by global interests, still shape how policy makers, practitioners, and populations view their healthcare needs, and how responses to those needs are structured and evaluated. History, which composes a core portion of a country's identity and shapes its external relations with other countries (Whiteford 1990, 1992, 1993, 1998a, 1998b), uniquely structures relations between members of the population and their government, and defines governmental authority and the role of the central government in the provision of health care. Simultaneously, the very definitions of health and illness, disease and sickness are culturally constructed, reflecting the cultural interpretations of what it means to become ill, what courses of treatment are possible, and what are the expected roles of the individual and the government alike during illness, disability, and death.

Allopathic medicine or biomedicine, so dominant in the United States, shares its purview in other countries with more holistic healing systems. Indigenous medical systems relying on naturopathy or other more holistic responses **[p. 449 ↓]** to altered health status find currency in many parts of the world. A perspective that emphasizes the dominance of biomedicine tends to envision health-care systems as undergoing a global transformation toward convergence to models developed in highly industrialized Western countries. Following 20 years of discussion of convergence and divergence, Mechanic and Rochefort (1996) conclude that, in general, there is convergence in health-care delivery systems in response to global politics and concerns. However, they caution that these similarities are difficult to demonstrate because definitions and measures are not always the same and are subject to culturally generated interpretations.

While health-care systems are strongly influenced by international, globalizing factors such as sources and conditions of funding and the education and values of policy makers and practitioners, it is local culture, history, and experience that ultimately determine the efficacy and durability of a health-care system. Responses to globalization can only be understood through the lens of a particular culture and history. To emphasize this point, a brief description of health-care reform in Chile is presented to illustrate the application of what Frenk refers to as relational analysis. The Chile example shows the profoundly political process of health-care reform, in the Chilean experience of ‘emerging convergences.’

SAGE knowledge

Several identifiable worldwide trends in health-care reform became clear in the 1990s. In Latin America in general, and in Chile in particular, four reform strategies are notable: (1) privatization (Chile); (2) decentralization and devolution of central government responsibility (Bolivia, Brazil, and Mexico); (3) decon-centration (Cuba); (4) delegation of functions to semiautonomous agencies (Brazil and Mexico) (Frenk and Gonzalez-Block 1992). Latin America is a provocative example of trends in comparative health systems research and health-care reform because of the postmodern approach taken by leading reform analysts in their attempt to create mosaics that combine a recognition of global pressures and a validation of national and indigenous histories.

Reichard (1996) notes that while market forces and the general health status of a population may be fundamentally linked, it is history and societal values that shape a nation's institutions and through which meaning and conflict are interpreted. In his careful account of health reforms in Chile from 1873 to the present, Reichard details how Chile's health-care system grew out of early labor movement reforms generated by nitrate miners and, later, railroad workers. Labor strife led to major redistributive laws by the 1920s, and in 1925 social legislation mandated sick pay, disability payments, and free medical coverage for all citizens (1996: 83). Reichard's analysis demonstrates how the establishment of the British National Health Service in 1948 influenced the creation of the Chilean National Health Service in 1952. Clearly the enduring support for a distributive health system was rooted in Chile's labor history, but the system also found both popular and political support through the political process. The Chilean National Health Service was established to provide comprehensive health care for all citizens, and in so doing established institutions to meet those needs and developed educational and training programs to provide staff for those institutions. A conservative retrenchment of social programs in the 1950s gave rise to the labor alliance that elected President Eduardo Frei (1964–70), and later the Socialist/Communist alliance of President Salvador Allende (1970–73). The 1973 coup d'etat set the stage for the military dictatorship of General Augusto Pinochet and 'dismemberment' of public sector health programs such as health education, sanitation, occupational health service, medical education, and hospital staffing. Between 1974 and 1983 there was an overall reduction of 10 per cent in public health spending (Reichard 1996: 87) as the Pinochet government brought in economist Milton Friedman and the University of Chicago group of economic theorists to guide Chile's turn toward a market economy.

The Chilean turn toward a market economy has been referred to as the ‘Chilean miracle,’ a set of economic policies being duplicated throughout Latin America. However, the miracle did not extend to the improvements in Chile's public health system. It is a sad irony that 100 years after the Chilean/Bolivian War of 1873 (when Chile seized lands high in nitrates, initiating nitrate mining and its consequent labor movement which agitated for health care), President Salvador Allende, physician and former Minister of Health, was assassinated in a bloody coup d'etat that marked a turn away from comprehensive health coverage for all Chileans. Privatization began in 1982 with the development of private health insurance modeled on the US health maintenance organizations (HMO) and preferred provider organizations (PPO) systems. The government cut subsidies to the public health system, reduced the University of Chile's Medical School budget by 46 per cent and its personnel by 40 per cent in the decade between 1980 and 1990, and ended the previous governments' redistributed tax policies (Reichard 1996). This reduced the middle class and increased the number of those without access to health insurance. **[p. 450 ↓]** During and following the Pinochet era, healthcare reform turned toward privatization and decentralization, reducing the influence of grassroots and union organizations. Cost containment became a process as well as an economic goal, which undermined cultural and historical values supporting the state in the delivery of, and access to, health care. Cost containment became a process of social control and marginalization, with far-reaching and long-term health consequences. The turn toward a market economy exacerbated the social, educational, economic, and epidemiological differences within the Chilean population, as exemplified by the disparity of public health services in the rural and urban areas (Montoya-Aguilar and Marchant-Cavieres 1994: 286).

Although the current data show the same trends in health status in Chile as compared with the United States, other social indicators suggest the difficulty of using a system designed for another country without the same social history. The Health-for-All statistics provided by the World Health Organization suggest that Chile was able to eradicate infectious diseases, control malnutrition, reduce the infant mortality rate, and provide proper sanitation for 100 per cent of the population in the urban areas in spite of the economic and political upheavals they endured. On the other hand, the data depict less than one-third of the rural population having access to safe drinking water or adequate human waste disposal. These and other discrepancies

also show the likelihood of absent information from the rural areas where infectious diseases, malnutrition, and high infant mortality are rampant. Therefore, although the incorporation of a Western market-driven biomedical model may have improved the health of some citizens, those with the greatest need still are not provided with adequate public health services.

Previous to 1973, the Chilean National Health Service was financed through the central budget (at about 65 per cent) and by compulsory insurance contributions paid by workers and their employers. The overthrow of Allende and the move to neoliberal and structural adjustment policies led to large direct reductions in the central government contributions, leaving a significant gap in funding to be made up by direct user payments and increased compulsory worker insurance premiums. In 1980, the increased emphasis on market economy policies resulted in the creation of private, for-profit health organizations that marketed health insurance plans against the compulsory contributions (Montoya-Aguilar and Marchant-Cavieres 1994). The result was increased epidemiological polarization.

To resolve the 'epidemiological polarization' (Frenk and Gonzalez-Block 1992: 42) that has defined health conditions in Latin America and much of the rest of the world requires that health-care systems provide for prevention and intervention, maintenance and cure, and programs designed to supplement nutritional needs to children, prevent infectious disease, provide assistance to the elderly, and guarantee access and equity. Instead, what has happened in Chile is increased polarization of society. This has intensified the 'inequalities in health as the dominant causes of death and disease have become different among social and geographical groups' (Frenk and Gonzalez-Block 1992: 42). Health-care systems in Europe and the United States do not face epidemiological polarization to the same degree as in Latin America. Thus, the 'indiscriminate application of economic theories that have shown success in the developed nations of Europe can result in an inequitable social cost in the poor and underdeveloped nations. This has been the experience of Chile' (Alfredo Jadresic, quoted in Reichard 1996: 89).

The Chilean example demonstrates the consequences of borrowing a 'system' or theory from another place and applying it as though the country in which it is being applied has no history, no culture, and no identity of its own. As the emerging CHS research

suggests, it would be more advantageous to apply a 'mosaic' of ideas, a range of options that are appropriate to the unique history and cultural context, as well as to the particular sets of alliances and relations within and between countries. In Chile, as in other countries, often the proximate variables and indirect causes provide important information for the comparison of health systems. As various authors have pointed out (Montoya-Aguilar and Marchant-Cavieres 1994; Whiteford 1992, 1993, 1998a, 1998b), public health systems can override radical economic changes-for a while. It takes time for the health indices to reflect the consequences of such changes if populations have had access to basic sanitation, immunization, prenatal care, health education, and nutritional supplements, but they will show up as increased rates of infectious disease, deterioration of health-care infrastructures, reduction of number and quality of health-care personnel, and even more difficult to measure, loss of faith in the government to provide those basic needs for its population (Whiteford 1993, 1998a).

Analysis of health reform in Chile exemplifies some of the difficulties encountered in CHS research. To be meaningful, health-care system comparisons must take into consideration the political, social, and historical context under which they were developed, but to do so often **[p. 451 ↓]** makes the resultant data ungeneralizable to other locations. Without doubt one of the effects of globalization is that ideas from one national context and experience rapidly influence others. In the case of Chile, the diffusion of ideas from other national contexts played an important role in its health reforms. While some consider Chile a model for other Latin American countries, others are less sanguine about the relative success of Chile's health-care reforms. They point out continuing increases in malnutrition among some high-risk populations, continuing increases in chronic disease, and the increasing inequality in health-care services between urban and rural areas. The loss of political and personal freedoms that accompanied the transition to a health-care market economy in Chile must be recognized in any analyses of its health system reform. The health-care reforms undertaken in Chile and touted as part of the Chilean 'economic miracle' were accomplished at great and continuing costs to Chilean citizens. Pinochet's use of 'terror as an element of popular control' (Reichard 1996: 86), and the application of an autochthonous model of laissez-faire capitalism to the Chilean health system, succeeded in generating funds from international lending institutions, such as the World Bank, by disconnecting from Chile's history of national comprehensive health care.

SAGE knowledge

Although it may 'follow' Mechanic's convergence model with similar health problems, international pressures, and health policy goals as other developed nations, the inability to provide basic health services to target populations in the rural areas shows the failure of a single (US) system approach and the need to incorporate a 'mosaic' In this case, we used only one country (a baseline for any comparison) to suggest how important it is to incorporate ideological (Jimenez de la Jara and Bossert 1995), epidemiological (Frenk and Gonzalez-Block 1992), historical (Reichard 1996), cultural (Montoya-Aguilar and Marchant-Cavieres 1994), and economic indicators in any CHS analysis.

Conclusion

Comparative health system research, like its subject matter, is in the process of change. Information is more immediate, whether through the World Wide Web, television, 24-hour news stations, e-mail, fax, or phone, and more available than ever before. Not only can we download data that took years to collect, we can also do it without ever leaving our home. In addition to written data, information is visually available both through the Web and on television, and the images are global – we can see events that occur in England, Rwanda, and Costa Rica. According to some social scientists (Kleinman, for example), this immediacy carries with it responsibilities to step out of disciplinary boxes, destabilize established categories, and collapse old dichotomies. As social scientists challenge the utility of the old categories, they question the need to separate the 'individual from social levels of analysis, health from social problems, representation from experience, suffering from intervention' (Kleinman et al. 1997: x). In CHS research, this means that health systems must be seen as stemming from, and a reflection of, the social fabric.

CHS research has moved from an unquestioning stance where primarily quantitative data were collected and categorized and researchers struggled to compare what in essence are apples and oranges, to an attempt to contextualize health-care research in relational modes, linking attributes in a mosaic whose overall shape is still unclear. Earlier CHS research used a systems metaphor to compare items (policies, practices, indicators, outcomes, economies) that themselves were not comparable because to make them comparable researchers had to remove or ignore underlying cultural and historical differences – thereby making them apparently comparable, but falsely so.

The emerging metaphor of a mosaic suggests a myriad of small, self-contained pieces that when placed in relation to one another form a new image. It suggests that both the pieces and their relations are equally important to the whole.

The most exciting new directions in CHS research build on the writings of previous CHS analysts, but incorporate lessons learned from postmodern thought, particularly the importance of identifying biases in research, including those of the researchers, funders, and participants as well as those who use the data. In a time of rapid social and technological change, Mechanic's hypothesis of health system convergence reflects a technological-dependent bias that has generally marked medicine and social science. Mechanic posits that global forces are '… a certain macro process in which a narrowing of the system options takes place, compared with those theoretically possible, due to forces that generally lie beyond the control of particular national actors or institutions and to which more and more societies are being exposed' (Mechanic and Rochefort 1996: 242). According to Frenk, Gonzalez-Block, and Reichard, among other writers, while those unifying global forces do exist and cannot be ignored, diversity arises from the strength of the cultural traditions of a country that also **[p. 452 ↓]** cannot be ignored. A belief in the primacy of technology (and other globalizing influences) is a conceptual box that the relational mosaic metaphor allows the researcher to break out of and consider other variables in relation to one another.

Our example of health-care reform in Chile attempted to show how the incorporation of an autochthonous model results in epidemiological polarization, a disjuncture with the social fabric of previous generations of Chilean health objectives, and was possible only by way of massive social upheaval. To ignore these effects when describing the Chilean health system is to reify the social suffering experienced in Chile and to diminish the power of comparative health system research.

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