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### Comparing health policy: An assessment of typologies of health systems

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# Comparing Health Policy: An Assessment of Typologies of Health Systems

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**ABSTRACT** *Typologies have been central to the comparative turn in public policy and this paper contributes to the debate by assessing the capacity of typologies of health systems to capture the institutional context of health care and to contribute to explaining health policies across countries. Using a recent comparative study of health policy and focusing on the concept of the health care state the paper suggests three things. First, the concept of the health care state holds as a set of ideal types. Second, as such the concept of the health care state provides a useful springboard for analyzing health policy, but one which needs to be complemented by more specific institutional explanations. Third, the concept of the health care state is less applicable to increasingly important, non-medical areas of health policy. Instead, different aspects of institutional context come into play and they can be combined as part of a looser “organizing framework”.*

Comparative policy analysis has become a “growth industry”. Advances in information technology have expanded the availability and dissemination of data across many countries, while at the same time many policy fields have become increasingly internationally oriented. The greater interest in information about policies in other countries has also been fostered by the perception of shared policy challenges arising from economic and welfare state crises. DeLeon and Resnick-Terry (1999) refer to this development as the “comparative renaissance”. The comparative perspective is now widely used in both the academic field of public policy analysis and in more applied policy studies (see for example Castles 1999, Heidenheimer *et al.* 1992). Parallel to discussions about the insights generated by comparative analyses is a debate about the methodologies of cross-country comparison (for comparative

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politics see for example Lane and Errson 1994, Peters 1998; for comparative social policy, see for example Clasen 1999, Hantrais and Mangen 1996).

The use of typologies has been central to the comparative turn in policy analysis and they have been used to conceptualize the (institutional) context in which policies are embedded. Prominent examples include: Castles' (1993) notion of "families of nations", which describes different clusters of cultural, historical and geographical features of nations; Esping-Andersen's (1990) welfare state regimes, which identify distinct welfare state logics; and Lijphart's (1999) and Blondel's (1990) typologies of democratic and state regimes respectively. Cross-country comparison generates an abundance of information and ordering this information through typologies is central to using comparison to build, review and revise explanations about policy emergence, policy making and policy cycles.

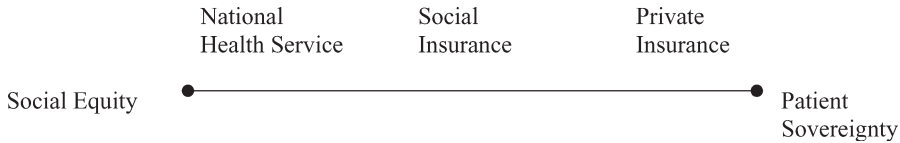
This paper contributes to the debate in comparative policy analysis by analyzing the uses and limitations of typologies of health systems in the comparative study of health policy. This is an area of comparative analysis that has grown significantly over the last 20 years (for an overview of the literature see Marmor *et al.* forthcoming), but it has featured less prominently in the mainstream literature on comparative policy analysis and social policy analysis.

Using a recent comparative study of health policy the paper assesses the use of typologies of health systems and their capacity to capture the institutional context of health care and thereby to contribute to explaining health policies across countries. More specifically, based on Moran's (1999, 2000) typology of health care states the paper suggests three things. First, modeled on paradigmatic cases the concept of the health care state holds as an ideal type. Second, as such the health care state provides a useful springboard for the analysis of health policy, but one which needs to be complemented by more specific institutional explanations. Third, the concept of the health care state is less applicable to increasingly important, non-medical areas of health policy. Instead, different aspects of institutional context come into play and they can be combined as part of a looser "organizing framework".

The paper begins by reviewing the comparative literature on health policy and suggests that while the OECD typology of health system has been influential, studies have more or less explicitly adapted the definition of the health system. A prominent example is the concept of the health care state developed by Moran (1999, 2000). The following two sections apply the typology to a recent comparative study of health policy that included a wide range of countries and areas of health policy. From this, the concluding discussion summarizes the uses and limitations of typologies of health systems.

### **Typologies of Health Systems in Comparative Health Policy**

The comparative analysis of health policy often uses typologies of *health systems* to help capture the institutional context of health care and contribute to explaining health policies across different countries. In this regard, the typology developed by a series of OECD studies has been particularly influential (see Figure 1). The typology defines the health system as an ideal typical set of macro-institutional characteristics based on variations in the funding of health care and corresponding differences in the organization of health care provision. This reflects the fact that the public funding of

**Figure 1.** Types of health care systems by provision and funding

health care (or lack of it) is often seen as the defining characteristic of the degree of public involvement in health care (Freeman 1999).

The first of these studies was especially influential (OECD 1987: 24) and classified the health system on the basis of a dichotomy between patient sovereignty (and the predominance of incentives) and social equity (and the predominance of control), and introduced three basic models of the health system. The national health service (or Beveridge) model is characterized by universal coverage, funding out of general taxation and public ownership and/or control of health care delivery. Although this model is most identified with the UK, New Zealand created the first national health service in its 1938 Social Security Act that promised all citizens open-ended access to all health care services they needed free at the point of use. Sweden is another example of the national health service model, although all three countries, to varying degrees, have moved away from this pure model.

In contrast, in the social insurance (or Bismarck) model compulsory, universal coverage is as part of a system of social security. Health care is financed by employer and employee contributions, through non-profit insurance funds, and the provision of health care is in public or private ownership. Germany, Japan, and the Netherlands are often viewed as examples of this type. Singapore, with its compulsory Medisave system is a variation on the theme of social insurance, although in terms of the sources of funding, private insurance dominates.

Finally, in the private insurance (or consumer sovereignty model), employer based or individual purchase of private health insurance is key. Health care is funded by individual and/or employer contributions and health delivery is predominantly in private ownership. This type is most clearly represented by the US and until recently by Australia, but many systems contain some elements of this type.

The initial typology developed by the OECD is a descriptive categorization of how health care is organized in different countries and reflects its specific origins in applied policy analysis. As Freeman (2000) observes, the typology emerged from a search, dominated by economists, for better solutions to common problems. This corresponds to a focus on the internal workings of health care rather than on its political and social embeddedness. However, this situation has changed with the wide use of the basic typology in the comparative analysis of health policy (see for example Freeman 2000, Ham 1997, Raffel 1997, Scott 2001, Wall 1996). Together with the increasing interest in neo-institutionalism, the typology has been a facilitator for critical analyses of the health system as the institutional framework in which health policies are embedded and how the institutions of health care (among others) shape health policies (and politics). Scott (2001), for example, uses the typology as part of her framework to analyze public and private roles and

interfaces in health care across different countries. In contrast, Ham (1997) in his cross-country comparative analysis focuses more explicitly on health reform. The same applies to Freeman (2000), who specifically looks at the politics of health in relation to a range of areas of health policy.

However, these analyses also have in common their consideration of other aspects of the institutional context of health care in addition to the typology of health systems. Freeman (2000), for example, explicitly includes in his analysis the mechanisms by which health care is co-ordinated (“health care governance”). This inclusion clearly demonstrates that applying the typology of health systems to a wider range of cases has also led to its adaptation. As Collier and Levitsky (1997; similarly Collier and Mahon 1993) note, such a process is characterized by a tension between increasing analytical differentiation in order to capture the diverse forms of the phenomenon at hand, while avoiding the pitfalls of conceptual stretching and applying the concept to cases that do not fit. The literature on comparative health policy has addressed this tension by adding, although more or less explicitly, new attributes to the definition of the health system.

Moran’s work (1999, 2000) is particularly interesting here as he explicitly sets out both to better account for the institutional embeddedness of health care and to revise the typology of health systems. He starts with the observation that health policy is about more than health care and that modern health care systems are about more than delivering a personal service: “Health care facilities in modern industrial societies are great concentrations of economic resources – and because of this they are also the subject of political struggle” (Moran 1999: 1). This means shifting the focus of the analysis from the organization to the governance of health care. Moran goes on to argue that with its emphasis on the access to health care the OECD typology only captures one aspect of the governance of consumption and also misses out on other important dimensions of governing health care. On that basis, he introduces the concept of the health care state that consists of the institutions related to governing the consumption, provision and production of health care.

The institutions of governing the consumption of health care are concerned with the mechanisms by which individual patients have access to services (such as social citizenship and earned insurance entitlements) and the mechanisms that decide on the total volume of resources allocated to the financing of health care (such as governing through public management and setting regulatory frameworks). In contrast, the institutions of governing the provision of health care include the mechanisms for regulating hospitals (such as the amount of public regulation and the mix of differently owned hospitals) and the regulation of doctors (especially different forms of private interest government). This reflects the centrality of hospitals and doctors for the provision of health care. Finally, the institutions of governing the production of health care focus on the mechanisms regulating medical innovations. The three sets of institutions vary in terms of the relative degree of public control and on that basis Moran constructs four different types of health care states.

The remainder of the paper applies the typology of health care states to a recent cross-country comparative study of health policy. The analysis uses examples from a recent comparative study of health policy (Blank and Burau 2004) that is distinct because it covers both a diverse range of countries and multiple areas of policy. With its emphasis on complexity and inclusiveness, the study is well suited to offer new

insights into the uses and limitations of typologies of health systems and, specifically, the concept of the health care state. The study includes nine countries (Australia, Britain, Germany, Japan, New Zealand, the Netherlands, Singapore and the US) that differ not only in relation to the key dimensions of the health care state, but also on other factors that impact on health policy such as type of political system and the wider cultural, economic and societal context. In addition, the study incorporates a wider range of areas of health policies than often studied, including home and community based public health policies. Although both have traditionally been marginal, they have become increasingly central to health policies. This shift reflects demographic changes, especially the ageing of population, and the increasing focus on the responsibilities of the individual for his or her own health.

The next section applies the concept of the health care state to the nine countries included in our study and discusses the importance of institutional embeddedness beyond the health care state. The subsequent section assesses the use of the concept of the health care state in relation to non-medical health policies and explores an alternative “organizing framework”. The key question here is if the concept of the health care state also captures the new cases presented in the study. Or, to paraphrase Harrop (1992: 3; similarly Arts and Glissen 2002), does the concept of the health care state help to discover how countries vary (or are similar) in the health policies they adopt and to gain insights into why these differences (or similarities) exist.

### **Health Care States and Institutional Embeddedness**

Based on the distinction between institutions related to the governance of consumption, provision and production, Moran (1999, 2000) constructs different types of health care states, three of which are especially relevant for our set of countries. In entrenched command and control health care states, the governance of consumption consists of extensive public access based on citizenship and extensive control of resource allocation through administrative mechanisms. This gives the state a central role in governing the collective consumption of health care. The same applies to the governance of provision with hospitals in public ownership and subject to extensive public control, and with the private interest government of doctors closely circumscribed. There are also moderate constraints on medical innovation, which is at the heart of the governance of production.

In contrast, in the corporatist health care state funding through social insurance contributions makes for de facto public access to health care and gives public law bodies (such as statutory, non-profit insurance funds) an important role. This limits the public control over health care costs. The same is true for the governance of provision, where private hospitals are often prominent and where there are only some constraints on the private interest government of doctors, who therefore play a potentially influential role in the governance of provision. Not surprisingly, there are only some constraints on medical innovation.

The role of providers is even more extensive in the supply health care state, where funding through private insurance limits public access to health care as well as the public control of costs. Similarly, private hospitals not only dominate, but also remain relatively unchecked. The same applies to doctors, and private interest

government is strong. There are also de facto no constraints on medical innovation. Table 1 maps out our countries using the typology of health care states developed by Moran.

Looking at the health care states in our countries across the different types and respective dimensions of governing health care several findings stand out. Only four out of the nine countries included in the study fully fit one of the three types of health care state. In contrast, the remaining countries are more or less close approximations of the individual ideal types. This highlights the fact that the institutional contexts of governing of health care are more complex than suggested by the definition of the health care state. Instead, institutional contexts are often highly specific in terms of how individual aspects combine themselves in individual countries. Such specificities also point to additional aspects of institutional context. Consequently, within a country the two sets of institutions associated with the governance of consumption may actually fit different types of health care states thus making categorization problematic. The same problem might also apply to the governance of provision and production.

According to the typology, public control of the total resources allocated to health care can be expected to be highest in entrenched command and control health care states with access to health care based on social citizenship and lowest in supply health care states where access to health care is based on private insurance, with public control in corporatist health care states lying in between. This is true for four of our countries, but the picture is more complex in the remaining five countries, pointing to the importance of country-specific institutional contexts. In Australia, for example, federalism combined with the legacy of the private insurance systems weakens government authority over funding (Palmer and Short 2000). In contrast, the unitary political system in Japan helps to concentrate authority in the hands of central government (Campbell and Ikegami 1998). Despite significant decentralization of health services and insurance plans, for example, all billing and payment in Japan is centralized through the payment fund of the National Health Insurance.

The Netherlands and Singapore are particularly interesting examples of how country-specific institutional contexts shape the public control of health care costs, thus making differences between countries particularly pertinent. In the Netherlands, the high public control of funding reflects the unusual combination of a social insurance with strong universalist elements (for an overview see Exter *et al.* 2004, Maarse 1997). Health funding combines a considerable diversity of sources, including private insurance for acute medical risks for those earning above a certain ceiling, and compulsory social insurance contributions in case of exceptional medical risks. This reflects the historical legacy of a society segmented into different groupings and the gradual weakening of this legacy in the Netherlands. The semi-federal political system also helps to concentrate authority in the hands of the central government, and, in contrast to Germany, corporatism is confined to the national level.

In Singapore, country-specific institutional contexts are such that public control is strong not only in relation to health care costs but also other key aspects of health care (for an overview see Barr 2001, Ham 2001). Strong government control of funding co-exists with health care funding that is predominantly based on individual responsibility and limited familial risk pooling. Health care is funded by individual

**Table 1.** Health care states across nine countries

	<i>Governance of consumption</i>	<i>Governance of provision</i>	<i>Governance of production</i>
	<ul style="list-style-type: none"> <li>• extent of public access to health care</li> <li>• extent of public control of total health care costs</li> </ul>	<ul style="list-style-type: none"> <li>• extent of public control of hospitals*</li> <li>• extent of constraints on private interest government of doctors**</li> </ul>	<ul style="list-style-type: none"> <li>• extent of public constraints on medical innovation</li> </ul>
<i>Entrenched command &amp; control health care state</i>	BRITAIN SWEDEN Australia (access) New Zealand (access) Netherlands (cost control) Singapore (cost control) Australia (cost control)	BRITAIN SWEDEN New Zealand	BRITAIN SWEDEN Netherlands New Zealand
<i>Corporatist health care state</i>	GERMANY Japan (access) Netherlands (access) New Zealand (cost control)	GERMANY Australia Japan Netherlands Singapore	GERMANY Australia Japan
<ul style="list-style-type: none"> <li>• extensive public access, high public control of costs</li> <li>• high public control of hospitals, highly constrained private interest government</li> <li>• moderate constraints on medical innovation</li> </ul>			
<ul style="list-style-type: none"> <li>• moderate public control of hospitals, some constraints on private interest government</li> <li>• some constraints on medical innovation</li> </ul>			
<i>Supply health care state</i>	US Singapore (access)	US	US Singapore
<ul style="list-style-type: none"> <li>• limited public access, low public control of costs</li> <li>• little public control of hospitals, few constraints on private interest government</li> <li>• de facto no constraints on medical innovation</li> </ul>			

\*share of hospitals in public ownership together with the degree of public regulation used as proxy for extent of public control of hospitals.

\*\*share of publicly employed (hospital) doctors together with the degree of professional self-regulation used as proxy for extent of constraints on self-government of doctors.



savings accounts, which are compulsory. The government also caps contribution rates, while out-of-pocket payments are high. As such, Singapore defies the dictum that private funding is unlikely to make for public control. The strength of government control reflects not only the spatial concentration of political power typical of city-states, but also a strongly centralized approach to health policy. Government education programs are aimed at lowering the demand for health care and also emphasize the importance of primary health care and prevention over hospital care. Not surprisingly, public health policies are strong, and the government heavily subsidizes health promotion and disease prevention programs that emphasize the responsibility of the individual to look after his or her own health.

The importance of country-specific institutional contexts also applies, though to a lesser extent, to the governance of provision and production. In the Netherlands and Singapore the respective institutions fit different types of health care states and together with the institutional specificity of the governance of consumption, the two countries emerge as hybrids. As noted earlier, in relation to the governance of consumption the Netherlands combine access based on social insurance contributions with extensive public control of health costs. This ambivalence extends to the other dimensions of governance. The governance of provision is closest to the logic of the corporatist health care state. Private, non-profit hospitals dominate, but are subject to extensive public control through centralized hospital planning. The same is true for doctors and, for example, while many hospital specialists are independent entrepreneurs they work under a public contract. In contrast, the governance of production resembles the logic of entrenched command-and-control health care states, where central regulation together with hospital planning put moderate constraints on medical innovation.

Singapore, for its part and as mentioned above, has a highly controlled health system but one based on individual savings accounts that give the impression of minimal government control over consumption. Thus, it crosses the line between a corporatist and supply health care state. Furthermore, Singapore gives those persons with sufficient Medisave account balances considerable freedom of choice as to public and private doctors and hospitals as well as allowing them to purchase private insurance with their account should they so desire. While provision and especially production appear to best fit a supply health care state, a large proportion of health care is provided in publicly-owned hospitals by government-set salaried doctors. Despite this, there are few controls on medical intervention in Singapore because in the end individuals have the choice of what services to use with their compulsory but private accounts.

What does the analysis presented so far say about the concept of the health care state and its capacity to capture the institutional arrangements across our countries and contribute to explaining health policies? The analysis suggests two things. First, the concept of the health care state holds as an approximation of “real” health care states. It is therefore a classical ideal type that is useful as a heuristic device that simplifies the complex real world of governing health care (following Weber 1949). Thereby, the concept of the health care state helps to move the analysis beyond the specificity of individual cases and towards more generalized observations, overcoming a salient tension inherent in comparative enquiry (Goodin and Smitsman

2000). The health care state as an ideal type, therefore, does not need to fit the real types completely in order to be useful.

Second, it is important to remember, however, that it is primarily through the comparison and contrast with real types that explanations can be advanced (see Arts and Glissen 2002). The central question, then, is how to explain the extent to which “real” health care states do or do not fit the ideal types of health care states. The different degrees of “misfits” among these nine countries and the types of health care states presented in the analysis raises many such “why” questions. In turn, this underlines the fact that the concept of the health care state indeed only provides a starting point for a comparative analysis and must be complemented by additional, more specific institutional explanations. The importance of a detailed study of institutional contexts is well recognized in the comparative study of health policy (see for example Döhler 1991, Immergut 1992, Wilsford 1994). Nevertheless, this point is particularly significant in the present context, because the concept of the health care state specifically aims to better account for the institutional embeddedness of health care. In this respect, Moran (1999, 2000) emphasizes that understanding health policy requires examining the ways in which health care is embedded in the broader contexts of market economies and democratic competitive politics.

Significantly, then, there is institutional embeddedness beyond the health care state. As the analysis of our countries suggests, governing health care is embedded in institutional contexts that are broader than those institutions making up the health care state, and institutional contexts that are often also highly specific to individual countries. As the literature emphasizes (see for example, Campbell and Ikegami 1998, Feldman 2000, Ham 2001, Klein 2001, Raffel 1997) such contexts can encompass a wide range of aspects, including social values and cultural factors, as well as the legal and political systems together with social structures. Our analysis, for example, points to the importance of the specific characteristics of political systems (such as federalism in Australia), social structures (such as the legacy of societal pillars in the Netherlands) and social values (such as the high degree of individual self-reliance in Singapore). The governing of health care reflects specific configurations of these different aspects of institutional context, all of which are changeable over time. Therefore, more often than not, health policies follow trajectories that are highly complex and specific.

### **Health Care States and Non-medical Health Policies**

The analysis presented in the previous section suggests that the institutional context of governing health care itself is highly complex. This echoes Freeman’s (2000: 7) observation that the organization of health care is actually not very systematic. The complex historical emergence of policies of health care often defies the order implied by the notion of a *system*. As a result, the health system perspective may be looking for order where there is little. Instead, the institutional context of governing health care is highly differentiated, to the extent that such contexts are often somewhat specific to individual countries. Importantly, there is also specificity in relation to subsectors of health care and policy. This is particularly apparent in relation to those subsectors that have traditionally been at the margins of the “health system”, but that are increasingly central to health policy. Focusing on home and community

based health care as an example, the present section assesses the use of the concept of the health care state for capturing the institutions central to non-medical health care and for explaining such “new” health policies across countries.

Debates about ageing populations and their implications for health care costs and services have put home and community based health care on the health policy agenda. At international level it is indicative, for example, that long-term care for elderly people was one of the components of the recent OECD Health Project (OECD 2005). More specifically, the project reviewed policy developments across countries as well as the organization of long-term care in terms of financing, expenditure and care recipients. The OECD Health Project echoes developments across the countries included in our study in which there are many examples of major policy initiatives relating to home and community based health care (Glenn Dinning 1998, Jacobzone 1999, Jenson and Jacobzone 2000). Such policies often aim at the expansion of existing services to support informal care givers by integrating home and community based health care into the regular organization of health care. The expansion of the social insurance in Germany and Japan is an indicative example. Starting in the late 1980s, the government in Japan introduced a publicly funded scheme, the so-called Gold Plan, to expand care services for older people. The scheme was extended in the late 1990s and in effect became a separate branch of the social insurance, funded by a mixture of social insurance premiums and taxes. Considering the traditional strength of family responsibility for care of the elderly, this is a significant policy development (Furuse 1996).

This emergence of non-medical based health care raises the question of how policies related to home and community based health care fit into the concept of the health care state. The concept focuses on institutions and policies related to medical care. This is apparent in Moran’s (1999, 2000) definition of the governance of provision, which is concerned with the institutions related to the regulation of doctors (as the key providers of health care) and hospitals (as the key settings for the provision of medical care). In contrast, home and community based health care is located on two sets of interfaces: between formal and informal care, and between health and social care. In relation to the first aspect, it is indicative that few older people receive home nursing care and even when they do it only accounts for a small share of their care. Instead, home care predominantly means unpaid (informal) care by women and often also includes social care, such as help with domestic tasks. This reflects not only the inadequacy of existing home nursing services, but also the fact many of the health care needs of older people are often not principally medically related.

This puts a number of limitations on using the concept of the health care state for capturing the institutions governing home and community based health care and for explaining corresponding health policies. The institutions related to the governance of consumption are relevant to the extent that home and community based health care is part of the organization of medical health care. Traditionally, parts of home and community based health care have by default been funded by the same scheme as medical health care. At the same time, parallel funding schemes relating to social care have existed. In Germany, for example, before the introduction of the long-term care insurance, funding for home and community based health care came from both the health insurance and locally funded social assistance schemes. In many cases this organizational division continues and also applies to the newly established schemes.

This is also the case in Japan whereas in Australia, New Zealand, the Netherlands and Sweden funding of home and community based health care is integrated. Further, there tend to be formal or de facto limits to the scope of collective consumption. Instead private consumption in the form of private payments for formal services and informal care paid by lost income are important complementary aspects of consumption. The last aspect even applies to countries like Sweden, where the level of publicly funded services is relatively high. A study in the mid-1980s for example found that informal care accounted for 64 per cent of the total care time (OECD 1996: 166). There are even more extensive limitations in relation to applying the definitions of the governance of provision and production. Medical technology is of little importance for home and community based home care. The same applies to hospitals as settings of care provision and doctors as providers of care. Instead, care workers such as community nurses, care assistants and social workers together with informal carers, all working in home and community based settings, are central to the provision of this type of health care. Taken together this suggests that shared values and beliefs (and corresponding practices) are important for understanding non-medical health policies. Freeman and Ruskin (1999) refer to this as “cultural embeddedness” and thereby point to diversity beyond the macro level and, notably, a type of diversity that is shaped by organizational bases that are ethnic, gendered, local and personal, rather than national and public.

Where does this leave capturing institutional arrangements as they apply to home and community based health care and explaining corresponding non-medical health policies across our countries? The concept of the health care state is of some use, notably to the extent to which home and community based health care is part of the organization of medical health care. However, beyond that, using the concept of the health care state has clear limits, as some institutions do not have the same importance, whereas others not included in the definition are central for understanding non-medical health policies. Considering the extent of such limitations adding new attributes to the concept of the health care state is not necessarily an option. Instead, different aspects of institutional context need to be taken into consideration. This requires two things: first, redefining the institutions related to the governing of consumption and provision so as to reflect the specific characteristics of home and community based health care (and, where applicable, across the health and social care divide); and second, to include gender as a set of social and cultural institutions. In this respect Pfau-Effinger’s (2004) concept of “gender arrangements” is particularly useful. The concept consists of two components. Gender order describes existing structures of gender relations not least as reflected in gendered divisions of labor. Gender culture for its part refers to deeply embedded beliefs and ideas about the relations between the generations in the family and the obligations associated with such relations.

Against this background one way forward would be to combine the different yet complementary aspects of institutional context discussed above as part of an “organizing framework”. In the context of their study of multilevel governance Bache and Flinders (2004: 94) define this as an analytical framework that provides a map of how things relate and that leads to a set of research questions. The value of such an approach is that it helps to explore complex issues and identifies interesting areas for further research.

### **Putting Typologies of Health Systems in Perspective**

The present paper set out to assess the use of typologies of health systems in the comparative analysis of health policy. Here, the central question is to what extent typologies help to capture institutions central to health care and thereby contribute to explaining health policies across different countries.

The review of the literature demonstrates that the early typology of health systems developed by the OECD has provided a springboard for many comparative analyses of health policies that examine how sector-specific institutional contexts shape health policies. The definition of the health systems, though, has changed in the course of this process with new attributes being added, thus reaffirming the complexity of the institutional context of health care. Moran's concept of the health care state systematically engages with both institutional embeddedness and typology building, and as such provides a suitable basis for assessing the use of typologies of health systems. Based on a recent study that included a diverse range of countries and areas of health policies the analysis suggests three things.

First, modeled upon paradigmatic cases the concept of the health care state holds as an ideal type and as a heuristic device to help capture theoretically relevant aspects of the institutional context of health policy. Second, despite this contribution, as with all typologies the concept of the health care state is historically and culturally contingent. Not surprisingly, in our analysis only few countries fully match the ideal types and some even emerge as hybrids. At the same time, it is also clear that cross-country comparisons cannot do without a common framework. As Marmor and Okma (2003: 749) observe, in comparative health policy analyses there is a need for a framework that is applicable across different countries and that helps to describe and understand the anatomy and the physiology of the organization of health care. So what are the options? If the institutional context of health care is more diverse and complex than the concept of the health care state, it needs to be treated first and foremost as a starting point for more detailed analyses of the country-specific institutions of health care. Such a complementary analysis has to take account of the country-specific trajectories as well as the broader institutional contexts of health care. It is, therefore, through analyzing the relative degree an individual country matches the respective ideal type that a more detailed understanding of the country-specific institutions emerges.

Third, complementing the concept of the health care state with more specific analyses of the institutional context is particularly appropriate in the case of medical health policies, whereas this is not necessarily possible in relation to the increasingly important non-medical health policies. Here, it is more appropriate to work with a looser organizing framework that brings together the very different and diverse aspects of institutional contexts of non-medical health policies, such as those related to home and community based health care. However, no matter how inclusive, such a looser framework has its own limitations. As Mabbett and Bolderson (1999) argue, the deconstruction of single broad-brush categorizations (and typologies) makes all encompassing cross-country comparisons and contrasts more difficult. In relation to non-medical health policies, however, limitations of this kind may be outweighed by the advantage of being able to include a new set of policies in the comparative analysis of health policy. Although this more complex approach might lack the

comfort that comes with the orderliness of typologies it more accurately reflects the real world of health policy.

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