

Comparative Health Policies: A World of Difference

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EXPLANATORY MODEL

The political elements in health care policy derive from an observation that the health sector has historically been a "private government". With few exceptions (confined to European countries in the last several decades), the provision of medical services has been a private matter between supplier and consumer, between doctor and patient. Power¹ over "well-being" or personal health status was exercised by an active agent with specialized knowledge over a passive recipient without such knowledge or expertise. The concept of self-care obviously lies outside this political framework, although one might argue that the very act of removing oneself from a dyadic relationship is itself a political act.

The novel change in recent history has been the willingness, the readiness of governments to enter the domain of hitherto private relationships in order to regulate behaviour of both providers and patients. The political mandate of proactive governments (howsoever they are selected) is exercised through their administrative machinery. Government agencies take the form of bureaucracies comprised of specialized roles based on the division of labour, which in turn are hierarchically arranged and accountable both within the organization and, sometimes, externally to political leaders.

Consequently, there are four broad categories of relevant actors in the health sector of contemporary nation-states. These categories are (1) the political leaders (or politicians) who represent (whether badly or adequately) the views and preferences of the 'people'; (2) the administrators (or bureaucrats) who serve (whether badly or adequately) the political leadership; (3) the professionals who, based on

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¹Power is defined as the ability to influence patterns of behaviour, to make others do what they would rather not do (or not do what they would rather do). A power-relationship is inherently asymmetrical; if both parties to the relationship have equal power (on the same dimension), neither can make the other change behaviour patterns.

their expertise and training, provide the health care (usually medical services *per se*); and (4) the patients or clients who receive and/or consume these health services. Since all flesh is mortal and subject to disability, decay and ultimately death, this fourth category subsumes all previous three categories at some time or another in the lifecycle. Hence the fourth category is also equivalent to the public who comprise the whole population. Automatic constraints or liabilities of attentiveness (distraction) and size (disorganization) relegate this fourth category to a residual in the political model of the health sector.

Given that all humans have health needs at one time or another in their lives, each of these broad categories of actors has specific roles (that is, expectations as well as patterns of behaviour) attached to it. The politicians set the stage by choosing among alternatives (if any) in order to establish the goals for health care; they thereby legitimate the system of health services. Politicians also raise and allocate resources (financial, material, human) to the health sector. Politicians can set the stage by inaction as well as action, since the former either reinforces the *status quo* or by default delegates the decision making to other actors in the system. By their actions in seeking help, members of the public can influence the patterns of health services; they can also raise some resources independently of the government (e.g., voluntary labour or direct payment). Sometimes, however, the government and the public are at loggerheads in that the former tries to change the latter's behaviour. My guiding presumptions are that (a) most of the public acquiesce to government decisions although they do not necessarily support them actively; and (b) if the political leaders in government exceed the limits set by an acquiescent people; then those leaders will be replaced.

The roles of the bureaucrats are somewhat simpler, although they, too, can by default resemble those of the politicians. That is, while a bureaucracy is expected to carry out the orders of the government, the bureaucrats also can and often do pursue political roles. The study of implementation in the policy process has clearly suggested that even more political activity occurs within the bureaucracy and among administrators in relation to their peers and outside pressures (e.g., interest groups) than occurs in the phase of policy formulation and legislative legitimation. Aspirations among bureaucrats and administrators to obtain recognition as professionals further complicate their roles in the health system.

The professionals who provide medical services have critical roles in the whole health system. As long as health care remains invasive, based on specialized knowledge, and the product of dyadic relationships, medical professionals will continue to influence (if not, indeed, dominate) the health sector. Some providers of health care are 'less professional' in the sense that they have less training and greater interchangeability; but all providers aspire to, if not already recognized as holding, professional status; and they furnish the point of first contact for patients in the

health system. That is to say, whether curing or helping or even just caring, the health provider sits at the centre of the system. Try as they will, politician and bureaucrat cannot replace the functions of the health professionals; and this centrality of function is a source of power over all other actors. To be sure, various sanctions, penalties, incentives and rewards exist which can be used to channel and direct the behaviour of health providers. But – to belabour the obvious – one cannot provide personal health services without providers. Only the patients themselves have the power to by-pass the professionals by taking care of themselves; and such self-care, can only supplement the direct provision of health services. One cannot perform an appendectomy on oneself – at least within the confines of any commonly acknowledged parameters of human behaviour. Health professionals remain crucial; as Fuchs puts it in a gamesman's metaphor, the physician is captain of the team.

Finally, the residual roles of the public are germane to the health system. General habits and attitudes toward health care do shape health behaviour – though sometimes to the lament of professional providers, bureaucrats, and politicians alike. Hence, health care patterns must be understood and must be appreciated in cultural context, whether one looks at single case studies or compares them. Given constraints of time and topic, of course, this rich range of nuanced health behaviour by the public cannot be addressed here. But the caveat must be made explicit that, as with all model-testing and theorizing, the previous three categories and their roles are limited, partial players in the system.

Initially, in order to explain outcomes in health policy, the primacy of political leaders in directing (or redirecting) health policy was assumed. This assumption was predicated on the legitimate control that democratically elected governments wield over their citizens, and on the likelihood that the closer decision making over health care came to the public, the more input the lay sector would wield over the behaviour and performance of health professionals. In short, government works best when the political directives are clear and immediate and when they emanate from decentralized sources. On matters as important as life and death and well-being, health care had better not be left to the professionals. Also, in a Millsian sense, participation is in itself a good thing and can direct resources and efforts toward ends that are directly relevant to the people. This was, unabashedly, a utilitarian argument of the greatest good for the greatest number, as self-determinedly as possible.

Over time in field experiences, however, evidence emerged to counter and in a sense reverse these initial assumptions. Without explicitly detailing all the factors, the public was evidently passive, disorganized and/or inattentive except in a very individualized, atomistic sense. (That is, one worries about one's own aches and pains or those of near kin, but rapidly loses interest in the ills of others.)

Another assumption that fell by the empirical wayside was the public-enhanc-

ing nature of decentralization of decision making over health care. Participant-observation as well as indepth interviews indicated that the more decentralized the decision-making system, the more health professionals wield power over their lay colleagues. Status and expertise are professional resources which the lay participant finds hard to counter — even given the obvious argument that only the wearer knows where the shoe pinches.

The emergent model, then, is one where health professionals hold pride of place in decision making. Political leaders still retain the function of legitimating decisions that are made, and indeed raising the resources whose allocations are then largely determined by health professionals. Professionals supply the advice and information on which politicians to a large extent base their decisions. Not surprisingly, the information and advice rarely run counter to the interests of the professionals. The primary source of dispute is within the community of 'helping professionals' as to how the resources are to be divided among specialities. Frequently political leaders delegate authority for these decisions to committees which rely on advice from medical professionals.

In the emergent revised model, the roles of the public and the politicians become less central. One suspects that the issue of 'participation' may leave behind some residual rituals and perhaps provide some additional market information about health care preferences on a regular basis. But power-wielding in an overt sense by the political sectors (whether mass or elite) will be routinized into formulae. At the same time, however, the influence and indeed power of the bureaucrats will rise. The reasons for the augmented power of bureaucrats are at least two-fold.

First, as government expands by taking on new responsibilities and functions, and passes the laws which legitimate such activities, the state bureaucracy is charged with implementing these mandates. The actual applications of these activities are via the rules and regulations that bureaucrats devise. The amount of discretion left to these bureaucrats grows in direct proportion to the inattentiveness of the political sectors (which are distracted by other issues, by crisis management, and the general attention cycle). Hence the relative size of the bureaucracy to the whole population grows.

Second, organizations which provide health services are themselves becoming bureaucratized. As size increases along with an elaborated division of labour and function, the clinics and hospitals and other health service agencies (including those for planning) become internally differentiated. Despite the power of health professionals, derived from their expertise and centrality, these same providers are countered by bureaucrats who aspire to professional status. The administrative bureaucrat has become as ubiquitous as the medical professional in the health system, and supplies the most pervasive immediate challenge to the latter's power and influence.

In its clearest form, then, the explanatory model emphasizes decentralization

of authority (both political and administrative) and professional penetration of administrative and decision structures as the two primary independent variables determining resource allocation in the health sector. The model assumes a neo-institutional perspective in that the structured patterns of health care practices as well as the agencies of government channel and constrain behavioural dynamics among the categories of actors. Changes (or the lack of them) in allocations over a specific period can thus be noticed and measured against initial institutional conditions. Between the independent variables (decentralization and professional penetration) and the dependent variable (resource allocation) lie such process-channeling variables as the nature and extent of governmental regulation of health care services, and the prevailing political culture.

SUBSTANTIVE FINDINGS

During the past fifteen years, I have conducted several different research projects on the politics of the health sector. The initial projects – not reported here – dealt with the impacts of intergovernmental relations on health care in the United States and with the political context of comparative health planning. The former examined the effects (direct, indirect, and reciprocal) of changes in child health policies at federal and state levels over forty years; and the latter examined problems of effectively implementing health planning programmes in Europe and the United States. A second undertaking investigated who governs the health sector in Western industrialized states. And a third project is examining how health resources are allocated in Third World countries. I will report briefly on the second and third of these studies, then discuss methodological issues in the conduct of comparative health policy research.

The question of “who governs” in the health sector has been pursued through a “most similar design” method by examining health politics in Britain, Sweden, and the United States. These societies provide appropriate systems for comparison because they are very much alike in shared culture, health status, democratic institutions, and industrial economy. Yet along the dimension of how authority over health services is distributed, these nation-states differ sharply. Britain is highly centralized and its National Health Service is directly financed by the central government from general tax revenues. Sweden, although a unitary state, has granted important financial and organizational roles to regional levels. In contrast, although recently marked by a dramatic experiment in capping federal payments for Medicare costs, organizational and financial arrangements for health care in the United States remain fragmented and pluralistic. Therefore, these three nation-states can be arrayed along a continuum of policies for allocating decision-making authority over health care, as Table 1 indicates:

Furthermore, Sweden, Britain and the United States differ in the degree to

Table 1
Comparative Health Expenditures by Source of Funding
(by Approximate Percentage of National Total)

	Britain	Sweden	United States
Total Public (Central Government)			
1950	85 (79)	78 (26)	28 (13)
1970	85 (80)	85 (31)	38 (25)
1985	93 (87)	92 (27)	43 (28)
Total Private (Patient Derived)			
1950	15 (15)	22 (16)	72 (57)
1970	15 (15)	15 (15)	62 (35)
1985	7 (6)	8 (8)	57 (27)

which various constituencies are represented on decision making and/or advisory bodies and at what levels as well as differ in methods of selecting representatives at various levels of activity and function. Some modes of selection emphasize a descriptive representation of the surrounding community. Others stress the substantive representation of selected "natural" or "deserving" interests, while other interests are ignored or excluded. And still other selection modes experiment with novel forms of "mediated" participation. The field studies investigated what difference it makes for planning, financing and operating health services as to who is represented and who participates in the decision making process; and what difference different mixes of participants make at various levels of decision making.

In order to research the question of "who governs", three successive case-studies were conducted in subnational health regions which were also selected through the "most similar design" method. Each multi-county region had similar geographic and population size; broad historical continuity; similar levels of morbidity and mortality; and a single major medical school plus teaching hospital. The regions differed primarily in terms of relative autonomy or dependency along the dimension of decentralization discussed above. Fieldwork focussed on participants at the regional level, but inquiries and interviews necessarily extended up to central authority and down to local units.

Current goals of the health systems in Britain, Sweden and the United States are very similar, as indeed they are (at least in terms of lip-service) throughout the world. These goals include the expeditious provision at reasonable cost of good

quality medical care for every citizen when needed. Against such an ideational consensus, however, different organizational and financial arrangements have been developed throughout the world for approximating these ends. And such alternative arrangements generate political questions that underpin the delivery of health (specifically medical) services. The basic questions are broad but simple: who decides and enforces health policy? Who makes binding decisions in the health sector, especially during provision of medical services? Once decision makers in health policy and operations are identified, one enquires why they have such power? What are the sources of their ability to make binding decisions? Thirdly, do perceptions about power vary among those who plan, finance, and operate health services? If so, how and why? Finally, is there a preferred state-of-affairs which at present is not being achieved? If so, what alternative arrangements should be made and how might they be attained?

The problem of how health resources are allocated in Third World states has been examined through a "most different design" method at two distinct levels. First, the countries of South Asia, East Asia, and subsaharan Africa have distinctly different political systems even though they all broadly share similar resource constraints. And second, the experiences of India, Sri Lanka, Pakistan, China, Kenya, Senegal, Tanzania and Zaire over the past decade are contrasted with the advanced Western systems. Although this second "most different design" method was not initially intentional, when retrospectively applied it illuminated patterns of resource allocation and highlighted problems of comparative research even within the "most similar design" method.

As background to research on health resource allocations in the Third World, a campaign launched in 1978 by the World Health Organization and its 134 member governments seeks to achieve "Health for All by the Year 2000". The vehicle for attaining this worldwide goal is primary health care provided by community health workers, and the campaign seeks to increase the political commitment of member countries toward meeting the health needs of the rural and urban poor. Primary health care is not merely front-line or first-contact care, but rather includes a package of principles which distinguish it from the narrower, more medically-exacting understanding of primary health care. These principles are: equitable distribution, community involvement, focus on prevention, appropriate technology, and the involvement of other sectors of the economy. Obviously the 'primary health care approach' has a thoroughly political theme in redesigning decision making.

The magnitude of this undertaking to meet health care needs and to redesign decision making in the health sector is evident from Table 2. In low-income countries life expectancy at birth averages only 51 years while mortality rates are ten to twenty times higher than in developed countries for infants and for children. Yet for those who reach the age of five, life expectancy is only eight or nine years less than the average elsewhere.

Table 2
Health Related Indicators (1979) by Income-grouping

	Low-income Countries (N = 34)	Middle-income Countries <\$370< (N = 60)	Industrialized Countries (N = 18)
Per Capita GNP	\$240	\$1420	\$9440
Crude Birth Rate per 1000 Population	42	34	15
Crude Death Rate per 1000 Population	16	10	10
Life Expectancy at Birth (in Years)	51	61	74
Infant Mortality Rate per 1000 Live Births	49-to-237	12-to-157	13
Child Mortality Rate per 1000 Children Aged 1-4 Years Old	18	10	1

National statistics in the aggregate, of course, disguise wide disparities between the conditions of the rural and urban poor, on the one hand, and the conditions of the more affluent city dwellers on the other. The latter not only have higher incomes but tend to be better educated and have better access to health services. Consequently, their health status closely resembles the general average profile of industrialized countries. As economic development proceeds in Third World countries, the more prosperous regions of a country gain advantages not only of greater individual and collective wealth but also of greater political leverage. National policies therefore give priority to their needs so that the limited health resources available are concentrated in urban areas, and the gap between urban and rural populations widens.

Furthermore, in the quest for economic development, protective measures for occupational health and safety as well as for the environment tend to lag behind. Such measures are often initially expensive and only enforceable by firm legislation followed by competent inspection procedures with meaningful sanctions. Rapid development thus produces new personal health problems as well as environmental

pollution. Most probably urban health problems will increasingly dominate health patterns in the developing world, even though at present its needs are predominantly rural. It is estimated that by the year 2000, the urban population in developing countries will average 43 percent of the total Third World, so the primary health care approach for rural health problems will need to be modified to address the emerging problems of the urban setting as well.

The overwhelming problem of developing countries is that they must meet the range of urban and rural health needs with just a fraction of the financial and human resources available in the developed world. Expensive new technologies that are (disputably) appropriate for the developed North will not serve the purposes of the South. Yet the latter's health systems remain dominated by physicians and medical associations whose training, aspirations, and psychological (not to mention financial) rewards are drawn from the counterparts in the North. At times the pervasiveness of communications in this global village leads to counterproductive reference systems and pernicious results.

Consequently, health services in the Third World are maldistributed in terms of both need and appropriate technology. Access to health services is uneven, and large segments of the rural population are not reached. Health facilities and skilled personnel are concentrated in urban areas, where their services are further biased toward the middle- and upper-income city dwellers. Both the urban and rural poor are neglected and, unless there is sustained political commitment to apply resources where the need is greatest, little progress can be expected.

Good health is, of course, a product of many factors, which include adequate nutrition, a supportive unpolluted environment, quality housing, education to practice self-care, access to personal medical services, and an organizational system to deliver these factors when and where needed. But in the shorthand of common usage, "the politics of health are the politics of medicine" because medical care providers centrally influence all developments in health care. The medical profession is of special importance because clinical decisions by its individual members have great impact on the demand for health facilities and the consumption of resources for diagnosis and treatment. In particular, the model of medical care preferred by these providers is very important for determining outputs (from both the private and public sectors of medicine) and ultimately for influencing outcomes in health.

If a medical model emphasizes high quality, capital-intensive, sophisticated technology which is oriented toward curative medicine, the results will be quite different from a medical model which emphasizes adequate quality, labor-intensive, appropriate technology oriented toward preventive medicine. Usually the standard rhetoric by government officials, politicians, and medical spokes-persons advocates a health care system which is rural and preventive in its biases, and based on community-level workers using simple techniques. Yet the end results in outputs (in health

services), which determine ultimate outcomes (in health status), are to the contrary. Empirical patterns of distribution of medical manpower are skewed toward the urban areas; training in medical schools is oriented toward high-quality, highly specialized medical care; local health centres are under-staffed, under-resourced, and over-worked.

A political analysis of the relationship between health and development in South Asia alone begins to explain this persistent paradox between rhetoric and reality. First, at a macro-level of policy-making, the relevant governments have other goals that take precedence over health services. If we look past the rhetorical claims of politicians and instead examine actual investment patterns, we find much greater emphases on such items as defense, industrial development, and agriculture. Indeed the primary imperative for development in South Asian countries has been argued (Nayar 1972) to be the quest for strong defense capability rather than the quest for social welfare.

Second, there are plausible political explanations why the governments in South Asia – with the exception of Sri Lanka – have neglected basic investments in health services. For one thing, the locus of authority over health care is diffuse; health is constitutionally a state subject, not a central subject, and even at state level it is administratively malcoordinated. Also, governments defer to the role of the ‘professional expert’ in the health care system. Although spokesmen for private medical interests like the Pakistan, Sri Lankan, or Indian Medical Associations are not as powerful as their counterparts in Western countries, publicly financed medical schools generate much of the problem. Governments have basically written blank checks (within limits) to medical schools, which in turn promote medical training based on a Western-derived curriculum. Indeed, while medical colleges in South Asia have expanded very rapidly and educated large numbers of physicians, these physicians are often alienated and embittered. They concentrate in urban areas (where, ironically, a literal surplus of MDs can be found); or they migrate to greener pastures, which leads to the problem of Foreign Medical Graduates elsewhere.

Third, South Asian countries – again with the exception of Sri Lanka – have neglected their poor, rural majorities in the early stage of national development efforts. Their primary development strategy has been to emphasize investments in large-scale industrial and agro-industrial projects rather than in social services. However, some third-world countries have attained significant social goals in spite of poverty. In particular, birth rates in Taiwan, Korea, and Sri Lanka started to decline sharply as the condition of the poor majority improved well before the introduction of effective national family planning programmes. Health and education statistics in these three countries are far more favourable than in other poor countries – and these accomplishments are due to effective, low-cost, mass delivery systems for

education and health care. In per capita terms alone, Sri Lanka spends nearly three times as much on government expenditures for social services as do either India or Pakistan.

Furthermore, as a fourth explanation, it might be added that South Asian governments were excused from hard thinking about investment strategies and health services because, on many occasions, public attention was diverted from the need for a comprehensive system of primary, secondary, and tertiary units for delivering health services. Those diversions of attention have occurred because governments set aside relatively huge sums of money – or obtained the money from outside sources – in order to run mass campaigns against specific diseases such as malaria, smallpox, leprosy, filaria, and the like. While the intrinsic value of such campaigns *per se* cannot be gainsaid, some argue that such campaigns have hindered the development of a permanent, easily accessible health services system in the rural areas of South Asia where most people live.

Money alone, of course, cannot ensure good health in the developing world. But the extreme poverty of most of the population in the South is the primary constraint on improving health status. Within the already low per capita GNP which yields little tax revenue, health services must compete with other pressing developmental needs. Likewise the analysis of health expenditures in developing countries is hampered by an abysmal lack of financial information on programmes operated by different levels of government as well as by the private sector. In some extreme cases, like Bangladesh and Zaire, annual public health expenditures are less than one dollar per capita. Since recurrent expenditures are concentrated in urban areas where hospitals and medical personnel are located, it may be inferred that resources to operate health services for the rural population are very limited indeed. Furthermore, given organizational problems as well as pervasive poverty, the capacity of local government to generate tax revenues is severely limited. This situation would be unbearable were it not for the popular self-help movements (such as Sarvodaya in Sri Lanka and India) where community participation mobilizes voluntary labour (shramdan) and materials for constructing health facilities plus some in-kind support for community health workers.

Even such voluntary activities are, however, inadequate to meet pressing health needs. As elsewhere, out-of-pocket payments plus access to nonwestern health systems helps to alleviate (although not solve) the problem. Private spending on health care in many developing countries is estimated to be three or four times greater than government expenditures on health, so the share of GNP devoted to health services logically approximates 4-5 percent. But the efficacy of this private spending (other than for psychological support) is questionable, and research into alternative systems of indigenous health practices is needed.

There are a number of obvious divergencies between my studies of the develop-

ed North and underdeveloped South but, considering health policies and politics in all the countries examined, one finding repeatedly emerged: no matter what the organizational arrangements or modes of financing or economic background, professionals dominate decision making in the health sector. Not that they ever admit as much. Like everyone else, physicians insist they have no power and are the victims of circumstances and inertia. At times, one ponders whether anyone is in charge at all. But the protestations of medical professionals are less convincing than those of other players; their exaggerations of powerlessness are less pronounced. Many other participants admit that they defer to physicians in matters of judgment over health policies — including trade-offs among financially expensive items; but physicians rarely acknowledge deference to anyone else, including other professionals. In India, to take the major Third World example, physicians have dominated every major health commission since independence. The regulations in the rule-books and the social codes that govern behaviour were devised or at least greatly influenced by medical personnel; they have already provided the precedents on which subsequent administrators make their binding decisions. Only under conditions of economic scarcity in otherwise well-organized countries, such as in Britain, are the decision-making powers of medical professionals weakened; but even there they are not eliminated.

There remains, then, a “private” government of medicine even in the public sector, comprised of physicians and administrators, who rule those who pay (insurers, government agencies, and ultimately the citizenry). The medical professionals are dominant, although periodically they must repel challenges from the administrative “professionals” while the public continues to pay. Efforts by the public sector — whether politicians, planners, or nonmedical interest groups — are spasmodic, unsustained, and generally unsuccessful in shaping the closed deliberations of this private government. The health sector throughout the world remains governed from within, not from without; and expectations of rapid, frequent public leverage over health services delivery systems are misplaced.

METHODOLOGICAL ISSUES

Given this broad and judgmental conclusion from several research projects into the politics of health policy, a series of methodological issues come to the fore. How valid, how replicable is this finding? Is it an artifact of one’s method of enquiry? Does one find what one (perhaps subconsciously) looks for, despite the use of both most-similar and least-similar designs? All enquiries, but particularly comparative enquiries, are subject to problems of control and inference; to problems of operationalization and measurement; to problems of data within variable cultural contexts.

There is, of course, no particular rank order to this series of problems. But

the problems of control and inference are classic and cannot be wished away. No matter how well thought out one's research design may be, there are always exogenous variables that another can cite which could contaminate one's study and obviate one's conclusions. These variables may be ideational, in the sense of either an overriding, internalized ideology (e.g., "scientism" or the authority of expertise and knowledge) or just a common garden-variety sense of prevailing culture (e.g., "doctor knows best") in matters of health care. Alternatively, these exogenous variables may be physical in the sense of resource constraints; even given the pump-priming nature of Keynesian economics and/or the ability to borrow from future generations for today's expenditures, there are limits to how much money or other material resources are available. A vast, complicated agenda of other needs competes with allocations for health services (in either the narrow sense of medical care, or the broader sense of infrastructural investments in sanitation, water-supply, housing, education, whathaveyou).

One of the devices to manage, at least in part, these problems of control and inference is to employ discriminant function analysis. If one knows that a dependent variable (say, the proportion of GNP devoted to health care; or, the allocation of health monies to inpatient care) obtains different values in relatively similar contexts during the same period of time, then one traces back the sequence of antecedent conditions and intervening variables in order to account for these variations. Hence the fact that for 30 years Sri Lanka has spent more than three times as much as India on per capita education and health is not due to natural resource constraints; both countries have had similar per capita incomes, although always about a 5:4 ratio to Sri Lanka's advantage. Rather one looks to (a) political history, since Sri Lanka got the universal suffrage in 1931 — sixteen years before India and only two years after the United Kingdom itself — that provided the basis for competitive party politics over domestic policy issues; (b) structure of the economy, since Sri Lanka's plantation sector provided more easily monitored resources for extracting taxes to allocate elsewhere; (c) compact geographic size which makes medical communications — e.g., clinic placements and referral networks — easier in rural areas; and (d) competing claims on resources, since India maintains a relatively impressive defense establishment that annually consumes 20–22 percent of central government revenues — or about four percent of its GNP — whereas Sri Lanka is virtually demilitarized. Nevertheless, in both countries, the allocation of health monies (at the 3:1 ratio, respectively) have gone to 'allopathic' (i.e., western) medical facilities rather than to the indigenous systems of medicine (e.g., Ayurvedic, Siddhi, Unani Tibbi) because the government commissions as well as health departments were staffed almost exclusively by western-trained physicians. Even after independence, both countries established and/or expanded medical schools that reproduced large numbers of allopathic doctors — many of whom, ironically, migrated to the North to

work as Foreign Medical Graduates in American and European health systems. But that is another story to illustrate the international context within which so-called domestic health policies and programmes operate.

A similar set of arguments can be adduced as to why Sweden spends almost twice as much of its GNP on health as does Britain – and even more on a per capita basis. But the methodological issue is the same; one looks for antecedent conditions to account for the known variations and then discovers that within the respective pools of allocated health monies, the medical professionals determine the pattern of their utilization. In each case, however, one can sense (at least psychologically if not quantitatively) that the explanatory agenda is incomplete and almost infinitely expandable.

A second, and more familiar, set of methodological problems deals with operationalization and measurement. In terms of the concept of health care itself, its nature, content and context are constantly changing. There are disputes about the definition of health *per se*, ranging from the all-inclusive perfectionist ideal of the World Health Organization, to various mechanistic, environmental, and socio-culturally determinative conceptions. As time passes, the content of health care also shifts from treatments for and precautions against infectious diseases to coping with the occupational diseases of industrial and postindustrial development and the degenerative diseases of affluence and old age. The North – both its First and Second Worlds of development – has largely eliminated the earlier conceptualization of health care as infectious disease and now struggles with the successor stages. But due to both geographical location and economic system, the South has yet to contain, much less vanquish the astonishing range of pernicious tropical diseases (malaria, filaria, schistosomiasis, onchocerciasis, trypanosomiasis, leprosy, etc.) while simultaneously trying to anticipate the emergent health problems of accelerated economic development. In a very direct sense, comparing health policies between North and South is like the proverbial apples and bananas; the units for comparison are quite dissimilar. Yet when the issues are (a) political control and (b) proportionate resource allocations, a strong case can be made for the least-similar-design. If a similar pattern appears in these relational concepts across such diverse contexts, then one feels justified in claiming some reasonable explanatory power for the independent variable(s). Professional penetration has occurred in all these contexts; intra-sector allocations are made according to the preferences of medical professionals.

At the same time, one begins to question the other independent variable (the decentralization of authority) for its impact on proportions of GNP allocated to health care. Given the most-similar-design study, it appears that unitary states (like Britain and France) spend less on health services because they can “cap” and control finances, whereas decentralized or federal systems (like Sweden, on the one hand, and the United States and Germany on the other) spend more because they hemor-

rhage through a variety of financial conduits. But when applying the most-similar-design to South Asia, one finds that the unitary state of Sri Lanka spends much more on health care than the federal state of India, where responsibility for health is consigned constitutionally to the component states as well as to a reasonably lively private sector. Each of these most-similar-design projects would lead to a conclusion directly contradicting the other. So the least-similar-design (even when applied *ex post facto*) makes one question the explanatory importance of government structures as a determinative independent variable.

Concepts *per se* are not, of course, meaningfully comparable for they are only conveyors (containers) of data or information. Rather, the indicators of the concepts must be functionally equivalent in order to compare one nation-state or system with another. So a central methodological problem concerns the measured data. Are they valid? Are they comparable? Are they reliable over time as well as at any given point in time?

The dimension of time in particular needs to be emphasized, for no causation can occur without its passage. In a strict sense, cross-sectional deployment and analysis of variance can only show association and correlation. One may impute causal relationships on the basis of common sense but epistemologically such causation is assumed, not demonstrated. Only a series of observations over two or more points of time can provide an adequate basis for causation. Of course, despite such scientific language as 'cause and effect', it is understood that comparative research seldom allows for anything approaching really scientific experimentation.

In countries with stable traditions of accounting and empiricism, data are arguably more reliable than in those where record-keeping has only recently commenced. Indeed, for many subsaharan African countries, one senses a great skepticism in the adequacy of even government statistics, much less other sources of data. The concepts are available; the categorical entries exist to be filled; but the validation of reported data is suspect. Even in statistics reported to and published by agencies of the United Nations, the 'trend-line' of growth in certain indicators is so smooth and perfect that it could only be derived by a careful, systematic annual multiplication of the (putative) base-line by some constant (and politically palatable) increment. At times, too, one finds more vaccinations reported for a specific disease than the number of denizens of a district would merit; and one concludes either that some people have received multiple vaccinations or that the reported data are fictitious. (A few repetitions of such questionable data rapidly erode one's confidence in all government documents and data of a particular country.)

Fortunately the tradition of 19th century British empiricism has not only been shared by its Anglo-American successors in the North but also has penetrated its erstwhile Afro-Asian colonies in the South. On a sliding scale of inter-subjective validity, South Asian as well as European data can be trusted. Nonetheless, previous collabora-

tive research efforts in both North America and Western Europe have demonstrated pitfalls and problems with data under the 'best' of conditions. For example, the categories for recording public health data and expenditures are periodically re-defined, expanded or subdivided. Except for overall aggregates, it is very difficult to establish unambiguous trend lines. This difficulty is not surprising, of course, since knowledge about health care (not to mention its shifting conceptualization mentioned above) is constantly changing.

More pessimistically, this problem of shifting data-base can be partly traced to efforts by bureaucrats, politicians, and even professionals to evade accountability. That is to say, just as reorganization of an administrative agency can temporarily distract and confuse participants about who is responsible for what functions until a new routine settles in, so also the reorganization and reconceptualization of categories for data collection makes it difficult if not impossible to trace trends accurately and assign responsibility (particularly blame, but also conceivably credit) for the developments or changes. Since few actors are intentionally self-liquidating, a little persiflage can help protect one's security. Whether one is a politician, bureaucrat, or professional, one's first aim is to survive.

Empirical data come through several media which raise additional methodological issues. In comparative health research, types of data can be arrayed along a continuum in terms of how "hard, medium, or soft" they are. That is to say (to reiterate the old saw of the spending-services cliché), financial records and accounts of money (both revenue and expenditures) are palpably 'hard' because they can be metrically measured, cross-checked, audited, and quantitatively compared. Monies allocated to health services in national plans, government budgets, institutional accounts, and post-audit records do indeed give one a fairly secure (at least psychologically speaking) basis for intra-country comparisons. Inter-country and inter-sector comparisons are more questionable, for reasons of data-categorization mentioned above. But with appropriately acknowledged simplifying assumptions (like proportion of GNP; or conversion at international exchange-rates; or even functional-equivalency in terms of some third referent within a country), comparisons and inferences can be made.

The classic problem with expenditure data, however, is that they do not necessarily translate into health services *per se*; and they say even less about impacts on health status. Indeed, one might quibble that over-spending reduces health by increasing chances for iatrogenic disease. Hence, one needs to collect and compare some 'medium hard' sets of data — specifically morbidity rates and vital statistics. Like financial records, these body-counts are palpable in that they can be normalized against a base-population, and changes over time can be observed. The unit of analysis is also pragmatic in that one compares human beings and their life-chances. The problem of such medium-data, however, is that they are subject to greater variation

in initial reporting than even financial outlays. Vital statistics go unreported or misreported; and causes of illness or death can be wrongly – purposively or accidentally – assigned. Furthermore, unlike the more or less metric or interchangeable nature of money, body-counts may mean different things in different contexts. To take an extreme example, in a hierarchically organized society, some ‘bodies’ count for less than other ‘bodies’ – either in being noticed or worthy of being reported. Ethnic minorities in many pluralistic nation-states go under-reported; and in some religions, women and children receive less recognition than men. The problems of cross-cultural reporting and cross-national comparisons are thus exacerbated; and the eventual plethora of exceptions, variations and cultural nuances leaves a researcher somewhat skeptical of recorded evidence.

This problem becomes even worse when access to records is restricted, either for political reasons or because of simple incompetence. Fascinating as recent developments in the People’s Republic of China may be, it has not been possible to piece together a complete picture of its health policy, practice, and performance. The same is true of many African states; and even in rural South Asia, non-allopathic practices are difficult to track and record with any overall precision. At best, estimates and guesstimates form the basis for comparisons – or, more appropriately, educated culturally-sensitive ‘hunches’.

Finally, the ‘soft’ data required for comparative policy research are enough to cause scientific purists to throw up their hands in horror and utter despair. The reasons are similar to those afflicting attitudinal research ventures within a single culture or geographic entity. Interview data on what people believe, recall, predict, or assume are inevitably “squishy soft”. The same respondent may – for various reasons – be open or closed to an interviewer; he/she may share truthfully his/her experiences and observations, or may deliberately distort the facts; or perhaps a respondent may not understand the context and content of the question, thus providing unintentionally misleading information.

Furthermore, the status or importance of an interviewee can vary across cultures so that, for example, a bureaucrat in country-A is considered to be beneath contempt while in country-B he/she is considered to be above reproach. The necessary corrective to this inherent cross-cultural problem is to poll a panel of area-experts about how to weight different categories of respondents’ roles; simultaneously one should eschew any pretense of quantification other than simple direction and ordinal scale. In comparative research, one cannot assume equal weighting among survey respondents. At best one can compare respondents within specific role-positions, but always place their pooled responses within the larger social or institutional context.

In short, as one meditates on the variety of methodological issues and problems in comparative research, one begins to doubt the validity of any comparative research

findings. Speaking for myself and several projects that try to employ discriminant function analysis, the problems of control and inference are legion. Exogenous factors crop up everywhere; data are chronically suspect; even countries and regions selected through a most-similar-design method seem to become more and more unique as I delve into their respective histories and appreciate their nuanced developments. Certainly cross-national differences in the least-similar-design studies would seem to overwhelm the relatively simple model that I had initially posited.

But oddly enough – if one can credit this current stream-of-consciousness – I feel even more certain that health policies and politics are determined in large part by the views and actions of medical professionals. It is difficult to demonstrate this dominance with a single integer or some unambiguous formula but, in case after case, interview after interview, and country after country, the medical professionals took (and take) precedence over the other actors – whether politicians, bureaucrats, public groups, whathaveyou. Sometimes, of course, the medical profession “loses a battle” and seems to say, “see, we are no more powerful than anyone else”. But such loses are quickly turned to advantage, as with the 1965 passage of Medicare in the United States where doctors cried all the way to the bank; or in Sweden where salaried physicians suddenly found themselves with a lot more leisure time by earning the same income in fewer hours; or in South Asia, where the indigenous practitioners have been held at arm’s length from the public coffers or, at best, contained within a very narrow domain of publicly funded activity.

CROSS-POLICY COMPARISONS

Has this ‘finding’ about the health sector any parallels elsewhere? Is health a unique, unusual policy field – characterized at base-line by control over pain and suffering, over life and (sometimes deferable) death? Probably not. As one reads about other complex policies like energy-supply, defense, or even foreign affairs, one can observe how those who control “expertise” dominate in their respective arenas. These fields also have professionals who share what John Stuart Mill once called “received opinion” or the set of beliefs about preferred values, rules of evidence, and causal logic that collectively comprise a prevailing paradigm.

Such received opinion gives enormous advantage to the professionals because it is widely shared by the non-expert public as well. Through a long and fairly unconscious, almost unintentional process, laymen are socialized to accept the same paradigm and the notion that only an expert can and should wield its decision-making power. It is psychologically comforting to think that “doctor knows best” so one need only follow his/her advice to become well or avoid illness. Likewise, it is comforting to believe that the generals and other military personnel who defend a nation are experts in their craft and competent in its exercise. Ditto that diplomats know the niceties of promoting national interests while avoiding possible trouble; or

that engineers and scientists have the potential knowledge to resolve chronic energy crises. Woe betide one's psychological well-being if such trust in the efficacy of experts is replaced by anxiety and insecurity.

This is not, of course, a recommendation that all submit to the dominion of sectoral experts and specialists. Rather, it is just a cautionary recognition that often it is easier to "go along to get along" through deference than to challenge a prevailing paradigm. While humans are quite clearly social and thinking animals, they are also more often than not subject to "group think". And political activities in the health field are no exception.

Technological complexity, however, has its own pitfalls and problems. Not only is such expert knowledge as involved in nuclear weaponry or in brain surgery beyond the ken and ability of most people; it is also often beyond the grasp of many so-called experts. While one may believe that somewhere, somehow, someone understands the whole edifice of scientific knowledge in a given field, usually each of the professional actors has only a partial grasp of the whole. At such points, the technological complexity of a speciality eludes or overwhelms even those who putatively wield it. Out of control, the whole proceeds on its own inertia. No individual can be held directly and specifically accountable for the overall situation; only a series of partial, marginal adjustments can be made.

Even so, the professionals will defend their political turf, their influence over decision making, because of their knowledge base itself. Each has made considerable investments in time, resources and skills to obtain the basic expertise as well as adequate information on which to ground activities. Such investments represent "sunk capital costs" that cannot easily, if ever, be retrieved. Hence the expert professional has additional reasons to fend off any critics or, when at all possible, to block any proposals about sharing decision-making powers.

Finally, in each of these cross-policy comparisons, questions of ethics arise. In an era of rapidly expanding knowledge and interdependent relationships, who judges the judges, guards the guardians, or even defines the good? These are classical problems of normative political theory, which affect complex policy areas just as much as the Greek pursuit of the good life. These are no answers to these reiterative dilemmas; only a process of sifting and sorting options in which it is desirable that as many as possible take part in order to understand the problems and thereby cope with the inherent limitations of all proffered solutions.

What, then, can one conclude about the methodological issues raised in comparative studies of health policy? Are there any lessons to be learned from this discursive enquiry into comparative health policies on a North/South continuum? Probably the most salient political finding is the evident limitation of leverage over policy choices and implementation. There are, of course, some parameters within which policy choices can be made and effected. And there are some conditions

necessary and others sufficient in order to achieve even a modicum of change from the *status quo*. But the range of change is restricted and viable options narrow to a few. At best a pragmatic idealist can only confront reality with successive approximations of solutions and thereby adopt a mode of satisficing behaviour in order to get on with the job.

As for the "scientific" dimensions of comparative enquiries into national health policies and their concomitant politics, potential lessons depend on one's judgemental perspective on the virtues of epistemological purity as well as where one's objectives fall on a continuum from the elegantly theoretical to the mundanely pragmatic. Objectives may be defined as theoretical if, when, and to what extent the researcher aims at formulating, falsifying and/or modifying "hypotheses, that is, propositions stated in terms of universally defined variables . . ." Wiatr (1977, 356). But objectives may also simply try to establish "patterns of similarity and/or dissimilarity between countries, when the analysis does not intend to extend beyond description of these patterns. . . . Any study, even the most descriptive one, can bring very useful material for theory, and most theoretically oriented studies produce also descriptive analyses" (*ibid*: 357). Indeed, Wiatr later elaborates the argument that "existing dissimilarities, large as they may be, do not exclude the possibility of a general theory. General theory does not imply that all cases it refers to are identical or even similar; it only implies that they are comparable in the sense that they share certain common dimensions" (*ibid*: 367).

Hence cross-national research is not necessarily useless if it fails to test general hypotheses. Often the data alone are sufficient justification for a descriptive enterprise because the study of comparative health policy badly needs facts set in cultural context — particularly on countries where little, if any, research has to date been done. Of course, the data collected should be of a standardized character so that base-lines are laid for systematic comparisons as well as simple replications. Against such considerations, a partial but adequate foundation has now been laid for future in-depth and more rigorous studies of comparative health politics — all within the clear advance understanding that a certain amount of imprecision, not to say sloppiness, is inevitable. To revert to the egregious world of horticultural metaphor, neither the apples of the North nor the bananas of the South may be polished to perfection such that one's own image reflects back in their surfaces, but both remain types of fruit that are eminently palatable and in fact quite tasty.

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Comments on “Comparative Health Policies: A World of Difference”

The paper is based on a review of field research conducted by the author in South Asia, Africa, Europe and North America related to pattern of resource allocation in health care. Without going into author's findings, I would like to discuss a few points which are relevant to Pakistan. The author first proposes a model, describing the health sector as a “private government”. Thus, he claims that in most countries the provision of health services has been a private relationship between the supplier (health professionals) and the consumers (clients). He further postulates, that in the provision of health care by the state, there are four “actors” namely: (1) the political leaders; (2) the administrators; (3) the professionals or physicians; and (4) the patients or the clients.

I would tend to agree with the observation by the author, that the health sector serves as a private government, however only in the non-communist developing countries as well as in most of the western world, due to the leverage it enjoys among the people, in the latter, due to the strong lobby of Medical Associations mostly in conjunction with the multinational pharmaceutical companies. In the developing countries on the other hand, since the provision of health services serves as one of the most important political leverage, the government owned health sector becomes one of the most visible aspect of government's social policy. Multinational pharmaceutical companies, however, play a more dominant role through their control of both the public and the private sectors. In all this interplay the client or the patient only plays a subsidiary role. The author's model therefore, needs to take into consideration the role of pharmaceutical companies as well. Thus the model needs to be modified by recognizing the pharmaceutical companies as one of the key actors. Since these companies are mostly owned or controlled by the multinationals, they tend to play more dominant roles. Thus, the non-recognition of the multinational pharmaceutical companies' roles on the one hand and identifying the client or patient as an actor (which is mostly passive) on the other hand, are the major weaknesses of the model.

In fact, in the present set up, in most of the developing countries the client or the patient plays the same role as of low caste Harijans or untouchables, in the Hindu Caste System while the four main actors, namely political leaders, administrators, health professionals and multinational pharmaceutical companies fulfill the roles of

the four major castes. Of course due to its financial leverage, the multinationals could be easily equavated with the Brahmins.

The paper further on reviews the development of health system in the Western countries as well as in the developing countries. The author rightly recognizes the problems related to financing of health care in the developing world and limited resources available for the purpose. However, the maldistribution of health services seen by him as the outcome of the lack of resources appear misleading, especially when he had already recognized the health care as a "private government". It needs to be recognized that with the new cetegories of actors (with multinationals playing the dominant role) delivery of health care is mostly a business proposition. The providers would invest where there is maximum return and in this process the rural and the deprived urban populations are ignored. Thus, while the urban and the rural affluent populations enjoy the best medical care which are concentrated in the large cities, the rural and the urban poor have no such access. As far as health care as a political leverage is concerned, for politicians, there are many more other leverages which can keep them afloat without providing proper health care facilities to the poor masses.

In his conclusion the author asks a very relevant question which has to do with learning for the developing countries, from the experience of the developed countries. Perhaps he recognizes the inherent problem therein, through his statement that, "the study of comparative health policy badly needs facts set in cultural context . . ." (pp 19-22). Since most of today's developing countries have been colonized (politically or economically) by today's developed countries, the health system in the former have been developed in isolation of the local culture and needs. Therefore, each of the developing countries needs to first re-define its own health strategy and should re-assign the roles of each of the actors. Perhaps one way is to put the client or the actor at the centre stage and each of the other actors namely political leaderships, administrators, health professionals and pharamaceutical companies address his needs. Such re-assignments of the roles are somewhat evident in the new "health policy" of Pakistan. But it is a long way for the general public or client to benefit and enjoy the harvest of the so-called health for all by year 2000.

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Comments on “Comparative Health Policies: A World of Difference”

Health status in the developing world especially in South East Asia is an issue which calls for an immediate and concerted efforts of economists, educationists and health experts. Every week, for example, a quarter of a million children die in the developing world, millions more are living in a state of ill health and poor growth. Poverty is one of the main issues behind this tragedy. Another important cause of the poor health status are the lack of proper, problem-oriented education (especially health education) and relevant national development programmes.

I would compliment Dr Björkman for his very elaborate presentation on the issue of policy-making in the context of the improvement in health facilities in two distinct group of countries. The author has very clearly identified the factors which not only affect policy-making but also its implementation. Dr Bjorkman in this paper has highlighted the role of at least four categories of people – actors in the health sector – politicians, administrators (bureaucrats) professionals and the beneficiaries (patients or clients). The role and interaction of these actors in a health system has been elaborately discussed particularly with reference to their effectiveness in formulating and executing policies.

One set of countries chosen for the study of health sector functions include Sweden, Britain and the United States. These industrialized nations present a more homogenous environment with more or less shared culture (in a broader sense), well-established, committed democratic institutions and highly industrialized economy – all contributing to a mature and effective health status of a nation. These countries showing marked similarities mentioned above differ only in the implementation of their programmes or, one can say, their service delivery systems. The goals set by these countries cannot be achieved in certain developing countries because of differential selection of their priorities. The setting of priorities in developing countries in itself is a difficult proposition: political instability, bureaucratic influences and quality and quantity of available professional manpower, all contribute to the complexity of the problem.

The industrialized nations as politically and economically stable countries hardly make any news headlines on the international scene in contrast to countries in the developing category where changes of governments are often fast and frequent. This instability takes the development clock back and in some cases governments

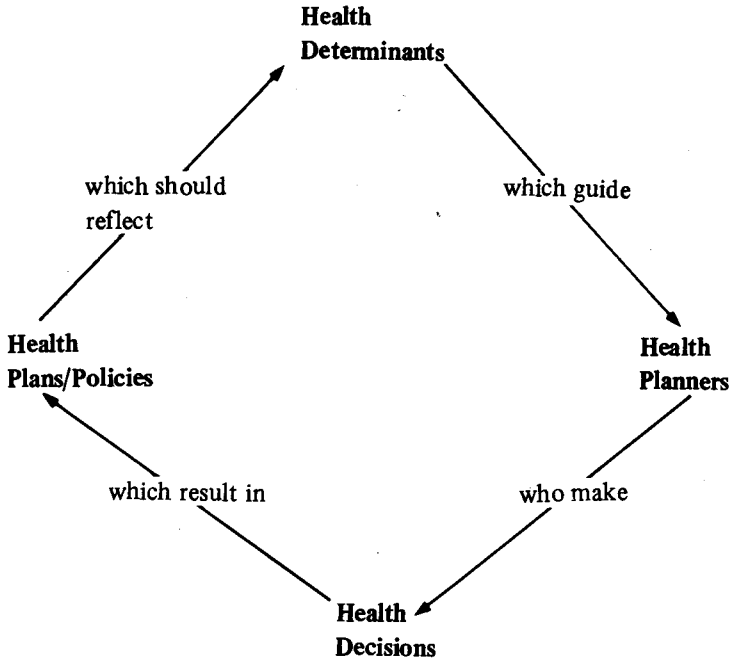
in order to take credit start all over again with policy formulation. By the time new policies are designed (in some instances this is mere rephrasing of the earlier ones, purely on political grounds) it is time for them to depart.

While attempting to analyse formulation and implementation of policies like the one on health sector development between developed and developing countries I feel, one should take into consideration, the political aspects into a little more detail. Some countries in South Asia have particularly suffered from this political instability.

Dr Bjorkman in his presentation has discussed the importance of the professionals in policy-making and implementation, their role in the developed world has been well narrated, however, I feel, the role of health professionals in developing countries should have been discussed more with a particular reference to the qualitative and quantitative aspects of the available manpower and extent of their utilization.

The training of health personnel has been debated at great length during the last two decades than ever before. The necessity, both qualitative and quantitative, of health personnel is becoming increasingly obvious and widely felt. The qualitative needs cannot be measured but are no less impressive and concern practically all countries where health workers are trained. In 1970, the International Education year, the then Director General of UNESCO, Mr R. Maheu in a meeting in Brussels said "though Education is everywhere expanding, it is also everywhere, or almost everywhere, faced with crisis". Medical education is no exception. A variety of factors contribute to this. In developing countries the medical curriculum is a derived one from western sources, often the curricula are not relevant to the real needs of the society that the graduates are to serve. When these graduates are entrusted with the responsibilities of formulating health programmes they exhibit obvious lacunae in their understanding of the problems and hence are unable to determine the needs and priorities of the society. In summary, it may be said that each country should build up its own made-to-measure health services, staffed by national health workers who are adequately trained to meet the health needs of the community they serve. In some, rather most, of the developing countries there is an urgent need to look back on the whole of the educational process. New roles have to be evolved for effectively and meaningfully employing educational strategy. The most important task for the planner is to define the competencies to which the programme or policy must be directed. Methods to be used for carrying out those functions or plans have to be outlined for systematic and sequential actions towards the goals. Another role which can be important in executing policies/programmes can be of a manager. His actions can be vital for achieving the objectives. To keep policy-making a continuous and responding exercise a third role can be of an evaluator. In this way the whole process of policy-making and implementation will

be truly accountable to those it serves. Thus, four parts of this “accountable” model (determinants, planners, decisions, and plans) are linked and integrate the whole process of health policy (which is a product) with the process of formulation, providing a rational framework against which the adequacy of a programme/policy can be assessed.



In the end I must confess, Dr Björkman, has done a great effort to put together all the aspects reflecting variations in policy-making and its implementation in his sample countries, for which he should be complimented. However, it would have been more informative and useful had he analysed his findings in the South Asian Context in more detail.

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