Scandinavian Political Studies, Vol. 3 – New series – No. 3 1980
ISSN 0080-6757

The Health Services System: The Interaction of Medical, Socio-Cultural, Economic, and Political Logics*

Ole Berg, University of Oslo

Health sector research has increased in quantity over recent years: qualitatively, however, it has scarcely escaped from traditional disciplinary boundaries. Since the health sector has become a meeting ground for several disciplinary research traditions, it would seem necessary now to attempt to view the sector as an entirety. This paper suggests how the health services system may be viewed as a whole, and sketches a possible theoretical foundation for, and possible topics within, an integrated health sector framework.

The health sector has become a meeting ground for researchers from a number of disciplines, or rather subdisciplines. Sociologists have particularly been interested in the health services system, the relationship between care providers and receivers, and the effects of health care. The same phenomena have also to some extent been investigated by anthropologists, psychologists, social epidemiologists and other medical men, economists, and demographers. Political scientists and, partly, economists have studied the links between governmental authorities, interest organizations, and the health services system.

Although representatives of the various mother disciplines have as a rule retained their original identification and professional approach, one can also discern the growth of a new, common, and genuinely cross-disciplinary, health care research orientation. Those who most openly identify with this tendency often refer to themselves as health services researchers. Despite this increasing cross-disciplinary sentiment, however, there has been little concern with the health sector as a totality. Practically

*An earlier version of this paper was presented at the ECPR Workshop on Health Policy, Florence, 1980. I am grateful for comments made by participants at this workshop. I would also like to thank Derek Urwin for his encouragement and insightful suggestions for improvements.

Scandinavian Political Studies, Vol. 3 – New series – No. 3 1980
ISSN 0080-6757

The Health Services System: The Interaction of Medical, Socio-Cultural, Economic, and Political Logics*

Ole Berg, University of Oslo

Health sector research has increased in quantity over recent years: qualitatively, however, it has scarcely escaped from traditional disciplinary boundaries. Since the health sector has become a meeting ground for several disciplinary research traditions, it would seem necessary now to attempt to view the sector as an entirety. This paper suggests how the health services system may be viewed as a whole, and sketches a possible theoretical foundation for, and possible topics within, an integrated health sector framework.

The health sector has become a meeting ground for researchers from a number of disciplines, or rather subdisciplines. Sociologists have particularly been interested in the health services system, the relationship between care providers and receivers, and the effects of health care. The same phenomena have also to some extent been investigated by anthropologists, psychologists, social epidemiologists and other medical men, economists, and demographers. Political scientists and, partly, economists have studied the links between governmental authorities, interest organizations, and the health services system.

Although representatives of the various mother disciplines have as a rule retained their original identification and professional approach, one can also discern the growth of a new, common, and genuinely cross-disciplinary, health care research orientation. Those who most openly identify with this tendency often refer to themselves as health services researchers. Despite this increasing cross-disciplinary sentiment, however, there has been little concern with the health sector as a totality. Practically

*An earlier version of this paper was presented at the ECPR Workshop on Health Policy, Florence, 1980. I am grateful for comments made by participants at this workshop. I would also like to thank Derek Urwin for his encouragement and insightful suggestions for improvements.

all research is specialized and part-oriented. Much of it in addition is of an applied nature. It seems, therefore, appropriate now to try to view things in a more encompassing perspective. Partly, the task will be to determine how the health services are related to their environment, and partly to identify the links between the various parts of the system itself.

The purpose of this paper is to suggest one way of putting the health sector pieces together, and to point to possible topics for comparative health research. To some extent I shall also, in a more sketchy way, present a theoretical foundation for such research.

1. The Health Sector: A Conceptual Model

Societal modernization means above all structural differentiation. This differentiation, as Talcott Parsons has argued (1959, 1960, 1963), has taken place in three main directions: cultural, economic, and political. Cultural institutions have emerged to satisfy people's 'identity needs'; economic institutions to fill people's 'adaptive needs' (or resource needs); and political institutions to take care of the organizing tasks created by the emergence of differentiated economic and cultural institutions.

In a way inspired by Stein Rokkan (1975), the above points are illustrated in Figure 1. In the A part of the figure the differentiation process is illustrated; in the B part the need satisfaction process. Talcott Parsons originally constructed his model to establish a typology for the very earliest political systems, but also suggested how it could be applied to the nation-states emerging in Western Europe before, under, and after the Renaissance. Stein Rokkan has in a number of studies (1967; 1970, ch. 3;

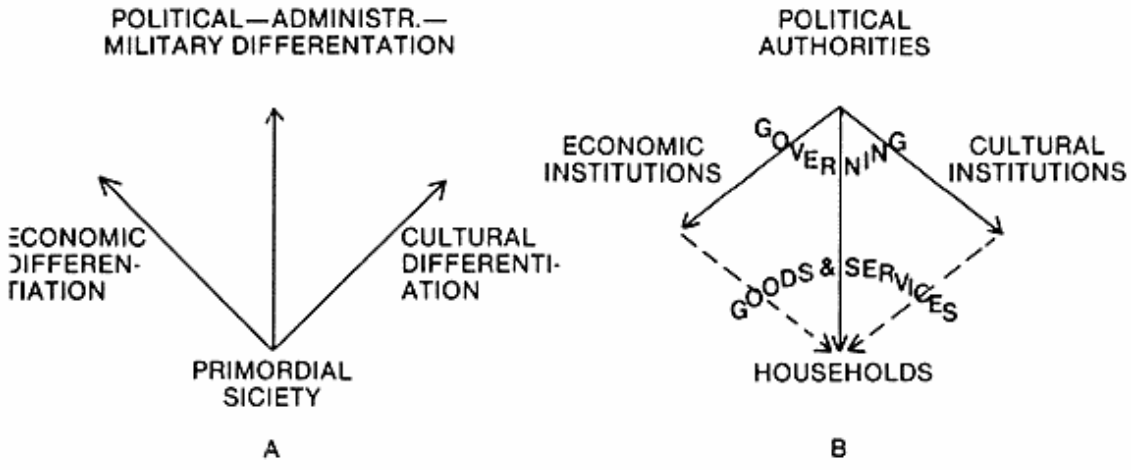

Figure 1. A: The Three Directions of Societal Differentiation.
B: The Three Basic Types of Societal Need Satisfaction Processes.

Table 1. A suggested Categorization of Society's Adaptive Institutions.

Type of resources	Artificial resources		Natural resources	
Approach	Produce	Preserve	'Produce'	Preserve
Examples	Manufacturing Construction Commerce Financing	Repair work Fire protection	Hunting Fishing Farming	Health care Social work Veterinary services Environm. protect.

1971; 1973; 1974) refined and differentiated the Parsonian schema for the purpose of mapping the sources of variations in the *internal* structure of western societies, with particular reference to politics. I shall try to follow up his stimulating work with respect to the health system.

The health services system, like the social services system, is located to the left in Rokkan's representation of the Parsonian model. It is part of the economy, or more precisely, the adaptive system, being concerned with society's resources, with naturally given or produced, rather than with artificial or man-made, resources. Furthermore, it is oriented towards the preservation, as contrasted with the production, of such resources. Thus the health services system has a defensive calling; a very defensive one in so far as it is responsible for restoring people to full capacity, a less defensive one when it is expected to forestall the 'unnecessary' deterioration of human resources.

In Table 1 I have indicated how some of the adaptive institutions of society may be characterized and categorized. It should be stressed that the two distinctions on which the table is based are not always entirely clear-cut. They are even becoming increasingly diffuse. There is a movement towards the left in the table. Thus natural resources more and more tend to assume a semi-artificial nature, while much preservation work has also taken on a productive character.[1]

1.1 The Health Services System

When we talk about the health services system, we tend to think mainly of the cure-oriented, medically dominated part of it. But the health services system consists of more than that. It also contains a structure, or rather several structures, that we could call the allied health services. I shall

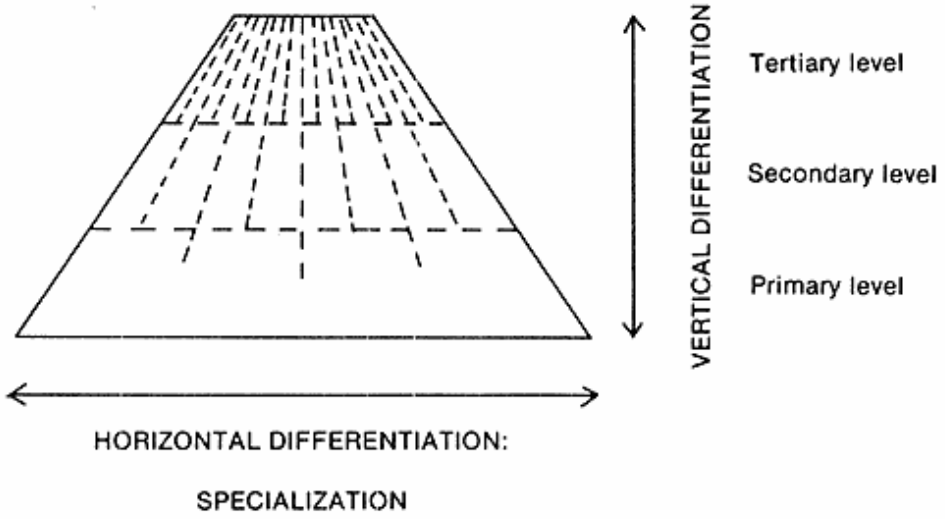

Figure 2. The Basic Structure of the Health Care System Proper.

revert to that structure in a moment. First we shall look at the health services system in the more narrow sense of the word.

The basic characteristics of the medically dominated system is its three-tiered (or latent four-tiered) vertical structure. These tiers are commonly referred to as the primary, secondary, and tertiary health care services (cf. Figure 2). Within each tier, then, there is a horizontal division. The services are specialized. But they are not equally specialized at all levels: the degree of specialization increases as one moves upwards in the system. At the bottom the system may partly be non-specialized, or general.

It should also be pointed out that the system's degree of 'crystallization' increases by service level. The tertiary service is very crystallized, i.e. it is based in huge and highly technologized institutions. Also, the secondary service is clearly crystallized; it is an institutional service. Only the primary health care part of the system is non-institutional, though it too is not entirely extramural: to some extent it may be characterized as semi-institutional. I am referring to health centers, health stations, group practices and the like.

The remainder of the health services system, that is the allied health services, may be thought of as an (or perhaps several) adjunct(s) to the medically dominated structure. This adjunct is attached to the core system at the primary and, to a lesser extent, the secondary level of that system (cf. Figure 3).

It would be too much to discuss here the internal structure of the adjuncts. But as a beginning, one might distinguish between totally prevention-oriented adjuncts, and adjuncts that are also (or primarily) cure-

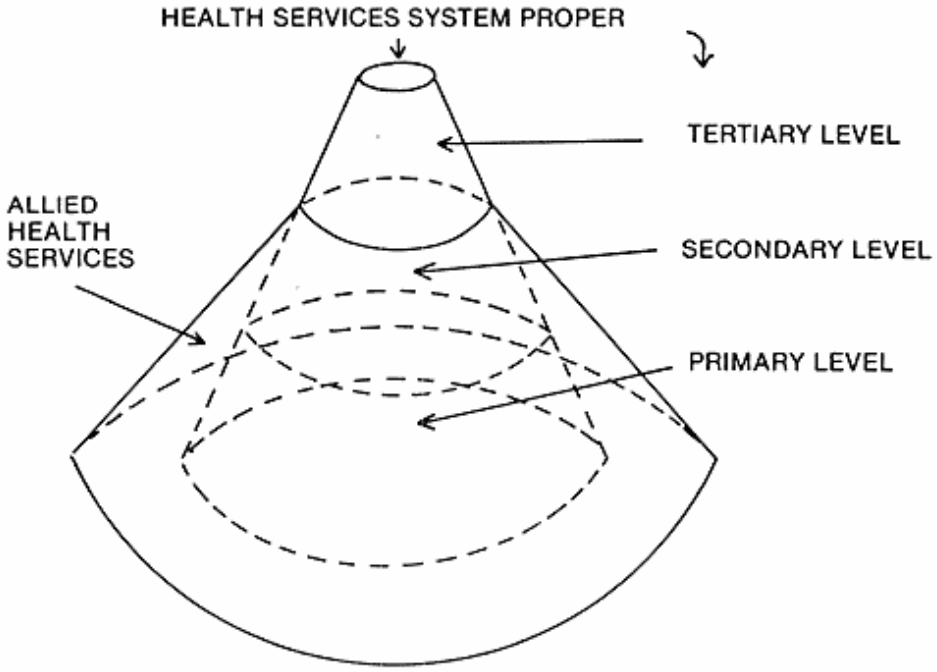

Figure 3. A Schematic Presentation of the Entire Health Services System. (The division of the allied health services into separate structures is not illustrated in the figure.)

oriented – e.g. the postmedical nursing service, physical therapy outside medical institutions, etc. It ought to be mentioned that the health services system, through the adjunct structures, overlap with other service systems, particularly the social services system. I should also stress that although the other parts of the health services system are linked to the core, they are not necessarily dominated by it. To some extent they operate on their own.

1.2. The Health Services System and Its Clients

The (professional) relationship between the health services system and its clients is of varying kinds. On the basis of the orientation of the system, one may distinguish between three main kinds of relationships. The orientation can be toward: 1) *Specific persons:* i.e, all cure and care, and some preventive services; 2) *unspecified persons:* i.e. health information and propaganda; 3) the *environment* of all non-personal unspecified persons: i.e, preventive services. Here I shall comment only on the first kind of relationships, the most personal ones.

We have seen that the health services system has a three-tiered structure. People enter this service system mostly at the bottom, through the primary care part. By and large, they also do so on their own initiative, or alternatively on the initiative of relatives and friends. The system itself

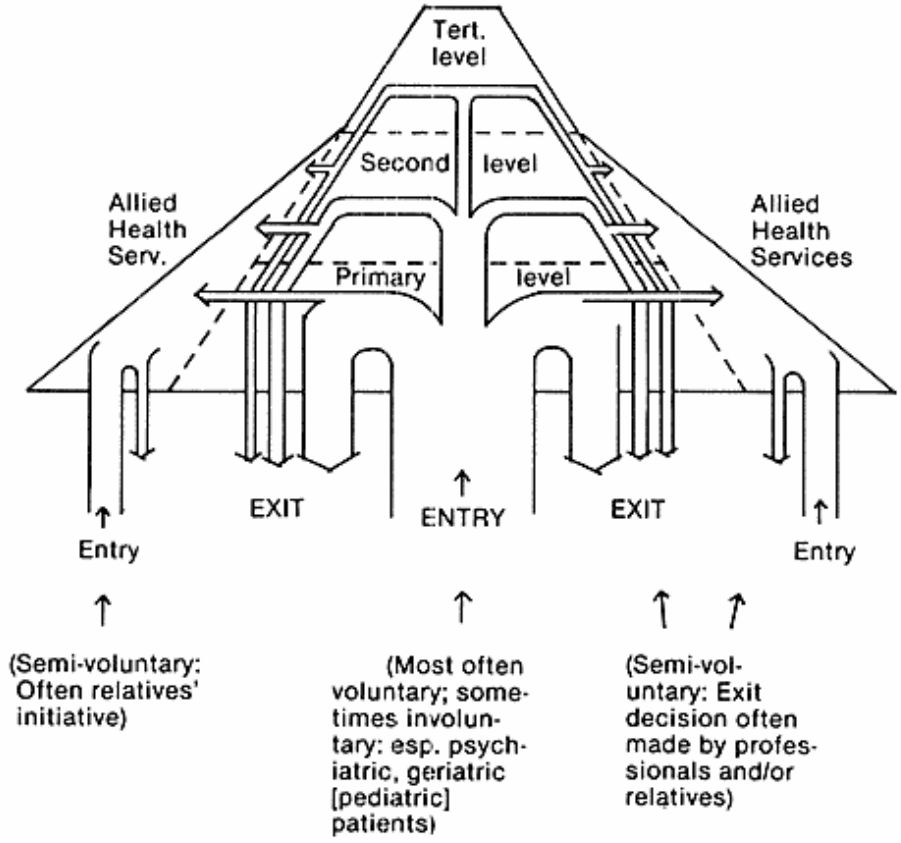

Figure 4. A Schematic and Simplified Illustration of the Flow of People into, through, and out of the Health Services System.

does not recruit clients. For most people contact with the health services system is of an episodic character. They seek out providers of primary care, and leave the helping system soon afterwards. Some however are likely to be channeled further up into the system. They require more specialized and more technology-dependent services than can be provided at the bottom. In the most severe cases, they are sent all the way up to the tertiary service level. As a rule, people are returned directly to society even from the higher service levels. Some, however, are sent back in a more gradual way; for example via post-treatment or rehabilitation agencies. A few are not resocialized at all, ending up in nursing homes, homes for the aged, or the like. It should also be mentioned that for most people in today's society the institutional parts of the health services system are the end station of life.

The main points of the above discussion are illustrated in Figure 4.

We have so far looked at the flow of patients through the person-oriented part of the health services system. We must also consider the more direct and personal relationships between patients and health care

providers. I have asserted that people enter the health services system voluntarily. But that does not mean that the system appears equally inviting to everybody. I do not have in mind here scepticism based on technically negative experiences or on fear, but rather the fact that the system, or the individual health care provider, may seem unequally culturally congenial to different groups of (prospective) patients. In general, I will hypothesize that the greater the socio-cultural distance between health care professional and patient, the less inviting the system will appear, and the less productive the possible encounter between the two will be,We may also expect that great socio-cultural distance will to some extent reduce a person's proclivity to seek the assistance of health care providers.

It is likely that there is a high positive correlation between degree of formal education and degree of socio-cultural patient compatibility with the health care system. That is to say, the more a person has been culturally shaped by a formal *educational* institution (to the right in our model – Figure 1), the more competent he or she will be in utilizing the formal *health care* institution (to the left in our model). But it is also clear that patients' socio-cultural compatibility with the health care system may vary according to the level of that system. The higher up in the system one goes, the more socio-culturally distant the system is likely to appear, irrespective of educational background.

Provider-patient relationships are not only professional and cultural, they are often, (but not always) economic. To some extent the patient, or consumer, has to pay (directly) for the services rendered (cf. Figure 5). We may say that the greater fraction of the total costs the patient has to pay, the more 'economized' is the provider-patient relationship. Also, the more 'economized' the relationship is, the more we can talk of a health services

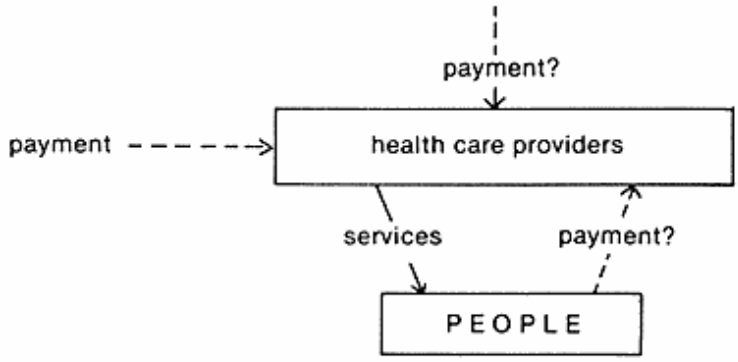

Figure 5. An Illustration of the Economic Relations Between Health Care Providers and Consumers.

market. To the extent that people do not themselves pay (directly) for the services they demand, others (must) cover the balance (and take over some of the role of the market). We shall revert to these points later. Non-personal preventive services are of a much more collective nature than personal services. There can therefore hardly be any market for such services. They are paid for by other sources.

1.3 The Health Services System and the Corporate Environment

The health services system is located at what we may call the intermediate, or corporate level of organization of society. At this level it is dependent upon, and interacts with, several other institutions. We shall now try to identify these other institutions and their linkages to the system. First of all, the health services system is professionally dependent upon a number of other corporate-level institutions. Some of these are clearly located on the economic, or left, side in our model, others tend more toward the cultural, or right, side. On the economic side the health services system is primarily dependent upon the medical industries (i.e. producers of certain 'artificial resources'), particularly the producers of pharmaceuticals and of medical instruments and devices. More indirectly, it is also linked to the building industries, to producers of hotel services, etc. We shall disregard these institutions here. On the cultural side the health services system is primarily dependent upon educational and research organizations. In Figure 6 I have tried to illustrate these horizontal inter-connections.

In passing it may be noted that the increasing coupling of cultural

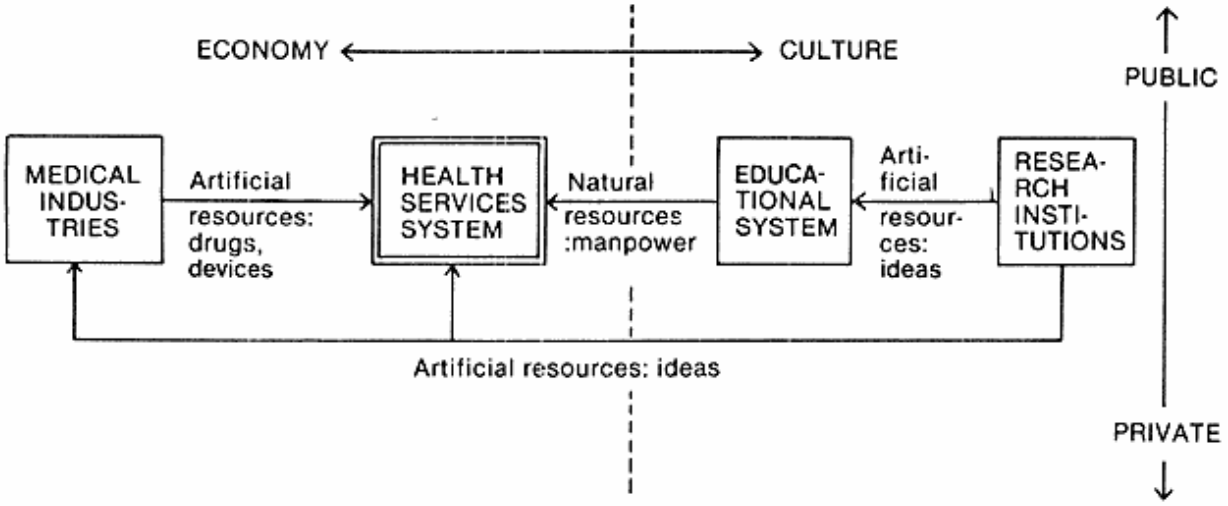

Figure 6. A Schematic Illustration of the Professional Dependence of the Health Services System upon Other Corporate-Level Institutions.

institutions and the health sector (or any other part of the economy for that matter) may be said to represent a 'decultur(al)ization', or an 'economization' of these institutions. They lose some of their original purpose and become servants of the various economic institutions; they become 'useful' in the restricted sense of the word.

As we have seen, the health services system can to some extent be financed directly by the service consumers. Corporate agencies of various sorts will, however, in most cases also play a significant, and often dominant role. These agencies are of three kinds. First, one has the more or less voluntary non-profit sickness funds. Originally, these were as a rule generated from below, though provider interests have sometimes also played a vital role. Next, one has the private, for profit, insurance companies. They tend to have a purely corporate background. Finally, there are the government-created non-profit health insurance agencies. The links between the health care system and the various financing institutions are illustrated in Figure 7.

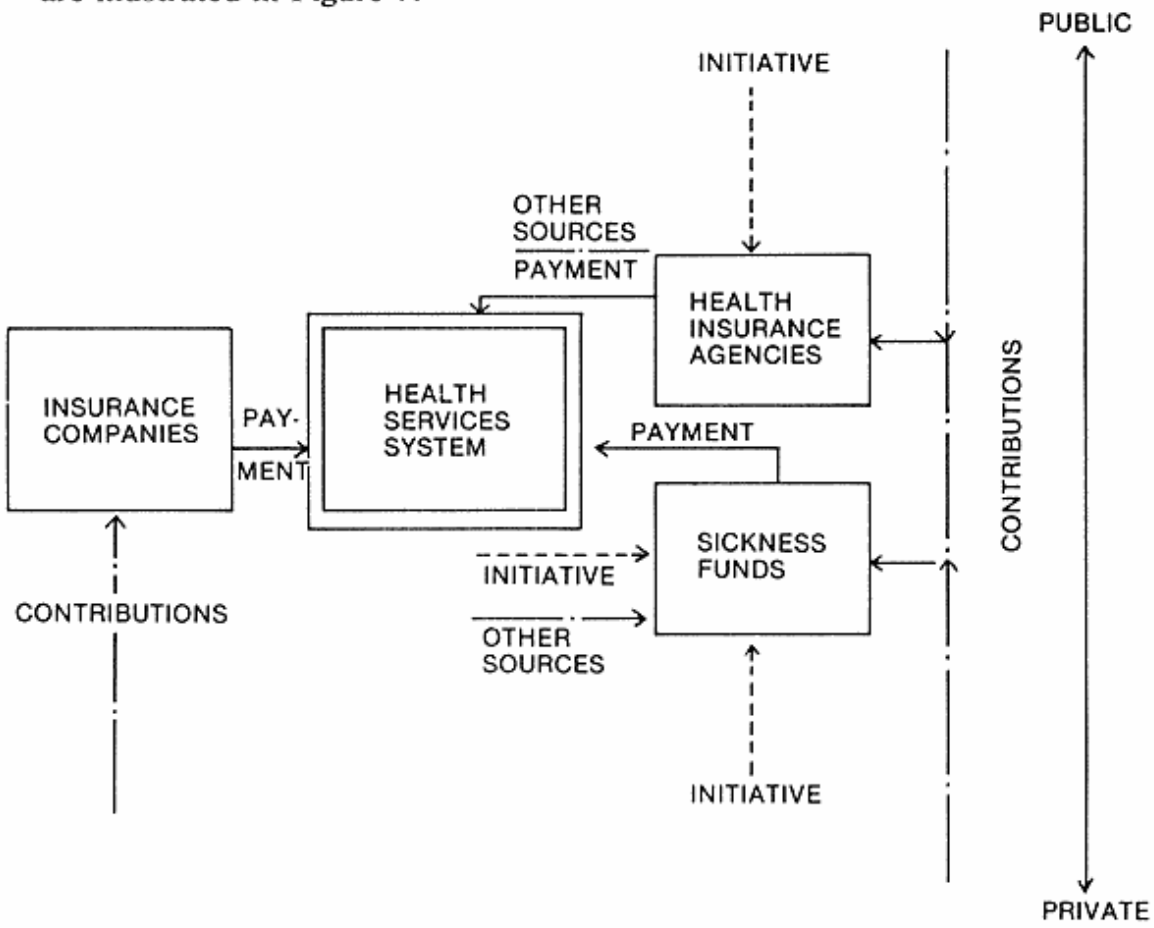

Figure 7. A Schematic and Simplified Illustration of the Dependence of the Health Service System on the Major Financing Institutions.

The health services system then is professionally and economically dependent upon other corporate-level institutions. Strictly speaking, these are also the only other such institutions upon which the system is dependent. They are, however, not the only institutions at this level to which the system is closely linked. The health services system is in various ways and to varying degrees connected to a number of interest organizations.

The other institutions we have discussed *serve* the health services system. Interest organizations do not serve the system; they serve themselves, or rather, their members. And they do so by trying to have their own premises accepted as operational premises in the decision-making processes within the health services system. We may therefore characterize the premise-exporting activities of interest organizations as political, or more aptly, parapolitical.[2]

We may divide interest organizations in the health sector into two groups, according to the character of their primary interests. On the one hand, we have organizations that are mainly, but not solely, oriented toward the furtherance of general, or more specific, health concerns, for example, public health and patient group organizations. On the other, we have those which primarily, or at least to a large extent, are set up to protect non-health interests, usually the material interests of a group. Examples are medical industry, insurance company, hospital owner, and personnel group organizations. The main parts of the above discussion are summarized in Figure 8.

1.4 The Health Services System and the Political Institutions

The health services system, like most other institutions in western society, is governed - not totally, but governed nevertheless. We have a health policy. Thus the health services system is also linked to political institutions. We shall consider these institutions in order to determine the nature of their linkages to the health services system.[3]

As we know, Western political systems are divided into geographically defined levels, usually three or four major ones – for example a national, a regional and a local level (or a federal, a state, a regional and a local one). At each of these levels we may identify three, more or less distinct, institutions: a representative assembly, a government, and an administrative institution. The geographically defined systems are hierarchically ordered, and so in most cases are these institutions. All levels and all institutions take some direct part in health policy-making. By direct policy I have in mind the policy that has as its direct address the health services

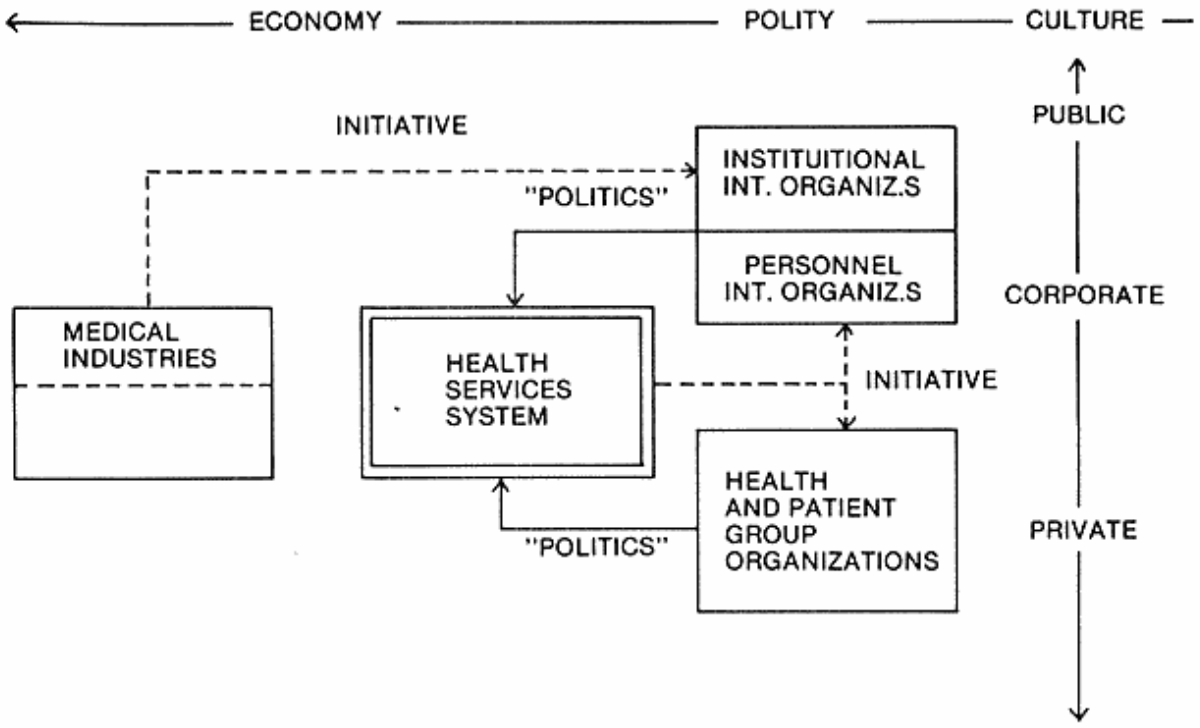

Figure 8. A Schematic Illustration of the Interest Organization Environment of the Health Services System.

system. We shall in a moment turn our attention to what we could call indirect health policy-making.

If we take as the point of departure unitary political systems (or start at the state level in federal systems), there seems to be certain similarities in the health policy-making division of labour. Central agencies have a kind of overall responsibility. But they do not always, or at least not primarily, take part in the direct governing of the health services system. Usually, and increasingly, they govern through agencies at lower levels. The policy directives that emanate from lower level organs are thus a blend of more general inputs sent from above and more specific and concrete inputs generated at the lower levels. Local health agencies may sometimes be under double fire from above, but they may also be subjected to orders from the national level. If state agencies govern directly, they customarily do so through separate state, regional, and local agencies.

If we now turn to the direct links between the political-administrative agencies and the various parts of the health services system, we will probably find that they go between regional or state organs at the regional level and the secondary and (but not always) the tertiary part of the health services system, and between local and state organs at the local level and

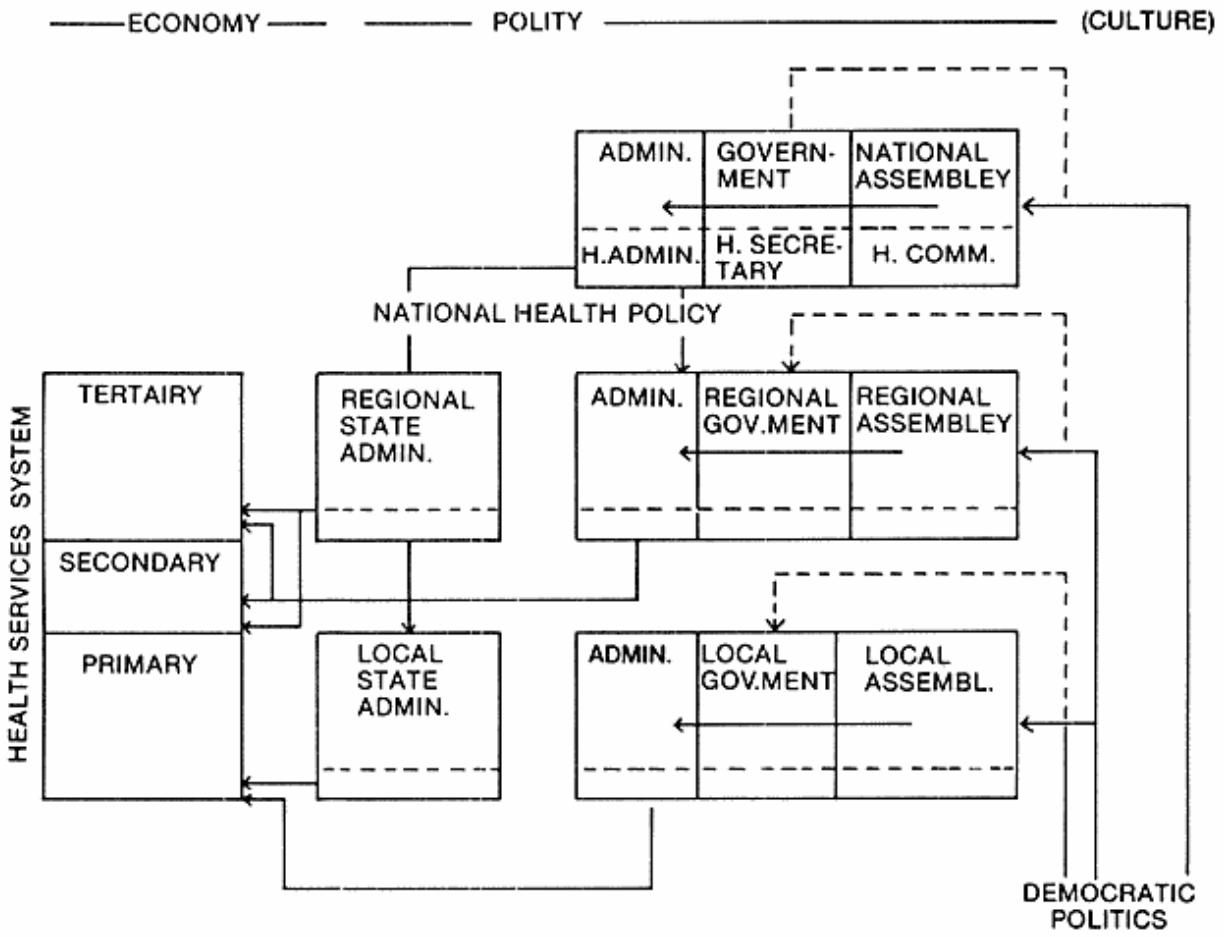

Figure 9. A Schematic Illustration of the Main Links Between the Health Services System and the Various Health Policy Organs.

the primary part of the health services system (often also the allied health services system).

In Figure 9 the main points presented above are illustrated. In addition, a few other aspects of the health policy arena are included. I have, for example, tried to indicate that at all political levels, in all the main institutions, there are special suborgans responsible for health policy – a health (sub)committee, a secretary (or minister) of health, and a department, directorate or the like of health. Together these suborgans may be designated a *health policy segment* (cf. Egeberg et al. 1978).

It should also be mentioned at this point that there is one other type of health policy that can be regarded as 'direct.' This policy is not, however, aimed at the health services system, but more at actual, and prospective, patients. This, for example, is the focus of certain kinds of health information and propaganda campaigns.

So far we have seen how the health services system is directly govern-

ned, from whatever geographical level. We may label such health policy sectoral, or segmental. But the health services system is also indirectly governed. This is the case when the direct object of governing is one of the corporate-level organs upon which the health services system is professionally or economically dependent. Thus, educational, research, industrial or insurance policy is also partly health policy. Or perhaps we should rather say it *can* also be health policy: it *is* to the extent that health-oriented premises are accepted as legitimate and important premises in the formulation of these other policies. We may term this kind of health policy cross-sectoral, or cross-segmental.

Such indirect health policy is carried out in two major ways. First the primary health policy authorities are directly responsible for the health-connected parts of the educational, research, etc., systems. On the other hand, health policy agencies have to influence educational, research, etc., institutions via the special educational, research, etc., policy authorities. This kind of health policy may therefore be said to be doubly indirect. In Figure 10 I have tried to show how the two indirect ways of carrying out health policy can be illustrated. The reference is to one geographic-politi-

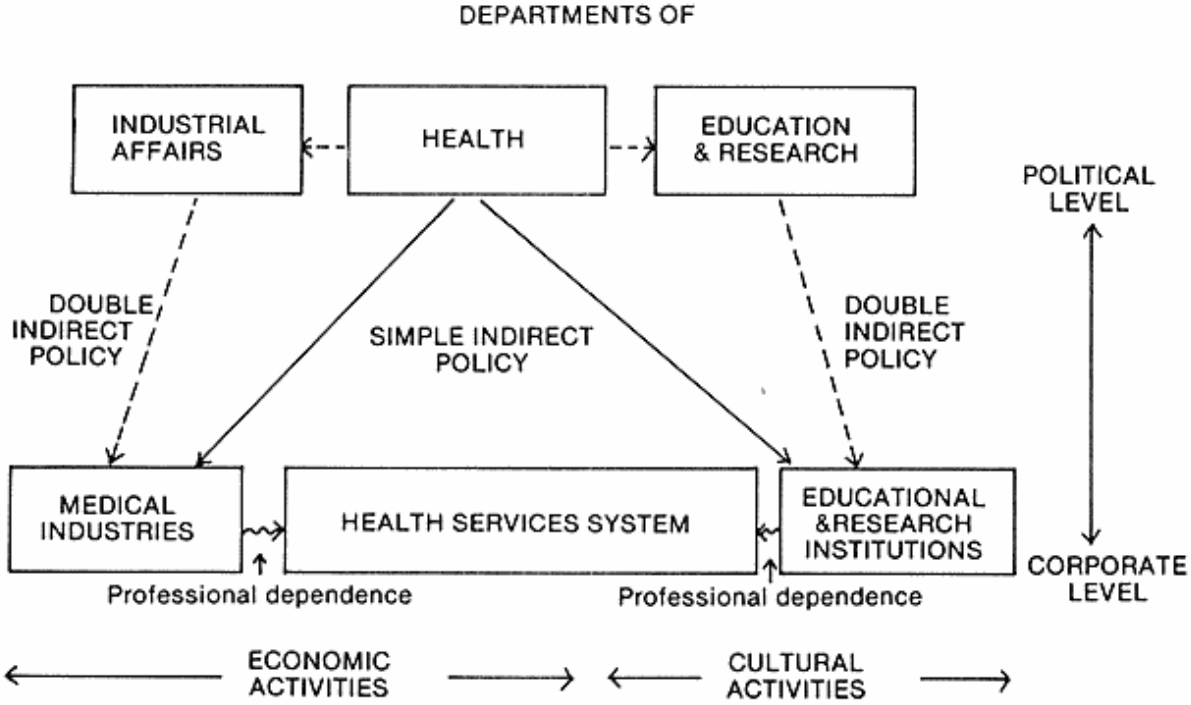

Figure 10. A Simplified Illustration of How the Two Primary Types of Indirect, or Cross-Segmental, National Health Policy are Carried Out. (Here only with reference to the institutions upon which the health services system is professionally, not economically dependent).

cal level, the national one. To simplify the figure still further, I have only included the corporate institutions upon which the health services system is *professionally* dependent.

Before we proceed, a short note is in order on a type of health policy that is purely cross-segmental. Purely cross-segmental health policy is one that is not even directly related to the health services system. The point of departure for such policy is as a rule a department of health (or of social affairs). This department 'exports' health premises to non-health departments. These premises then become part of the policy carried out by these 'alien' departments. This policy is usually aimed at corporate bodies in so far as they operate independently of the needs of the health services system. Thus housing policy, urban policy, communications policy, etc., can be examples of purely cross-segmental health policy. Such health policy is of course almost solely preventively oriented.

1.4.1 Techniques of Governing

The techniques of governing that are employed in the area of health are not in principle different from those employed in other areas of public policy. The major part of the following discussion will therefore have to be rather general in nature.

Ultimately, we may say that when one is engaged in governing activities one is consciously trying to affect other individuals, particularly their behaviour. This can be done in four ways. First, one may *deter* others; that is, make it clear to them that if they do not do as we wish, they will suffer a loss of something they value, such as property, reputation, freedom or even health and life. Second, one may *induce*, or tempt, others; that is, promise them something they cherish in return for acting as one wanted. The two first techniques, then, are in a way opposite; in one case one uses negative, in the other positive, sanctions (or rewards). Third, one may seek to affect the behaviour of others by *enabling* them to do what they were not previously able to do (but perhaps not unwilling to do); for example, by providing them with economic or other resources. Fourth, one may influence others by trying to make them see certain things differently than before (cognitive influence), or feel otherwise about these things (affective influences); that is, by means of information, marketing, propaganda, and the like. In cases 1, 2 and 4, then, the influencing activity is aimed at the *will* of others, in case 3 at their *ability or capacity*.

These four types of techniques of *influencing* are integrated into several forms of governing. I shall distinguish between three major forms: regulation, directing, and propaganda.

Regulation is of course governing through general rules (laws). It is thus a kind of non-personal and, from the point of view of the governed, a relatively predictable form of governing. By enacting laws and other general regulations, political authorities anonymize and programme their own future actions, and reactions. To some degree, they even impersonalize the changing of laws and regulations. Higher order laws, or rules, regulate the procedures and frequently even the content of the changes. However, it must also be mentioned that laws and rules are often little specific and therefore have a low programming potential. We may call such rules (or laws) 'open'; 'genuine' rules are 'closed' rules. If rules, or laws, are very open, they tend to be at least partly closed by supplementary rules (or regulations). But since supplementary rules are easy to change, such closure can only give some degree of predictability for the governed.[4] The technique of influencing built into rules is commonly and traditionally that of deterrence. Some legislation may, however, contain both 'enticing' and 'enabling' elements; welfare legislation is an example of the latter.

While regulation is a general and programmed form of governing, *directing* is a specific and unprogrammed form of governing. It may take the form of individual and concrete orders, but may also consist of a number of coordinated and coupled individual decisions. Examples of directing of the latter kind are budgeting, or resource allocation and planning. it should also be mentioned that (meta-)laws on occasion may contain elements that in reality are more specific decisions than general regulations, for example decisions to establish, or alter, political institutions. I have mentioned that rules may be rather open and therefore have a low programming function. If such rules are not already filled out with more concrete details they may have to be made so with direct orders. Directing may of course also be vague and imprecise in the first instance. In such cases it has to be made more concrete, for example through more detailed directions. 'Ordinary' directing may involve threats, inducements, and enabling measures.

So far I have portrayed regulations and directing as clearly hierarchic, or asymmetric, ways of governing. Some govern and others are governed. But this is not always so. Sometimes the 'closing' of open laws and directions is often done in cooperation with the governed, or rather, with those who are most affected by a public programme. *Negotiations* frequently precede the formulation of the final and operational rules and directions. Thus governing becomes a much less hierarchic activity. In extreme cases, the distinction between governors and governed may become blurred. When negotiations become part of the regulatory and

directive processes, the last mechanism of influencing obviously also become relevant; that is, the mechanism of persuasion.

Regulations and directing are forms of governing which imply the manipulation of the actual or prospective *situation* (or welfare) of those who are to be governed. With respect to propaganda, the governors endeavour to manipulate how the governed *view* their actual and prospective situation (one may then also distinguish between 'objective' and 'subjective' governing). *Propaganda* may be aimed at either actors' cognitive or affective attitudes. In the first case, the propaganda may assume the character of rational argumentation; it is then often referred to as information. But cognitively oriented propaganda may of course also be misleading and deceitful. In pluralist countries, with a competitive opinion market, information is a more likely form of propaganda than manipulation. In non-pluralist countries the element of misinformation is likely to be of greater importance. Purely affective propaganda is seldom of any significance in pluralist countries.

It almost goes without saying that propaganda is a form of governing where persuasion is the predominant influence mechanism. I would add, though, that the mechanisms of negative and positive coercion play an indirect role in much cognitively oriented propaganda. Those who propagandize are frequently attempting to make people *understand* that if they act in a certain way they will be punished, or rewarded – by either 'nature' or by public authorites. In the latter case the purpose of the propaganda is to make people aware of public policy, particularly laws. Propaganda may thus be regarded as a form of governing whose purpose is also to make possible effective regulation and directing.

In Table 2 I have summarized the main points of the preceding discussion. I have also tried to indicate how major types of health policy measures can be categorized.

Table 2. A Classification of Techniques of Governing, with Examples from Health Policy

	Forms of Governing		
Influence Mechanism	Regulation	Directing	Propaganda
Deterrence	Very important	Very important	Unimportant
Inducements	Little important	Very important	Unimportant
Enabling	Important	Important	Unimportant
Persuasion	Unimportant	Unimportant	Very important

Type of Health Policy	Examples		
Direct Health services system policy	Laws regulating the rights/obligations of health personnel. Laws regulating the accrediting and operation of health institutions.	'Non-automatic' health appropriations. Primary care, or hospital services plans	
Indirect health services system policy	Health insurance laws. Drug laws. Medical devices laws. Laws regulating the education of health personnel.	Medical research appropriations	
Purely cross-segmental health policy	Laws regulating working conditions, traffic safety conditions, and the like	'Non-automatic' appropriations for the improvement of working conditions, traffic safety, and the like. Road safety plans, etc.	
Direct population-oriented health policy	Some public health laws and regulations		Health information campaigns about new health laws, or about the utilization of various health services.

1.4.2 The Content of Governing

I have tried to characterize, in crude terms, the technical aspects of the 'arrows' emanating from (health) policy authorities. I shall now move on to suggest how we may characterize and classify the material content

represented by these arrows. Again I have to be relatively general in the first part of the discussion.

Governing is a purposive activity. Hence it may be described according to (intended) effects. I have placed 'intended' in parantheses, but not because the distinction between intended and actual effects is unimportant. For most purposes it is crucial. For the present purpose, however, it is inconsequential. The effects we are to characterize are all that *could* be intended (or all potentially intended effects).

Much of public policy affects corporate level institutions first. Its ultimate address, though, may be said to be individual citizens.[5] Public policy intends to affect people's living conditions, or, as economists would say, people's welfare. People's living conditions, or welfare, can, as with Easton (1953), be defined as the values, or goods or services, to which they have access. Public policy may therefore be described in terms of how it affects people's access to values. But how it affects people's welfare will depend upon how people relate to different values; that is, whether they are in basic agreement or disagreement about the 'value' of the various possible values. Some are valued highly, or at least positively, by almost everyone; they are pure positive values, e.g. property, or health and educational services. Others may be assessed negatively by most people; they are pure negative values, or disvalues (or evils), e.g. noise, polluted air, hazardous working conditions, etc. But with respect to yet other values there may be disagreement. The disagreement is dramatic if values which are positive for some are negative for others – for example religious services or goods, or other cultural goods or entertainment services like pornographic literature and films, night clubs, and the like.

I will argue that public authorities do two things when they affect people's value situation (or welfare). They determine *which type of values* (goods or services) or disvalues people shall or shall not have access to, or be subjected to; and also *how much access* each individual is to have to various values and disvalues. Public policies thus involve either the *setting of value priorities*, or the *distribution of values*. One may also say that in the first case *values* are weighted (which are more, which are less important?), in the second case *people* are weighted (who should be more, who should be less rewarded?). In some contexts I shall use the term *qualitative* about the first type of public policy, *quantitative* about the second.[6]

Quantitative policies particularly concern the values that are most highly regarded by everyone; but to some extent they may also concern clear disvalues. According to which criteria are such values distributed?

They are not of course distributed on a person-oriented basis. They are distributed according to general individual characteristics; these characteristics may be ascribed or achieved. There are of course a great number of characteristics that can be employed. The most common are geographic attachment, type of occupation (social status, class), ethnic origin and gender. An emerging criterion is age. Thus we have a number of types of allocation policies.

In the area of *health* policy it is obvious that it is the *quantitatively* oriented policy that is of importance, particularly such policy with reference to the criteria of geographic anchoring and social status. The reason for the predominance of quantitative policy is of course the widespread consensus about the importance of health services.

Throughout the western world almost all quantitative policy has had a clear thrust. It has aimed at a gradual equalization of the access to highly regarded values. But this tendency has been particularly strong in the case of health policy. Here the goal has been, in most countries, full equality. The two main means have been the establishment of posts for public doctors, and national health insurance; the first to achieve geographic equality, the second to achieve social equality.

But to some extent qualitative policy has also played a role in the area of health. We see it most clearly with respect to the definition of what are to be considered as health services. The options have been folk medicine, 'alternative' medicine, and scientific medicine. In all countries the latter has been accorded a very high priority while the others have been regarded as more or less negative values (quackery). One may also say that the question of establishing priorities between the different kinds of (scientific) health services has had a ring of qualitative policy. Primary health care is to some extent seen as representing a decentralized, community-oriented, and 'warm' type of service, while secondary and tertiary medical care likewise are regarded as representing centralized, institution-based, technological, profession-oriented, and 'cold' services. It should be added, though, that priority-setting in this context cannot be classified as pure qualitative policy. It is at least equally as much quantitative policy. The reason is that these services are of different interest and relevance to different people (or to the same people at different points of time). Shifting the emphasis from secondary and tertiary services to primary services will thus mean to move assistance from the seriously and chronically sick or disabled to the moderately and episodically sick. In a similar way, one may say that stepping up the relative attention given to preventive health services is to follow up such a shifting of services from those who are in

most trouble to those who are in least trouble – namely from the sick and disabled to the healthy, or more correctly, to the 'pre-sick' and 'pre-disabled'.

2. The Health Sector: A Framework for Comparative Research

2.1 Health Services Research: Reflections on the Choice of Dependent Variables

As noted in the introduction, the health sector does not correspond to a scholarly discipline. It is a meeting ground for researchers from a great number of fields. But all parts of the sector are not yet equally thoroughly studied and analysed. Some aspects of it are indeed poorly, if at all, investigated. Our knowledge of the sector is therefore imbalanced and biased. I think a major reason for this *is* the multidisciplinary character of health services research. There is no one discipline that bears an overall responsibility – one that would and could discover possible imbalances. Moreover, the major part of health services research has focused on the 'lower' parts of the sector, that is, on the health services system itself and its downward relations. Comparatively few have moved outward, or upward from the health services system (cf. Figure 11).

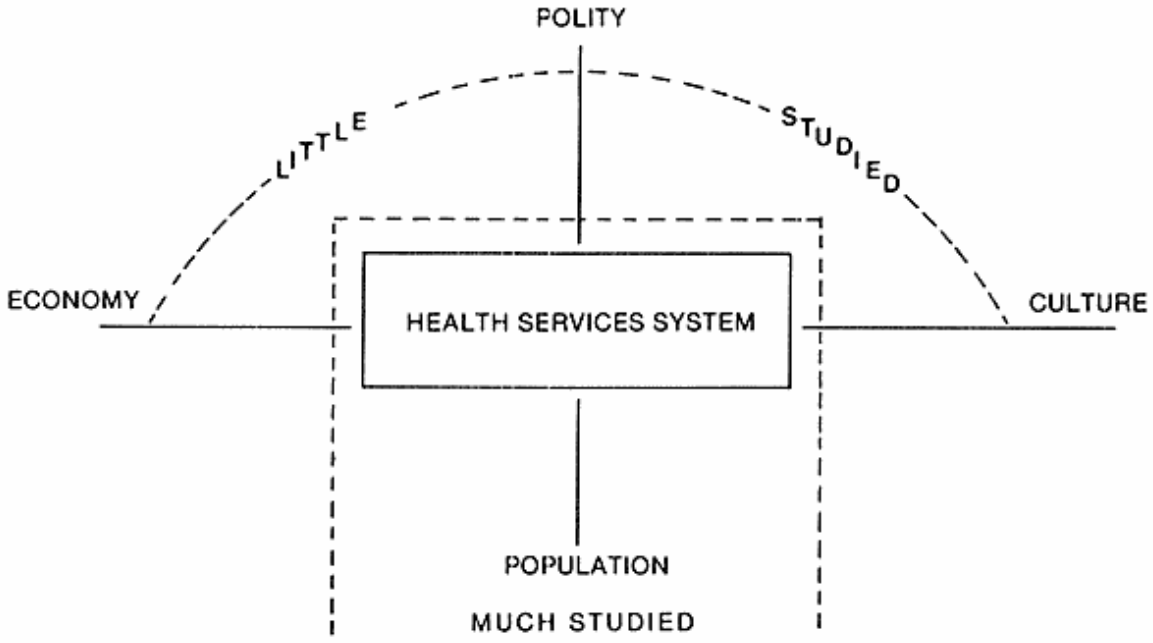

Figure 11. An Illustration of the Imbalance in Health Services Research.

But this bias is hardly surprising. Research has of course in great measure followed health services practice. To some extent this research has even had a clear practical bent itself. And that has implied a concentration on the health services system and its downward relations. The health services system has traditionally been relatively independent, or so it has seemed, both of other corporate-level institutions and, even more, of political institutions. It has, ostensibly, been able to take care of its primary obligations without much reliance on other agencies. Now this is obviously not the case any longer. The system's professional and resource (economic) dependence on other corporate agencies has become clear for all to see, and its gradual subordination under political organs is also obvious. In the wake of this development researchers have been attracted to the sideward and upward relations of the health services system. Thus political scientists and economists are increasingly taking an interest in health matters. But this development also seems to mirror popular concerns. Thus the corporate linkages that presently attract the greatest interest are the ones that bind the system to private and public insurance agencies. And as regards politics, it is direct health services system policy that has been of greatest interest, particularly in so far as such policy concerns the geographical distribution and the financing (i.e. the social distribution) of services. The health services system's professional dependencies, some types of indirect health services system policy, all cross-segmental policy, and policy aimed directly at the population, are little studied. The same is, of course, the case with the health policy institutions and their interrelations.

We see, then, that the 'thin' research areas are to be found at the sides and top of the sector. However, it is also important to stress that the study of the sector as a whole is the most neglected topic. There is more to be said about health services research, however. We have to bring in the two important dimensions of *space* and *time*. Almost all health services research has been, and still is, basically non-spatial and non-temporal. That is to say, it is non-comparative. Much research does of course contain some comparative references, but rarely of a rigorously systematic character (cf., however, Abel-Smith 1963). The customary pattern with respect to the cross-spatial aspect is to introduce references from other countries to highlight a phenomenon in the country one is investigating. The rare studies we have with a more direct comparative intention are as a rule organized as parallel national descriptions (cf. U.S. Department of HEW 1975; Roemer 1977; Stephen 1979). Time as a dimension is nearly always included as a non-systematic historical introduction or background

presentation. Needless to say, combined cross-national and cross-temporal health services research is virtually nonexistent. However, a good beginning was made by Odin Anderson (1972) in his study of the health care systems of the United States, Great Britain, and Sweden. Important contributions have later been given by Arnold Heidenheimer (1975) and Howard Leichter (1979). Also the path-breaking and expanding research on the development of welfare states in the West touches upon topics and themes of interest to health services researchers (cf. Flora 1976).

From the point of view of the total health sector, then, it would seem that the research that above all ought to be stimulated is that which tries to identify differences and similarities between nations with respect to the developmental trajectories of the sector and of its macro-structural features. However, it may well be that it is premature to try and cover this in any depth. To begin with, one could concentrate on one or more of the main structural parts of the sector. The health services system itself, and the governmental apparatus of health, are the most obvious candidates. But if this is to be done, it is crucial that it is done in a 'total-sector perspective'. We shall in a moment see what this can imply.

2.2 *Health Services Research: Reflections on the Identification of Independent Variables*

Representatives from the various 'mother' disciplines have focused on 'their' topics within the health sector. Social anthropologists have studied phenomena near the 'bottom' of the sector, sociologists have climbed a little higher, while political scientists have been occupied with the upper sectoral regions. Economists have specialized more according to relation or functional, than structural, criteria; they have particularly concentrated their attention around the financial transactions taking place between the central actors in the sector.

This specialization according to topic is also reflected in the explanatory approaches. All have chosen relatively 'familiar' variables. Anthropologists start out from socio-cultural variables, sociologists from socio-structural variables, political scientists (primarily) from political variables, and economists from economic variables. One may therefore say that different 'social logics' are unfolded within the various subdisciplines. This is, however, being done in somewhat different ways. In anthropology, sociology and, partly, political science, it is done mostly inductively, in economics more deductively.[7]

Since the representatives of the various disciplines tend to pursue disciplinary approaches, it is obvious that they contribute more to the

development (theories) of the various mother disciplines than to the (theoretical) construction of the new discipline of health services research. In the remaining part of this paper I shall indicate one possible way of furthering the growth of genuine cross-disciplinary health services research.

I have above suggested that one can focus on a limited part of the health sector, and yet do so in a way that might contribute to the more total understanding of the sector. As candidates I have mentioned the very core of the sector, the health services system itself, and the health policy apparatus. Here I shall indicate how one might go about studying the health services system.

The health services system, like all other intermediate- and top-level social institutions, is the product of a process of gradual structural differentiation. First, a flat system developed, one consisting mostly of individual, independent, doctors. The system grew and after some time also started to 'rise from the ground' – and 'retreat' from society. Specialization, and later subspecialization, produced a three-tiered service pyramid. This pyramidization of the system also was accompanied by a progressive 'demedicination'. Occupational groups other than doctors have moved in, and have become increasingly dominant. In crude terms I have described this system above (cf. also Berg, 1980).

In major respects the health services system has developed in a remarkably similar way in most North-Western, even in Northern, countries. There are variations, however. Some started earlier, some later. Some have developed faster, some more slowly. Some have built up a very steep and slender pyramid, others a flatter and more broad-based one. Some have kept the system relatively 'medicinated', others have gone further and faster in 'demedicinating' it.

How can these similarities and variations in developmental courses be explained? We have seen that the health services system is coupled to several other institutions and groups of actors. My suggestion is that we regard these couplings as indicative also of a transmittance of causative premises to the system (here we can disregard the 'traffic' in the opposite direction). Thus the emergence, growth, and internal transformation of the health services system can be viewed as a function of the timing of the interactions of the various external logics with the internal logic of the system itself (cf. Figure 12).

My expectation would be that four groups of external logics, plus the internal, are of particular interest. From 'below' a socio-cultural logic affects the system, from the sides different professional logics exert their

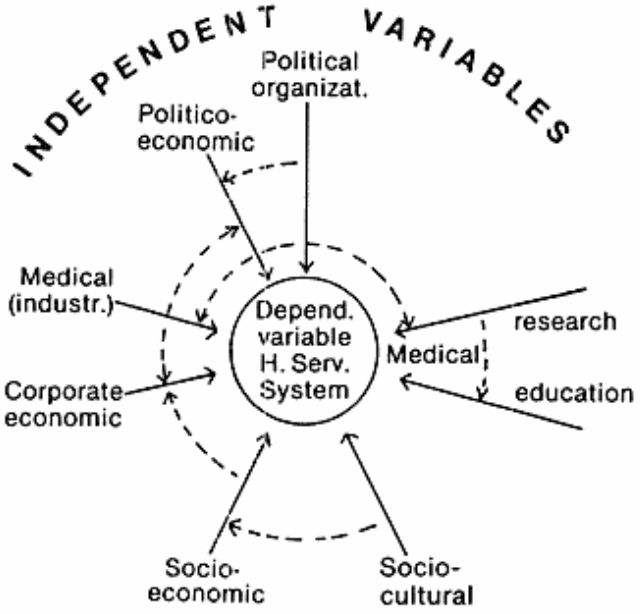

Figure 12. A Schematically Presented Strategy for the Cross-Disciplinary Study of the Development of Western Health Services Systems.

influence – research and educational institutions on the cultural side, industrial institutions on the economic side. From above the political logic impinges on the system. From several sides the economic logic can make itself felt; it depends on which character it has assumed. It makes itself felt primarily from below, and is a market logic, if patients have to pay for all services; it makes itself felt also from the left side, and is at least a modified market logic, if third party payers exist; and finally it makes itself felt from, or via, the top, and is at least partly an administrative-economic logic, if governmental agencies control the finance of the health services system. It should also be added that in the first case the sociocultural and the economic logics will interact and blend, in the latter case the political and economic logics will do so. But also the various professional (medical) logics will be closely associated. From within, finally, a socio-organizational logic will shape the development of the system.

The various logics are themselves dynamic. Hence they will change character all the time. The importance of the various logics must therefore change as well. Nevertheless I do think one type of logic has been of continuing high importance. That is the medical logic; oddly enough perhaps the most neglected one in health services research. Thus I think one can trace the chief sources of the striking cross-national similarities in the system's development back to the unfolding of the medical-scientific logic. In the early phases of the emergence of the health care system, say

up to about 1870–80, I think also the socio-cultural logic was of crucial significance. Later, from about the late nineteenth century, the weight of the economic market logic became more apparent. In this century, then, the other factors also entered the picture, and have become increasingly important. The influence of the political logic has risen particularly quickly. Thus the economic logic also has become politicized. The role of the internal organizational logic has probably grown throughout the modern period – in step with the expansion and differentiation of the system itself, but its role has hardly become very important.

NOTES

1 This trend can be discerned even within the area of human health. Up to now we have by and large taken the naturally produced man as a matter of course. We have not talked about the production of humans, as to some extent we have done about 'useful' plants and animals. The day now seems to be nearing when we will also interfere with the creation of our descendants. Gradually then, we may become designed beings, like many plants and animals already are. But the more designed we become, the more semiartificial we will also be. And if we are unhappy with the design, or if one of our organs simply begins to fail, we may in the not too distant future be redesigned and have the deficient organ replaced with an artificial, and improved new one. (Cf. Maxmen 1976, ch. 6.)

2 It resembles politics in being organizational in orientation, but is different from genuine politics in being more narrow in scope.

3 The organization of (health) policy may of course be regarded as a steering instrument. From the point of view of organization theory, it is even *the* means of governing (cf. Olsen 1978). When I here treat the policy structure as given and later only discuss functional techniques as techniques of governing, it does not imply a tacit acceptance of existing structures or a disregard for structural governing. It is simply a reflection of pragmatic considerations regarding the organization of my argument.

4 We might distinguish between procedural, or institutional, rules, and ordinary rules. The former may also be termed meta-rules and the latter simply rules. As already indicated, the purpose of meta-rules is to regulate the formulation of ordinary rules; thus meta-rules are an indirect means of governing. For our purpose it may be fruitful also to subdivide ordinary rules into two types, administrative rules and non-administrative rules (e.g. civil and penal law). In the first case the rules are to regulate the behaviour of the official administrative agencies. In the second case the objective of the rules is to affect the conduct of non-administrative corporate institutions as well as ordinary citizens.

5 Strictly speaking, this is doubtful. Some public policy may be aimed also at larger entities, like households, communities, regions – even the entire nation. Although such policy as a rule – perhaps always – can be reduced to individual-oriented policies, it is doubtful whether such a reduction is warranted. This does not need to bother us here, because the way I classify values is not dependent upon whether the policy is addressed to individuals or collectivities.

6 Quantitative policy can also be said to concern the question: how much equality? It might also be asked whether qualitative policies may not be reinterpreted in pure quantitative terms. When certain values are accorded higher priority than others, that is, are produced or provided in greater quantities then others, a welfare (re)distribution takes place. That is of course true, but this kind of distribution is in principle different from 'pure' distribution. The reason is that it is an integral part of qualitative policy also to try and change people's value preferences. We may therefore say that the rationale of qualitative policies is not to reward some at the expense of others; it is to improve the situation of everyone (in so far as

there is value disagreement). And the more successful such a policy is, the more it will be converted into quantitative policy.

7 Such variations also reflect variations in degree of scientific development. The former disciplines are moderately developed and do not have any well specified and confirmed promises (theories, axioms) from which to start out; economics has. Thus sociology, and the other less precise disciplines, have to proceed in a more open and searching way. They cannot yet discriminate sufficiently between their 'pet' variables. They have had to be relatively 'neutral' in the selection of variables. Hence, 'correlationism' becomes the predominant research strategy. Economics has laid behind itself the neutral stage; it has achieved a fairly solid deductive basis.

REFERENCES

Abel-Smith, B. 1963. *Paying for Health Services: A Study of Costs and Sources of Finance in Six Countries*. Geneva: WHO.

Anderson, O. W. 1972. *Health Care. Can There Be Equity?* New York: Wiley.

Berg, O. 1980. 'The Modernization of Health Care in Sweden and Norway,' ch. 1 in A. Heidenheimer and N. Elvander, eds., *The Shaping of the Swedish Health System*. London: Croom Helm.

Easton, D. 1953. *The Political System*. New York: Knopf.

Egeberg, M. et al. 1978. 'Organisasjonssamfunnet og den segmenterte stat,' ch. 2 in J. P. Olsen, ed. *Politisk organisering*. Bergen: Universitetsforlaget.

Flora, P. 1976. 'On the Development of the Western European Welfare States,' *International Political Science World Congress*. Edinburgh, mimeo.

Heidenheimer, A. J. 1975. 'Health Care: Delivery Options and Policy Constraints,' ch. 1 in A. J. Heidenheimer et al., *Comparative Public Policy*. New York: St. Martin's Press.

Leichter, H. M. 1979. *A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations*. Cambridge: Cambridge University Press.

Maxmen, J. S. 1976. *The Post-Physician Era* (New York: Wiley).

Olsen, J. P. 1978. 'Folkestyre, byråkrati og korporativisme,' ch. 1 in J. P. Olsen, ed., *Politisk organisering*.

Parsons, T. 1959. 'General Theory in Sociology,' pp. 39–78 in R. K. Merton et al., red., *Sociology Today*. New York: Basic Books.

Parsons, T. 1960. 'Pattern Variables Revisited,' *American Sociological Review 25*, 467–83.

Parsons, T. 1963. 'On the Concept of Political Power,' *Proceedings of the American Philosophical Society 107*, 232–62.

Roemer, M. I. 1977. *Comparative National Policies on Health Care*. New York/Basel: Marcel Dekker.

Rokkan, S. 1967. (With S. M. Lipset). 'Cleavage Structures, Party Systems and Voter alignments: An Introduction,' pp. 1–64 in S. M. Lipset and S. Rokkan, eds., *Party Systems and Voter Alignments*. New York: Free Press.

Rokkan, S. 1970. *Citizens, Elections, Parties*. Oslo: Universitetsforlaget.

Rokkan, S. 1971. 'Nation-building,' *Current Sociology 19* (no. 3), 3–86.

Rokkan, S. 1973. 'Cities, States, Nations,' pp. 73–97 in S. N. Eisenstadt and S. Rokkan, eds., *Building States and Nations*. Vol. I. Beverly Hills: Sage.

Rokkan, S. 1974. 'Entries, Exits, Voices: Toward a Possible Generalization of the Hirschman model,' *Social Science Information 13* (No. 1), pp. 39–53.

Rokkan, S. 1975. 'Dimensions of State Formation and Nation-Building: A Possible Paradigm for Research on Variations Within Europe,' pp. 562–600 in C. Tilly, red., *The Formation of National States in Western Europe*. Princeton: Princeton University Press.

Stephen, W. J. 1979, *An Analysis of Primary Medical Care*. Cambridge: Cambridge University Press.

U. S. Department of HEW, 1975, *National Health Systems in Eight Countries*. Washington, D. C.: GPO.

there is value disagreement). And the more successful such a policy is, the more it will be converted into quantitative policy.

7 Such variations also reflect variations in degree of scientific development. The former disciplines are moderately developed and do not have any well specified and confirmed promises (theories, axioms) from which to start out; economics has. Thus sociology, and the other less precise disciplines, have to proceed in a more open and searching way. They cannot yet discriminate sufficiently between their 'pet' variables. They have had to be relatively 'neutral' in the selection of variables. Hence, 'correlationism' becomes the predominant research strategy. Economics has laid behind itself the neutral stage; it has achieved a fairly solid deductive basis.

REFERENCES

Abel-Smith, B. 1963. *Paying for Health Services: A Study of Costs and Sources of Finance in Six Countries*. Geneva: WHO.

Anderson, O. W. 1972. *Health Care. Can There Be Equity?* New York: Wiley.

Berg, O. 1980. 'The Modernization of Health Care in Sweden and Norway,' ch. 1 in A. Heidenheimer and N. Elvander, eds., *The Shaping of the Swedish Health System*. London: Croom Helm.

Easton, D. 1953. *The Political System*. New York: Knopf.

Egeberg, M. et al. 1978. 'Organisasjonssamfunnet og den segmenterte stat,' ch. 2 in J. P. Olsen, ed. *Politisk organisering*. Bergen: Universitetsforlaget.

Flora, P. 1976. 'On the Development of the Western European Welfare States,' *International Political Science World Congress*. Edinburgh, mimeo.

Heidenheimer, A. J. 1975. 'Health Care: Delivery Options and Policy Constraints,' ch. 1 in A. J. Heidenheimer et al., *Comparative Public Policy*. New York: St. Martin's Press.

Leichter, H. M. 1979. *A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations*. Cambridge: Cambridge University Press.

Maxmen, J. S. 1976. *The Post-Physician Era* (New York: Wiley).

Olsen, J. P. 1978. 'Folkestyre, byråkrati og korporativisme,' ch. 1 in J. P. Olsen, ed., *Politisk organisering*.

Parsons, T. 1959. 'General Theory in Sociology,' pp. 39–78 in R. K. Merton et al., red., *Sociology Today*. New York: Basic Books.

Parsons, T. 1960. 'Pattern Variables Revisited,' *American Sociological Review 25*, 467–83.

Parsons, T. 1963. 'On the Concept of Political Power,' *Proceedings of the American Philosophical Society 107*, 232–62.

Roemer, M. I. 1977. *Comparative National Policies on Health Care*. New York/Basel: Marcel Dekker.

Rokkan, S. 1967. (With S. M. Lipset). 'Cleavage Structures, Party Systems and Voter alignments: An Introduction,' pp. 1–64 in S. M. Lipset and S. Rokkan, eds., *Party Systems and Voter Alignments*. New York: Free Press.

Rokkan, S. 1970. *Citizens, Elections, Parties*. Oslo: Universitetsforlaget.

Rokkan, S. 1971. 'Nation-building,' *Current Sociology 19* (no. 3), 3–86.

Rokkan, S. 1973. 'Cities, States, Nations,' pp. 73–97 in S. N. Eisenstadt and S. Rokkan, eds., *Building States and Nations*. Vol. I. Beverly Hills: Sage.

Rokkan, S. 1974. 'Entries, Exits, Voices: Toward a Possible Generalization of the Hirschman model,' *Social Science Information 13* (No. 1), pp. 39–53.

Rokkan, S. 1975. 'Dimensions of State Formation and Nation-Building: A Possible Paradigm for Research on Variations Within Europe,' pp. 562–600 in C. Tilly, red., *The Formation of National States in Western Europe*. Princeton: Princeton University Press.

Stephen, W. J. 1979, *An Analysis of Primary Medical Care*. Cambridge: Cambridge University Press.

U. S. Department of HEW, 1975, *National Health Systems in Eight Countries*. Washington, D. C.: GPO.