

INTERVIEW WITH JULIA LYNCH

Can you tell us a bit about your background?

I have a very strange background. I grew up next door to the campus of Cornell University, and am the daughter and granddaughter of university professors. My siblings are all university professors. This bizarre family history means that I'm particularly attuned to the notion of academia as a vocation, but also as a caste. I'm deeply committed to the goal of making academic careers seem like relevant and plausible options to people from a variety of backgrounds.

How do you view your role on the editorial board of Socio-Economic Review?

I think what distinguishes SER is its willingness to publish work that is critical and policy-relevant, that pushes into the boundaries between social science disciplines, and that is methodologically ecumenical. I want SER to be the kind of place to which political scientists who do this kind of work want to submit – and so I see one of my roles as an editor as promoting the journal in that community, where at the moment it is probably less visible than it is in sociology or economics. Ultimately, I would love SER to become a place where policymakers look for evidence to inform their work – and my sense is that most policymakers are at least as interested in compelling qualitative work as they are in regression discontinuity results or formal models.

How did you become interested in health care systems?

I came to the topic of health about 10 years ago because I was interested in inequality, and it seemed to me that the way that health care systems produced and reproduced stratification was under-studied. Initially, I was interested in trying to understand how public attitudes toward inequalities in health might be shaped by these institutions, but as I

learned more about health inequalities I realized that health care systems are actually only the tip of the iceberg.

Is it fair to describe your research as getting a handle on inequality by way of national health care systems?

It would be more accurate to say that I'm trying to get a handle on inequality through studying health, not health care systems. By the time most people need to get their health "cared" for in the medical system, they are already sick – and they are differentially likely to be sick for reasons related to much broader aspects of social organization, like the distribution of income, the quality of public housing, or the organization of social services.

Your comparison of health care systems and inequality covers a vast geographical sweep. Could you tell us a bit about your methodology? For example, why do you choose government reports and documents from the countries in your studies instead of other sources of analysis?

I'm a big believer in using the tools you need to answer the questions you have. So for various parts of my larger research agenda on the link between health inequalities and the politics of inequality in general, I've used survey experiments, network analysis, elite interviews, archival research, process tracing, and quantitative and qualitative content analysis.

For the book that I'm just finishing now [provisionally titled *Regimes of Inequality: The Politics of Health in Europe*, forthcoming from Cambridge University Press], I analyze government reports on health inequalities at both the national and international (WHO, EU) level because they are an important source of data about the presence of particular ideas about health inequalities in policy discourse. I also look at other government publications like annual public health reports, newspaper reporting, parliamentary records, politicians' speeches and party manifestos – but government reports tell us what the people who are drafted as experts to produce these reports think is important and/or politically feasible.

These reports have also proved to be a really interesting way of following how ideas about health inequalities – how they ought to be defined, what are their causes, who is responsible for solving the problem, and what tools they ought to use – travel through the international organizational field of health policy over time. By looking at who contributed to drafting the reports, which countries they are from, who finances their research, who they cite, etc. I can see that the framing of health inequalities that has become a kind of “international consensus view” mainly came from the UK and a few research centers in Sweden and the Netherlands; was taken up within the World Health Organization’s Regional Office for Europe; from there spread to the European Commission; and from there was pushed out to other countries in Europe.

What are some of the main distinctions between the U.S., France and Belgium, Finland, and others?

A key difference when thinking about how governments approach the issue of health equity is whether they still think of it mainly as an issue related to access to health care, or whether they have adopted the international consensus view that focuses more on health status inequalities as related to inequalities in the social determinants of health. For different reasons in different countries (but often related to perceived constraints on redistribution, social spending, or market regulation), governments in many countries have adopted the international consensus view in recent years. But in countries like France and the US, where there are really strong historical and contemporary reasons for worrying about access to health care as a barrier to health equity, the new health inequalities frame is really just a thin veneer atop a politics of health that is still mainly about health care.

In a recent article you write that the countries in your study stop short of doing the necessary to solve the problems of inequality in health care. What should they do?

The main lesson I draw from the research for the book is that the center-left really needs to re-think how it talks about inequality. Since the mid-1980s, center-left politicians have tied their own hands when it comes to reducing social inequality, insisting that it is either too dangerous or fundamentally undesirable to do anything that would upset the neoliberal market order. As a result, they have begun to frame the problem of social inequality in new ways. It's no longer a problem to be solved by redistribution or political regulation of the market, but instead by taking on more distal, technocratic issues like social investment and health inequalities. This allows them to show that they are still "for" equity – but as I show in my book, it also makes the problem of inequality much harder to solve. So my message is that if you want to be "for" equity, you really just have to insist on using the policy levers that you already know work to reduce inequality: redistributive taxation and public spending, and market regulation. Essentially, I'm saying that if the center-left wants to become relevant again, they are going to need to be bolder when it comes to talking about and acting on social inequality, particularly income inequality.

Everyone must ask you this – we will too. Which of the countries you study has the best health system and why?

Ha! Yes, everyone asks me that. My answer is that "it depends" – on what you want your health system to do, and for whom. Some people are most concerned about having a choice of providers, or being able to select how much insurance you want to carry, or in getting cutting-edge medicine to market as quickly as possible. While those things are all valuable, they aren't my priorities. When I think about an ideal health system, I'm really evaluating it based on its ability to do three things: First, I think it's important to keep health care costs low enough that health spending doesn't crowd out public or private spending on those other things that we know are

ultimately far more important for producing healthy lives, like high-quality education for all, or great public transit systems. Second, I think it's important that health care should be equitably financed and delivered: that is, the health care you receive should be related to your health needs, and people who can afford to pay more should do so in order to help keep costs lower for those who can't afford it. Third, I think that health care systems need to provide high quality care in a timely manner so that health care makes people healthier, not sicker.

Adequately-funded national health service models have historically been the most successful at combining these three desiderata of cost control, equity, and quality. But if one were to create *de novo* a properly-structured and properly-regulated social insurance-based system (or even a private not-for-profit insurance system) with a reasonable global budget cap, one could probably also get the job done that way. I don't think there's any particular magic to public provision or single-payer – it's just that in the real world, health system features that drive up costs tend to be associated with multi-payer social and private insurance models.