This first issue of the *International Journal of Public and Private Healthcare Management and Economics* (IJPPHME) is appearing in the age of global transformation in health and welfare services and markets. Long standing structures for delivering, financing and managing services have been challenged by the aging society since the 1990s. Traditionally, healthcare systems have been private and market-based (e.g., United States, Switzerland), public, state-controlled (e.g., Great Britain and Scandinavia), or mixed provision (e.g., Canada and Japan). However, these “types” are misleading, because the reality of financing and organizing these systems can be paradoxical, blurring, complex and chaotic, whether it is based on national health insurance, private insurance, or out of pocket. The main reason why healthcare remains *terra incognita* for citizens, politicians, and managers is because of the narrow-minded definitions of health itself and general preconceptions concerning the public-private distinction. Therefore, for the journal, healthy society is a reflection of functional services and markets as well as citizenship. The scope of IJPPHME is based on the idea that health is promoted by effective and efficient public, private, and hybrid service providers in all social layers, not only health prefixes of management or policies.

Although the distinction between “public and private” has been a central characteristic of Western thought since classical antiquity (Weintraub, 1997), the prevailing consensus, at least among American scholars, on management is that this distinction is not worth much (Rainey & Chun, 2007). However, today almost every government has new forms of “public and private”: out-sourcing, contracting-out, public and private partnerships, and lately hybrid public services. In a broad sense, we can even talk about privatization of public values (Bozeman, 2007; cf., Kristiansen & Gyrd-Hansen, 2009). Nevertheless, because of the influence of “New Public Management”, private sector managerial attitudes are emulated in publicly administrated organizations through measurement and quantification and an emphasis on service quality and consumer orientation (Poole et al., 2006). In healthcare this form of “privatization”, the tailoring of public services to users, is a main topic of debate in Europe.
(Needham, 2010; Tritter et al., 2010; see also www.healthcareeuropa.com). In particular, a growing need exists to understand how those governments in which the private healthcare sector is heavily dependent on public sector spending will impact on the new forms of services delivery.

THE ANCHORING DISCIPLINE OF PUBLIC-PRIVATE DISTINCTION: DOES IT EXIST?

A comparative study of public and private management has been ongoing since the 1960s, but an interdisciplinary study of public and private healthcare management and policy has not been explored. Several practical reasons can explain the lack of this type of research (e.g., healthcare systems are difficult to compare), but theoretically the different chairs of management, business, health and policy sciences, and economics do not have a long dialog. Some scholars derive their knowledge from health economics and medicine (cf., Maynard, 2005), others from policy sciences (cf., Blank & Burau, 2010), and some apply leadership, management, and business theories (cf., Goodwin, 2006). Therefore, the IJPPHME will serve as an interdisciplinary forum for those managers, policymakers and researchers interested in the complex and comparative issues of public and private management and services in global settings, especially concerning healthcare.

Does the discipline of public-private distinction exist? On one hand, the answer is no, but on the other, the question is rhetorical, because public-private as a grand dichotomy is an inescapable element of theoretical and scientific vocabularies as well as the institutional and cultural landscape of modern societies (Weintraub, 1997, p. 38; Hayashi, 2006). But whenever we use the distinction for one particular analysis, we may be in a danger of obscuring other important purposes (cf., Mg-Carthy & Edwards, 2001). Critically speaking, the exploration of the discipline should debunk the stereotypes between different public–private sectors based on ownership, funding, and control (Boyne, 2002). Rather than having the unit of analysis of public-private healthcare comparisons based on these dimensions, we must focus comparatively on the semantic differences (Jorna et al., 2010).

SUMMARY

The scientific challenge of comparing public-private forms of service delivery manifests itself in the epistemology of a priori knowledge. In other words, for scholars and researchers the language barrier prevents us from understanding how other cultures reconstruct the public-private distinction. However, the more comparable the public-private concepts ($p$) are the more a truth $p$ is a priori and definable independent of experience. It is not enough that the differences converge, because scholars cannot share basic assumptions about the following comparative problems:

If the differences between public–private service providers can be explained by “public” or private dimensions, what are the semantic differences of “public” and “private”?

If the public and private managerial differences exist, do they exist because of the myths about public and private managerial behavior and comparable experiences of behavior?

In any case, the global need for comparative public-private knowledge will remain. The world of healthcare services will become the world of global services (e.g., health tourism). Therefore, the rise for evidence-based knowledge concerning public, private, and hybrids forms of service delivery should be comparative to achieve more efficient healthcare systems.

In this first issue of IJPPHME, the comparative unit of analysis in most of the articles is at the government level between different nations. In addition, some articles explore new forms of service delivery. In Asia, Ichiro Tsukamoto
and Mariko Nishimura examine and compare the shifting relationships between third sector organizations and local government under the current public service reforms in Japan and the UK. In South America, Gonçalve et al. analyze the relationship between the so-called participative communities and their influence on local public health policies through city health councils in Brazil and Uruguay. In Brasil, Gomes et al. focus on stakeholders’ expectations of a healthcare department. In Scandinavia, Kokkinen and Lehto examine how different service delivery solutions implemented by a policy entrepreneur in a public organization influence the structural environment of specific health services in Finland.

The IJPPHME encourages contributors to link their public–private research with an understanding of how comparative knowledge fits within a country’s service delivery and managerial systems of health or welfare in general.

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REFERENCES


