Exploring Theory for Citizens’ Preferences in Health Policy: The Contribution of Health Policy Cultures to Understanding the Roles of Public and Private Health Service Providers

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ABSTRACT

Preferences have been analyzed extensively in health care, but few studies have examined how culture driven preference formation may impact on resource allocation decisions in public and private health service delivery. This paper explores and develops a theoretical framework that distinguishes different approaches to institutionally and culturally informed preferences. The analysis shows that the appropriate approach depends on normative considerations and the particular health policy context which it is applied. In particular health policy cultures, mediating culture driven preferences (such as fatalism, hierarchism, individualism, egalitarianism and autonomy) which have not been used as part of health policy analysis before, challenge the roles of public and private health service providers. In view of the scarcity of studies in this field, the authors suggest a rationale for studies that enhance the understanding of how health policy cultures are embedded in normative health policy and propose a research agenda on cultural biases.

Keywords: Culture, Health Care, Health Policy, Health Service Provider, Preference, Private, Public

INTRODUCTION

Over the last few decades there has been growing interest among health policy makers in citizens’ preferences regarding allocation rules for public and private health service delivery (Allen & Jones, 2011; Magnussen, Vrangbæck, & Saltman, 2009). Throughout the world, citizens have become increasingly interested in the welfare and health services they receive and pay for, both as tax-payers and users. At the same time in nations at all levels of political and economic development, health policy...
makers seek to determine whether goods and health services are best provided by government, markets, communities, some set of hybrid forms, or how much should citizens take more responsibility for their welfare and health care. They ask, “Under what arrangements are the public health needs and welfare best served?” and “How and by whom should health services be provided, and why?”

Increasingly, the questions about allocation of goods and health services receive market answers. In recent health policy reforms consumerism as a form of individualism has been a taken for granted solution and as a manifestation of “new public management” and “value for tax-payers money” (Battaglio, 2009). However, the consumerist model may weaken accountability and values such as fairness and social justice, as Brewer (2007) argues. Medical paternalism produced by hierarchism on the other hand demonstrates traditional and authoritarian doctor-patient relationships as a key basis of service delivery (McLaughlin, 2009). But the rationale behind health service systems is very different, as social value is much more than the aggregation of consumer or patient centered benefits. For the purposes of health policy, a wider conception of health and welfare is inevitably required. There are at least three competing and forgotten institutionally informed health policy cultures that mediate different preferences in health policy making: egalitarianism, fatalism and autonomy. These health policy cultures may provide unexplored opportunities for organizing health services in more pluralistic way, beyond the public and the private sectors.

Public interest in health policy is often restricted to governmental organizations or market intervention, rather than asking what citizens prefer in public and private health services, we ask in this paper what makes a health service organization more likely to provide for public and private outcomes in relation to citizens’ preferences. In contrast to a dichotomous view of public and private health service organizations based entirely on ownership or funding (Rainey, Backoff & Levine, 1976), the institutionally and culturally informed view of publicness and privateness presented in this paper recognizes varying degrees of political authority (public influence) and economic authority (private influence) over all forms of health service organizations (Bozeman, 1987; Dahl & Lindblom, 1953; Rainey, 2009; Wamsley & Zald, 1973). Correspondingly, in contrast to dichotomous view of consumers and patients, it recognizes citizens’ political and economic authority that manifests itself in their preferences and choices in ordinary life. Furthermore, some citizens may have well-formed preferences that trump default rules produced by the dichotomous view of public and private values. Therefore, sensible health policy planners make multiple choices available when citizens’ preferences vary most (Sunstein & Thaler, 2006). For this reason, we should know how much preferences vary across individuals and health policy cultures.

We have at our disposal several excellent conceptual tools for analyzing citizens’ preferences. A considerable effort has been directed towards defining benefits that a citizen derives from health care (Dolan & Tsuchiya, 2005), in choosing health services (Thompson & Dixon, 2007; Dent et al., 2011), or between public and private health services (Vuori & Kingsley, 1999). In addition to the analysis of personal preferences, recently there has been recently a growing interest in social preferences regarding a wider range of distributional considerations (Dolan et al., 2003). But by placing the emphasis on the internal and external forces of health service systems, there are limited conceptual tools for analyzing cultural driven preferences in respect of health service systems (Geva-May, 2002; Lockhart, 2001; Dolan et al., 2003). Culture driven preferences have been analyzed extensively in respect of the institutional theory of culture (Douglas, 1966, 1982a; Geva-May, 2002; Hendriks, 1999; Swedlow, 2008; Thompson et al., 1990; Wildavsky, 1987, 1994) but few studies in the field of health management and economics have examined how culturally informed preferences may impact on public and private values in health service delivery (see e.g. Swedlow, 2011).
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