Introduction

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1 Introduction

Central to the current debate on national healthcare, both in the USA and other countries around the globe, are issues concerning economics and cultural values that shape decisions affecting the scale, scope, and delivery of healthcare services made available to a country's population.

While most agree on the goal of seeking quality healthcare at an affordable price, wide disagreement exists, both within and across nations, about who (government, individual, or third party) should pay for which service and whether national healthcare should operate as a business, public welfare programme, or a social enterprise. In the absence of a clear consensus favouring one option over another, policymakers engage in 'strategic choice' (Child, 1972), choosing between value-based priorities and criteria of operational effectiveness in making national healthcare decisions.

This thematic issue of *EJIM* aims to inform the current debate by examining a range of fundamental tensions between economic concerns and cultural values surrounding national healthcare. Four papers are presented here, which were selected from over 30 submissions by scholars around the world. As a group, these four papers represent a diverse set of country settings and perspectives on the critical issues facing healthcare policymakers. They also identify a set of strategic choice options and offer these as topics for future research. A brief summary of the thematic issue papers follows.

2 Tensions and choices in healthcare

In the first paper in this issue, 'Strategic choices in healthcare, with reference to the UK National Health Service', Child examines a number of systemic problems facing national healthcare and illustrates these by referring to the UK system. The UK National Health Service, which provides for free a vast majority of its services to all persons having permanent residence in the UK, has gone through 15 major structural changes in the past three decades to deal with a wide range of operational and financial problems. According to Child, these changes expose many of the strategic choices facing the UK system, both in the past as well as in the future. He also argues that many of such choices are intrinsic to all healthcare provision and that they cannot be avoided.

To help advance future research, Child identifies three broad areas in national healthcare (funding, organisation, and roles) where strategic choices are needed and offers some policy options for consideration. With respect to funding, strategic choices involve (i) cost versus quality of healthcare, (ii) ability to pay versus clinical need, and (iii) type of payment and patient-physician relationship. Regarding organisation, strategic choices centre on the linked core processes of coordination and control (Cheng, 1983; Cheng and McKinley, 1983) and whether decision-making should be centralised or decentralised. The final set of strategic choices concerns the roles that should be played by various constituent groups within a healthcare system, including the managers, medical professionals, patients, healthcare providers, and others.

As advice to policymakers and researchers, Child comments that "We cannot escape taking social criteria into account because, ultimately, the strategic choices made on the healthcare reflect fundamental values concerning the kind of society we want to live in". Instead of judging different healthcare systems and making policy decisions on ideological grounds, he calls for the conduct of international comparative research (Cheng, 1994; Cheng, 2007) to learn more about the basic strategic choices that are involved and how these are addressed by different countries.

The second paper, by Kimberly, 'Global health and the business of illness', takes a more macro view of the healthcare system and examines two strategic choice issues at both the national and global level. The first concerns the proper balance in preventive versus treatment care. The other is the emphasis on individual versus collective health and responsibility. He also calls attention to the glaring disparities in the health of populations across nations and the startling differences in per capita spending on health among these same countries as additional issues to be addressed.

As reported in the paper, a great majority of the global spending on healthcare is on medical care, the treatment of illness, instead of its prevention or the promotion of (good) health. In fact, much of the current debate on healthcare in Europe, the USA and elsewhere is primarily about reform of medical care, about how doctors and hospitals are paid and how to make the services they provide more accessible. Because it is more difficult to make a 'business case' for enterprises to get involved in the prevention of illness, business opportunity has flourished in medical care, but not in health promotion.

A separate but related issue is the emphasis placed on individual versus collective health and responsibility. Compared with the USA, European countries in general have a much stronger commitment to collective well-being and in investing in the preventive care business. In the USA, the emphasis is on individual freedom and responsibility for

one's own health. This cultural value has made it very difficult for the country to pass legislation providing universal health coverage to its citizens, as evidenced by the Republican Party-led opposition to Obama's healthcare reform bill.

To help promote the business of health (as opposed to illness), Kimberly calls for public-private partnerships to provide the appropriate incentives and institutional support to motivate strategic movement in advancing global health for the collective.

In the third paper, 'The challenge of healthcare accessibility in sub-Saharan Africa: the role of ideas and culture', Wireko and Béland investigate healthcare availability and use in sub-Saharan Africa (SSA) and identify the tension between modern and traditional medicine as a strategic choice issue needing attention. They report that, despite the presence of numerous healthcare infrastructures in many African countries to ensure universal accessibility of modern healthcare, it has an overwhelmingly lower rate of use than traditional healthcare. They also found that, to many African patients, traditional healthcare is not adopted as an alternative but rather as the preferred option, even when modern healthcare is available.

While this disparity can be partly explained by economic factors (e.g. herbal medicine is cheaper), the authors argue that cultural beliefs are the main reason why traditional healthcare is much more used than modern healthcare in SSA. For example, many illnesses are regarded by the general public as 'not-for-hospital and untreatable by modern medicine'. In Uganda, many locals believe that a convulsion is a supernatural ailment that is best treated by traditional medicine. In Tanzania, malaria is believed to have something to do with witchcraft; and witches can imitate symptoms of malaria.

Going forward, Wireko and Béland call for researchers to study national healthcare from a cultural perspective, incorporating background ideas into the investigation about what healthcare means to the users and how it should be delivered. This will complement the economic approach, which tends to focus on issues related to making healthcare infrastructures available, helping people to pay for healthcare, or getting them insurance coverage. Finally, citing the success of China in integrating the traditional and modern medical systems, the authors recommend that SSA learn from China's experiences.

The final paper by Wokutch, Zhang and Zhao, 'Chinese healthcare system and workers' welfare', examines healthcare availability in China and reports that it remains far behind the needs of the people. Not only are medical services difficult to access and expensive to consume, there also exist various inefficiencies and widespread corruption in the healthcare delivery system. These problems are worsened for people living in the rural areas and also those not employed by the government or state-owned enterprises. Because of the government's emphasis on economic growth as priority for national development, workers' heath and safety have taken a back seat, resulting in reduced welfare for this large population group.

Although the paper does not identify any specific strategic choice issues facing healthcare in China, its analysis of the existing problems points to two fundamental tensions that need to be addressed. The first concerns the tension between privileged versus common access to healthcare. The second is the balance between economic growth and social wellbeing as a priority in national development.

To help maintain the one-party political system in China, government employees and party officials are provided many privileges, including access to (quality) healthcare, that are not available to the general public. This disparity is exacerbated by the rapid pace of economic development in recent years, which was made possible by the government's

willingness to accept reduced social well-being (e.g. polluted air) as a necessary cost. These two tensions have resulted in much public anger, which the government would need to resolve in order for the country to reach the next level.

In sum, these four thematic issue papers have identified a set of critical strategic choice problems facing policymakers in national healthcare. Some of these choice problems (e.g. centralisation versus decentralisation) are common across different national settings; others (e.g. traditional versus modern medicine) are relevant to specific countries. As a group, these strategic choice problems represent exciting and worthwhile research topics for scholars interested in national healthcare. We hope you will enjoy reading this thematic issue and be motivated to conduct investigation on one or more of these topics.

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