

EDITORIAL PREFACE

Toward Personalized Public and Private Health Services?

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We are living in a world of diminishing resources and increasing demands as far as public and private health services is concerned. Basically, there are many health care organizations and even governments that are searching for new human resources all the time from all parts of the world. In particular, the shortage of qualified nurses and doctors is some of countries so disturbing that governments must constantly address it. However, the shortage is not only caused by the lack of workforce, but irresponsible services and incompetent human resources. In addition, some customers do not want wait for doctors any more: they go private for a higher standard of healthcare, with better facilities and shorter waiting time to see specialists. Nevertheless, if all citizens who have a urgent need do not get access to services, the cost of their treatments (cf. cancer) will be extremely high. Therefore, all governments need to find a way to provide more tailor-made services that are close to their users with the fewer amounts of health care organizations and human resources as well. How governments can rebuild their healthcare systems with questioning the institutional structures of their health care systems?

The societal need for answering this question is exceptionally important for the following four reasons. First, managers and policymakers have to produce more personalized, tailor-made services that are close to their users in order to curb the rising costs of the aging societies. Second, currently organizations mainly deliver services that are professionally-defined, rather than citizen-defined. We need to highlight that citizens' preferences may be for services that encourage self-management for a healthier lifestyle. Third, for those more f citizens, who are indifferent to their health, the costs of their treatments may be prohibitively expensive for hospitals, because, the citizens will not access services until they have an urgent health need. Fourth, the more services are based on the classic dichotomy of public-private services, the more unlikely human resources are to be managed efficiently or services personalized. In the future, we will need to be sure that public and private health services are personalized in line with citizens' preferences through co-production. This raises crucial question: How we can have more co-productive services based on shared decision-making in health care?

First, we can investigate more strategic dilemma management as a tool for controlling risks and legitimacy in the management of change in the public-healthcare sector. (cf. Kuoppakangas, Suomi and Horton in this issue). Second, healthcare organization and health policy making is heavily related to problems and dilemmas. Achieving evidence-based patient choice or involvement is extremely difficult, because of the complex roles of clinicians and key stakeholders.

We need to identify the key networks behind this phenomenon. For example, in the United Kingdom, despite the greater emphasis placed by policy makers and researchers on non-profits, there were substantially more for-profits. (see Matchya, Allen, Turner, Bartlett, Perotin and Zamora in this issue). Third, the wicked problems can be related to the fact that even if healthcare systems have experienced with different kinds

of innovations, assessments show that the impacts of innovations in reality have not met expectations particularly in primary health-care centers (see Aslani and Naaraoja in this issue). In a nutshell, we cannot have effective co-productive and personalized services until we are willing to question how the way things are in the institutionalized networks of health care service providers. Can citizen choice and evidence based medicine co-exist is still open question, because institutional inertia. It may even remain enigma in spite of the fact: we know that the shared decision-making approach helps doctors and patients decide on the most appropriate treatment.

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