**Roundtable discussion "Cultures and resulting behavior"**

**By Larry Brown**

"Culture" is sometimes dismissed as a mushy and "non-scientific" term that has little payoff in the analysis and improvement of health policy and management. But culture constitutes an important part of the context in which health affairs play out. "Follow the money"—just examine and tweak payment methods—is useful advice only to a point because financial incentives exert their effects in a cultural context.

Culture should be understood not as a rigid and immutable set of "norms and values" that people store in their heads but rather as patterns of meaning that are subject to reevaluation in light of changing circumstances. And societies do exhibit marked differences in the meanings they assign to consumers, providers, payers, and the State in their health care systems.

Discussants at the table identified three broad cultural patterns.

1. Solidaristic: This orientation characterizes European nations, plus Canada, Australia, and Japan. Health care is a right of citizenship, universal and equitable access is of the essence, government is expected to set system-wide rules of the game (what services are covered, how the money is raised, how and how much providers get paid, extent of cost sharing, how technologies are assessed, and so on) that reconcile universality and affordability over time. Redistribution from the better off to the less well off (defined on various criteria) is crucial, indeed basic, to the element of, equity.

2. Voluntaristic: The USA does not formally acknowledge health care as a right, but rather treats it as a highly important set of goods and services that ought to be made available as widely as possible, and preferably by private and voluntary organizations. An employer-based system is viewed as a check on overreach by public authorities. Government should enter the scene and redistribute taxpayers' hard-earned dollars if and only if the beneficiaries are deemed "deserving," which in practice means the aged (high needs, out of the workforce, and unable to afford adequate coverage on their own) and a subset of the poor (mainly women and children, who cannot be expected to work and acquire employer-based coverage). Likewise, government is expected to limit its control of the system as a whole: rules of the game are viewed as legitimate mainly for public programs (Medicare, Medicaid, CHIP) and to protect consumers from salient abuses by private actors (e.g. regulation of managed care and of the enrolment and pricing practices of private insurers). Solidarity is in short supply (the term is almost never used in health policy debates in the USA) and is widely regarded not as the essence of equity but, on the contrary, as an unfair transfer of funds from the virtuous to those who have failed to take personal responsibility for their lives.

3. Traditional: In the Middle East, health systems tend to be stratified along lines of caste, class, and gender. Nationals, expatriates, and laborers (single males) have distinct rights and channels of access to care. The nationals often seek care in Europe or the USA and tend to distrust home-trained providers. There is some pressure on governments to improve access to and the quality of care in their nations, and some progressively-inclined officials in government ministries seek lessons from abroad, but change comes very slowly in systems constrained by deeply rooted cultural patterns.