News

Making health care affordable in China

China is taking steps towards its goal of providing every single person in the country with access to modern health-care services, in part through health financing schemes. Jane Parry and Cui Weiyuan report.

When Shi Liuchang, a worker at a state-owned electricity plant in Pingdingshan, Henan province, China, was diagnosed with hepatitis B in 1982, his work unit gave him a blank cheque to pay the medical bill. "All I had to do was bring the cheque to the hospital to have it filled in with the total cost when I was discharged," he explains.

The 1000 yuan bill for a second three-month stay in hospital in 1987 – the equivalent of US$ 268 at that time – was also picked up by Shi's employer. But by 2000, the cost of a two-week stay in hospital had spiralled to over 10 times that amount and his health insurance no longer met the cost. At a time when his monthly salary was 900 yuan, Shi had to pay over 6000 yuan out of his own pocket as his health insurance only covered 4000 yuan of the bill.

And things got worse. In 2007, he was diagnosed with liver cancer, after he had been made redundant and was no longer covered by an employer-based health insurance scheme. "After being 'retired' for quite a long time, I could not get any type of insurance because I had hepatitis B. It is impossible with commercial insurance," Shi, aged 58, recalls. It was not until 2007 that he finally got insured through an urban cooperative health insurance scheme, but even that only provided partial coverage for inpatient care at designated hospitals.

Beforehand, Shi has received treatment in the city. Now he was restricted to the local clinic, which lacked staff and facilities to treat liver cancer. "They refused to refer me to the provincial capital-level hospital, saying that cancer was a terminal disease and no matter where I got treated, the final result would invariably be death anyway."

Later that year, Shi managed to round up 120 000 yuan (US$ 17 600 by today's rates) to pay for some of the treatment at the prestigious Beijing Cancer Hospital. "This was a big fortune for me, but without the operation I would have died," he says. Still, he has completed only one of three recommended follow-up rounds of chemotherapy, as 18 000 yuan per round is prohibitively expensive, and he fears bankrupting his family.

Shi's story is a microcosm of China's health-care financing issues, of how, over three decades of economic liberalization, hospitals became driven by profits and access to care became uneven. His experience of battling a chronic disease also illustrates the health problems affecting China's ageing population – problems the government has recognized are in need of new financing solutions. But current efforts fall short. Health insurance reimbursement levels are often woefully low, while health insurance schemes are limited in scope and fail to address the key issue of how health-care providers are paid for their services.

> "The government expenditure on health care has seen a dramatic change."
>
> *Lei Haichao*

Moreover, compared to their rural counterparts, urban residents like Shi, are the lucky ones. In the countryside, the rural cooperative health schemes that covered over 90% of peasants in the 1970s collapsed in the 1980s as China's agricultural sector was privatized. Although rural health insurance schemes have been reintroduced, out-of-pocket expenditure remains high and rural health-care services remain inadequate.

For consumers, out-of-pocket expenses including user fees are the main problem, but for the health authorities there are three challenges to reforming China's health-care financing structure: how to raise the money, how to pool what is raised and how to reimburse

WHO/Cui Weiyuan

Shi Liuchang

service providers. The government realized that patchy health insurance coverage was a problem in 2003, when the outbreak of severe acute respiratory syndrome exposed weaknesses in the country's health system. But it was not until 2006 that health officials recognized that reinforcing the health system was just as important as prevention and treatment of infectious diseases.

"In 2007, the central government began to subsidize community health-care services in central and western China at the level of 3–4 yuan per urban resident, which the local authorities are required to match," says Dr Lei Haichao of the Department of Health Policy and Regulation at China's Ministry of Health. "Since the inception of the New Rural Cooperative Medical Scheme in July 2003, it has covered more than 800 million rural residents. The funding level (premium) was 50 yuan per capita in 2007. This will be increased to 100 yuan by 2008 or 2009, depending on the provinces. Of the 100 yuan (annual premium), 80 yuan will come from the central and local government. The peasant only needs to pay 20 yuan out of his pocket."

Public financing of health care is increasing, according to Lei. "The government expenditure on health care has seen a dramatic change. Government budgetary financing accounted

WHO/Cui Weiyuan

He Yanguang and Chen Zhaolian

for 15.9% of total health spending in 2001, and the percentage increased to 18.1% in 2006," he says. This year the central government announced it would increase health spending again, by another 25%, taking this to 83.2 billion yuan, some of which will be earmarked for enhancement of the rural and urban health insurance scheme and health infrastructure at the community level. Details of these health-care reforms were released as the *Bulletin* went to press.

"The Chinese government argued that the burden is reduced because out-of-pocket payments as a percentage of total health expenditure have been reduced," says Dr Henk Bekedam, director of health sector development at WHO's Office for the Western Pacific Region in Manila. "It's an achievement, it's good, but it's not sufficient information to argue that people are paying less. You also have to look at other indicators, such as health-care spending as a proportion of total household expenditure, which was 4–5% seven to eight years ago, and is now 6–8% and more in poorer areas."

In the past, universal health care for people in rural areas meant reliance on barefoot doctors with rudimentary training and few medicines. Today, the government has a vision of universal access to modern health-care services. Bekedam praises China for this and says it has found the mechanism to see that everyone in rural areas is signed up to a health insurance scheme in the next few years.

Coverage in urban areas is more of a patchwork. Some 140 million urban residents, a third of the total urban population, are covered by the workplace-based health insurance called Basic Medical Insurance. Improvements to this scheme are in the pipeline, such as inclusion of spouses and children. In some parts of China poor urban residents are covered by the Medical Financial Assistance Scheme, but the country's 200 million migrant workers and the unemployed have yet to be covered.

Out-of-pocket payments for health should not exceed 30% of a person's income, according to the Organisation for Economic Co-operation and Development's definition of universal access.

In China, the Rural Cooperative Medical Schemes and Medical Financial Assistance schemes, for lower-income groups in cities, only reimburse 30% of health costs which means out-of-pocket payments of 70%, regardless of income.

"The very poor cannot pay for medical services upfront and cannot afford to pay 70% of the costs. Their premiums end up subsidizing scheme members who can afford to pay what the insurance doesn't cover," says Bekedam.

A rural health insurance scheme enabled He Yanguang's family to recoup just over half of the cost of her husband Chen Zhaolian's treatment for a brain tumour in 2004. "The 31 000 yuan reimbursed through the scheme was a big relief to my family. We'd borrowed almost 30 000 yuan from relatives and neighbours, so the reimbursement at least kept us out of debt," she said. "We kept borrowing from so many people. In the countryside, no single person

has that much money on hand, plus the hospital won't treat you if you don't have enough money for the deposit."

However, once the reimbursements were exhausted, her husband's treatment came to an abrupt halt and his condition deteriorated. "In the countryside, how much you are treated depends on how much money you have. When the money is used up, you quit your treatment," Chen said two weeks before his death.

Public financing accounts for only 7–8% of public hospitals' income, according to the health ministry, with user fees for services bringing in the rest. This often results in wealthier patients receiving unnecessary services, while poorer patients are unable to access the health care they need.

Dr Tang Shenglan, health and poverty adviser at WHO's country office in Beijing, discusses this in an internal report on China's health-care system. "There has also been evidence [of] supply-induced demand, particularly for inpatient services, which are covered by most Rural Cooperative Medical Schemes in China," he writes. "Irrational use of health technologies, such as prescribing unnecessary diagnostic tests and medicines, and referring more patients for hospital admissions are, as observed, part of revenue-driven approaches used by the Chinese service providers to make more money that can be used to increase the income level of doctors and other staff."

> "In the countryside, how much you are treated depends on how much money you have. When the money is used up, you quit your treatment."
>
> *Chen Zhaolian*

Whether China should move towards the United Kingdom model of direct government funding of health-care or premium-based insurance has yet to be decided. "There are a lot of debates domestically on which model China should follow, but there is no answer yet. The government will continue to support both the supply side and the demand side in the anticipated future," says the Ministry of Health's Lei.

Moving away from a reliance on user fees is not only a challenge for China, but for many middle-income countries. However, if China had a system of universal insurance with a 70% minimum reimbursement level, says Bekedam, insurance companies and funds would have an incentive to make service providers improve efficiency by introducing prepayment and other mechanisms. Pooling of premiums could be expanded up to the provincial level, which would make insurance companies and funds more capable of negotiating good deals with service providers.

All this should bring China closer to the goal of universal health care, says Dr Hans Troedsson, WHO's representative in China. "WHO is pleased to see that the Government of China has made a firm commitment to universal coverage of essential health care," he says. "However, China has a long way to go in terms of improving equity in financing and provision of essential health care for all." ■

Sharing the burden of sickness: mutual health insurance in Rwanda

Mandatory participation in mutual health insurance schemes and public subsidies for the poor have led to considerable improvement in public health and health care in Rwanda, but even at US$ 2 a year, the price for some members of the population remains prohibitively high. Aimable Twahirwa reports from Kigali.

Courtesy of Partners in Health

Families in Rwanda, such as this one, are benefiting from mutual health insurance schemes.

Rwanda's Ministry of Health plans, to boost community participation in the financing of health-care services in the 1980s and 1990s, were hampered in the immediate aftermath of the war and genocide of 1994. But since those dark days, Rwandan authorities have engaged in an effort to strengthen communities' role in managing and co-financing health-care provision. One of the ways it has done this is through mutual health insurance schemes, known in Rwanda as *mutuelles de santé* or *mutuelles*.

Mutuelles were reinitiated as pilot projects in Rwanda in 1999 and uptake accelerated sharply in 2004–2005 with the adoption of a national policy on *mutuelles* and a roll-out of the schemes with the financial and technical support of development partners. As of April this year, every Rwandan is obliged by law to have some form of health insurance.

There are currently several health insurance programmes in Rwanda targeting specific groups of the population. However, the biggest in terms of

Laurie Wen/PIH Rwanda

A patient at Rwinkwavu Hospital, the main referral site of nongovernmental organization Partners in Health in Rwanda. *Inshuti Mu Buzima* painted on the wall means: "Partners in Health" in the local language Kinyarwanda.

membership is the *mutuelles* scheme, participation in which is organized on a per household basis, with an annual payment of 1000 Rwandan francs (US$ 2) per family member.

For WHO's Laurent Musango, former director of the School of Public Health at the National University of Rwanda, the growth of the mutual health insurance system has been a great success from the point of view of the affordability of the programme, and the fact that all comers are covered: "Rwanda is the only country in sub-Saharan Africa in which 85% of the population participates in mutual insurance programmes for their health coverage," he says, adding that coverage is afforded to, "the rich as well as the poor, the young as well the old, the urban as well as the rural population".

Musango argues that mutualization has also led to a reduction in health-care costs, and the increased use of health-care services. Taken together with other reforms such as the decentralization of health-care services, performance-based financing, quality insurance and improvements in quality control through supervision, Musango believes mutualization has made a significant contribution to the well-being of the population.

But there have been suggestions that people are being pressured into participating in a scheme they can ill-afford. "In the poorest regions of Rwanda there are people who are finding it difficult to pay for the *mutuelle*, but the government is doing a lot to help," says Didi Bertrand Farmer, director of community health and social development with Partners in Health, a nongovernmental organization that is working in eastern Rwanda.

> "Rwanda is the only country in sub-Saharan Africa in which 85% of the population participates in mutual insurance programmes for their health coverage."
>
> *Laurent Musango*

Musango notes that participation in *mutuelles* has increased since 1999 because people can see the advantages, a view supported by Cyriaque Muhayimana, a farmer with five children, living in the village of Rulindo 30 kilometres from Kigali: "At first most of the people in my village said that this system wouldn't work and that the cost of participating was more than they could afford," he says, adding that, "today nearly everyone in the village, most of them farmers, understands the usefulness of the *mutuelles* system."

Adélio Fernandes Antunes, health systems management analyst at the Department of Health Systems Financing at the World Health Organization (WHO), while keen to emphasize the advantages of *mutuelles* is also aware of the challenges they face: "The current *mutuelles* still have to improve their financial sustainability," he says, noting also that while the current *mutuelles* scheme enables most families to join on the basis of solidarity, these schemes could be fairer as payments are not yet based on capacity-to-pay. In other words, the rich and the poor all pay the same contribution. "Even in a country like Rwanda one may want to search for opportunities to increase the contribution of better-off households and to support the access of the poor with those monies," Antunes says

The *mutuelles* system is partly financed by external aid, from partners such as the Global Fund to fight AIDS, Tuberculosis and Malaria, which covers insurance premiums for about 1.5 million vulnerable Rwandans. But Rwanda's *mutuelles* system doesn't cover all health costs confronting poor people in this country of some nine million people.

"*Mutuelles* provide, in theory, access to all levels of the system. They don't remove all financial barriers to access services but they do reduce them, even at hospitals when people have been referred, using public subsidies," says Antunes. Beyond concerns about financial sustainability, he says the *mutuelles*' success will also hinge on having strong insurance institutions that build on each other.

That said, Rwanda is in many ways an inspiration to other countries in its commitment to universal health care. Says Antunes: "Rwanda remains one of the poorest and most vulnerable countries in the African continent and in the world but it has realized that by basing its health financing systems on solidarity and fairness it can move towards the universal coverage needed for its society to grow socially and economically." ■

Public tensions, private woes in Chile

In 1981 Chilean health-care insurance was partially privatized to offer more choice to those who could afford it. Twenty-seven years later the government is struggling with the resulting inequities. Mireia Bes reports.

Chile's health-care sector was opened up to the forces of the market by a new law in 1981 that allowed private insurance companies, called Isapres, (Instituciones de Salud Previsional) to compete for business. Prior to that, all Chileans were obliged to pay 4% of their income into the state-run Fondo Nacional de Salud (FONASA). The new law gave people, who could pay more, a greater choice and access to better services. "The idea was to allow people who were obliged to contribute 4% of their incomes to FONASA – a service they rarely if ever used – to take their 4% to the Isapre of their choice," says Ricardo Bitrán, an economist and Chilean health finance consultant. And if they wanted to contribute more for better service, they could do that too.

> "This is a double inequity, because people who haven't contributed to the public system end up spending huge amounts of the public system's money."
>
> *Camilo Cid*

The resultant transfer of funds out of the public scheme, FONASA, fed the private Isapre schemes until 1997, when nearly 25% of the Chilean population was insured privately. But the same funds transfer created a deficit for FONASA, which the government sought to rectify by raising mandatory contributions to 7% of individual incomes. Since then, there has been a progressive decrease in the Isapres' share of the market, and at present they insure only 15% of the population.

One of the reasons for this decline is that as the Isapre beneficiaries grew older, they found themselves confronted by higher premiums imposed by the private schemes to reflect increased risk. Ageing Isapre adherents unwilling or unable to pay the higher premiums returned to the public scheme. Meanwhile, because the Isapres could refuse to cover new clients due to pre-existing conditions, many joined the public scheme because they had no other option.

This movement of higher-risk people away from the Isapres has placed a burden on the public sector that some consider unfair. Camilo Cid, economist and researcher working in the public sector says: "When people who have been with the Isapres their whole life start to become ill, they realize they can't go on paying those [high] premiums, and then they move to FONASA. This is a double inequity, because people who haven't contributed to the public system end up spending huge amounts of the public system's money."

In 2000, the Isapre private insurance schemes responded to public criticism that they were only insuring those who least needed their services by offering what they called catastrophic insurance coverage, effectively broadening the claims they were willing to cover. A round of government regulation followed, culminating in 2005 in a new law called Plan de Acceso Universal con Garantías Explicitas (AUGE), which established a list of 56 priority health problems that both FONASA and the Isapres were obliged to cover.

For Bitrán, the AUGE legislation is a significant step forward as it includes commitments to quality and timeliness of treatment. AUGE also sets a ceiling for consumer co-payments. President Michelle Bachelet, who came to office in 2006, has promised to increase the list of 56 illnesses and conditions covered to a total of 80 before finishing her four-year-term, but it remains to be seen whether she will achieve that goal. In 2008, the Isapres had to adjust their premiums to 8% or more because there was a considerable increase in payouts attributed to AUGE, a situation which has resulted in even more people going to FONASA.

"About 53% of health expenditure is spent on 70% of the population, while the remaining 47% is spent on 17% of the population," says Cid, citing Ministry of Health figures. "It is neither proportional nor equitable." Those figures do not cover insurance schemes for the military, which represent around 5%. Meanwhile, about 8% of the population is not covered by any scheme at all.

> "Isapres weren't created to insure all Chileans ... They were created to insure the people who chose to join them."
>
> *Ricardo Bitrán*

On the other side of the argument Bitrán points out that "Isapres weren't created to insure all Chileans, both rich and poor. They were created to insure the people who chose to join them and who are willing to pay at least 7% of their salary to be insured through them." That said, because the private insurance schemes tend to reject higher-risk consumers, they inevitably increase the risk, and therefore the cost of premiums within the public system. Moreover FONASA is burdened with a high proportion of people considered poor or destitute – a group which represents a staggering 40% of all FONASA beneficiaries. These people pay neither the 7% contribution, nor the co-payments due on receipt of services.

Supporting the public health insurance scheme and its members is of course a laudable act of social solidarity, but it also begs the question: shouldn't the richer consumers with the private Isapres schemes share the burden?

Cid believes that further reform will be necessary to make the current system more equitable, for example, by requiring private insurers to compensate FONASA, for the greater risks and additional financial burdens it shoulders. Whether reform will come about is another matter. For Cid, any meaningful discussion of the problem is unlikely in the short-term. "It seems that from time to time some doors open to political and technical discussion, but at the moment they are closed again because there are municipal elections coming up in Chile, and no one wants to speak about this complex issue openly," he says. ■

Portugal's rapid progress through primary health care

Portugal has made rapid progress in providing a comprehensive range of health services to the whole population, but gaining public acceptance of a reduction in the number of health centres remains a challenge. Richard Waddington reports.

"It really is a great time for a family doctor to be working in Portugal," says Dr André Biscaia. Speaking from the Cascais Health Centre where he works at Sao Joao de Estoril, some 15 kilometres north along the coast from Lisbon, Biscaia says that reforms initiated by the Portuguese government are transforming the way family practitioners work and the way they relate to their patients.

Launched in 2005, these changes have improved job satisfaction among family doctors and are beginning to reverse a worrying decline in their numbers, while at the same time winning strong levels of approval from patients attending the country's health clinics.

At the heart of the changes are the new Family Health Units, *Unidades de Saúde Familiares* (USF), groups of family doctors, nurses and administrative staff who work together as a single team to bring a more personal and flexible approach to the care of patients.

"The key thing about the USFs is that they really encourage team work," says Biscaia. "They function in an autonomous way. The big decisions within the team are taken democratically, by vote – one health professional, either doctor, nurse or administrative staff, one vote," he adds. Patients benefit because important decisions on health issues and on treatment are brought closer to the communities in which they will be applied.

"The USF teams know their communities very well and can organize resources to meet community needs. We can adjust our schedules very quickly, in accordance with what is needed and wanted at any particular time," he says.

> "The USF teams know their communities very well and can organize resources to meet community needs."
>
> *André Biscaia*

In the year of the 30th anniversary of the World Health Organization's (WHO) Declaration of Alma-Ata on health for all, the Portuguese reform embodies the spirit of that landmark agreement.

Courtesy of USF Marginal – Cascais Health Centre

Dr André Biscaia examining an infant at the Cascais Health Centre where he works.

At a conference in Alma-Ata, the then capital of the former Soviet Socialist Republic of Kazakhstan, now called Almaty, countries pledged to combat health inequities both within and between countries. They agreed that a primary health care approach would be the key strategy for achieving what they called 'health for all', in other words, equal access to a comprehensive range of health services for everyone, regardless of ability to pay.

Portugal is one of the countries that has been determined to put those primary health care principles into practice over the past three decades. And the results are plain to see. Since the 1970s, infant mortality rates have halved every eight years to reach three per 1000 in 2006, on a par with levels in the rest of western Europe, and down from more than 40 per 1000 in 1975. Life expectancy among the country's 10.6 million people has increased 9.2 years in a generation.

Portugal first recognized the right to health in its 1976 Constitution, approved two years after a democratic, army-led revolution ended more than 40 years of authoritarian rule. Under political pressure to reduce large health disparities, the democratic government created a national health system (NHS), which the constitution describes as universal (for everyone), comprehensive (full-range of services) and "approximately" free of charge.

"Primary health care in Portugal is one of the pillars on which the public health system rests," says Anabela Coelho Candeias, head of the integrated disease management division at the General-Directorate of Health in Lisbon.

But it would be wrong to say that health reform in Portugal began with democracy. Even before the so-called Carnation Revolution of 1974, the previous authoritarian rulers had already sought to address the country's appallingly high levels of infant and maternal mortality.

"A lot of studies were done in the 1960s that showed that in Portugal the health situation was 'catastrophic'. We were at the bottom of the table for all health indicators," says Biscaia.

The solution adopted was to promote universal access to a comprehensive set of health services through a nation-wide system of public sector health centres.

"The spirit of those health centres was the spirit of Alma-Ata, but several years before that meeting," says Biscaia, referring to the 1978 International Conference on Primary Health Care where WHO Member States agreed on the Declaration of Alma-Ata.

"Portugal was at the forefront of public health reform in Europe at that time and perhaps now it is again," he says.

To be eligible for NHS benefits, patients need to register with a family physician in a health centre, considered the first point of contact.

But these health centres are often large organizations with as many as 70 doctors attached to them and with tens of thousands of patients. It was to make these centres more manageable and responsive to patients' needs that the USF reforms were launched. Doctors and nurses were once paid a fixed salary, but now remuneration is based on performance and productivity.

"There are more doctors wanting to become general practitioners. Conditions are competitive with the private sector and they have more autonomy," says Biscaia. Some 20% of the total population now has access to USFs and this percentage could more than double within the next year, Biscaia says. "Patients are very satisfied. For instance, in a recent study in my health centre levels of satisfaction with the USF were twice those of other health centres."

The next phase of the 2005 reforms will focus on the health centres themselves to make them more responsive to community needs. They will be given more financial autonomy and their number will be cut from 355 to 74 – a move that may not be easily accepted by the public.

> "The spirit of those health centres was the spirit of Alma-Ata."
>
> *André Biscaia*

Moreover, despite its achievements, the Portuguese health system is not without its problems. The Portuguese face some of Europe's highest out-of-pocket expenditure for health services, at 22.1% of people's incomes in 2005 according to *World health statistics 2008*, despite the constitution's promise of a system that would be largely free.

Most services, whether for drugs and medicines, for in-patient care or consultations at health centres, carry some charge to the user. However, half of the population is exempt from such payments either on economic grounds or because they fall into one of the more vulnerable groups – pregnant women, students, children and people with diabetes – that are excluded from health payments.

There are also imbalances between the number of nurses and doctors. Many health-care professionals who retire are not being replaced due to restricted admissions to medical schools in recent years, according to the 2007 publication *Health systems in transition: Portugal – health system review*. Also, many patients still go to the emergency department of a hospital for treatment rather than to the local health centre. But this is a problem which should ease as the USFs take root around the country, Biscaia says.

Coelho Candeias agrees: "While 95% of the population's health needs can be taken care of at health centres, we recognize that not everybody has a family doctor and some people go to the emergency rooms rather than a health centre."

She adds: "This is because they think that going to the hospital ensures … better quality care. Resolving this requires a cultural change and mass information campaigns among the general population." ■

Recent news from WHO

- In Almaty, Kazakhstan, on 14 October, WHO launched *The world health report 2008* calling for a return to a primary health care approach. ***Primary health care: now more than ever*** marks the 30th anniversary of the International Conference on Primary Health Care held in Alma-Ata in 1978. Read the report here: http://www.who.int/whr/2008/en/index.html
- WHO said, on 10 October, that it is working with experts in South Africa and Zambia to investigate **a new disease** that has killed at least three people.
- A new WHO programme launched on 9 October aims to address the lack of treatment and care for 75% of people suffering from **mental disorders** in developing countries.
- At a meeting in Madrid, Spain, from 6 to 8 October, WHO agreed with over 80 top researchers on a research agenda to develop an evidence-based framework for action in response to implications of **climate change** for human health.
- WHO and the United Nations Food and Agricultural Organization called on countries, on 26 September, to look out for **melamine-contaminated dairy products** to avoid their spread after thousands of infants became ill after consuming such products in China.
- There is no evidence to back claims that the **electronic cigarette** is a proven safe nicotine replacement therapy, WHO said on 19 September. Users puff on this steel device as if using a real cigarette, to produce a fine mist instead of smoke that is absorbed into the lungs.
- On 26 September, WHO called for greater efforts to control **dengue** in the Asia Pacific Region. WHO also warned that the *Aedes aegypti* mosquito, the principal vector, is expanding to new geographical areas that were previously unaffected and that more collaborative activities are needed to address dengue.
- WHO supplied Kyrgyzstan with **emergency health kits** following an earthquake on 5 October. Each kit provides enough medicines, disposables and instruments to support the emergency health needs of 10 000 people during a three-month period.

For more about these and other WHO news items please see: http://www.who.int/mediacentre

Time is ripe for health-care reform

Dan Deitch

Professor Paul Krugman

Paul Krugman is a professor of economics and international affairs at Princeton University, a columnist for the *New York Times* and the winner of this year's Nobel economics prize, that recognized his work on international trade and finance, and globalization. The author or editor of 20 books, including his latest title, *Conscience of a liberal*, and more than 200 journal articles, he has taught at Yale and Stanford Universities, and was the senior international economist for the US President's Council of Economic Advisers under Ronald Reagan.

The global financial crisis has created an environment that is more favourable to government intervention, social protection and health reform in the United States of America (USA) than in recent years. Paul Krugman, this year's Nobel economics laureate, talks to the *Bulletin* about the challenges of pushing through health reform and the shape this could take after the 4 November presidential election.

Q: About 45 million Americans have no health insurance and cover health costs out of their pockets or not at all. Does mandatory health insurance challenge core American values of self-reliance, hard work and merit?

A: There's a lot of exaggeration on the extent to which those are core American values. After all, we have a universal retirement system, and we have a social security system in some ways more comprehensive than in many European countries. We also have universal health insurance for the elderly, Medicare, which is immensely popular. If we could have some kind of guaranteed coverage for all, it would become a universal, accepted feature of American life and the public would find it inconceivable we would do away with it. Most younger Americans are covered by employer schemes. If you listen to right-wing talk radio, you may find people railing against this, but it's not widespread.

Q: Is universal health care in the form of mandatory health insurance feasible given the federal system and autonomy of the states?

A: A strong majority thinks everyone should have health insurance, though that support erodes once you talk about costs. At the state-level there is currently an attempt in Massachusetts to provide this, and though the programme is having teething problems, it bodes well for providing something like this to the population as a whole. Mandatory individual insurance alone is a clumsy solution, but a lot of people will argue we already have centralized national programmes.

Q: California has also tried to provide universal care has it not?

A: That proposal, for a mandatory system, unfortunately has not made it through the legislature. Massachusetts started with very low rates of health insurance. With a more thoroughly covered population, there will always be the problem of limited state fiscal resources. States have little ability to run deficits, even in recessions, which means state-level health programmes are vulnerable to a downturn. The Massachusetts programme could be in danger, owing to the state of the US economy, even though these kind of economic stresses come at a time when universal, guaranteed health care is needed.

Q: Why did the Hillary Clinton-led taskforce fail to deliver universal health care and coverage in the 1990s during her husband's term in office, and how can we be sure the next US president will not face the same obstacles?

A: The next president *will* run into the same obstacles. The question is whether they can jump the hurdles better. In 1993, the political fundamentals were weaker. The Democrats had the White House, but their majority in Congress was not cohesive and did not have the necessary broad, progressive outlook. Second, Hillary and Bill Clinton mishandled their plan. They were slow in moving. President Lyndon Johnson signed Medicare in July of 1965, little more than six months after he was sworn in. Bill Clinton didn't give his first major speech on health care until September 1993 – six months after he came to power. Third, the Clintons were confused about what they were trying to do and tried to do too many things at once. Universal coverage was not the central focus.

Q: Do you think part of the battle is ensuring the public are properly informed about the options available to those in power?

A: There will be deliberate misinformation out there but you have to counter that. There were the infamous but very effective ads against the Clinton plan in 1993, paid for by the insurance lobby, about an imaginary couple called Harry and Louise, who complained they couldn't get the health coverage they needed under the Clinton plan. There will no doubt be something similar here. You need to have very careful and simple explanations.

Q: If Barack Obama were to win the presidential election, what kind of health plan would you expect from the Democrats?

A: There's broad agreement on the outline of the plan unlike in 1993, when President Bill Clinton was elected with no clear mandate or vision [for health-care reform]. All the pieces are in place for a quick decision. Legislation could be drafted within weeks, though this would not come into force until 2010 or 2011. There are four pieces to this plan: a community rating, to prevent 'cherry-picking' by private insurers; subsidies to help lower-income people afford insurance; a form of mandatory insurance for children; and government-run plans so people can opt out of private insurance. Many people think such a federal health insurance system would eventually merge with Medicare and Medicaid to form a larger national system. ■

Devolved power: key for health care in India

Courtesy of ISEC, Bangalore, India

Prof. Michael Tharakan

Michael Tharakan is a professor in decentralization and governance at the Institute for Social and Economic Change in Bangalore and a member of several academic boards and committees in his native India. His areas of specialization include social and economic history, development studies, and decentralization and local government.

India's colonial past, embedded caste system and uneven approach to decentralizing services have impeded universal access to health care. Professor Michael Tharakan talks to the *Bulletin* about the challenges of getting health care to the masses in India, the world's second largest country with a population of 1.1 billion.

Q: What has been India's experience since independence in 1947 in extending health-care services to the masses that were once there to serve the colonial elite?

A: The situation has improved quite a bit since independence. There is a national health system and we have medical colleges, research institutes and primary health care centres in almost all regions. Nevertheless, access to the health system is not the same for everyone. Colonial rule established an unequal system, while the caste system remains strong in certain regions. The result is that health and other basic facilities are inaccessible to certain groups. In addition, the centralized planning of the past 50 to 60 years has not produced even development throughout India, and that has affected basic services, including health.

Q: When did India start decentralizing? Is decentralization the key for making services more accessible?

A: During the colonial period there was some decentralization by local governments. One of the major advocates of decentralization, in fact, was Mahatma Gandhi, who talked about *gram swarajya* or village self-rule. Many attempts at decentralization after independence could not be sustained. Finally in 1992/1993, parliament passed two constitutional amendments, creating local governments in rural and urban areas. Since then, there has been a concerted effort to devolve powers and finance to local governments all over India.

Q: How effective is this structure compared with the centralization of the colonial period?

A: This is definitely a better system. At the tertiary political level, a decentralized system offers better service delivery, transparency, accountability and accessibility. India's decentralization has been uneven, however. Each village administration, the *gram panchayat*, must issue a charter of citizens' demands. But these objectives have not been achieved everywhere. Some states have fared better, notably Kerala, Karnataka, Sikkim and West Bengal.

Q: Can an effective system of health financing promote development and reduce poverty?

A: India's government seems to be moving away from a centralized system. The liberalized economy was one of the first demands of the growing middle class, which forms about 20% of the population. There is strong demand from this class for a health and health financing system to suit their demands, but if you cater only to that section, you neglect the poor. In a country like India where there is mass poverty, there will be great demand for funds for the health of the marginalized groups, but developing the health sector alone might not solve their problems; there has to be greater emphasis on development and poverty reduction.

Q: Should health insurance be mandatory for all Indians?

A: In the past 10 to 15 years, there has been much talk of making health insurance available for all Indian citizens, but this has not happened for two key reasons. One, insurance has not taken root over all India; it is voluntary. Second, where insurance schemes have been established for certain groups, such as agricultural workers, the premiums might be affordable, but to take advantage of them requires administrative experience and know-how. Because many Indian villages do not know much about insurance schemes, it requires a third party to act as a catalyst to convince them that they should be part of an insurance system. This is being done with some success by nongovernmental organizations.

Q: Would it be politically acceptable to make health insurance mandatory in India?

A: Passing legislation may not solve the problem. There must be a demand from the poorest of the poor for insurance to be successful and that demand has not emerged from most rural areas. Some states have introduced comprehensive group health insurance but it's not mandatory, it's still only for specific groups.

Q: How do you see the future of health financing in India's states?

A: Financing the health system cannot be the responsibility solely of the federal government. Linguistic and wider cultural differences mean it has to be coordinated more effectively at the state level also; the constitution of India envisages it this way. Delegating responsibility for health care to district and village authorities would benefit mass insurance schemes as the remittances or premiums can be realized with the help of elected local officials more effectively than centralized institutions. These local institutions require financing from state resources, so the devolution of financial powers and the way in which tax revenues and funds are distributed between states has to be examined to ensure a more even development across the country – and not just in and around the major metropolitan cities such as Kolkata, Mumbai and Chennai as has been the case in the past. ■