

B4 | DYSFUNCTIONAL HEALTH SYSTEMS: CASE STUDIES FROM CHINA, INDIA AND THE US

In Chapter B2 we discussed the need to develop sustainable financial mechanisms that can adequately resource equitable health systems in low-income countries. Paradoxically, three of the largest countries in the world – China, India and the US – are clear examples of health systems that are dysfunctional, in large measure owing to unsustainable financing systems. The cases are instructive also because they involve two countries (China and India) that are proclaimed the ‘success stories’ of neoliberal economics and the third (the US) is by far the richest country on the globe.

China: health care and financing under economic transition

Economic development and health China’s gross domestic product (GDP) has grown rapidly in recent years (an average of 10.2 per cent per year from 2000 to 2007).¹ This growth is largely taking place in the industry and services sectors. Value added in these sectors (48 and 40 per cent of GDP respectively in 2007) far outweighs the value added in agriculture (12 per cent of GDP in 2007). Household consumption expenditure as a proportion of GDP is quite low by international standards (much lower than in India, Brazil and Russia), while gross capital formation has been very high by international standards; in other words, a relatively small proportion of profit and tax has gone to households; a relatively large proportion has gone to capital investment.²

Average per capita GNP increased from US\$800 in 1990 to \$6,020 in 2008.³ However, income inequality has widened greatly since the commencement of economic reform; the Gini coefficient rose from 0.31 in 1978/79 to 0.45 in 2004, similar to that of the USA.⁴ In 2000–07 around 16 per cent of Chinese were living on less than \$1 (international dollars) per day.⁵ Per capita GDP in 2000 varied from less than 5,000 RMB in Guizhou to over 25,000 RMB in Shanghai, with corresponding differences in life expectancy from 66 in Guizhou to 78 in Shanghai.⁶

In terms of health development, the indicators are mixed. Aggregate data are good by international standards with life expectancy in 2008 (74 years) well above the average for the high-middle-income countries (71 years).⁷ Under-five mortality is just below the average for the high-middle-income countries (21 per 1,000 live births compared with 23).⁸ Stunting among under-fives is comparatively high – 21.8 per cent in 2000–09, which was a very slight improvement over the period 1990–99 (20.7 per cent).⁹ However,

these average figures obscure wide variation, with child malnutrition three to four times more common in the rural areas than in urban areas.¹⁰ Maternal mortality in China is less than half the average for the high-middle-income countries (45 per 100,000 live births compared with 91).¹¹

China spends a relatively small percentage of GDP on health care (4.3 per cent of GDP, US\$233 per head in 2007) with a high proportion of this being out-of-pocket expenditure (51 per cent in 2007).¹² There have been massive increases in government funding for health care since 2007.

In technical terms the breadth and depth of specialist tertiary care in the leading hospitals is world class. However, poor people face significant price barriers to accessing care; resources are inequitably distributed; quality and safety are uneven; and there are significant inefficiencies in service delivery. Primary health care is poorly equipped, staffed by less well-trained practitioners and generally not trusted.

Health care financing and economic transition Under the ‘socialist planned economy’ (1949–76) health care was a responsibility of the ‘work unit’, the factory or school or government department in the city and the collective farm or commune in the country. The work unit employed the primary health care staff (health centre or clinic) and larger enterprises also ran secondary hospitals. The work unit also contributed to the cost of tertiary care if employees accessed such care. The military and the railways and some other sectors administered their own hospitals. Hospitals were budget funded and user charges were very limited. These arrangements were referred to as the Government Insurance Scheme; the Labour Insurance Scheme and the Cooperative Medical Scheme (CMS) in the country. Under the CMS the cost of primary health care (a part-salary for the barefoot doctor or village doctor) was met out of the general revenues of the collective farm or commune, and a small contribution could also be made to meet user fees if the patient needed attention in the township or county hospital.

These enterprise-based welfare arrangements ensured universal coverage at a relatively basic level. Health care was overwhelmingly provided at the primary level with a small proportion of cases being referred to secondary hospitals and a very small proportion being admitted to tertiary hospitals. There was a much greater emphasis on doctors from tertiary and secondary hospitals actually travelling out to provide training and advice at the primary level than on patients moving from primary to secondary to tertiary. However, it was basic care. The village doctors were commonly six-month certificate trained; the doctors in the clinics in the cities and in the hospitals in the country were largely secondary or tertiary diploma trained.¹³ Only in the tertiary hospitals were bachelor-trained doctors employed and in the early years there were very few of either.

With the commencement of economic reforms (from 1978) enterprise



9 Medical college in Tianjin (David Legge)

welfare came to be referred to as ‘all eating from the common pot’ and the reforms included ‘smashing the iron bowl’. The main concern was not enterprise welfare per se; rather it was the low productivity of the planned economy. Pre-1978, enterprises were assigned staff, budget funded and given output targets. Since the prices of inputs and outputs were all administratively determined and surplus revenue belonged to the administering ministry or bureau, there was no incentive to increase volume or reduce unit costs. The reforms sought to improve productivity by giving enterprise management greater discretion with respect to the procurement of inputs, the production process and output levels and keeping ‘profit’. However, state-owned enterprises (SOEs) were still operating within a complex regulatory framework with staffing levels and prices closely controlled by different government authorities, which made the reform of production very slow.

During the 1980s it became clear that internal reform was not moving very fast and the focus shifted to corporatisation and competition; encouraging private enterprises, including joint enterprises with foreign firms, to compete with the newly corporatised SOEs. One of the big differences between the private enterprises and the SOEs was enterprise welfare. Unless the SOEs were able to reduce the ‘burden’ of education, housing, health and aged care for their employees there was no way they were going to be able to compete with the new private enterprises. Smashing the ‘iron bowl’ became a necessary condition for the survival of the SOEs.

Another feature of the ‘iron bowl’ was secure lifetime employment. This

was recognised by the reformers as a major brake on enterprise productivity with overstaffing, often inappropriate staffing (due to lack of hire power) and lack of management levers to encourage greater individual productivity (lack of firepower). It was also a major brake on labour mobility, a key prerequisite for efficiency at the system level. It was recognised by the policy-makers early on that the establishment of autonomous social ‘sectors’ (education, housing, health care and social security) and the divorce of welfare functions from employment were conditions for allowing greater labour mobility.

The move from a planned economy to a market economy had profound implications for government revenues. Under the planned economy government revenues were based on top-slicing economic transactions controlled by the state. Prices and volumes were controlled in accordance with the plan and the plan made provision for transfers to general government revenues. As the SOEs were required to compete with private enterprise within a market economy SOE revenues came to depend more on market demand and market-determined prices and government revenues necessarily moved towards a greater dependence on formal taxation.

One of the earliest and most dramatic reforms was the return to family farming (following the collapse of collective farming). The return to family farming is widely regarded as part of the reason for dramatic improvements in farm productivity in the 1980s, which provided the basis, in terms of food and labour, for the spurt in industrialisation. However, the consequence of the collapse of collective farming also led to a complete collapse of the funding base for rural health care, and it has taken almost 30 years for the policy-makers to put in place an alternative funding base (the New CMS or NCMS). During this time farming families have been largely without any form of health security while the costs of health care have escalated.

The demise of enterprise welfare and the winding back of micro-regulation of SOEs have also been long drawn-out affairs and are far from finished. There was a long delay between the elimination of enterprise-based health care and the development of functioning health insurance. This commenced with the establishment of the Urban Employees Health Insurance Scheme (UEHIS) in the late 1990s.¹⁴ This was a contributory scheme (with employee and employer contributions) administered through the Labour and Social Security portfolio at the municipal level. This scheme extended the existing coverage of the Labour Insurance Scheme (covering SOEs) to other large employers. The UEHIS does not cover the informal sector and many small or struggling enterprises are allowed to remain outside the scheme. It does not cover rural migrants working in the cities, the ‘floating population’.¹⁵ The benefit levels provided are limited and patients commonly face high out-of-pocket costs.

Over the last five years there has been a dramatic increase in government support: for rural health care (through the NCMS); for safety net provision for poor people through the Medical Assistance scheme (MA) and through

budget support for urban community health. The New CMS, based largely on government funding, is moving towards universal coverage (including in some cases urban migrants), although the depth of cover remains thin with high out-of-pocket payments. The Urban Residents Insurance Scheme extends similar coverage and benefits to the floating population and the informal sector in the cities.

The necessary condition for the increasing flow of funds to health care over the last five years has been growth in GDP and the availability of resources. However, of comparable importance has been the rising concern in Beijing regarding 'social instability'. The Chinese government and the Chinese Communist Party are concerned that rising inequality, anger at corruption and frustration with the health care system could contribute to disaffection and instability.

Macroeconomics and health care financing There is also a strong macroeconomic logic for the central government to increase the flow of public funds to health care, particularly for low-income people.¹⁶ During the early period of reforms the policy focus was firmly on economic growth with rising exports and cheap capital. The logic of cheap capital was to encourage investment in export production, but it also encouraged huge infrastructure investments (roads, bridges, airports, urban renewal, etc.). Two factors contributed to the flush of loose capital: high household savings rates and high money supply.

From the early 1990s to the early 2000s, Chinese households had good reason to maintain high levels of savings against the cost of illness, unemployment, retirement, university education and housing. The cost of education, particularly university education, was increasing; retirement benefits were vanishing and the cost of an episode of illness could bankrupt a family. High savings rates were essential for families, and the flow of household savings into the banking system contributed to keeping interest rates low and continuing the flow of resources to investment.

The other reason for low interest rates and loose capital was the rapidly increasing money supply. As export revenues grew the Chinese government was concerned to keep the value of the yuan relatively low so that the price of Chinese products in the stronger foreign currencies was kept cheap. If profits made in dollars (or other tradable currencies) were repatriated to China and converted into RMB the price of the RMB would be pushed up and with it the price of Chinese exports. The government adopted an arrangement whereby the Central Bank purchased the US dollars from Chinese trading enterprises and reimbursed them in RMB (at a fixed exchange rate) in China. The US dollars so acquired were stored by purchasing US government bonds. Several consequences flowed: first, China accumulated huge reserves held in US dollars from the early 1990s to 2008; second, the US dollar remained strong, allowing US consumers to continue purchasing Chinese products; third, the

domestic money supply in China grew rapidly, contributing to loose capital and low interest rates.

With the global financial crisis of 2008, the international market for Chinese exports, particularly in the USA, shrank considerably. It became suddenly urgent to expand the domestic market if Chinese manufacturers were to keep selling and workers were to keep their jobs. Suddenly it made sense to fund health and social security to encourage consumption spending (by reducing the need for high levels of household savings) and to boost the domestic market. This was a critical turning point for the funding of the New CMS, the new Urban Residents Health Insurance Scheme, Medical Assistance and urban community health centres.

However, the situation is not stable. The banks are in some degree dependent on household savings to maintain the flow of low-interest loans to developers. The prospect of reduced export revenues and reduced household savings has implications for the volume and cost of capital available to the banks. Rapidly increasing money supply during the boom years has allowed very low interest rates to prevail, which has allowed ‘developers’ of various kinds to embark on large-scale investment projects, including huge real estate developments, without close regard to long-term returns. Low interest rates have also encouraged medium- and high-income families to move their savings out of the banks (earning nothing) into real estate, often with high levels of leverage, albeit at low interest rates (for the present). The combination of loose money for both developers house purchasers has led to rapid inflation of house prices.

Real estate developers are highly leveraged and are sitting on huge overcapacity which is not earning revenues. If interest rates were to increase, the cost of servicing their debts would start to bite and they would need to reduce sale prices quite rapidly to realise the value of their capital and pay their debts. Falling house prices would mean that mortgaged householders were also carrying debt far in excess of the value of their property and facing increasing costs of servicing that debt. There could be serious flow-on effects, including mortgage defaults and repossessions and the possibility of a banking crisis; not so different from what happened in the US in 2008.

This situation is complicated by China’s international trade. During the decade prior to the global financial crisis China maintained a relatively cheap currency by keeping high levels of its export earnings in US dollars (purchasing US bonds). However, as part of its strategy for managing the financial crisis, the US has resorted to printing money in large amounts. This will stoke inflation in the US (and beyond) and diminish the value of Chinese reserves held in US dollars. However, if China reduces its holdings of US dollars the value of the US dollar will fall, making Chinese imports more expensive in the US. As the Chinese yuan appreciates the cost advantages of assembly and manufacture in China will be reduced and jobs will be lost to lower wage platforms.

Policy interdependence and regulatory dysfunction Throughout the early parts of the reforms era the central government stood firmly against increasing public funding to health care despite the collapse of enterprise welfare and collective financing. Public revenues were significantly affected by the economic transition and the policy priority was to build the economy.

From the late 1980s hospitals depended more and more on fees for service revenues as government subsidies failed to keep pace with rising operating costs. As operating costs increased so the proportion of total revenue derived from direct budget funding fell.

Revenue from user charges has been constrained in some degree by pricing controls, which have retained tight control over labour-intensive service items but much looser control over drug pricing and technology-intensive service items. This has driven seriously perverse servicing patterns with over-servicing (in volume terms) with respect to pharmaceuticals and high-tech service items and understaffing of labour-intensive functions. A model of health care has emerged which includes high-volume, low-margin, rapid-turnover, understaffed outpatient clinics from which are harvested those patients who can be provided with high-margin services, including drugs, tests and other high-tech procedures.

Remuneration arrangements provide further drive for this model of health care delivery. Hospital staff are paid in two forms: official regulated salaries and bonus payments. Official salaries are tightly regulated and have been maintained at relatively low levels. Bonus payments were introduced in the early 1990s as part of the reaction against ‘all eating from the common pot’. If low wages with small differentials were a cause of low productivity it was reasonable to expect that bonus payments tied to agreed performance indicators would enhance productivity. As hospital managers faced rising operating costs and fixed government subsidies it made sense to offer bonus payments to those departments (and their employees) which showed improvements in ‘productivity’ (as reflected in revenue).

Bonus payments were not part of the planned economy and so there was no ministry or bureau with a mandate to regulate them. Each hospital’s supervising bureau¹⁷ would be cautious about discouraging such payments if they contributed to the hospital’s survival in the face of the inability of the government to provide increased budget funds. However, there is a certain circularity about the use of bonus payments to drive over-servicing to meet operating costs which are increasing, in part, because of increasing bonus payments. Clearly many senior clinicians in the more affluent cities are receiving (and generating) very generous remuneration packages. It is not clear there is any capacity in the system to regulate total remuneration (rather than just the ‘basic salary’).

Conclusions China’s economic transition from a planned to a market economy

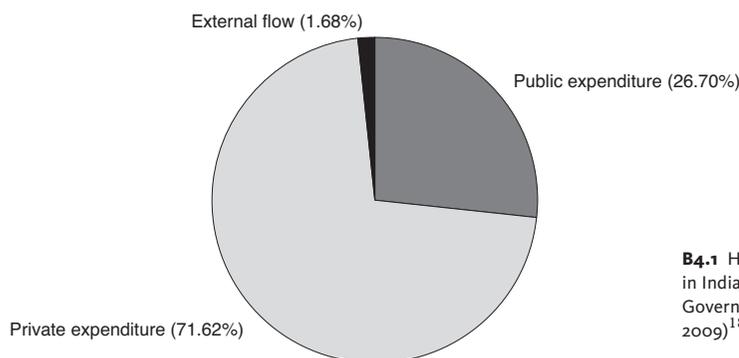
led to three decades of rapid economic growth but widening income inequalities. The institutional reforms associated with the transition ('smashing the iron bowl') precipitated a collapse in collective health care financing with the emergence of high price barriers to access. With changing macroeconomic circumstances and growing concern regarding social instability, the central government is increasing public funding to health care largely through various health 'insurance' schemes, creating a number of large-scale 'purchasers' of health services. On the provider side there remain major problems, including over-servicing, variable quality and low efficiency. These problems arise from the ways the health care providers adapted to the collapse in collective financing in the context of regulatory arrangements persisting from the period of the planned economy.

India: misguided reforms to introduce social health insurance

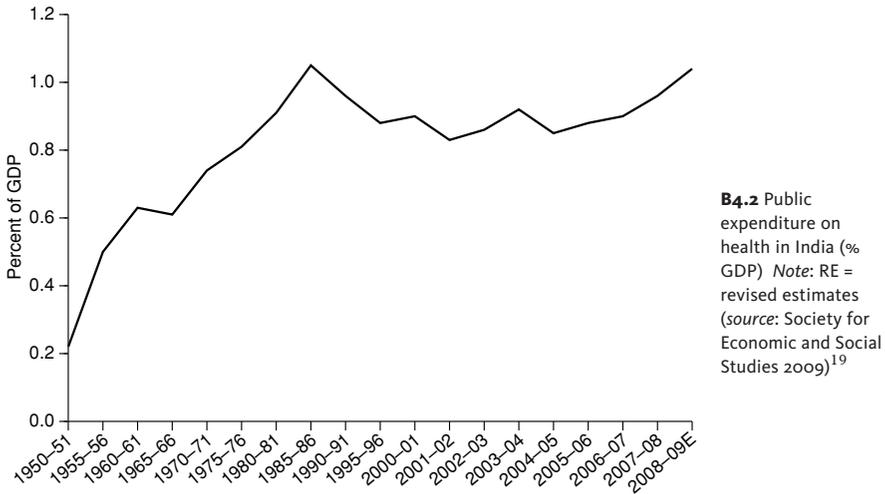
Introduction India is, in many ways, an exemplar of how not to develop and sustain public health services. The country has one of the most privatised health systems in the world (see Chart B4.1) and one of the poorest records in terms of public spending on health (see Chart B4.2).

India's mechanism of budgetary allocation of funds to the health sector has remained archaic, obsolete, and resistant to change over the years. Inflexible budgetary transactions led to the creation of over 4,000 line items that were more suited to auditing than to addressing health needs.²⁰ The primary care system is an extensive network comprising sub-centres (covering population areas of 3,000–5,000), Primary Health Centres (covering population areas of 20,000–30,000) and Community Health Centres (covering a population of 100,000 people). Across the country, as of 2007, there were a total of 145,272 sub-centres, 22,370 Primary Health Centres and 4,045 Community Health Centres. While impressive on paper, in large parts of the country the network barely functions as a consequence of poor resourcing and maintenance. Shortage of personnel and material resources plague the system.²¹

The National Rural Health Mission (NRHM), launched in April 2005, is



B4.1 Health expenditure in India, 2008/09 (source: Government of India 2009)¹⁸



a response to the large body of criticism regarding the performance of the public health system in India. While there has been only a marginal increase in financial allocation during the six years of operation of the NRHM (despite a planned substantial increase), certain ‘innovative’ ways of channelling funding – through off-budgetary transactions involving mission flexipools, untied grants, etc. – have, to an extent, improved the uptake of health services among the population.

Simultaneously, in the past five years several new schemes have been launched to enhance financing of health and secure people against the catastrophic impact of out-of-pocket (OOP) expenditures on health care. In the following sections, we examine in more detail the contributions of the public and private sectors to health financing, analyse financial risk protection measures, and examine the likely outcomes.

Trends and patterns of health financing in India India’s large public health service delivery infrastructure has suffered from sustained underfunding and overall neglect since the 1950s. Except for a brief period in the mid 1980s when public spending showed a consistently upward trend (albeit of low amplitude), it has remained consistently below or around 1 per cent of GDP.²² The public health system, which was already grossly underfunded, faced a further squeeze in the immediate aftermath of the initiation of neoliberal economic reforms in 1991. The severity of ‘fiscal discipline’ during the late 1990s forced the governments in various states of the country to introduce austerity measures, and the ‘soft’ sectors, such as health, were targeted for expenditure compressions (in India 70–80 per cent of expenditure on health care is made not by the central government but by state governments). Therefore, overall allocation by the centre to the states both for the health sector and for overall

TABLE B4.1 Share of households' OOP and drug spending in India, 2004/05 (%)

States	OOP expenditure as proportion of households' overall expenditure			Drugs as proportion of OOP		
	Rural	Urban	Combined	Rural	Urban	Combined
All India	6.30	5.22	5.87	73.90	66.07	71.17

Source: Extracted from Unit Level Records of the National Sample Survey (NSS), 2004/05

transfers was affected, leading to large-scale reduction in health spending in the country.^{23, 24} This, in turn, led to the deterioration of the already ailing public health service delivery system and to the further strengthening of the private health sector.

The very low level of public spending on health in India places a huge financial burden on households. This is characterised by low public spending (less than 1 per cent of GDP) and an extremely high share of burden on households. In 2004/05, per capita public spending on health was Rs242 (roughly US\$5–6), while private spending was almost four times that figure at

TABLE B4.2 Out-of-pocket expenditure on health care: 1993/94 and 2004/05

Impact on households	1993/94	2004/05
ALL INDIA		
Average per capita monthly OOP (Rs) at current prices	16.78	41.83
OOP on health care as % of total household expenditure	5.12	5.87
Percentage of households reporting OOP on health care	59.19	64.42
Households paying more than 10% as OOP*	11.92	15.37
RURAL		
Average per capita monthly OOP (Rs) at current prices	15.28	36.47
OOP on health care as % of total household expenditure	5.3	6.3
Percentage of households reporting OOP on health care	59.94	64.05
Households paying more than 10% as OOP*	12.69	15.82
URBAN		
Average per capita monthly OOP (Rs) at current prices	20.99	57.64
OOP on health care as % of total household expenditure	4.6	5.22
Percentage of households reporting OOP on health care	54.61	65.41
Households paying more than 10% as OOP*		

Note: * OOP as a percentage share of total household expenditure

Source: Based on National Sample Survey Organisation estimates



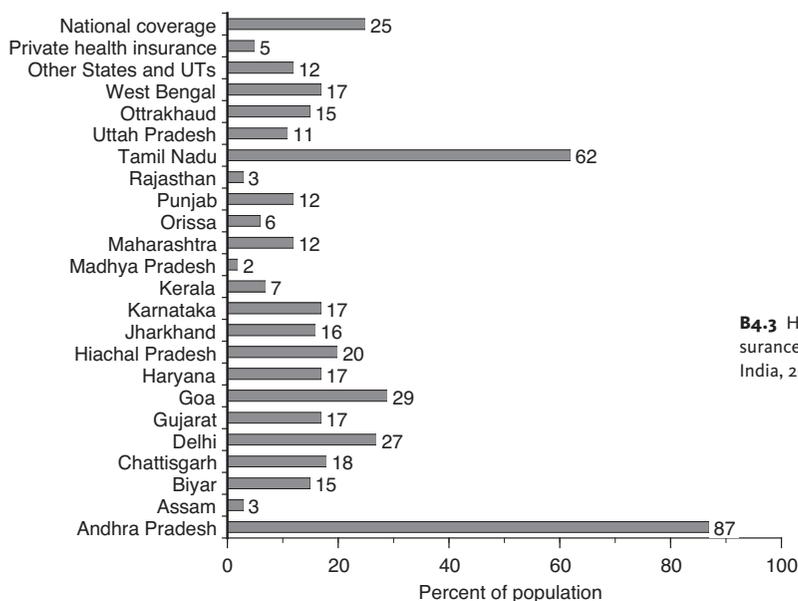
10 Demonstration for free health care in India (Abhay Shukla)

Rs959 (US\$20) (we use figures from 2004/05 because that is the last period when disaggregated data is available from the National Health Accounts). As a consequence, the number of people pushed below the poverty line (as defined by the government) because of catastrophic OOP expenses incurred on health care has risen from about 26 million in 1993/94 to 39 million in 2004/05.²⁵

Indian households, on an average, devote about 6 per cent of their overall consumer expenditure to health care. Rural households spend a larger proportion of household income on health care than their urban counterparts because of poorer access to public health facilities. Ironically, while India is a major manufacturer of generic medicines and exports over half of its production of medicines, expenditure on medicines constitutes the single largest item in OOP expenses incurred by households (see Table B4.1).

Evidence also clearly suggests that lack of access to health facilities and lack of finances are major reasons for the sick not seeking treatment. In 2004/05 over 12 per cent in rural areas reported that they did not seek treatment because of lack of access to health facilities and 25 per cent cited financial reasons for not seeking treatment (up from 15 per cent in 1986/87).²⁶

*Health Insurance in India*²⁷ The penetration of health insurance (of all kinds) remained low till 2007. Private health insurance in particular has had (and still has) very low penetration – accounting for under 1 per cent of total health



B4.3 Health insurance coverage in India, 2010

expenditure in the country. The two social insurance schemes in existence were the Employees State Insurance Scheme (ESIS) launched in 1952 and the Central Government Health Scheme (CGHS) launched in 1954. The former covers employees in the organised sector (about 7 per cent of the total workforce²⁸) while the latter covers employees working for the government. Both are funded through co-payments made by employees and employer.²⁹

There has been, however, a rapid transition since 2007 after the launch of several government-initiated social health insurance schemes. The three largest – the RSBY scheme launched by the central government, and two state-government-run schemes, Aarogyasri and Kalaingar³⁰ – now cover over one-fifth of India's population (247 million). The RSBY scheme (national in its reach) is limited to specific sections, viz. people who are designated as poor or marginalised in government records.³¹ In contrast the Aarogyasri and Kalaingar schemes cover a majority of the population in the respective states (87 per cent in Andhra Pradesh and 62 per cent in Tamilnadu – see Chart B4.3). All health insurance schemes, put together, covered about 302 million people in India in 2010 (roughly a quarter of the country's population).

There is a large variance in the depth of coverage (i.e. benefits provided in an insurance scheme) among the different social health insurance schemes. Unlike the older ESIS and CGHS schemes, the new SHI schemes only cover for hospitalisation. The Aarogyasri and Kalaingar schemes cover for almost all types of inpatient care, including high-end tertiary care (the RSBY is less ambitious and has a ceiling of Rs30,000 – US\$650 – per year for a family of five).

The new SHI schemes are almost entirely publicly funded – through con-

tributions from the central or state governments. They do mitigate against the risk of impoverishment as a result of OOP expenses for inpatient care. However, the protection is relative and not absolute. Moreover, the RSBY particularly puts a cap on the expenses that are covered in a year for a household.

While the SHI schemes are still relatively new, some interesting trends are discernible which are a cause for concern. Data drawn from the RSBY scheme shows that the hospitalization rate is about 20 per thousand beneficiaries. This is much lower than the long-term national hospitalization rate of 31 per thousand – which includes all hospitalized cases, irrespective of whether they are covered by any form of insurance.³² It is also much lower than the hospitalisation rate for private health insurance (about 64 per thousand). The hospitalisation rates for the Aarogyasri and Kalaingar schemes are even lower than that of the RSBY scheme. This indicates that a large number of people, though nominally designated as beneficiaries of the new SHI schemes, do not seem to be benefiting from them.

The new SHIs (as well as, increasingly, the older CGHS scheme) explicitly separate financing and provision of health care. They allow beneficiaries to access care in accredited facilities – which may be in the private or the public sector. In practice, an overwhelming majority of the accredited facilities are in the private sector – almost all providers of hospital care under the Kalaingar and CGHS schemes, and 80 per cent under the Aarogyasri scheme, are in the private sector. This assumes special significance when we examine the data regarding hospitalisation costs (per annum) for beneficiaries of the different SHIs. While the mean hospitalisation expenses of the private health insurance sector were Rs19,637 (US\$450) per annum in 2009/10, they were Rs33,720 (US\$760) and Rs25,000 (US\$560) respectively for the Kalaingar and CGHS schemes. There is thus indirect evidence that private providers not only benefit from these schemes by securing a ‘captive’ market, they also overcharge (with the possible complicit participation of the administrators of the SHI schemes).

Such a trend is likely to have long-term consequences. In 2009/10, direct government expenditure on tertiary care was a little over 20 per cent of total expenditure. However, if this were added to the expenditure on the social health insurance programmes that focus entirely on hospital-based care, the total public expenditure on tertiary care would be about 37 per cent of the total expenditure. Such a high proportion of public expenditure (which is likely to rise further) on tertiary care, largely provided by the private sector, would lead to the following impact:

- 1 The increase in public expenditure would not build or strengthen the public health system but would further strengthen the private sector (especially the large tertiary care sector that increasingly is constituted of corporate-run hospital chains) – which already accounts for 70 per cent of health care in India.

- 2 Distortion of the country's health system, with grossly inadequate funding for primary care.
- 3 Continued cost escalation of the SHI programmes, owing to their being premised on provision of care by the private sector. This may well make the newly launched SHIs unviable, or would lead to a further distortion of health care spending, with the government forced to pump in larger and larger amounts.

Conclusions India's situation is different from that of developed countries, which have been successful in implementing social health insurance programmes that provide near-universal access. Given the very large levels of income poverty in India, the ability to contribute to such schemes in any risk-pooling exercise is limited to a very small portion of the population. Linking such schemes to the workplace is also a marginal option, which could be feasible only in the case of the organised sector of workers, who constitute about 7 per cent of the total workforce.

The recent SHI programmes were initiated against the background of huge existing gaps in the public health system and the distressing phenomenon of poverty linked to catastrophic OOP expenditure on health care. However, as our analysis indicates, these schemes are not only unsustainable, they also further distort the health care system in the country. At best they can be considered interim measures. Even for such interim measures to have an impact, a robust regulatory system needs to be introduced that includes regular financial, technical and social audits of the SHI schemes. Today market mechanisms determine the cost of these schemes, and are unviable.

The only long-term solution that is feasible is to plan for a public health system that is funded through taxation. For such a tax-based system to succeed, the quantum of public spending on health care has to increase very rapidly – from the present 1 per cent of GDP to at least 3 per cent or more.

United States: medicine as politics at the largest scale

'Medicine is a social science, and politics is nothing but medicine on a larger scale' Rudolf Virchow (founding father of social medicine), 1848

Historically, the health care financing system in the US has worked by fragmenting the population into hundreds of patient risk pools and requires no mandatory contribution.³³ The exception is that, in 1965, most legal residents over 65, and many people with disabilities, were included in Medicare, a national social health insurance programme. The rest of the population obtain medical care insurance from private insurance corporations as a benefit of employment, or, if they qualify as poor, in other government-funded programmes. The result is that there are now approximately 50 million people in the US without insurance, and many millions more who are underinsured.³⁴



11 Separation of health financing and provisioning can mean public financing of the private sector (Indranil Mukherjee)

In the US, ‘primary care’ means something different to what it does internationally. Focused on the clinic, rather than the community, US-style primary care emphasizes clinical preventive/early detection services and treatment of common illnesses. Primary care specialities are low-prestige and primary care providers earn much less. Primary care generates less revenue for health care businesses than speciality care. As a result, most health expenditures in the US go towards expensive curative and tertiary-level services.

These characteristics of the health system in the US are among the underlying reasons why the US spends more than two times as much per capita on health than any other country but has relatively poor health outcomes. Both individual and public expenditures go mainly to private corporations such as pharmaceutical and insurance companies, while the health of the US population remains an afterthought.

New reforms in US health care Many misconceptions exist, both in the US and abroad, about the health care reform law passed in the US in 2010. The Patient Protection and Affordable Care Act (PPACA) implements a series of health care and insurance-related provisions to take effect over years – most by 2014.

On the positive side, the law will extend health insurance to 32 million more Americans. Many will get insurance through Medicaid, a federal social insurance programme for the poor, which will be expanded to cover all citizens and some legal residents up to 133 per cent of the federal poverty level. The PPACA will subsidise insurance premiums for lower-income individuals and families, and give financial incentives to businesses to provide health care benefits to employees. It initiates consumer protections from certain insurance



12 Memorial to Rudolph Virchow in Berlin (Amit Sengupta)

company abuses such as being cut off (‘rescission’) and discrimination against those with pre-existing conditions. It will mandate that all legally residing US residents obtain medical insurance, and state-based insurance ‘exchanges’ will be established. It will establish a non-profit Patient-Centered Outcomes Research Institute to assess the relative outcomes, effectiveness and appropriateness of various treatments. Funding for community health centres and payments for primary care services are increased. Cost sharing for preventive care is eliminated. It will also eliminate co-payments for prescription drugs for those with Medicare,^{35, 36}

Despite its claims, the PPACA does little to change the US healthcare system, primarily because it does not challenge the for-profit framework. Larger pools will not be created. Instead, it will create ‘marketplaces’ in each state where insurance products meeting minimum standards will compete for the individual purchaser. These exchanges are new bureaucracies that will add millions of dollars of expense to the system. Surging health care costs will not be contained, and the uncontrolled costs of health care and insurance threaten the sustainability of the reform. Similarly, the mandatory contribution element is fatally flawed in the PPACA. Unlike other national programmes that require that everyone contribute to the health care system based on ability to pay, the PPACA requires that everyone not covered by one of the government health

insurance programmes must purchase, or have purchased for them by their employer, a health insurance product from a private corporation.

Although more people will obtain insurance once the law is fully in effect in 2014, this actually ensures that more public and private funds will flow to pharmaceutical, insurance, hospital and other health care industry corporations. An estimated \$447 billion in taxpayer money from the new law will go directly to the health insurance industry alone.³⁷ While the PPACA creates some important consumer protections and will expand health care coverage for millions, it continues to strengthen a profit-driven and fractured approach to health in the US.

Impact of the PPACA on marginalized and vulnerable groups Poor people, among whom people of colour are over-represented, will benefit from the expansion of Medicaid and increased community health centre funding.³⁸ However, under the new law, an estimated 23 million Americans will remain uninsured. This translates to 23,000 unnecessary deaths annually.³⁹ Many previously uninsured will be mandated to spend a significant portion of their income on health care from private insurers and still may not have comprehensive coverage. On average, poor people will spend 10 per cent of their income to cover 70 per cent of health care expenses, with co-payments and fees still unaffordable for many.⁴⁰ Medicaid expansion will largely be outsourced by the federal government to private insurance companies, raising concerns over for-profit abuse of Medicaid.⁴¹ Federal payments to hospitals with a large proportion of uninsured and low-income patients will be lowered, limiting much-needed services.⁴²

Under the new law, the health rights of women have been undermined. Gender-based higher insurance rates for women will remain legal until at least 2017, and large employer-based insurance programmes will be exempt from the new PPACA provision on gender rating prohibition. Women's reproductive rights have been eroded, as the law seriously restricts access to abortion by requiring segregation of federal insurance funds for abortion from all other medical services. This means that government funds to finance insurance programmes in the PPACA cannot be used for abortion services except in cases of rape, incest, or if a woman's life is in danger.⁴³ Contraception is currently not considered a 'preventive' service, so women may continue to pay for this out of pocket, despite the PPACA law that eliminates fees and co-payments for preventive services.⁴⁴

Under the new law, documented immigrants are subject to the health insurance mandate upon entry to the US, but still face waiting periods of five or more years to qualify for government social services such as Medicaid. This means the large expansion of Medicaid under the new law excludes all recent immigrants.⁴⁵ Undocumented immigrants will be unable to access state exchanges to purchase their own insurance. Nor will Medicaid (except

in cases of medical emergency) or other social services be open to them. This continues a dire and inhumane practice for asylum seekers and undocumented immigrants that denies them essential health care.⁴⁶

How the movement for universal health care became the PPACA Almost none of the benefits the public will receive from the PPACA come at the expense of the hugely profitable medical industries.⁴⁷ To the contrary, many of those benefits were granted only because they also benefit those industries by increasing the amount of public and individual funds that will go to pay for additional products and services.

When the push for health care reform from activists got serious, health care corporations saw an opportunity to get the government to help them address looming threats to their profits and preserve revenue streams. The struggle in the US Congress was really about the different sectors of the health care industry – insurance companies, pharmaceutical companies, organised physicians, the hospital industry, and other smaller sectors – competing for the limited amount by which Congress was willing to increase spending on health and for the most favourable regulations for their sector. Progressive organisations were co-opted by sophisticated public relations campaigns to take national health insurance off the table and to increase public support for whatever legislation finally emerged.⁴⁸

All the health care industry sectors could agree on one thing: more people with insurance means more revenue. Thus there was support for the mandate to obtain insurance, for government subsidies to buy it, and other measures to increase insurance coverage. Each sector also had its particular concerns and the legislation did not fail to take them into account.

Pharmaceutical companies emerged as the big winners. The increase in the number of people with insurance and a restructuring of Medicare drug benefits means more people will be able to buy medications. PPACA increases patent protection for new biotech drugs⁴⁹ just as the blockbuster drugs of the past 15 years are reaching the end of their patents, or, in the metaphor of industry investors, falling off the ‘patent cliff’.⁵⁰ Pharmaceutical industry lobbying prevented negotiated Medicare rates and competition from foreign drug imports from being included in the new law.⁵¹ Thus the pharmaceutical industry will continue to profit far more in the US market than in other countries that use these price control mechanisms.

In spite of increased regulation under the PPACA, insurance companies will still benefit financially. Between 1980 and 2009 the percentage of people under 65 covered by private insurance decreased from 79 to 63 per cent.⁵² The mandate to have insurance, and income-based subsidies for people to purchase insurance, will eliminate this decline. Since a large part of the federally funded programme for the poor, Medicaid, is now funnelled through privately managed care plans, the expansion of the programme also increases insurance company



13 Demonstration for health care reform in the US, October 2009 (© Ryan Beiler| Dreamstime.com)

revenue.⁵³ The new regulations on individual market plans such as no lifetime maximum payout, restrictions on rescission, and elimination of pre-existing condition discrimination, will cut into revenues or require increased prices. However, insurance companies already abide by many of these conditions in the plans people get through their employers. Where insurance companies lost is in the fight over cost control. While cost increases benefit care providers, they cut into the revenues of insurance companies. Future corporate lobbying will seek to mitigate any negative effects of the new rules on corporations as implementation regulations are written over the coming years.⁵⁴

Organized entrepreneurial doctors and hospitals, especially prestigious ones with negotiating power, will have a continued waterfall of money, because PPACA does little to reduce the cost of medical services. Providers lobbied against measures that would have decreased service rates, even though these costs are higher in the US than in any other country. These measures included the public insurance option, which President Obama traded away in a backroom deal with for-profit hospitals.⁵⁵ Although Medicare has reforms that may slow rising costs within that system, most people agree that overall health care costs will continue to increase.⁵⁶ Massachusetts, a state that enacted a similar system to the one in the federal legislation, continues to have the most expensive health care in the country, even though all of its insurers are non-profit.⁵⁷ Like the other sectors, doctors and hospitals will benefit from seeing fewer uninsured patients.

Despite public opinion favouring a social insurance system, existing legislation pending in Congress to expand the Medicare programme to cover everyone was never considered.⁵⁸ Many so-called progressive activists were misled and sidetracked by a sham campaign to include a public insurance plan in the legislation.⁵⁹ Meanwhile, health care corporations overwhelmed Congress with lobbying, campaign contributions to key legislators, hints of future jobs for staffers,⁶⁰ advertising campaigns through disease advocacy groups and Astroturf organisations,⁶¹ and feeding talking points to the media. By the time the reform law was finally passed, about 1,750 businesses and organisations had hired some 4,525 lobbyists, eight for every member of Congress. More money was spent lobbying on this issue than any in history – between \$120 million and \$1.2 billion.⁶² Regardless of one's opinion about the specifics of the health care reform, the policy-making process demonstrated the complete inability of Congress to solve problems based upon evidence and the public interest.⁶³

If Virchow was right, the US health care system has it backwards. Medicine in the US is nothing but the result of our politics on the largest scale. That amounts to capitalist profiteering and has nothing to do with health or healing.

Notes

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