

INTERVIEW

FACING THE CHALLENGES OF HEALTH CARE REFORM: AN INTERVIEW WITH PROFESSOR GORDON LIU

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In this interview with Dr. Lu Shi (University of California, Los Angeles), Dr. Liu discusses the difference between health care reform in the United States and that in China, and noted several critical changes that may happen to China's health system.

1. Health Care Reform in the United States

Lu: As we know, the United States just passed a comprehensive health care reform bill. How does that compare to the ongoing health care reform in China?

Dr. Liu: The health care reform in the United States focuses more on containing healthcare inflation through universal insurance policy. To a large extent, it is a matter of health care finance.

About 16% of the American population do not have regular health insurance. These people, however, have access to health services via emergency care. In other words, many people who do not have health insurance tend to use emergency care even when they do not have urgent symptoms, leading to a very serious cost-ineffective mechanism for service delivery. Scholars from the United States talk of their 16% uninsured population as a failure case, yet it is inaccurate to say the U.S. does not have capability to provide all of its citizens with services. In fact, the U.S. health system does provide care to all residents regardless of insurance status, only in an inefficient way.

Why did health reform repeatedly fail in the U.S. since Franklin D. Roosevelt, while reforms of pension and unemployment insurance have been more successful? The answer lies in the basic American value that the individual liberty always remains the first priority, thus insurance mandate is not supposed to be imposed upon citizens until this recent reform. That is why the individual mandate in the recently passed health care reform bill has incurred considerable political cost for President Obama, who said earlier that he was willing to pay whatever a price it may take for this reform. Given what we see from the reaction to this reform, it is very likely that his reelection will be challenged or threatened by the Republicans for the passage of the health care reform bill.

Under the health care reform bill, insurance companies can no longer charge high premium for pre-existing conditions. This is actuarially very difficult, if not infeasible, for insurance companies to

operate, leading them to post a high premium for every customer as a result, which is not what we intend to see. This further drives healthier customers away from the insurance pool and force the insurance company to charge an even higher premium for the rest. Thus, the promise that every American has the same insurance as what congressmen have risks incurring a vicious cycle of “adverse selection.” In any case, we see that the theme of the U.S. reform is around insurance policy design.

2. Health Care Reform in China

Dr. Liu: The challenge and focus for China’s health care reform is quite different. The theme is supply shortage coupled with cost inflation. In terms of health care workforce, China has 1.5 physicians per thousand people, and the U.S. has 2.4 physicians per thousand people. Thus China has less aggregate physician supply than the U.S. But what we observe from the reality is still different from what the 1.5-2.4 contrast suggests. When you go to a physician appointment in the U.S., you usually need to wait for ten to twenty minutes before you go into a single room with the physician. An appointment typically takes half an hour. In China, an average physician would see several dozens of patients a morning, which means the physician has only about three or four minutes for each patient. With the room full of patients, you wonder how many questions the physician can really ask within three to four minutes. The numbers here do not match with what the physician density figure suggests, suggesting a highly inefficient bureaucratic system for medical profession where on-duty doctors are truly heavily overloaded while many others are not engaged in care workforce at all.

Furthermore, the reality is that, despite the low physician density in China, a lot of Chinese doctors are not in the practicing status. Chinese physicians are in a two-tier workforce. Among those in the big hospitals, a lot of doctors are working on the administrative affairs. So when we consider the physician density, it includes all those who have retired or semi-retired from their practice. This means that those who do practice are overloaded. For community hospitals, the quality of their training is low. Thus, better trained doctors are in big hospitals while second-tier doctors are in community hospitals which patients rarely choose to go to. These two groups of doctors do not interact or communicate with each other on a regular basis. As patients recognize this distinction, they go to the big hospitals all the time regardless of the severity of their symptoms, causing an inefficient physician labor supply.

China had not fully allowed physicians' multisite practice and thus there are no independent practicing doctors. To practice outside the hospital you work for required the permission from the hospital administration. This is one of the most flawed policies and has wasted lots of medical labor services. So the good news from China's state health reform roadmap is that multisite practice will be legalized and the doctors can now retain their job while practicing away from their full-time employers. If implemented, I believe that this reform will make a fundamental change leading to a more efficient allocation of physician supply in favor of community settings in China, which is exactly what we need at the moment. As I wrote in a book chapter¹ in 2009:

“This approach could lead to fundamental improvements in both the incomes and professional status of the medical profession by allowing increased opportunities for career development, without the need to increase pressure on public finance, while also ameliorating confrontational political challenges from nonmedical officials who may create discontent otherwise when facing wage differentials. In short, the idea is to minimize government intervention in the micromanagement of service delivery for

¹ This is from a chapter contribution by Dr. Liu for *China's Capacity to Manage Infectious Diseases*, 2009, published by the Center for Strategy and International Studies (CSIC), Washington DC.

productive efficiency to allow greater government capacity for macroeconomic policy and regulatory responsibilities.”

3. Challenges Facing China’s Medical Schools

Lu: Considering the changes that need to happen in China’s health care system, how do the Chinese medical schools live up to these challenges of this ongoing health care reform?

Dr. Liu: As we have discussed, supply capacity will be better if multisite practice becomes allowed. We will see more good doctors going to the community facilities, which also means that we will need many more primary care physicians. However, China’s medical schools do not provide adequate training for family medicine and thus do not turn out a sufficient number of primary care physicians as needed by the society. So we will need reform in medical schools too to accompany the state overall reform.

4. China’s Health Services Research Today

Lu: What about health services research in Chinese universities?

Dr. Liu: We still have not had a formal discipline of health services research (HSR) in China. Current HSR programs in China require years of clinical coursework and in some cases resident training, while we really need much fewer years of clinical courses but more health economics and policy trainings in an HSR program. The opportunity cost for multi-year clinical coursework is too high. But as much as we need to increase HSR core courses like applied econometrics, health economics, policy, and management, Chinese schools of public health are still unable to provide enough faculty manpower for solid training in those fields.

Of course, there is a historical reason for this situation. The traditional government-determines-all system does not leave much role for health services research to play in policy making or service management. But today under the so called scientific development approach as the guiding principle for China’s development, we must need evidence-based research to support policy making and service management, and therefore it is a right time for us to start building a strong discipline of HSR in China.

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