



Photographer: Alina Zienowicz

Health Care and Change

*the US, China and Postcommunist Europe
in a Reconfiguring World*

Convener: Dr Peggy Watson

Friday 24 June - Saturday 25 June 2011

CRASSH, 17 Mill Lane, Cambridge

Online registration and more information:

www.crassh.cam.ac.uk/events/1406



Wireless access:

Wireless Internet Access is available to CRASSH visitors.
To connect you will need to attach to the SSID – crassh
The WPA – Personal Passkey (password) is – crassh17



UNIVERSITY OF
CAMBRIDGE



Acknowledgments

The convener is grateful for the support of the Centre for Research in the Arts, Social Sciences and Humanities (CRASSH), the British Academy and the Foundation for the Sociology of Health and Illness.

Health Care and Change

the US, China and Postcommunist Europe in a Reconfiguring World

Friday 24 June 2011 - Saturday 25 June 2011
CRASSH, 17 Mill Lane, Cambridge

Convener

Dr Peggy Watson (Sociology, University of Cambridge)

Conference Summary

The health care changes originally proposed by Barack Obama were hailed as potentially the most significant advance in US social legislation since the New Deal. At the same time, the level of contention which the proposals provoked took many by surprise. At a fundamental level, it was noted, the disagreements involved competing views regarding the kind of country the US should be. Health care now promises to be on the political agenda for some time to come. However, the US is not the only country where controversial health reforms are being faced. The postsocialist countries have also seen dramatic and frequently problematic health care change - in Europe, the streets of Vilnius, Riga and Sophia saw violent protests early last year following social spending cuts. China's health care has also been radically redefined as the country pursues a place among the rich nations of the world. The present conference initiative brings the US, China and postcommunist Europe together within a single study frame. The aim is to gain insight into the quite different processes of change that are involved when countries with these radically different starting points move towards a globally shared health care framework. The conference has been constructed with a view to bringing together detailed ethnographic description, theoretical analysis, as well as issues of economic power and institutional design. It will explore the degree to which concepts developed within one research setting might have analytical purchase elsewhere. It will confront the interpretations and experiences of patients, professionals, and politicians of health care transformation in practice, and ask what the implications of the changes are for varying forms/ understandings of citizenship in a post-Cold War world.

This academic meeting on the globalisation of health care will facilitate new intellectual exchange on hitherto rather distinct areas of research. It will bring together speakers with diverse backgrounds, including anthropology, area studies, sociology, geography as well as public health.

Programme

Friday 24 June

9.45 - 10.15 Registration and coffee

10.15 - 10.30 Welcome

10.30 - 11.30

Keynote

Allyson M Pollock and David Price (Centre for Health Sciences, Queen Mary's College, University of London, UK)

Competing Bureaucracies: Market Risk Selection Versus Public Health Planning

11.30 - 13.10

Session 1

Wendell Potter (Centre for Media and Democracy, USA)

Producing Public Opinion: How The Insurance Industry Shaped US Health Care Reform

Nick Manning (Institute of Mental Health, University of Nottingham/ Notts HC NHS Trust)

Consequences Of Rapid Economic And Social Change For Health And Health Policy: A Comparison Of Russia And China

13.10 - 14.00

Lunch

14.00 - 15.45

Session 2: Ethnographies Of Change

Discussant: Darin Weinberg (Department of Sociology, University of Cambridge, UK)

Michele Rivkin-Fish (Department Of Anthropology, University Of North Carolina, USA)

Rethinking Problems Surrounding Access To Care: The Moral Economies Shaping Health Care Work Forces in Russia and the US

Anna Lora-Wainwright (School of Geography and the Environment, University of Oxford, UK)

Why do doctors serve the money and not the people? Perceived efficacy, social identities and the rejection of cancer surgery

Discussion in Absentia of **Mei Zhan** (Department of Anthropology, University of California, Irvine)

Human Oriented? Angels And Monsters In China's Health-Care Reform

15.45 - 16.00

Coffee/Tea

16.00 - 16.45

Session 3

Matthew Yu Wang (Department Of Geography, University Of Cambridge, UK)

A Geospatial Analysis Of Community Health Services In Jinan, China: Access To Services And Health Outcomes

16.45 - 17.15

End of day discussion

Saturday 25 June

10.00 - 10.45

Session 4

Meri Koivusalo (National Institute for Health and Welfare, Helsinki, Finland)

We Are All In This Together – European Policies And Change In Health Care Governance

10.45 - 11.15

Coffee/Tea

11.15 - 12.45

Session 5

Larry King & Piotr Ozieranski (Department of Sociology, University of Cambridge, UK)

Who Rules Postcommunism? The Case Of Drug Reimbursement In Poland

Peggy Watson (Department Of Sociology, University Of Cambridge, UK)

Catastrophic Citizenship: The Political Space Of Poland's Health Care Reform

Discussion in absentia of **Terry Cox** (School Of Slavonic, Central And East European Studies, University Of Glasgow, UK)

Sandor Gallai (Corvinus University, Budapest, Hungary)

The Making Of Health Care Policy In Hungary: The Case Of Hospital Privatisation

12.45 - 14.00

Lunch

14.00 - 15.30

Session 6

Howard Waitzkin & Rebeca Jasso-Aguilar (Department Of Sociology, Family & Community Medicine, And Internal Medicine, University Of New Mexico, USA)

Popular Protest And The Reimagining Of Health Rights

Panel-Led Discussion of Issues/ Questions/ Themes Emerging from the Conference (to be recorded)

15.30 - 16.00

Coffee/tea

End of conference

Abstracts

Terry Cox (School of Slavonic, Central and East European Studies, University of Glasgow, UK) and

Sandor Gallai (Institute of Political Science, Corvinus University, Budapest, Hungary)
The Making of Health Care Policy in Hungary: The Case of Hospital Privatisation

Our paper reviews the main measures introduced by successive governments since 1990 to bring about a transformation of the health care system in post-communist Hungary. It lays special emphasis on changes to the financing of health care; the issue of citizen and interest group participation; and the privatisation of hospitals with a focus on a series of (failed) legislative attempts at regulating hospital privatisation. A recurrent theme in the making of health policy has been its highly contested nature and the perceived ineffectiveness of several of the measures that have been introduced. The paper explores this problem through an analysis of key characteristics of the Hungarian polity as it has emerged since 1990 and the relations between policy actors in the making of health policy in Hungary. Drawing on interview-based research with a wide range of different state and social actors, including government ministers, civil servants, political parties, consultants, and representatives of doctors and other health care workers, the paper examines debates and competition between them in their attempts to influence policy making.

Larry King & Piotr Ozieranski (Department of Sociology, University of Cambridge, UK)

Who Rules Postcommunism? The Case of Drug Reimbursements in Poland

Political elites and private economic actors are by consensus seen as the most important forces in postcommunist society. We investigate the relationship between them by means of a case study of the drug reimbursement policy domain in Poland. We conducted 207 in-depth, semi-structured, anonymous elite interviews, supplemented by review of legislation, policy documents, official reports and press articles, as well as participant observation. Overall, our data strongly confirms Janine Wedel's clique theory of the postcommunist state. We contend that domestically based elite cliques form a "comprador class" that, thanks to its extensive social capital, helps Western multinational drug companies to transform their economic capital into political influence. We have four concrete findings to support this thesis. First, informal lobbying is a key instrument of securing positive reimbursement decisions on expensive innovative drugs taken by political and administrative elites. The effectiveness of informal persuasion stems from extensive personal relationships between clique members: pharmaceutical lobbyists, bureaucrats, politicians and medical experts. Second, we find that medical experts are structurally dependent on drug companies for their success in the scientific field. In other words, drug companies strengthen the professional position of medical experts through – largely informal in nature – transfers of expertise and money. Third, clique theory correctly predicts a distinctive "fire exit" mobility pattern, with deleterious consequences for

state capacity. In contrast to the “revolving door” syndrome, typical for countries like the US or the UK, in this case mobility takes place almost exclusively from the state to drug companies and entails the privatisation of vital state resources, such as exclusive insider knowledge, by the mobile state officials. Lastly, clique theory is supported by rapidly growing budgetary spending on new expensive drugs. Positive reimbursement decisions elevate the sales of the medicines and thereby meet the economic interest of multinational drug companies. On the other hand, by responding to the media campaigns engineered by the drug companies politicians belonging to cliques are able to boost their own popularity and increase the level of political capital.

Meri Koivusalo (National Institute for Health and Welfare, Helsinki, Finland)

We Are All in This Together - European Policies and Change in Health Care Governance

The role of European policies in relation to health systems financing, organisations and regulation has changed substantially during the last ten years. The politics of change have been driven by adherence and strengthening of Treaty basis and case law as basis for technical response rather than on the basis of explicit policies and policy preference of an increasing European Commission role in health systems governance. A particular area of contention between Member States and the European Commission has been the relationship between internal markets and health care systems. This paper discusses the politics of policy change, the ways in which policies were changed as well as the ways in which this has particular relevance to former CEE countries.

Anna Lora-Wainwright (School of Geography and the Environment, University of Oxford, UK)

Why do doctors serve the money and not the people? Perceived efficacy, social identities and the rejection of cancer surgery

Why do villagers in contemporary China deny themselves hospital treatment even when they may financially be in a position to afford it? Under what circumstances have they become convinced that such treatment is unreliable, inefficacious and therefore not worth investing in? Based on 16 months of ethnographic fieldwork in rural Sichuan, China, this paper examines the impact that healthcare reforms before the re-introduction of the rural cooperative medical system (RCMS) in 2006 has had on experiences and perceptions of medical treatment. It illustrates how hospital treatment (and cancer surgery in particular) is understood in a village affected by high cancer rates. It proposes that the widespread unwillingness to resort to hospital care has not only economic but also social, cultural and historical roots. Perceptions of healthcare providers as still putting profit before their patients' wellbeing, locals' past living conditions and their social positions intersect to configure expensive treatment as socially and culturally inefficacious.

After a brief background on the research setting, the paper presents an account of the developments of healthcare provision since the founding of the People's Republic (1949) at the national, provincial, municipal and village level. This elucidates the ongoing healthcare disparities between rural and urban and wealthy and poor regions both in terms of quality and quantity of care available and the clear structural obstacles villagers face in accessing extortionately expensive care. As cancer sufferer Uncle Wang stated, 'when we [farmers] get ill we can't even afford treatment, we're just left to die' (October 2004). This sentence was perhaps the one that recurred with the most frequency during my fieldwork. In this light, before the introduction of the new RCMS (a collective health insurance programme) in the area in 2006, the answer to the question why do farmers not seek hospital treatment for cancer may seem straightforwardly financial.

Nick Manning (Institute of Mental Health, University of Nottingham/ Notts HC NHS Trust)

Consequences of Rapid Economic and Social Change for Health and Health Policy: A Comparison of Russia and China

Russia and China have been through revolutions on their way to market based societies. For Russia this was a short and brutal change, symbolised by a massive increase in prices, including food, in 1992, and a currency collapse in 1998. For China this has been a smoother transformation, but no less fundamental, with enormous internal migration and urbanisation. In both countries inequality has burgeoned. This paper draws on fifteen years of fieldwork in Russia, and a more recent growing research collaboration with China.

There have inevitably been significant impacts on both health and healthcare. But these impacts have not necessarily been the same, and the reasons for differences or similarities are instructive. The first notable difference is the comparative life expectancy in Russia and China. In Russia the life expectancy for middle aged men took a disastrous downturn in the 1990s, arguable the consequence of stress induced by the rapid marketisation of all aspects of life, and in particular the way in which men and women dealt with this. For men, this heralded a retreat into alcohol and the avoidance of responsibilities, but for women the reaction was an intensification of the use of networks for survival. Both reactions constituted an exaggerated response of previous cultural habits. By contrast in China, the demographic consequences of change have been very different. Overall life expectancy has continued to rise, but vulnerabilities generated by rapid urbanisation and technological industrialisation have split along generational and spatial lines. Young people have been particularly subjected to competitive stress in the urban labour market. There is also strong evidence that in rural small towns, newly available ultrasound scanners are being used to guide the selective abortion of female fetuses, and accelerate growing infant gender imbalance.

Turning more closely to the cultural meanings of health, one of the findings that emerged from our fieldwork with poor households in Russia in 2006/7 was the apparent identification of a new category of health status which was neither well nor ill, but constituted a stable of state of 'not very well'. This has to be understood in relation to the prospects of taking some kind of health action to deal with it; it was the response of individuals with health concerns in the context of their judgement about the problems of gaining healthcare. It was an experience of poor health which was not life threatening, at least in the short term, in which the binary definition of health/illness was augmented by an additional definition of "not ill in relation to the problems of getting healthcare". This is in marked contrast with communist Russia, in which polyclinics were regularly overrun by trivial demand from citizens who had been sensitised by fashion or rumour to taking minor ailments for treatment. The situation in China here has strong parallels rather than contrasts. The unwillingness of individuals, particularly in rural areas, to take their ailments to hospital for treatment has been widely observed to have developed in the context in which hospitals have been operated in an increasingly commercial manner.

Allyson M Pollock and David Price (Centre for Health Sciences, Queen Mary's College, University of London, UK)

Competing Bureaucracies: Market Risk Selection Versus Public Health Planning

For the last 25 years, changes to public health care provision in developed and less developed countries have been driven by microeconomic theories of competition and markets. Among the most widely pursued reform policies are the substitution of competing, commercial providers for publicly administered government units and the introduction or refinement of competition among third party payers and insurers of health care.

Public health is concerned with redistribution and equity (equal access for equal need) across states or administrations and therefore with resource allocation and needs assessments. The analytic unit of public health disciplines is geographic universal populations. By contrast, in market systems the unit of analysis switches from geographic populations to the individual, whether user, patient or payee. Aggregate data are compiled from the patient lists of providers or from the membership of separate insurance pools and the focus is on individual risk measures. However, insufficient attention has been paid to the technical apparatus that underpins the creation of new market bureaucracies and in particular its new data requirements, research methods, analysis and resource redistribution mechanisms. Changes in all of these are associated with a switch in focus from a geographic to non-geographic populations and from population risk to individual risk.

We argue that a return to redistribution and normative public health bureaucracies are required if the goal of the NHS is to continue as a universal health service.

Wendell Potter (Centre for Media and Democracy, USA)

Producing Public Opinion: How The Insurance Industry Shaped US Health Care Reform

Health care reform advocates in the United States believed the stars had aligned for a fundamental restructuring of the American health care system when voters in 2008 elected Barack Obama president and put Democrats firmly in control of both chambers of Congress. Health care had been a major campaign issue for all the presidential candidates, and Obama's statements on reform led many advocates to assume that he would play a very visible role in shaping the legislation as they had envisioned it once he took office.

Obama's fervent supporters often thought they heard more than they really did, but his 2008 campaign promises were fairly clear. Crafted with the help of Harvard economist David Cutler, Obama's original plan called for employer mandates, federal coverage of catastrophic-care costs, and tax credits to help low- and middle-income families afford private health insurance. His platform also called for the creation of a public health plan to compete with private insurers, as did Hillary Clinton's. He said a public plan was necessary "to keep private insurers honest" and to help control costs. Obama's platform differed from Clinton's on a significant point: he opposed what came to be called the "individual mandate," a requirement that everyone buy insurance. He said numerous times during the campaign he did not think anyone should be forced to buy something they couldn't afford.

On March 23, 2010, after more than a year of contentious debate and often raucous town hall meetings across the country, Obama signed the Patient Protection and Affordable Care Act, which, at more than 2,000 pages, did indeed represent the most sweeping changes in the American health care system since the creation of the Medicare program for the elderly and disabled in the 1960s.

By the time the bill reached his desk, however, many reform advocates had become disillusioned with the president and Congressional leaders, believing they had capitulated to the insurance industry and its allies on too many important issues. The insurance industry had three major objectives going into the debate: persuade lawmakers to enact the individual mandate Obama had spoken against; strip out of the final bill any provision creating a new public insurance option like the one Obama had favored; and keep new regulations to a minimum.

Although the bill Obama signed does achieve many of the reform advocates' goals—it will, among other things, expand the Medicaid program for low-income Americans to cover many more families; it will make it illegal for insurance companies to deny coverage because of pre-existing conditions; it will provide tax credits to small businesses to encourage them to offer health benefits to their employees; and it will enhance the prescription drug benefit for Medicare enrollees—it also met the

insurance industry's objectives. The bill was enacted with the individual mandate, but Americans will not have a public insurance plan to choose as an alternative to the private insurers. While the law does impose numerous new regulations on the industry, they are not onerous for most insurers. So in many ways, the reform law is more beneficial to the industry—which is now dominated by five large for-profit corporations—than it is to many American citizens.

The paper will examine the role that a sophisticated, well-financed and often deceptive public relations campaign to influence public opinion, carried out largely by the insurance industry's business and political allies, enabled the insurers to shape the law largely to its liking.

The planning of the PR campaign began long before it was known which of the presidential candidates would be the eventual Republican and Democratic nominees. The paper will explain the challenges the industry was facing leading up to the 2008 election and why industry leaders decided that a PR campaign implemented by third parties, with no apparent connection to the insurers, would be considerably more effective than an industry-sponsored advertising campaign, as was undertaken when President Clinton attempted health care reform 15 years earlier.

The goal of the PR campaign was to turn Americans away from the reforms envisioned by Obama and Congressional leaders. The paper will detail how the campaign's success in influencing public opinion weakened the ability of Democrats to enact legislation to radically reshape the health care system. It will also describe how the insurers' PR initiatives, which did not stop with the enactment of the legislation, contributed to the Republican victories in 2010 that cost the Democrats control of the House of Representatives, and how it is continuing to influence the way the new law is being implemented at both the national and state levels.

Michele Rivkin-Fish (Department Of Anthropology, University Of North Carolina, USA)

Rethinking Problems Surrounding Access to Care: The Moral Economies Shaping Health Care Work Forces in Russia and the U.S.

Both Russia and the United States have great needs to extend access and improve their quality of health care. The particular characteristics of these two countries' health care systems and system needs are dramatically different: whereas Russia's problems of access stem from gaps in what is supposedly a universal model of free health care, the US's system of work-based insurance structurally ensures that tens of millions of citizens will face barriers to access because of lack of health care coverage. Russian health care reforms have focused on introducing new financing mechanisms while facilitating the emergence of private and semi-privatized services; in the US, contrastingly, new health care reforms aim to extend insurance coverage and

enhance the capacity of community-based, publically funded clinics for rural and urban residents excluded by the market-based, private health care system.

While these differences are substantial, it is also notable that in both contexts, workforce issues entail a key part of efforts to address existing needs. Health planners recognize that access and quality of care are intensely affected by the actions of physicians, but their vision of how to motivate workforce changes relies on narrow understandings of providing monetary behavioral incentives. I recognize that salaries are important, but argue that physicians' impact on access and quality of care needs to be understood in much broader cultural and political-economic terms. My goal in this paper is to bring the anthropological framework of moral economies to debates over how physician workforce trends affect access to care. Moral economies involve "consensual assumptions about reciprocal obligations" (Minkler and Cole 1997:40); and involve the circulation of goods both material (such as money and benefits) and non-material, such as dignity, integrity, and social standing. This essay highlights the ways Russian and US physicians' career decisions and daily practices regarding patient access to their services are affected by culturally shaped notions of professional entitlement and patient worth, as well as the perceived symbolic worthiness of particular sectors of health care vis-à-vis the system as a whole. Efforts to improve access to care by addressing physician workforce issues have not adequately conceptualized the ways health providers' experiences, aspirations, and strategies are embedded in moral economies that define (if ambivalently and with contradictions) professional entitlement and differential assumptions about social worth. Examining the moral economies of health care and professional work through which providers in Russia and the United States make sense of their career decisions and daily practice will open up new insights into the challenges of increasing access to underserved populations.

Howard Waitzkin & Rebeca Jasso-Aguilar (Department Of Sociology, Family & Community Medicine, And Internal Medicine, University Of New Mexico, USA)
"Health Care and Change": Popular Protest and Building Alternative Visions of Health Systems at the End of Empire

Public health and health services have played important roles during the rise of empire and during its subsequent decline. Although it is a complex, multifaceted phenomenon, we define empire in simple terms as expansion of economic activities – especially investment, sales, extraction of raw materials, and use of labor to produce commodities and services – beyond national boundaries, as well as the social, political, and economic effects of this expansion.

The connections among empire, public health, and health services have operated through several key mediating institutions. During the rise of empire, philanthropic organizations sought to address through public health initiatives several challenges

faced by expanding capitalist enterprises: labor productivity, safety for investors and managers, and the costs of care. From modest origins, international financial institutions and trade agreements eventually morphed into a massive structure of trade rules that would exert profound effects on public health and health services worldwide. International health organizations manifested an ongoing collaboration with institutions that sought to protect commerce and trade.

Conditions during the 21st century have changed to such an extent that a vision of a world without empire has become part of an imaginable future. We analyze several popular struggles in Latin America, where we have been involved during the past decade as researchers and activists. These struggles include resistance against the privatization of health services as well as efforts to expand public-sector health services. We also analyze recent efforts to reform health services in the United States, in the context of neoliberal policies that support the diversion of public sector funding to the private insurance industry. Overall, such scenarios convey a picture very different from that of the historical relation between empire and health – a picture that shows a diminishing tolerance among the world's peoples for the public health policies of empire and a growing demand for public health systems grounded in solidarity rather than profitability.

Peggy Watson (Department Of Sociology, University Of Cambridge, UK)
Catastrophic Citizenship: The Political Space of Health Care Reform in Poland

In April 2010, an aircraft carrying the Polish President crashed outside the city of Smoleńsk killing everyone on board. After the accident, the emotions and vociferousness of the clashes that took place among mourners were powerful and unexpected enough to prompt extended reflection on the condition of Polish politics, society and state. Drawing on the ideas of Marcus and of Fassin, I suggest that the paranoid style of the political sentiments which were widely expressed by the crowd presents itself as an illuminating point of departure from which to embark on an analysis of what has been happening with respect to health care reform in Poland during the last two decades, including the vulnerabilities, dissatisfaction and frustrations to which it has often given rise. Drawing on official data as well as interviews with patients, professionals and policy-makers, I discuss the new costs and financing of the reforms. I analyse the politics of memory that govern post-socialist experiences and perceptions of the health care inequalities to which these changes have given rise. I also consider how the disadvantaged position of Poland with respect to the global economy and international power relations and persisting ideas of East-West difference in Europe, serve both to produce and legitimate and mystify the new health care hardships and inequalities that – along with a lack of social influence in national politics - characterise catastrophic citizenship and postsocialist biopolitics in Poland.

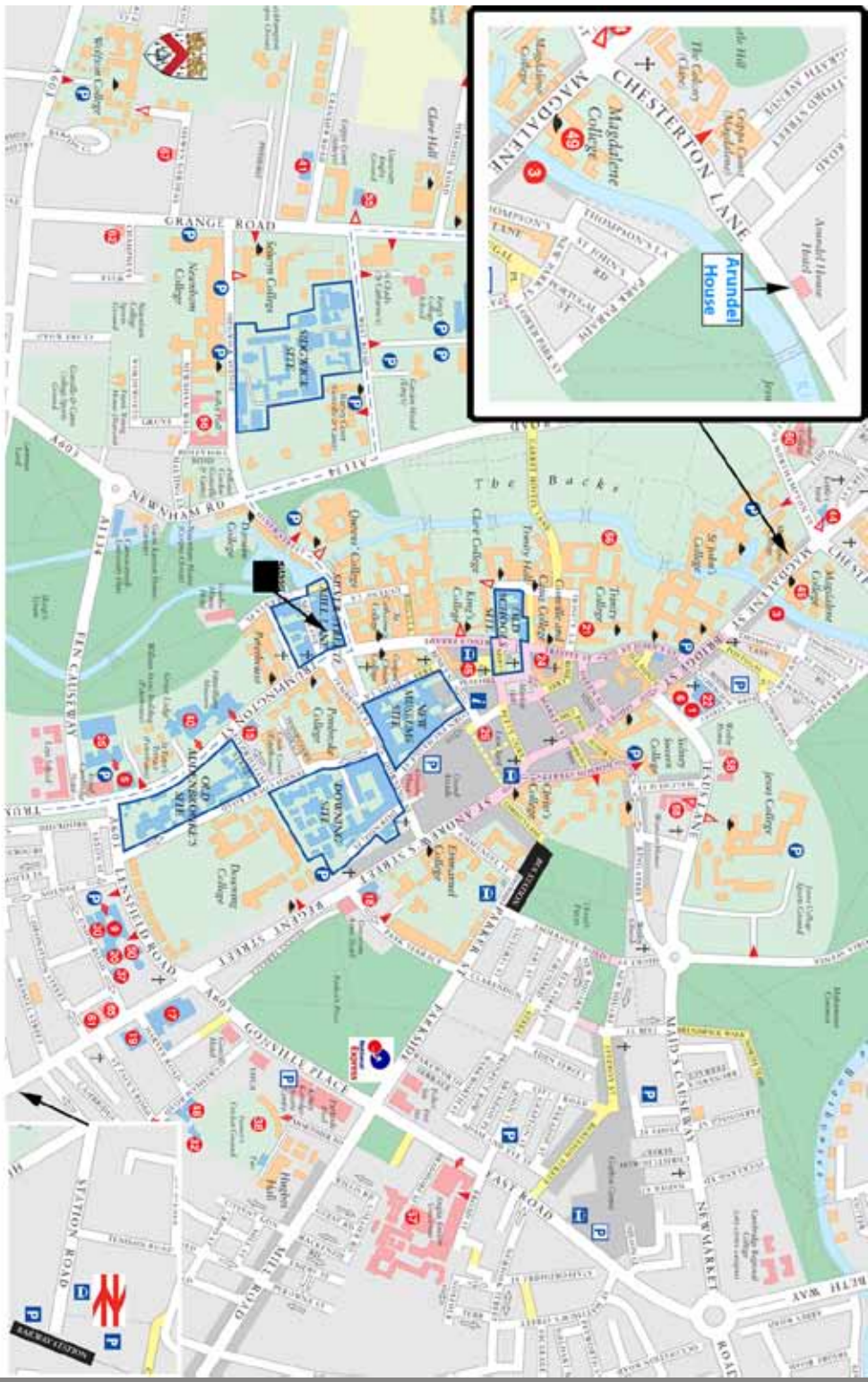
Matthew Yu Wang (Department Of Geography, University Of Cambridge, UK)
A Geo-Spatial Analysis of Community Health Services in Jinan, China: Access to Services and Health Outcomes

Inaccessible and expensive medical services have become one of the most concerning social issues in China today. Since the late 1990s, the Chinese government has started to develop a community health service (CHS) system along the lines of the UK's NHS with the aim of providing primary health care for all urban populations. However, the development of CHS in China is currently facing a series of problems and challenges, including geographical inequality the provisions of CHS resources and significant variations in the needs and utilizations of CHS across different population groups.

The principal aim of the project on which this chapter draws, is to apply an integrated approach to examine CHS from a geographical perspective. The research focuses on Jinan City, which was one of the first cities to launch a CHS in China. The study will examine access to CHS in Jinan from three perspectives: those of the government, patients and health professionals. This corresponds to three dimensions associated with the study of access to health care: (i) service provision, (ii) utilization and perception of services, and (iii) links to health outcomes. Hypertension is selected as a particular example for exploring the impact of access to services on health outcomes. By using GIS techniques, mapping and measuring the potential accessibility to CHS institutions across the City will be carried out based on existing local census and health service data. Data on people's perceptions and utilizations of CHS will be collected through questionnaire surveys on 1,800 residents from eight sampling areas, in order to assess the revealed accessibility to CHS. Information on residents' awareness and possible compliances of hypertension intervention will also be collected from the questionnaire surveys. This will be combined with results from the measurements of residents' blood pressures, which are implemented along with the questionnaire surveys, to investigate the health outcomes in relation to the access to CHS. A location-allocation model will be fitted on the basis of the findings to explore the improvements of medical resource allocations in the city. This research will be the first formal assessment of the delivery and access to CHS in China. It is hoped that the conceptual framework used in this study will contribute to the study of inequality of access to health services, and in longer term, that the research will help China's CHS system to implement improvements in access to health care.



Traditional Chinese Cupping Therapy
Photo courtesy of Jiong Tu



CRASH
17 Mill Lane

Arundel House
Cheselton Lane

 **Rail**
Station Road

 **Coach**
National Express
Parkside