simply increasing the tobacco tax from 110% to 125% without the payback to Philip Morris and BAT.

Health minister Julio Frenk explained the deal with Philip Morris and BAT on the grounds that the only way to ensure that the money went to Seguro Popular de Salud was as a "donation" from the tobacco companies.^{w20} This argument ignores the fact that the government in which he served could simply have appropriated to the insurance fund the money that an increased tax produced. The Ministry of Health's agreement provided the tobacco companies with immunity from one of the most effective tobacco control strategies agreed in the FCTC: tax increases.

The Mexican government also agreed to having weak warning labels that do not meet the minimum standard in the FCTC (covering 30% of the front and back of the cigarette or tobacco package) and abandoned any effort to introduce highly effective pictorial warnings that are already in force in other Latin American countries (Brazil, Venezuela, Uruguay) and elsewhere (Canada, Australia, Singapore, European Union, and Thailand).^{2 w1 w2} Mexico, like Uzbekistan, accepted the terms of the tobacco industry's voluntary code of advertising despite the fact that Mexico has ratified the FCTC and is obliged to pass a comprehensive ban on all tobacco advertising and promotion by 2009.

These experiences, as well as those in other developing countries,^{w21-w26} make the future clear: the tobacco industry has adapted to changing circumstances with ever more sophisticated strategies to protect its profits and forestall the kind of meaningful legislation on tobacco control envisioned in the FCTC. When asked for a formal opinion by the National Institute of Public Health of Mexico, the World Health Organization expressed no opinion on whether the agreement violated the FCTC.^{w27} This silence makes it crucial that the Conference of the Parties (the body

created by the FCTC to enforce its provisions) emphasises that deals like the one between the tobacco industry and the Ministry of Health in Mexico are incompatible with the FCTC. Failing such action, the multinational tobacco companies will replicate the Mexican agreement elsewhere, creatively using the FCTC to consolidate their position and undermine global tobacco control.

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President Bush's proposals for healthcare reform

New plan offers "consumer empowerment" through rationing by socioeconomic class

In his State of the Union address last week, President Bush blessed the latest thing in American health policy: "consumer directed health care," also widely and inaccurately known by the acronym HSAs, which stands for "health savings accounts."¹ The idea is to "empower" "consumers" (formerly "patients") to function as agents of both quality control and cost control in health care, through two instruments.

Americans would be enticed into private health insurance with very high annual "deductibles"—out of pocket payments before insurance kicks in, from \$2100 to \$10 000 or more per family. In the words of Alan B Hubbard, director of the White House National Economic Council, the idea is to provide "people an opportunity ... to have more skin in the game."² And Americans would be empowered with user friendly information on the cost and quality of the health services offered by individual doctors and hospitals—an ambitious vision that, so far, remains largely on the drawing board.

Not ever mentioned in the marketing of this "consumer empowerment" are two important side effects. Firstly, the approach inevitably delegates most of the expected belt tightening in health care to families in the lower half of the nation's income distribution, whose decisions on health care are most sensitive to high out of pocket costs. In effect, the proposal seeks to ration health care by income. Secondly, the approach would shift more of the financial burden of health care from the chronically healthy to the chronically ill.

Previous American presidents have tried to control health spending with sundry regulatory controls that were only half heartedly implemented and ultimately decried as socialised medicine. President Nixon tried system-wide price controls. President Ford tried constraints on capacity through system-wide health sector planning. Presidents Reagan and Bush Senior imposed on the federal Medicare programme for the elderly a system of centrally administered prices that

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resemble nothing so much as Soviet-style price controls. President Clinton favoured government regulated “managed price and quality competition” among private health insurance plans that would manage health care through direct interference in the doctor-patient relationship with controls on utilisation and clinical practice guidelines. This idea was nipped in the bud by political enemies who panned it as a government takeover of American health care and as paternalistic, cookbook medicine.

At some point, of course, Americans must confront in earnest the annual growth of US health spending, which has outpaced the annual growth of the rest of GDP (gross domestic product) by an average of 2.5% over the past four decades. In 2006 the US health sector will absorb one sixth of GDP, a share projected to reach 18.7% by 2014³ and, by my calculation, 40% by 2050, if the 2.5% growth differential persists until then. Yet for all this enormous spending, some 45 million Americans (17.8% of people under 65) are now without health insurance of any kind,⁴ as employers such as the large car building companies, who have provided generous health insurance to their employees, increasingly stagger under the load of ever increasing premiums for that coverage.⁵

President Bush would effectively bribe Americans to embrace the leaner health insurance by allowing them to make annual, tax deductible deposits of up to \$10 500 per family into a personal health savings account (HSA). The balance in such an account could then be used to finance the family's higher out of pocket spending for health care and premiums for catastrophe insurance bought directly by families.¹ Health insurance provided by employers has long enjoyed such a tax preference, because the premiums are tax deductible business expenses for employers but are not part of the employees' taxable income. Under a progressive income tax structure, of course, this tax preference makes health care cheaper, in dollars received after tax, for Americans on high incomes facing high marginal tax rates than for Americans on low incomes facing low marginal tax rates. It reflects a uniquely American social ethic.

The theory underlying consumer directed health care is that high deductibles will induce “consumers” to

shop around carefully among competing physicians and hospitals for high quality, cost effective health care and that they will also reduce their “consumption” of marginally beneficial health care. An experimental study in the 1970s showed that rates of visits to doctors and hospital admissions per capita tend to decline with higher sharing of cost by patients, although for low income families such cutbacks reduced their use of beneficial as well as unnecessary services and was estimated to have increased rates of death from preventable illness.⁶ How readily, however, can the ambitious infrastructure for information envisaged by the president be constructed?

Policy makers and leaders of health care outside the United States should study these ideas carefully. Long before Americans will have put them into workable practice, if they ever do, the usual American missionaries—management consultants, US foreign aid agencies, and the World Bank—will descend on the rest of the world to market this “new, new thing,” just as, only a decade ago, they eagerly marketed to the world the then new and now discredited thing called “managed care.”

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A new direction for NHS community services

The white paper tackles the right issues but may be hard to implement

The government's new white paper on the future of primary, community, and social care heralds more emphasis on preventive care, a greater choice of services from general practitioners; reduced health inequalities, and better support for people who need long term care.¹ The plan also promises more convenient access to general practices, together with an expanded range of other sources of primary care, such as walk-in centres. The NHS will seek new providers from the independent sector to tackle longstanding problems of poor access to health care in deprived areas, and perhaps elsewhere. In addition, many

services—including up to half of all outpatient care for some specialties—will be shifted out of hospitals and into community settings.

Patients will gain more power within the NHS. They will be offered greater choice over where and when they receive primary care, more information about their health and health services, more direct control over social care resources, and the ability to trigger fundamental service reviews of local health services. Furthermore, the white paper promises that patients' views of services will be assessed independently and acted on.