Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

and coauthors.[7] This approach involves listening to children's concerns and helping them to understand that they have rights—but that other people have rights as well and that these rights go hand in hand with respect and responsibilities. UNICEF[8] and the Roots of Empathy programme[9] have developed guidance to help teachers working with these themes in school. Mass entertainment or edutainment programmes could help young people to modify their attitudes and behaviour—eg, in southern Africa the programme *Soul City* tackles the problems of coercive sex, teenage rape,[10] and domestic violence, which young people too readily accept as just part of life.[11]

Population pressures are likely to increase the risks of child maltreatment, particularly in developing countries. Climate experts question whether the world can sustain current levels of consumption and the projected population increase.[12] To improve quality of life and reduce maltreatment in all its manifestations, child-health professionals should advocate not only for the Millennium Development Goal of child survival but also for family planning services, which currently are inaccessible to millions of couples.[12] Children who are wanted and planned according to parental and environmental resources must surely have a better chance of enjoying their childhood free of maltreatment or neglect.

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Reforming China's health care: for the people, by the people?

On Oct 14, 2008, the Chinese Government published a draft of its Healthcare Reform Plan, to solicit comments from the public.[1] Inviting people to participate in the development of public policies is unprecedented in China. The invitation reveals signs of how far the world's largest developing country has gone and where it might be going, and indicates open-mindedness in the current leadership or at least shows that they want to be perceived as being good listeners.

Despite China's rapid economic development since 1978, when the country embarked on a transformation from a planned economy to a market economy, a health-care crisis has been looming in the country. The outbreak of severe acute respiratory syndrome, the increasing incidence of sexually transmitted diseases including HIV/AIDS, constant threats of an avian influenza pandemic, and the recent milk scandal serve as reminders of the complex challenges confronting China's deficient and vulnerable health system and the serious economic, social, and global implications of the system's shortfalls. China's leaders, in their pursuit of an economic growth-dominated development agenda, have neglected the Government's responsibilities to adequately finance, organise, and regulate health care. The general complaint that it was "Too difficult to see a doctor, too expensive to see a doctor!" became one of the top issues in China's opinion polls.[2,3]

Out-of-pocket payments have soared more than tenfold since 1990. Now, the average cost of a single hospital admission is almost equivalent to China's annual per-capita income, and is more than twice the

Panel: **Major policy interventions of the Chinese Healthcare Reform Plan[1]**

Increasing financial access
- Expanding insurance coverage through premium subsidies
- Controlling drug pricing, establishing essential-medicine policy

Increasing efficiency
- Strengthening public health, health education
- Gradual separation of prescribing from dispensing
- Encourage vertical integration
- Gradually carrying out provider payment-reforms

Increasing physical access
- Strengthening rural infrastructure
- Establishing network of community-based health centres
- Encouraging development of private sector

Enhancing safety and quality
- Modernising medical information system
- Strengthening medical education
- Strengthening professional ethics

average annual income of the lowest two deciles of the population.[4] Meanwhile, only 55% of urban and 21% of rural populations have any health insurance.[4] Unsurprisingly, 13·8% of urban and 15·8% of rural households incurred catastrophic medical spending in 2003.[4] Further, 15·1% of urban residents and 21·6% of rural residents, when they were ill, forewent medical care because they could not pay.[5] Despite increasing costs, the Government's health budget accounts for less than 10% of the actual costs of public hospitals. China's fee-for-service payment system exacerbates cost escalation: doctors have strong financial incentives to overprescribe because they rely on service revenue and drug sales for their income. Moreover, in view of the low level of professional ethics, there is a widespread belief that health-care providers put financial interests ahead of the patients' medical needs.[6] Mistrust is the major reason for the worsening relationship between patients and doctors.

Responding to the people's mounting demand for policy actions to reform China's broken health-care system, the State Council Healthcare Reform Leading Group, which involved 14 Ministries, was formed in September, 2006. After 2 years of many commissioned studies, including ones by organisations such as WHO and the World Bank, heated internal debates, and deliberations among the various Ministries with diverse vested interests, this group finally submitted its policy recommendations to Premier Jiaobao Wen for his review and approval in the summer of 2008.

Had it been business as usual, the policy recommendations would have had a smooth ride through the Chinese bureaucratic process and would have been implemented by now. In this case, however, perhaps the top leadership perceived the importance and complexity of health-care issues. Wen held several hearings to discuss the draft with stake-holder groups. Moreover, he promised that the Plan would be posted on the internet for public review and comments.

As it stands, the Plan calls for establishment of a universal health-insurance system by 2010, which will provide every citizen access to basic health-care services that will be "affordable, convenient, safe and effective".[1] To achieve this goal, the Plan has 12 major policy interventions (panel).

The Plan clearly indicates a new determination and dedication by China's leaders to tackle health care as a priority. However, comments on the website are critical of the lack of specifics in the Plan. Indeed, the Plan does not contain a concrete timeline and strategies for implementing the policies, and there is no price tag for the new programmes. Meanwhile, the Chinese people are demanding that their leaders come up with concrete and innovative action plans to achieve the lofty goals of better health care for all. In an increasingly globalised information age, the public's sensibilities are often more acute than they are given credit for.

Throughout China's history, its people have been passive victims of bad policies, rather than active participants in the policy processes. Of course, health-care democracy might turn out to be just another political show, and the people's opinions might not matter in the end. But giving people a chance to be heard at least helps enhance the probability of preventing the government from making huge (unchecked) mistakes, or of promptly correcting the mistakes.

China's current experiment in health-care democracy might fail. Public expectations might be too high to meet. Interest groups could be too diverse to balance. Frustrated by all this, the government might decide to suspend their attempts to include the public in policy making. But, if the process is perceived to be

informative, with new and better ideas coming out; if the process can help prepare the masses for and obtain their support in implementing the new policies; if the process can help increase people's trust in and thus strengthen the Government's legitimacy and effectiveness to govern by establishing a new image of transparency, the experiment could have powerful spill-over effects beyond the health sector. Should the benefits from this experiment become clear without incurring out-of-control costs, both the Government and the people could be encouraged to try out a similar approach to reforming China's education, social security, and even its political systems. The flood gates of democracy will have been opened, which, once open, might be hard to close again.

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Paper of the year 2008: results

On Dec 19, *The Lancet*[1] posted the papers of the six finalists for paper of the year 2008 on our website and published Profiles from each research team.[2–7] After 25 days of voting, during which 21 556 votes (each from a unique IP address) were cast, three papers have proved clear favourites with readers (panel). Among these, the editors' choice was Werner Hacke and colleagues' study of alteplase for ischaemic stroke[8] and the people's choice was the PEACE study of carbocisteine in chronic obstructive pulmonary disease (COPD) by Nan-Shan Zhong and associates.[9]

What do these results tell us about research and readers in 2008? First, well-designed, imaginative studies that have the ability to change practice and benefit large populations are highly valued by the medical community. Such trials deserve the support of collaborators, funders, and journals, and should be the benchmark for future investigations.

Second, sound design and appropriate settings are essential to convince clinicians and policy makers that interventions are effective. Each of these studies was a multicentre randomised trial in populations and settings appropriate for the intervention.

Third, public health and global health matter. These studies provide new strategies for tackling large and important burdens of disease. Hacke and colleagues[8] extend the time-window for treatment of stroke, the most common cause of adult disability in the world.[10] The fourth Millennium Development Goal is a reduction by two-thirds in mortality between 2000 and 2015 for children aged less than 5 years. In Bangladesh, neonatal mortality accounts for 45% of the mortality in children in this age band.[11] The Projahnmo Study Group, led by Abdullah Baqui, reports a complex intervention that decreased neonatal mortality by one-third.[11] Such efforts have helped to reduce annual worldwide mortality in under-5-year-olds from nearly 13 million in 1990 to less than 10 million in 2007.[12] Cigarette consumption in China exceeded 2000 billion in 2006 and is increasing.[13] In addition, indoor cooking fires are common in rural areas. As a result of these risk factors, COPD is predicted to cause 65 million deaths in China between 2003 and 2033.[14] Hence, the work of Zhong and colleagues showing that carbocisteine can reduce exacerbations and improve quality of life at a relatively modest price has important implications for treating COPD in developing countries.

Fourth, research has become a global enterprise, with papers from Bangladesh, China, and Germany competing at the highest level. As emphasised in *The Lancet* Series on health-system reform in China,[15] the importance of science from Asia will continue to grow as researchers increasingly turn to the region for larger, faster, and less expensive high-quality studies.

Finally, each of these interventions underscores a failure in preventive health. Alteplase and carbocisteine are no surrogates for life-style changes to reduce risk factors for stroke and for COPD; just as community health workers