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Healthcare Reforms in India and China

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Abstract

Healthcare reforms are the most complex and daunting challenge faced by any government. Despite its high per capita income U.S. lags behind Asian and European countries in life expectancy due to high body mass index (obesity), high blood pressure and high blood sugar levels. While advanced countries struggle to increase spending on healthcare it is even more difficult for emerging economies like China and India which have to choose between spending on health and sectors like infrastructure. The U.N. Sustainable Development Goals (SDGs) chart out a number of goals for health policy. However China and India have only made limited progress towards these goals. The main challenges lie in the large breakout of non-communicable diseases in China and there is an urgent need to move away from a hospital-centered care system to a system where primary care providers play a critical role. The Indian health system suffers from various inadequacies such as low government spending, large out-of-pocket expenses and lack of insurance. While infectious diseases have been controlled to some extent new diseases like AIDS, hypertension, cancer and diabetes are on the rise as Indians live more affluent lives and adopt unhealthy diets high in fat and sugar. This paper examines how governments

may soon be facing difficulties if they fail to make the necessary reforms to health care systems.

Keywords: healthcare reforms, non-communicable diseases, primary care

> 'You need an educated healthy workforce to help sustain economic development'
>
> -Amartya Sen, 2013

Introduction

Economic growth if not accompanied by improvements in health and education can be severely constrained in its scope. Thus broader development outcomes need to be firmly entrenched in any growth trajectory. Despite its high per capita income the U.S. is lagging behind Asian and European countries in its human development index due to its health indicators.

While advanced countries struggle to increase spending on healthcare it is even more difficult for emerging economies like China and India which have to choose between spending on health and other sectors like infrastructure. However no growth model is complete without healthy and productive citizens. Thus it cannot be emphasized enough how much healthcare matters for citizens of a country.

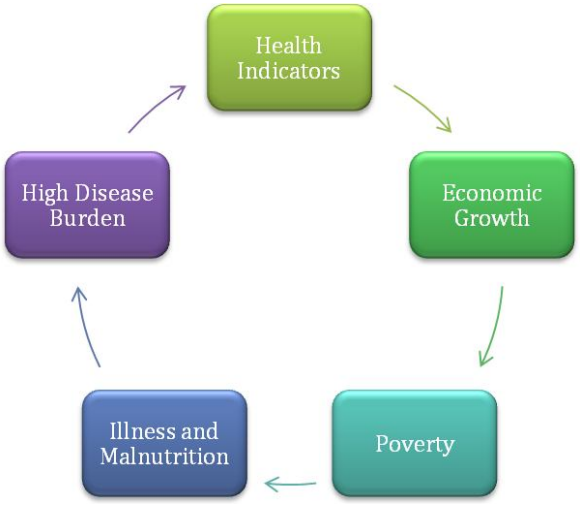


Figure 1: Vicious cycle of ill-health and poverty

Source: World Bank

As espoused by the World Development Report, (World Bank, 1993)[1] poor people in most countries have the worst health outcomes. They are pushed further into poverty due to ill health. They are also excluded from support networks that enhance the social and economic benefits of good health. Several authors have analysed data between 1965 and 1990 and have shown that the improvement in life expectancy was responsible for about 8 per cent of total growth.

According to these studies there are three broad mechanisms responsible for this effect:

Figure 2: Broad Mechanisms for how improvements in life expectancy affect growth

Source: World Bank

Health and Growth- Theoretical Models

Right up until the second half of the 1990s the role of human capital was mainly linked to education, although a few authors recognized the importance of other factors such as health and nutrition. Mankiw, Romer and Weil (1992)[2] in a groundbreaking analysis, cite the importance of including health and nutrition together with education in a broader concept of human capital. There was however a delay of several years before the link between economic growth and health became widely accepted as a field of economic debate. (Barro, 2013)[3]

To gain a more adequate understanding of the accumulation process driving health human capital and wealth it is essential to know how the

causal relationship between the two works. The main difficulty in any approach to this task lies in the possible existence of endogeneity between health and wealth. While good health may be considered as a form of human capital that has a beneficial effect on productivity, income also influences health in a positive way. The capacity to generate higher earnings facilitates an increase in the consumption of health related goods such as adequate alimentation or medicines. There is also an indirect effect on health via the improvements inherent in changes in life style, a more intensive participation in the work place, higher levels of education for the individual, all of which promote higher health levels through increases in income. The nature of this feedback creates a number of problems when it comes to carrying out estimations for the impact that health has on economic growth. Over the last few years a variety of theoretical and empirical research has given rise to a large body of literature that provides evidence supporting the thesis that health exerts a positive effect on wealth. (Bloom, Canning and Sevilla, 2001)[4]

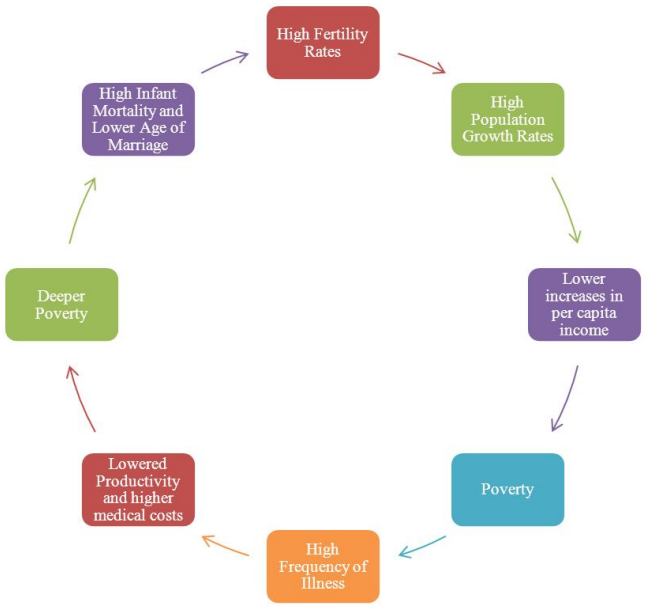


Figure 3: Model of High Population Growth, Poverty and Income

Source: United Nations

Health Sector Reforms

Reforms to health care systems are needed, as costs continue to rise and the private sector can play a pivotal role in the financing and provision of health care. Expanding health care coverage is important for many emerging economies. Reforming health care systems should be high on the list of priorities of governments as they continue to work on cutting deficits and debt.

Health care costs have spiraled over the past few decades with the introduction of new and very expensive technologies to treat patients. Aging populations are also contributing to cost increases. The central question is how governments worldwide can provide healthcare benefits for their citizens without compromising on education, infrastructure and other priorities.

Health care reform must balance various objectives, such as improving health outcomes, controlling spending, and achieving equity. In Asia and elsewhere, there is often overuse of hospital care and underuse of preventive and primary care. Cost containment reforms should minimize any potential adverse effects on the poor. (Bardhan, 2008)[5]

Healthcare Reform in China

Non-communicable diseases (NCDs) (cardiovascular diseases, cancer, diabetes mellitus and chronic lung diseases) are the main cause of mortality in China. More than 85% of mortality in China is attributed to NCDs. Although the main disease burden has evolved from communicable diseases to non-communicable diseases, communicable diseases remain a problem in some western provinces. (Wong, Tang and Lo, 2007)[6]

China operates a three-level medical service system: national level, province level, and county level. Health care in China remains a topic of popular discontent, particularly in rural areas, despite a wave of recent reforms and an unprecedented splurge in government health spending, The common phrase '*kanbing nan, kanbing gui*' (seeing a doctor is hard, and expensive) summarises the issues facing many Chinese citizens with regard to health care. (Li, 2011)[7]

From Mao to the present, China's health outcomes and health care systems have reflected rapid economic development and changing political systems. Under Mao, Chinese suffered from communicable diseases, reflecting rural conditions and extremely low per capita GDP. These conditions were treated successfully by "barefoot doctors" who operated through the commune-based rural health care system (CMS). Barefoot doctors received minimal medical training but their skills matched the health issues facing Chinese, and they were able to keep mortality rates comparatively low. Mao promoted barefoot doctors as part of his political emphasis on the rural population, which was vital to China's economy under Mao, as it relied primarily on agricultural production. (Hsiao, 2007)[8]

As China's economy grew rapidly and transitioned to a more market-based system in the 1980s, common illnesses shifted from infectious to chronic, similar to developed countries' transitions more than fifty years earlier. Barefoot doctors no longer sufficed, and were largely replaced by private practitioners dispensing more Westernized medicine. Concurrently with this transition, disparities in health outcomes between urban and rural areas grew. This generally reflected the growing wealth inequality in China, due in part to rapid economic liberalizations. China's use of outside experts (even American-trained), a publicly-disclosed government Commission, and solicitation of public comment reflects a willingness to incorporate some measures of transparency and international expertise into its health reform process. However, growing deficiencies in the public health infrastructure were brought to national and international attention most notably during the Severe Acute Respiratory Syndrome (SARS) epidemic of 2003.

The April 2009 health care reform announcement represented a significant milestone in China's path to establishing a strong national health care system. Following the guiding principle of building a harmonious society by balancing economic and social development, equity is given a high priority. Moreover, the reform announcement explicitly declares that the government has an important role to play in the health care sector and that this health care reform is government-led. This marks a major departure from the heavy reliance on the market that has been the hallmark of the financing and organization of China's health care system for the past two decades.

China's health reform structure is commonly described as "one goal, four beams, and eight columns" The principal goal is to establish a basic health service system that provides universal coverage. Beams supporting this goal include strengthening the delivery of medical care and the public health infrastructure, providing accessible health insurance, and ensuring a sound system for drug supply and security. Mechanisms to support the accomplishment of the primary goal and implementation of the four beams include: administration, operations, financing, pricing, governance, security for technology and human resources, information systems and legislation. (World Bank, 2012)[9]

Health Infrastructure

Health services in China are provided mainly by the public system, which covers 90 per cent of emergency and inpatient services. Although private hospitals have been permitted, their role is still quite limited: they account for only 6.5 per cent of China's hospital beds. At present, the country has three main types of private hospitals: high-end, service-oriented ones, which target expatriates and wealthy Chinese patients; specialty facilities, which typically focus on elective services, such as simple dental procedures; and large general hospitals. The first two types enjoy clear market positioning but have often been constrained in scale. Hospitals in the third category, which compete directly with large public institutions, have struggled to develop a differentiated and competitive value proposition. As a result, most Chinese patients still prefer to go to public hospitals, despite dissatisfaction with the level of service there.

The major institutions for rural areas are township health centers and county hospitals/maternal and child care stations. The major institutions for urban areas are community health centers (stations), district hospitals/ maternal and child care stations, municipal hospitals/maternal and child care stations, provincial hospitals/maternal and child care stations, and ministry owned (central level) hospitals.

Health Insurance

The urban employee basic medical insurance (UEBMI), the urban residents basic medical insurance (URBMI) and the new rural cooperative

medical system (NRCMS) are the most important components of the China health insurance system. Commercial health insurance, and a variety of other forms of medical insurance, serve to supplement the system. (Li, 2010)[10], (Liu, 2002)[11]

The need to expand healthcare coverage and quality is creating increasing opportunities for private health insurance providers. Premium healthcare has become a big business and has become part of the general boom in the consumption of luxury goods and services once unavailable in China. Although private insurance still accounts for only a very small amount of total healthcare spending, this is not an insignificant figure considering the size of the Chinese market. Spending on private insurance continues to grow steadily in absolute terms.

At the other end of the market, the government has announced a rural co-operative medical insurance programme. Poorer patients with severe medical conditions will be reimbursed at least 90 per cent of their medical expenses. The government's push for health-care reform and 12th five-year plan, combined with unfavourable reimbursement levels for premium products and cost pressures at the largest hospitals, have prompted multinationals to look more closely at deepening or expanding their presence in China through partnerships and acquisitions. In this way, they hope to compete in the lower-tier segments and to capture productivity gains. (Yip and Hsiao, 2009)[12]

The reasons for the problems in China's healthcare system are mainly due to the inefficiencies of the government. The government did not make adequate efforts to insure people's basic healthcare needs which led to breakdown of the public health service system; the lack of government regulations exacerbated market failure; and some hospitals and doctors induced too many unnecessary healthcare services, which not only increased the costs for the patients but may also have damaged their health. The Government reduced the budget in line with market principles, and people were paying for more and more medical costs out of their own pocket.

Healthcare Reforms in India

India's fundamentals are strong and investment and savings rates are

as high in East Asian economies. What India needs to achieve outstanding growth rates as pointed out by Amartya Sen is to focus on the social sectors like health and education in order to improve the quality of human capital, its greatest resource.

In the healthcare sector the implications of ineffective state institutions means the absence of medico personnel in remote areas, negligence by the health bureaucracy and lack of infrastructure including unavailability of Primary Health Care centres and Sub-Health Centres. Also the Primary Healthcare centres were mainly focused on family planning goals and suffered from shortages of staff, equipment, transport and medicines. Primary health care delivery needs to reinvent itself. Only then can India aim for universal health coverage. (Kumar, 2009)[13]

Life expectancy is rising and fast approaching the levels of advanced countries due to affluence and improving hygiene. India has traditionally been a rural, agrarian economy where 75 per cent of the population lives in rural areas. However the rapidly growing economy is leading to greater urbanization and an expanding middle class with higher disposable incomes to spend on healthcare. This is leading to a large rural-urban divide in healthcare.

Also more women are entering the workforce thus increasing the purchasing power of households. However despite women being educated the gender bias in health status and access to healthcare are of serious concern as even now men get better quality care as compared to women.

Another factor driving the growth of India's healthcare sector is a rise in infectious and chronic degenerative diseases. While ailments such as polio, leprosy and tetanus will soon be eliminated some communicable diseases once thought to be under control, such as dengue fever, viral, hepatitis, tuberculosis, malaria, and pneumonia, have returned in force or have developed a stubborn resistance to drugs. These trends can be attributed in large parts to substandard housing, poor water supply, sewage and waste management systems, a crumbling public health infrastructure, deplorable sanitary conditions.

Aside from infectious diseases there is an emergence of diseases such

as HIV/AIDS and lifestyle diseases like diabetes, hypertension, cancer and obesity. Some of these are a result of Indians living more affluent but sedentary lifestyles and adopting unhealthy diets rich in fat and sugar. It is projected that over the next 10 years these lifestyle diseases will take over infectious diseases as leading causes of sickness.

With India's population aging over time, with a higher incidence of NCDs in older age groups, and with evidence emerging that India's poor are at heightened risk of acquiring NCDs because of high rates of smoking and tobacco use, occupational risks and residential living conditions, NCDs will have an even larger financial impact.

Health Infrastructure

India's healthcare infrastructure has not kept pace with the growing needs of the Indian economy. The total healthcare financing by the public sector is much lower than private sector spending. Nearly 70 per cent of hospitals and 40 per cent of hospital beds are in the private sector. There is a large healthcare divide and while India provides high quality medical care to the middle class and medical tourists the majority of the population have limited or no access to quality care, not even basic primary healthcare facilities. Only 25 per cent of the population has access to Western allopathic medicine practised mainly in urban areas while the rural poor rely on alternative forms of treatment such as Ayurveda and Siddha medicine.

The government launched the National Rural Health Mission 2005-12 in April 2005. The aim of the Mission was to provide effective healthcare to India's rural population, with a focus on 18 states that have low public health indicators and/or inadequate infrastructure. These include Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. Through the Mission, the government is working to increase the capabilities of primary medical facilities in rural areas, and ease the burden on tertiary care centers in the cities. However only a few states like Kerala, Himachal Pradesh and Tamil Nadu have realized the importance of having good public health infrastructure.

There is an unprecedented focus on the large-scale replication of development programmes such as the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), the Mid-Day School Meal Scheme, the National Rural Health Mission, the Rajiv Gandhi National Drinking Water Mission, and the Self Help Group–Bank Linkage Program. The policy approach of these programmes is to create the right kind of transparent institutions at various levels to improve governance.

In India, public facilities receive the bulk of their revenues from government subsidies and provide services at low cost to those who cannot afford the more expensive private care. At the same time, the government allows private hospitals and practices to flourish, but with little regulation. This large and unregulated private sector is plagued with the consequences of market failures that have contributed to India's health spending inflation. (Haldar and Mallik, 2010)[14]

Health Insurance

A widespread lack of health insurance compounds the healthcare challenges that India faces. Although some form of health protection is provided by government and major private employers, the health insurance schemes available to the Indian public are generally basic and inaccessible to most people.

Only 11 per cent of the population has any form of health insurance coverage. For the small percentage of Indians who do have some insurance, the main provider is the government-run General Insurance Company (GIC), along with its four subsidiaries, The New India Assurance Company, Oriental Fire and Insurance Co., National Insurance Co., and The United India Insurance Co.

India's first medical insurance scheme for the poor was launched in the 1996-97 budget. The "Janarogya Yojana" scheme is marketed by the four subsidiaries of GIC, and covers people between the ages of five and 70 for pre– and post–hospitalization expenses, for up to 30 and 60 days, respectively.

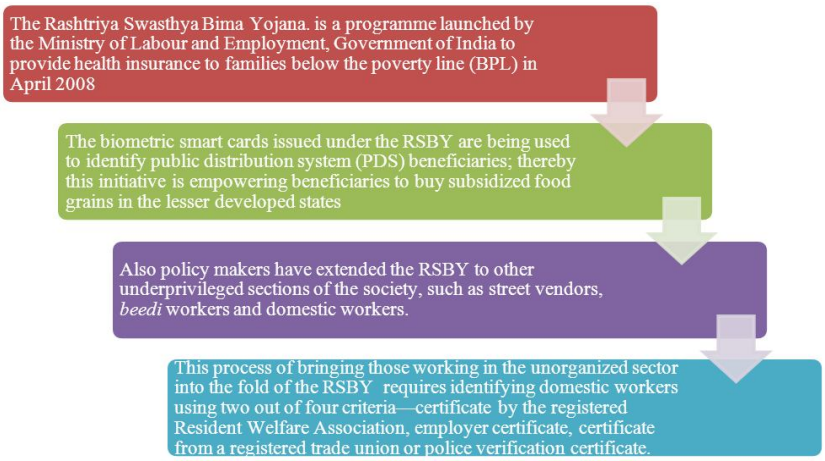


Figure 4: Rashtriya Swasthya Bima Yojana (RSBY): Some features

Source: Balooni, Gangopadhyay, Turakhia & Karthik (2012)[15]

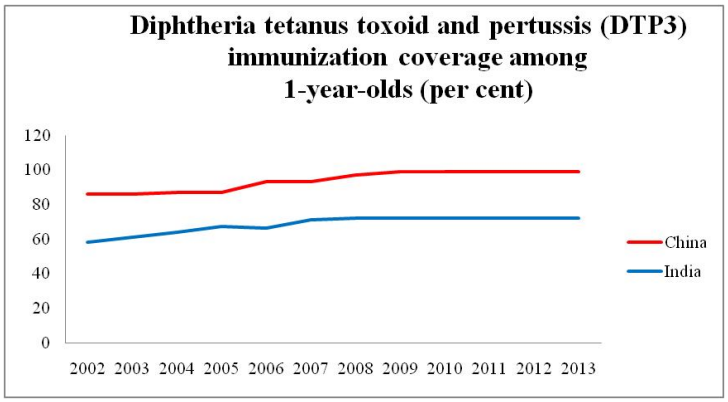
Because so little insurance is available to the people of India, out-of-pocket payments for medical care amounted to 98.4 per cent of total health expenditures by households. Without insurance, the poor must resort to taking on debt or selling assets to meet the costs of hospital care. It is estimated that 20 million people in India fall below the poverty line each year because of indebtedness due to healthcare needs.

Clearly there is an urgent need to expand the health insurance net in India. Among other things, that will require more state governments to pursue microinsurance initiatives, such as the Yashaswini Insurance scheme in Karnataka, so that most or all of the population can afford to purchase at least a minimum level of coverage.

Comparing Healthcare Systems in China and India

China and India have attracted much global attention in recent years because of their rapid economic growth. Both countries also face similar challenges in their health care systems. (Yip and Mahal, 2008)[16]

Health care delivery: In immunization rates of children China is far ahead of India as seen in the graph below.

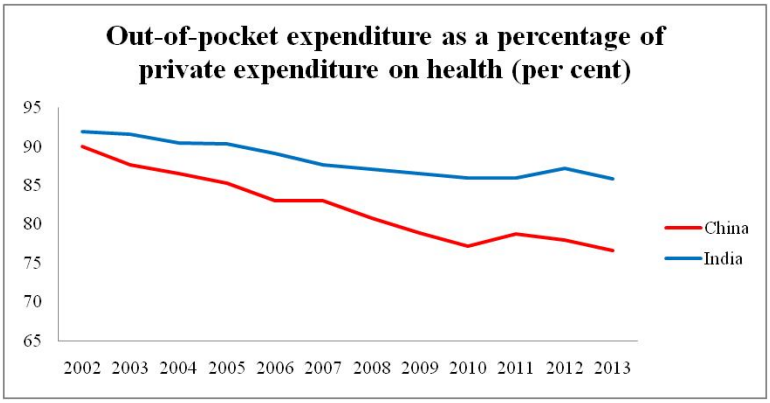


Graph 1: DTP3 immunization coverage among 1-year-olds (per cent)

Source: WHO

Health insurance coverage: Both China and India have limited insurance coverage, and low-income and rural households are the least protected. In Private prepaid plans despite fluctuations China is much ahead of India.

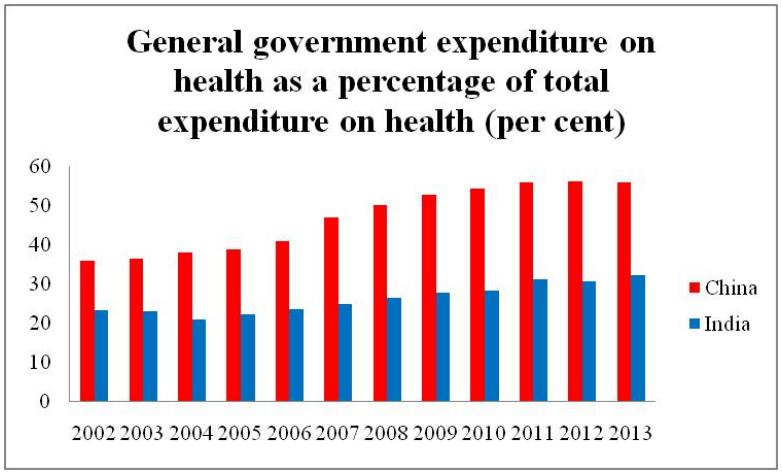
Financial risk protection: Households in both China and India are vulnerable to financial shocks associated with ill health. The metric for assessing whether the health system provides households with adequate financial risk protection is by calculating out-of-pocket spending on health care as a share of income. Out-of-pocket spending for India is higher than in China and has been falling faster in China than in India.



Source: WHO

Graph 2: Out-of-pocket expenditure as a percentage of private expenditure on health

Government spending on health: Reduced government spending on health reflected the policy priorities of the governments. Throughout the economic transition, health was viewed as a consumption activity rather than a productive good and therefore was given lower priority in government funding. The economic crises India faced in 2008 also led Indian policymakers to place a high priority on economic growth, just as China did.



Graph 3: General government expenditure on health as a percentage of total expenditure on health

Source: WHO

Conclusion

Although both the Chinese and Indian governments started with the good intention of assuring affordable access to basic health care for low income populations, their chosen strategies have been largely ineffective in achieving this goal. In China, when the government adopted a price schedule that sets prices for basic services below cost, the intention was to assure access to basic health care even for the poor. However, the same distorted price schedule has led to perverse incentives to overprescribe drugs and high-tech diagnostic services and procedures. These, in turn, have led to cost inflation and have rendered health services largely unaffordable for the poor and rural populations who have no insurance coverage and whose income growth lags far behind the growth of health spending. In India, the

government almost fully subsidized services provided by the public sector, to ensure access for low-income people. However, poor supervision has led to poor quality, unavailability of drugs, and high levels of absenteeism in the public sector, by default pushing patients to the private sector and subjecting them to uncertain and high health care costs.

Both China and India are likely to face even greater health policy challenges related to financial risk protection and affordable access to care in future years, particularly with the aging of their populations. The percentage of the population age sixty and older is projected to increase from 10.2 percent in 2000 to 29.9 percent by 2050 in China and from 7.6 percent to 20.6 percent in India. Both countries face major disease burden from non-communicable conditions that are expensive to treat, such as diabetes, heart disease, and cancer. Communicable conditions such as HIV/AIDS are likely to impose additional financial burdens.

After many years of government underfunding, both China and India have committed to sizable increases in government investment in health. Both countries have also recognized that the poor and rural populations are particularly disadvantaged in obtaining access to health care and face major financial risk in the event of illness. Thus, explicit policies are being developed to target the governments' funding toward the poor and rural populations. To date, however, neither country has a systematic policy for reducing inefficiencies in service provision and managing health spending inflation—a fundamental cause of unaffordable health care and heavy financial risk.

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