

## Market and State in health services : The case of India and China

**Gargi Biswas**

During the late 1940s, India and China were similar in many respects. Both faced the challenge of economic and social development, both had regional imbalances, huge population and over eighty percent of their population lived in impoverished rural communities with unequal access to resources, poor infrastructure and technological base. However, different political ideologies informed the nature of the state in both these countries. This paper compares the approach to human development in both these countries through the lens of health improvement and access to health services within the varied socio-political context.

During the late 1940s, health status indicators (life expectancy, infant mortality rate and maternal mortality rate) and health service indicators (e.g., doctor patient ratio) were almost on par between India and China. However, between 1940's and 1960's, China's health status indicators improved dramatically while India's achievements were modest. This paper seeks to analyze the reasons for health improvements by highlighting the differential role of the state in each of these countries. To understand why China has achieved whatever it has achieved, one needs to understand the fundamental socio-economic restructuring that took place in China.

The paper seeks to explain these aspects by periodizing the major eras in socio-economic development in both these countries. Broadly the Chinese experience can be studied by focusing on two phases – pre-reform and post reform. The pre-reform period can further be divided into 1949-1965 or from liberation to Cultural Revolution and then from 1966-1977 i.e., Cultural Revolution to the political changes and economic reforms. The Indian experience can be periodized as Nehruvian phase, post Nehruvian phase and the era of liberalization.

Both China and India fostered industrial growth to change its backward economy. China was committed to socialist economy whereas India was influenced by Keynes theory and opted for mixed economy and welfare state. The so-called socialist pattern in India did not question private ownership of means of production though it did not approve of uncontrolled capitalism and free economy. Indian ruling elite was cautious to go for radical land reforms, which was a contrast to the Chinese experience. Though land reforms were carried out both in China and India, the very conceptualization and implementation were different in both these countries. In China, 'Land to the tiller' was the basic concept and this meant redistribution of land to vast majority of landless peasants and also it saw elimination of landlords as a social class and end of exploitative tenancy. Land reform in China was not only an economic transformation but also social and cultural transformation. In India there was no such distribution of land though the Congress talked about necessity for agrarian reform. In fact feudal landlords became modern capitalist landlords and kept exploiting wage laborers. Also proportion of marginal landholdings increased leading to a decision to promote agricultural growth through technological rather than institutional change. Therefore, India's agrarian reforms unlike China failed to create an equal base and also failed to break linkage between landlessness and poverty or to mobilize masses to set up collective structures, which could generate and guarantee employment.

Land reform in China was followed by cooperativisation, which also served developmental purpose as they provided health and education. Chinese policy makers wanted to extend the

basic programmes of health and education to its entire population. The health care delivery model of China deserves special mention, which made use of widely dispersed health stations, bare foot doctors and collective health insurance wherein peasants paid a small joining fee and nominal charges for treatment. Though China was a predominantly agrarian economy, China's infant mortality rate, life expectancy and morbidity patterns were more typical of middle-income country than with China's level of income. Also due to collectivization, peasants were protected from uncertainties like bad weather, poor harvest, natural disasters and deprivation arising out of differential abilities. Communes were a measure of material security via the common rice bowl, welfare fund and public accumulation fund. Every productive household or individual had access to rural health insurance.

### **Approaches to Health Improvements**

After liberation, the Communist Party formulated certain principles to deal with poor health status of its people and the poor health infrastructure. It wanted to ensure availability of health care by publicly owned and financed health services, integrate traditional Chinese medicine and Western medicine, prioritize public health with special emphasis to the prevention of communicable and infectious diseases and to mother and child care, wanted health care to be combined with mass movements in the form of mass campaigns aimed at eradicating endemic infectious diseases and accompanied by health education presenting the benefits of personal hygiene and nutrition. Health institutions were transferred from private or foreign ownership to public hands either to the Ministry of Health or to the health departments of local governments. Preventive programmes were emphasized. Village workers were responsible for promoting personal hygiene and nutrition among villagers. There was rapid decline in mortality from infectious diseases. All aspects of health care delivery were developed and financed by public resources and a three tier system of city and county hospitals, township health centres and village local services was developed. A multilevel medical education was established. Local health workers, i.e., midwives, public health personnel and bare foot doctors were trained by a three month apprenticeship in township hospital centers to carry out health campaigns and preventive, mother and child and simple curative care for the rural population at the commune/brigade level. Three-college programs were established to provide doctors for township-level facilities and University medical schools prepared doctors in Western or Chinese medicine for county and city level hospitals. Within a short span of time, ratio of doctors to population increased and also there was a rise in total number of health institutions. Medical cooperation system ensured basic health care to almost all-rural population.

The Great Leap Forward, a wide spread industrialization effort launched by Mao brought about environmental damage, famine and loss of million of lives. However, after 1959-61, a system of grain transfer and distribution was developed that guaranteed each commune at least minimum grain supply per person and ensured survival in case of natural disasters. Water needed for industrialization was extended to remote parts of China and thus safe water was accessible to population and also the infrastructure helped in flourishing rural industry.

During the Cultural Revolution, there was turmoil in health sector. Higher-level education was stopped and many hospitals were closed. There was a decline in doctor patient ratio and also in number of health institutions. However, mainly urban health care institutions and personnel were affected. The rural health services continued to flourish and many efficient

medical personnel were put in rural health institutions. Training of rural brigades as health workers, bare foot doctors and mid wives was undertaken as a result of which there was an increase in the number of nurses and mid wives. By end of Cultural Revolution, almost every village had a clinic in which two to four bare foot doctors served the population. They could consult with and refer patients to the nearest township health center or to county hospital. Rural cooperative insurance scheme had become compulsory during the Cultural Revolution. Evidence suggests that China saw major achievements in terms of improvement in health status indicators during this time. Health services were owned and financed by public sector and were accessible and affordable to nearly all the population and majority of the population was covered by health insurance.

The nature of state intervention in India was unlike that of China and no major socio-economic restructuring took place in India. Health, education, and the public distribution system became the basis for the welfarist nature of India. Though the Bhore Committee envisaged health in a comprehensive manner, vertical and techno centric programs were accepted for disease control and maternal and child health. India did try to replicate the Chinese model of bare foot doctors through the Community Health Guide Scheme but it was an utter failure in absence of socio-political will. India signed the Alma Ata Declaration in 1978. However, it never got implemented and Comprehensive Primary Health Care was substituted by Selective Primary Health Care.

### **Era of Privatization**

China started its reform in 1978 much earlier than India. After Mao's death, people wanted change as people lost faith in the party because of constant reversals, power struggles and over mobilization. Also there were international pressures. Normalization of relations with Japan and the USA, end of Vietnam War and the advantage of maintaining leverage vis-à-vis the USA and the Soviet Union compelled rejoining of world community.

The financial crisis of 80's made India choose structural adjustment programme and health sector reform as a part of it in early 90's at the cost of the marginalized. Welfare sector was drastically pruned and handed over to the private sector and dependence replaced the goal of self-sufficiency in the name of globalization.

At onset of reforms in China in late 1978 (whereas in case of India it was 1991), the poor were better off in China than in India, a remarkable degree of social equity was achieved and there was a far more substantial programme of basic health and education which covered almost the entire population. The reforms had tremendous impact on the social, political life in both rural and urban China. The crucial change was brought about in rural China beginning in 1979 and firmly established by 1983 with dismantling of the collective structure and introduction of family farming under the household responsibility system. Individual initiative was given primacy and this deviated from the earlier ideology of emphasizing equity. The focus shifted from development to growth. Hence, state's role was far less comprehensive than before. For India, the liberalization policy of 1991 did not break with earlier periods and it did not emerge as a clear-cut strategy as that of China. Also In India, market reforms were introduced in far more inequitable base and they were initiated against the backdrop of poor human development indicators. Reforms hit hard the rural institutional framework, the collective canopy in China. The economic reforms had far reaching implications on the rural health services. Cooperative medical insurance schemes collapsed and privatization of almost half of the rural clinics took place within six years. By 1989, health services at reduced fees, or other systems of medical reimbursement were available only in very small percentage of villages in entire China. The factor responsible for

this is the collapse of financial basis of the commune as a result of dismantling of collective structures.

With the break up of the cooperative medical scheme, bare foot doctors had to bear all the cost and some of them joined rural industry or combined business or agriculture with medical practice. Most of the village doctors are now paid on a fee- for service system with fees being paid from patient's pocket or partially being covered by new emerging rural medical insurance schemes. Currently over half of the villages are served by private practitioners alone. The reforms have affected the three-tier rural health provision system. Township health centers are now dependent on patient's fees and on non-medical economic enterprises. Many township hospitals had to be closed down or reduce number of staff and bed. Links between three tiers have weakened and there is reluctance to invest in primary care. Economic reforms have led to user fees and thus considerable increase in out of pocket medical expenditures. Market has taken center stage. The recent privatization of Shanghai hospital is a case in point. There are indications that improvement in health status leveled off during the 90s and the health consequences of economic prosperity experienced in rural China since economic reforms are far from satisfactory. The nature of privatization in China and that of India were thus very different.

The paper argues based on evidence that there has been rising inequalities in terms of regional imbalance with rural-urban difference aggravating further, class imbalance and also there has been dichotomization of preventive versus curative services. Health sector reform meant shift from universal health care to selective health care tied to a global economic agenda. This involved an ideological shift that rationalizes the diminished role of state in health care and advocates for the increased role of market in health care. The rising role of markets in the health sector has raised some important concerns regarding equity, comprehensiveness and universality. There are issues of quality and standards of care as well as over prescribing. The state is moving from viewing health as need to viewing health as consumption. But health cannot and should not be viewed as any other commodity and cannot be left on the whims of market forces to determine its availability. The market approach excludes the impact of material forces such as poverty, inequality, social class, gender and age divisions in society upon the process of development and especially the disproportionate dependence among poor upon public provision. The market approach does not address inequalities and in fact aggravates inequalities. With reforms, the role of state has been shrinking and market has taken the center stage. The SARS epidemic of November 2002 in China can be explained in terms of decreasing surveillance by the state. There has been resurgence in poverty related communicable diseases like tuberculosis in China. Since reforms, there has been decline in public health expenditure in India, health indicators have almost stagnated, per capita monthly consumption of cereals has come down, and utilization levels have fallen in hospitals with introduction of user fees and there has been a resurgence of communicable diseases like malaria.

The paper concludes by arguing that China can be taken as a test case for stating what can be the consequences of increasing role of market in the health sector and reiterates the role of state in providing comprehensive, universal and equitable health services to all.

**References:**

- ❑ Acharya, A., Baru, R and Nambissan, G. (2000). The State and Human Development: Health and Education in Deshpande and Acharya (Ed.) Crossing a Bridge of Dreams : India China, New Delhi, Tulika.
- ❑ Ahmed, A and Hussain, A. Social Security in China : A Historical Perspective. In Ahmed et. al. Social Security in Developing Countries. Oxford Clarendon Press, 1991.
- ❑ Anson, O. (2002). Rural Health Care Reforms in the People's Republic of China. In Twaddle, Andrew, C (Ed.) Health Care Reform Around the World, Auburn House, London, PP-303-323.
- ❑ Baru, R. V. (2002). Health Sector Reform: The Indian Experience. In Twaddle, Andrew, C (Ed.) Health Care Reform Around the World. Auburn House, London.
- ❑ Qadeer, I. Health Care Systems in Transition III. India, Part I. The Indian Experience, Journal of Public Health Medicine, Vol. 22, No. 1, pp-25-32.
- ❑ Ed. Qadeer, I, Sen, K and Nayar, K.R. (2001). Public Health and the Poverty of Reforms: The South Asian Predicament. Sage Publications, New Delhi.
- ❑ Wong, L. (1998). Marginalization and Welfare in China. Routledge, New York.