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

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Introduction

Recently, China and India have received a lot of attention in the world economy and there is almost an obsession with these two countries and how their current growth presages the coming "Asian Century". They are often quoted as the current "success stories", the two economies in the developing world that have apparently gained from globalization, with relatively high and stable rates of growth for more than two decades. In India also, one can find obsession with China. The rapid economic growth and structural transformation in China are typically called upon to rationalize the economic policy of choice. These economies are often treated as broadly similar in terms of growth potential and other features. But, in fact, there are significant differences between the two economies which render such similarities superficial, and which mean that individual policies cannot be taken out of context of one country and simply applied in the other to the same effect (Ghosh, 2005). China's gross domestic product (GDP) has grown at the extraordinary annual rate of 8 percent during the past 25 years, and its economy is now among the world's largest and most rapidly expanding (as cited in Blumenthal and Hsiao, 2005). However, the economic development has occurred unevenly across China's communities. Also, while glorifying economic growth in the era of liberalization, its important to understand the **dialectics of 'growth' and 'development'.** Growth is a convenient empirical and analytical category generally measured in single aggregative indicators such as Gross National Product (GNP), labour productivity, national income and consumption that does not include or reflect the normative concerns of development. It is not even indicative of inequalities that might exist in stratified society. Many dimensions of the quality of life like health, education and other aspects of well-being are excluded in the statistics of economic growth. Growth as an end in itself in the hope of inducing trickle-down effect also inevitably generates new inequalities and perpetuates old ones. It's only in the last one and half decades that human development as a holistic concept has became a realistic tool for evaluating progress both on its own as well as comparative terms. Non-material components of living standards and their spatial distribution are very important. Development is thus a multidimensional concept and is defined as 'the process of widening people's choices and level of their achieved well-being. The most important ones are to lead a long and healthy life, to be educated and to enjoy a decent standard of living. Growth and development are in a dialectical relationship and there is a strong urge to subordinate growth to development in this neo-liberal era. Emphasis exclusively on growth is a form of escapism and here comes the role of state, the manner in which it establishes the socio-economic agenda for its societies and how it appropriates resources and shapes production, distribution, consumption and investment (as cited in Acharya et al., 2000). This paper compares the approach to human development in India and China through the lens of health improvement and access to health services within the varied socio-political context in these countries. The paper would briefly look at health systems of these two countries and then would focus on health services, which have strong interlinkages. Health systems cover more than health services for individuals. They include functions for which health is first priority and are essentially population based including public health, health promotion and assessment of health implications of other policies. The legitimacy of health systems is derived from political commitments made to citizens so that accountability and responsibility for their proper functioning lie in the public domain and cannot be left solely to consumer choice and action (Mackintosh and Koivusalo, 2005) .The paper would try bringing out the role of market and state in health services in China and India and analyze the shifts that have occurred since reforms in both these countries. The paper would primarily focus on role

of state and market in provisioning, financing, health insurance, staffing and drugs and would look at issues of accessibility to health services in post reform China and India. The paper finally looks at impact of market reforms on health status of population in these two countries. In light of deleterious effect of market reforms on health system in China, which earlier in the pre reform period had a far more equitous base with State intervention, the paper concludes that China can be taken as a test case to show that markets which view health as 'consumption' rather than 'need' do not address inequalities in access to care and in fact aggravates inequalities. The paper emphasizes that health care has unique characteristics that deviate from the basic pre-requisites of competitive market model and hence vouches for state intervention in health.

Role of State in development in pre-reform period

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.

Though apparently these two countries were similar, there were lots of differences also. Both China and India had different historical experience of foreign domination. India was a British colony for two centuries whereas China was a semi colony. In China it was the Communist Party led Chinese revolutionaries and in India it was the Indian National Congress who fought and raised voice against imperialist exploitation and they had very different ways of doing that. During the cold war, China and India had different equations in relation to the major powers of the Bipolar World i.e., USA and USSR and hence option for external assistance for economic development. As China is located in Socialist block, the world was quite hostile to it whereas India charted the course of non-alignment, which made it neutral. Hence, different sets of and advantages and disadvantages for China and India can be attributed to the similarities and dissimilarities between them. **Different political ideologies** informed the nature of the state in both these countries and they followed **divergent development models** (Acharya et al., 2000).

Broadly the Chinese experience can be studied by focusing on two phases – pre-reform and post reform period or Maoist phase and era of liberalization. Again, 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 pre-reform period and the era of liberalization.

The agency of the state in promoting growth and development has unquestionably been of decisive importance. Both in India and China, state has been central to the process of growth and development. But the nature of state has been radically different in socialist China and a liberal democratic one in India. Consequently, the ideologies of the two states and their approaches to economic growth and development have traversed different paths. Hence, the nature objectives and environment in which state intervention has taken place has also been quite different. (Acharya et. al. 2000).

China and India were heavily influenced by the Soviet model of centralized planning and controls to change its backward economy to highly industrialized and modern nation state. Also after the cold war, China could depend only on Soviet Union for capital and technical assistance. Indian political elite was influenced by Keynes theory and hence opted for mixed economy and welfare state. (Acharya et. al., 2000). A welfare state by its very nature does not question the societal processes of creation and appropriation of wealth. It merely invests a certain proportion into welfare to harness political legitimacy. At the same time, this welfare sector is also part of the same processes of appropriation, which steadily transform it into a sector for profit generation (Qadeer, 1994).

As compared to China, India was in a better position after independence as during colonial time; a huge number of bureaucrats were trained and they had experience in administration. Both viewed development of heavy industries as the quickest way to achieve growth. Though both fostered, industrial growth, there was difference is the essential character of economy in China and India as China was committed to socialist economy whereas India was characterized by mixed economy. By mid 50's Jawaharlal Nehru declared commitment to " the establishment of a socialist pattern of society". However, the socialistic pattern in India and China were very different in terms of goals, relative priorities attached to those goals and methods of attaining those goals. The so-called socialistic 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 too cautious to go for any drastic reforms, as there was widespread poverty, lack of resources and the apprehension of possible impact on the interests of the conflicting classes and groups that constituted the elite class. Interestingly enough, the same factors acted as an impetus in China for radical socio-economic restructuring. Communist Party of China under Mao Zedong had tremendous faith on its people and Mao believed that by channelising the will and energies of Chinese people, the society could be transformed. Such mass mobilization and mass involvement of people did not happen in India. Such mass mobilization and mass involvement of people did not happen in India (Acharya et al. 2000).

Though **land reforms** were carried out both in China and India, there is a lot of a difference in the very conceptualization and implementation of the same.The Chinese state initiated anti feudal programme of land reform in China and this led to transformation of rural economy and agrarian class relations. It started with Agrarian Reform Law of June 1950 and the process continued till 1952. **'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 the end of exploitative tenancy. Land reform in China was not only an economic transformation but also social and cultural transformation as poor peasants were inspired to talk about their bitterness and denounce the iniquitous system and its perpetrators that is the land lords. The main aim of the Chinese Agrarian Reform Law was to free rural productive force, develop agricultural production and hence support industrialization (as cited in Acharya et. al. 2000). The consequences of land reform were multiple: it broke the grip of the landlord power, created countryside of roughly equal smallholders and gave rise to a new class-based rural leadership. Land reform is among the enduring achievements of the Chinese revolution and it is one of institutional transformations related to early decades of communist rule that has survived the scrutiny of a reform leadership that has transformed China's political economy and institutional character by eliminating the collectives and communes and cutting the state sector to the bone. It also paved the way for land reforms that swept across Asia following the Second World War, both in reaction to and in emulation of Chinese approaches (Seldon, 2006).

However, in India there was no such distribution of land though the Congress talked about necessity for agrarian reform. Land reform merely paid lip service and land ceiling legislation was actually a mockery. 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. Hence India's agrarian reforms unlike that in China failed to create an equal base and also failed to break linkage between landlessness and poverty or mobilize masses to set up collective structures, which could generate and guarantee employment.

China combined a highly centralized political system with a **decentralized structure** to address social and economic needs. This again is very different from Indian context. Land reform was followed by **cooperativisation** as it was viewed necessary in face of resource crunch and as large

number of peasants were too poor to start production. Cooperativisation led to rise in peasant incomes and also it became a means to generate and guarantee employment in a wide range of agricultural and non-agricultural jobs. The objective was transformation of a cooperative to full collective ownership of land. (Acharya et al., 2000).

Most importantly cooperatives 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. Wide availability of primary and junior middle schools at brigade and commune levels improved the educational attainment of rural children. Also the health care delivery model, which is often recommended for developing nations, deserves special mention. Demand on state was minimal as the collectives took the main burden of production, consumption as well as distribution. The **collectives** thus played a very important role in welfare of its members.

Collectivization was completed by 1958 and after this there was creation of **people's communes.** The Chinese rural society was organized in a three-tiered structure-the commune, brigade, team with team being the basic unit of accounting. The communes were multifunctional units for production, consumption, residence, social service and development entrepreneurship (as cited in Acharya et al., 2000). Unlike private cultivation, peasants were protected from uncertainties like bad weather, poor harvest, natural disasters and deprivation arising from differential abilities. Communes with power to dispose off incomes could balance rewards according to effort without neglecting basic needs. Distribution was determined by labour input of individuals measured by **work points**. Households not earning enough 'work point grain' were entitled to per capita allocations i.e., basic grain which guaranteed subsistence for all producers. Hence, communes were a measure of material security via the **common rice bowl**. Collective withholdings via the welfare fund and public accumulation fund paid for common requirements. **Welfare fund** provided entertainment, medical expenses, education fees, childcare costs and aid to destitute. Public accumulation fund provided reserves for public works and production needs. (as cited in Wong, 1998). Every productive household or individual had access to **rural health insurance** and collectively financed primary educational facilities. There was provision of **five guarantees i.e., food, fuel, clothing, education and burial** for the elderly, disabled and young orphans who lacked family support, work ability or means of livelihood. For urban areas, the facilities were even better. As Wong (1998) points out " If rural residents ate from the iron bowl, the utensils of their urban peers must be made of stainless steel. Furthermore, this bowl is much bigger and better designed. It also held more enviable contents." The **danwei system** gave a degree of security that was unknown to employees in the most advanced welfare states. There was no chance of losing one's job and danwei provided full range of benefits in cash and in kind like social insurance or labour insurance, collective welfare amenities and goods and subsidies allocated by state.

The rural communes came into being in course of Great Leap Forward and were formally sanctioned in 1958. The Great Leap Forward, a wide spread industrialization effort launched by Mao brought about environmental damage, famine and loss of millions of lives. Allocation of most social resources and rural manpower to industrialization and implementation of inappropriate agricultural methods such as over farming, drained soil, forestry, health and welfare resources. 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 like flood or drought. Also water needed for industrialization was extended o remote parts of China and hence safe water became accessible to population and also the infrastructure helped in flourishing rural industry (as cited in Anson, 2002). Hence, one can conclude that in the pre-reform period in China, unlike India, there was a strong political commitment of the state for overall development of its population. The State in China addressed the **social roots of health** of its

population, which is extremely important given the fact that there is a dominant relationship between an individual's social position, his living condition and his health outcome.

Approaches to health improvement in China and India in pre-reform period

The development of health service system in pre reform China can be divided into two periods: 1949 – 1965 or from liberation to Cultural Revolution and then from Cultural Revolution to the political changes and economic reforms i.e., 1966—1977.

1949-1965:

After liberation, the Communist Party formulated certain principles to deal with poor health status of its people and the poor health infrastructure. At the time of liberation, poverty prevailed; housing conditions were inadequate, sanitation facilities were poor especially in rural areas. Health status of population was extremely poor. Life expectancy at birth was only about 37 years; infant mortality was about 250 per 1000 live births and maternal mortality was estimated at 150 per 100,000 live births.Health services were very poor and had urban bias and mostly were **private**. In 1949, there were only 0.67 doctors per 1000 population and some 3600 health institutions in whole of China (out of which 2600 in cities itself). Health services were largely inaccessible to rural masses (87.5% of population lived in rural areas) and they had to depend on traditional healers (as cited in Anson, 2002).

Poor health status and lack of health services were against ideology of Communist Party of China. Hence four principles were formulated in the first five-year plan itself.

- Health care to be provided to workers, farmers, and soldiers by **publicly owned and financed health services**;
- Health services should integrate traditional Chinese medicine and Western medicine in care provision;
- Priority should be given to **public health**, with special attention to the **prevention of communicable and infectious diseases** and to mother and child care; and
- Health care should 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.

These principles were put to practice in the second and third five year plans (1955-65). Most of the **private enterprises were nationalized** in health sector. 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. Growing public sector absorbed doctors from private sector. Data suggests that by 1962 only 3.2 % of the health personnel were engaged in private practice as compared to 56.5% in 1950. Lot of preventive programmes was emphasized. For example war was launched against four pests i.e. bedbugs, flies, mosquitoes and rats (some books mention sparrows instead of bed bugs). Village health workers were responsible for promoting personal hygiene and nutrition among villagers. Immunization drive started 1960 onwards. There was rapid decline in mortality from infectious diseases, in which animals; environmental factors and hygiene play an important role (Anson, 2002). The crude death rate except for sharp peak during famine years of 1959-1961 declined steadily from 20 per 1000 in 1949 to 6.3 in 1978. Life expectancy rose from 40 years in 1953 to 68 years in 1981 (Ahmed and Hussain, 1991). How China managed to reduce their load of mortality and morbidity is partly explained by the fact that there was reduction of deaths due to communicable diseases across all ages, which was directly related to improvements in socio-economic conditions of the population. The structural changes in the rural economy to ensure that no one was denied basic needs, was single most important factor for decline of a host of communicable diseases that are commonly referred to as " diseases of poor". This also reduced maternal mortality rates and under five child mortality. Whereas India continued to have

communicable diseases as the major cause of death, China underwent epidemiological transition during the late sixties whereby the major cause of death was no longer communicable diseases but included number of non-communicable ones like cardiac related disorders, cancers and other degenerative diseases. This epidemiological transition in a predominantly poor agrarian economy can be attributed to the unique way in which China built its health services (as cited in Acharya et al. 2000).

During this period (1949-65), 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 centers 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. Ratio of doctors to population increased by 50 % from 0.74 % in 1952 to 1.05 per 1000 in 1965. By 1952, there were close to 37000 health institutions, 10 times more than in 1948. Clinic increased from 769 in 1949 to over 29000 in 1952. Number of hospitals also increased during this time from 2600 to 3540 all located in country centers and in large cities. Each tier had to provide both preventive and curative care. Health insurance called " **the cooperative medical scheme"** started as a local initiative in several collectives and relied mainly on collective economic system and was based on voluntary contribution of residents of each village. In 1960, it was adopted by the Chinese Ministries of Health, Agriculture and Finance. Soon after the " Rural Medical Cooperation Rules" were published, over 90% of the villages established medical cooperative systems that financed health services from contribution of its members, welfare funds of the brigade and public welfare funds of the communes. Hence, medical cooperation system ensured basic health care to almost all rural population (as cited in Anson, 2002).

1966-1976:

One of the objectives of Cultural Revolution was to prevent the development of capitalist and Western orientations. During the Cultural Revolution, the residual **private economic enterprises** that had survived early nationalization period were **banned** and self-employment production was prohibited. This period of turmoil also affected the health sector. Few doctors who still practiced privately either stopped practicing or joined publicly owned facilities. Higher-level medical education was stopped and many hospitals were closed. Number of doctors declined from 1.05 per 1000 population to 0.85 per 1000 population and number of health facilities declined by 33 %. Many health campaigns were discontinued. The Cultural Revolution mainly affected the urban health care institutions and personnel. The rural health services continued to flourish and many competent medical personnel were put in rural health institutions. Training of rural brigades as health workers, bare foot doctors and mid wives was undertaken. While total number of health care professional decreased by 5 % between 1965 and 1970, number of nurses and mid wives increased by 25 %. The three-tier health delivery system was completed during period of Cultural Revolution and by end of it almost every village had a clinic in which two to four bare foot doctors served a population of 1000 to 3000. Barefoot doctors could consult with and refer patients to the nearest township health center, which served on an average some 25 villages or a population of 15000 to 50000. By end of Cultural Revolution, most health centers were equipped with inpatient facilities and the span of their services had expanded. Patients also could be referred to the county hospital, which was responsible for about 14 township health centers. Rural cooperative insurance scheme had become compulsory during Cultural Revolution. Rural health care providers were motivated to provide good service as their fellow farmers chose them and enjoyed good working status. However, not all the health

outcomes of the Cultural Revolution were positive. Some 17 million urbanites, most of whom were youngsters were sent for agriculture work, which had tremendous psychological impact. They were cut off from social support networks. The urban economy became largely paralyzed and unemployment rates increased. Despite this, health status of population continued to improve. Crude mortality rates decreased from 11.1 per 1000 rural population in 1952 to 6.47 in 1978. Mortality rates from 23 major infectious diseases declined. Mortality rates from infectious diseases fell from 18.7 per 100000 in 1965 to 4.4 in 1979 and morbidity rates from 35.0 per 1000 population in 1965 to 20.8 in 1979 (as cited in Anson, 2002). Hence, one can conclude that health services were owned and financed by the 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 postcolonial 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. State efforts were mostly influenced by ruling elite of the country and it was careful about any drastic reforms. The Bhore Committee report of 1946 envisaged health in a comprehensive manner and recommended health service system based on the needs of the majority who belonged to the deprived section of the population. It stated, " No individual should be denied adequate medical care because of inability to pay for it." Bhore committee emphasized free provision emphasized free provision of health services with heavy emphasis on preventive and rural services (Government of India, 1946). However, in practice, from the distribution of resources between various sectors (preventive and curative) within the health care system and between rural and urban areas, it was clear that public health services were not prioritized and there was **urban bias** in development of health services. The emphasis on **production of well-trained doctors** who were largely concentrated in urban areas deprived the rural poor of even basic medical facilities. In rural areas where more than 70 percent of population lives, only about 30 percent of doctors and 17 percent of beds were located in 1981. Also the health indicators in rural and urban areas were reflective of rural-urban disparities (Kethineni, 1991). **Vertical and techno centric programs** were accepted for disease control and maternal and child health. Magic bullets i.e., vaccination and antibiotics were already available and National level programmes for control or eradication of communicable diseases focused on individual diseases and were imposed from above. These programmes were thought to be **cost effective**, as they would require initial investments following which no further investment would be required. These programme required technical experts and equipments from abroad. Also these were appreciated by political leaders as they give visible results within short time and have support from international organizations (Qadeer, 2001). By the end of 80's though substantial health service infrastructure was developed, there were regional inequities, poor outreach and functional inadequacies. The infrastructure with a potential to provide primary health care was actually seized by the vertical family planning programme with its strong political and administrative backing (Qadeer, 2000). Force and coercion were the hallmarks of family planning programme and it reached its peak in 1977, which led the Congress government, lose its power. Only after this, some adjustments were made in terms of expanding primary health care network in rural areas and Minimum Needs Programme was implemented. 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 (Qadeer, 2001). 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. Hence, one can find significant differences in the way in which health services were developed in China and India. China in the beginning laid greater emphasis on strengthening preventive care at the primary level and then building institutions for delivery of medical care and provided the necessary medical infrastructure at the primary, secondary and tertiary levels. In India though there

was a great deal of rhetoric on primary health care but emphasis was on building hospitals at the secondary and tertiary levels (Acharya et al. 2000).

While in India, the state played a role in provision and administration of social services, **private interests were also accommodated** and over the years these interests have grown and have rooted themselves in the system (Baru, 1995). Since the 80s, the emerging middle class, which succeeded in achieving an adequate standard of living, lobbied for 'hi-tech hospitals', which conformed to their concepts of 'international standards' of health care. Private sector practitioners who had enjoyed state patronage since independence in India's mixed economy of service provision wanted to influence the policy further for their advantage (Qadeer, 2000). During the mid-1980's government formally recognized private health care as an industry and thus helped corporate hospitals to mobilize loans from public financial institutions. Land was leased at extremely low rates to many large private hospitals (Baru et al., 2000). Also government facilitated growth of large private hospitals by reducing import duties on high technology medical equipment and giving concessions if they are Non-Resident Indians. In 1980 alone, Rs. 20 crore rupees worth equipment was imported and by 1986-87, the figure rose to Rs. 65 crores. In case of India, though provision of public health and medical care was essentially publicly funded and managed, supportive services like the drug and instrumentation industry have been dominated by both domestic and foreign private enterprises. Even within the publicly managed medical services, private practice was accommodated and a majority of doctors in government service had private clinics. The nature of these practices underwent changes with the establishment of nursing homes and large hospitals in the private sector and the private interest of pharmaceutical and instrumentation industries played important role in shaping the content of medical care. With growth of corporate hospitals and nursing homes, linkages between public and private sector became even more complex and many government doctors besides practicing privately, started serving as consultants or even owning private nursing homes (Baru, 1995). However, in the 80's rise of corporate sector in medical care was largely confined to the southern cities of Hyderabad and Madras (now called Chennai). In pre-reform period in India unlike that of China, one can find the existence and growth of heterogeneous and unregulated private sector in medical care.

Table 1: Rate of Growth of Hospitals and Hospital Beds by ownership (in percentages)

Reference Years	Hospitals		Hospital Beds	
	Government	Private	Government	Private
1974-79	6	43	11	20
1979-84	3	17	3	7
1984-88	3	17	3	7

Source: Health Information of India, CBHI, GOI, Various years
Directory of Hospitals in India, CBHI, GOI, 1981; (as cited in Baru, 1995, Page no. 74)

Table 2: Public-private sector use for medical care, India, 1986-1987 (National Sample Survey Organization 1992)

Health Sectors	Outpatient care (%)		Inpatient care (%)	
	Rural	Urban	Rural	Urban
Share of public sector	**25.6**	**27.2**	**59.7**	**60.3**
Public hospital	17.7	22.6	55.4	59.5
PHC/CHC	4.9	1.2	4.3	0.8
Public dispensary	2.6	1.8		
ESI doctor	0.4	1.6		
Share of private sector	**74.5**	**72.9**	**40.3**	**39.7**
Private hospital	15.2	16.2	32.0	29.6
Nursing home	0.8	1.2	4.9	7.0
Charitable institution	0.4	0.8	1.7	1.9
Private doctor	53.0	51.8		
Others	5.2	2.9	1.7	1.2
Total	100.1	100.0	100.0	100.0

PHC: Primary Health Centre; CHC: Community Health Centre; ESI: Employees State Insurance
(As cited in Sen et al. 2002, Page no. 290, Table 11.3)

From the table, its clear that by mid 1980s, over 70% of outpatient care was provided by private sector in both rural and urban areas (74.5% for rural areas and 72.9 % for urban areas) whereas public sector accounted for 60 % of all inpatient care.

Table 3: Average expenditure on medical care in India in 1986-87 (National Sample Survey Organization 1992) is given below:

	Rupees per illness episode/hospitalization		
	Rural	Urban	Urban: Rural ratio
Outpatient care			
Public sector	73	74	1.01
Private sector	77	80	1.04
Total	76	79	1.04
Private: Public ratio	1.05	1.08	
Inpatient Care			
Public Sector	320	385	1.20
Private Sector	733	1206	1.64
Total	597	933	1.56
Private: Public ratio	2.29	3.13	

Urban: Rural ratio measures the urban-rural differential in average expenditure.
Private: Public ratio measures private-public differential in average expenditure.
(As cited in Sen et al. 2002, Page no. 291, Table 11.4)

From the table, it can be concluded that the cost difference between public and private inpatient care was high. Rural private hospitalization was over twice as expensive and urban private hospitalization over three times as expensive as public hospitals. Whereas patients resorted to private sector for outpatient services, **public hospitals were main providers of inpatient care,** especially for the poor. Though this varied across states, public hospitals were important alternatives to private sector and at significantly lower cost.

During the late 1940s, health status indicators (life expectancy, infant mortality rate and maternal mortality rate) 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 and this can be explained by differential role played by state in these two countries for health improvement.

Table 4: Decline in IMR and Death Rates in China and India, 1949 and 1985

Indices	China			India		
	1949	1970	1985	1949	1970	1985
Infant Mortality Rate	200	85	37	180	130	97
Death Rate	20		6.7	27.4		11.9

Source: For China-J.Banister, China's Changing Population, Stanford University Press, 1987.
For India-Health Information of India, Ministry of Health and Family Welfare, Government of India, Various Years. as cited in Acharya et al. 2000, Page no. 223 and Page no. 225. Table 3 and Table 5 combined)

While China was able to make significant health improvements in a short span of time in pre-reform period by ensuring comprehensive, universal health care to all, India failed to address class, rural-urban and gender differences in accessibility to health care.

Table 5: Infant mortality rates by total annual income of the households in India in 1984

Annual income of the households in rupees	Infant Mortality Rate		
	Rural	Urban	Combined
5000 and below	128.6	85.4	124.2
5001-10000	108.1	71.5	100.7
10001 and above	91.8	51.5	79.7

Source: GOI (1984), Mortality differentials in India: Vital Statistics Division, Office of the Registrar General of India, New Delhi, p-6 as cited in Qadeer, 2000.

The infant mortality differentials based on classes and geographical locations are evident from the above table.

Table 6: Gender differences in rates of morbidity and untreated morbidity, India, 1986-1987 (National Sample Survey Organization 1992)

	Rural	Urban
Morbidity rates (No. of ailing persons/1,000)		
Male (M)	64	30
Female (F)	63	33
Total	64	31
F: M ratio	0.98	1.10
Untreated morbidity rates (No. of untreated persons per 1000 ailing people)		
Male	172.4	98.1
Female	198.0	118.9
Total	184.8	108.6
F: M ratio	1.15	1.21

Untreated morbidity=(100,000-rate of treated morbidity)/100 (As cited in Sen et al., 2002, Page no. 286, Table 11.1)

From the table it is clear that morbidity rates as well as **untreated morbidity rates** were much **higher in rural** areas as compared to urban areas in 1986-1987. Untreated morbidity was 15% to 21% **higher among women** and girls than in men and boys. However, these rates are probably gross underestimates of the full extent of women's illness, as it do not include reservoir of untreated sexual and reproductive illness (Sen et al., 2002).

From the above facts and figures, it can be concluded that in late 1978, more than a decade earlier than Indian liberalization programme, the poor were significantly better off in China than in India, a remarkable degree of social equality had been achieved and a far more substantial programme of basic health extended virtually to the entire population (Acharya et al., 2000).

Era of Liberalization – An Era of commercialization of health services in China and India

This section would look at role of state and market in health services in post reform China and India. In this paper, the concept of commercialization is used as it is broader than privatization and it includes not only expansion of the private sector but also commercial behaviour of publicly owned bodies (Mackintosh and Koivusalo, 2005). The paper brings out the role of market in private and public sector, which are complexly interlinked.

China was in deep crisis at the end of the Cultural Revolution and agriculture was almost stagnant. After the death of Mao, people wanted change. Besides domestic imperatives, there were international pressures also. Thirty years of isolation prohibited China from becoming modernized. In the mean time, the success of Hong Kong, Taiwan, Singapore and South Korea capitalized on expanding markets in world trade in 1960s and 1970s influenced China. Also normalization of relations with Japan and the USA, end of Vietnam War and the advantage of maintaining leverage vis-a vis the USA and the Soviet Union compelled rejoining of world community. (Wong, 1998).

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**. Though land ownership continued to be vested in the collective, it was contracted to individual peasant families with remuneration firmly linked to output. A given amount of tax per unit of land was to be paid to the government and the rest could be sold in the market. 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 inequitous 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. Though peasants experienced increase in individual incomes, the gap between rich and poor increased. (Acharya et al., 2000). The economic reforms had far reaching implications on the health services. China made three major policy changes in health care. Firstly, the government **limited public funds available for health** care because of the drain on its budget that resulted from huge losses incurred by state enterprises. Whatever it failed to finance, it left to the private market with a **laissez-faire policy.** Secondly, the government altered financing of hospitals and township health centres, giving them a degree of **financial independence.** Finally, the government **liberalized the private ownership** of health facilities and private clinical practice (Hsiao, 1995).

The financial crisis of 80's made India choose structural adjustment programme (and health sector reform as a part of it) at the cost of the marginalized. In India, the main aspects of the International Monetary Fund (IMF)- World Bank initiated reforms were **cuts in health sector investments,**

opening up of medical care to the private sector, introduction of user fees and private investments in public hospitals and purely techno centric public health interventions. Hence, instead of learning from past experiences and contradictions in the Indian health care system, the prescribed reforms were accepted unquestioningly. Welfare sector was drastically pruned and handled over to the private sector and dependence replaced the goal of self-sufficiency in the name of globalization. International Monetary Fund and World Bank proposals of absorbing Indian economy into the global market is seen by ruling elite as an advantage. These adjustments are not necessarily a response to either people's needs or growing body of public health knowledge. The health care system is rooted in the political economy of each country and its links with the global process of economic and political change. Borrowed technology became central to disease control programs and more aid and increasing dependence became part of health sector reforms. The national health institutions lost their autonomy because due to cut backs they had to depend on donors who dictated planning priorities and nature of research performed (Qadeer , 2000).

One of the consequences of market reforms in China is the **increasing cost of health** care and this has prevented many from accessing health services and puts households who use health services into financial risk. Out of pocket expense for medical care in China as a whole has increased from 16% in 1980 to 38 % in 1988 to 61% in 2001 (as cited in Zhang and Kanbur, 2003)

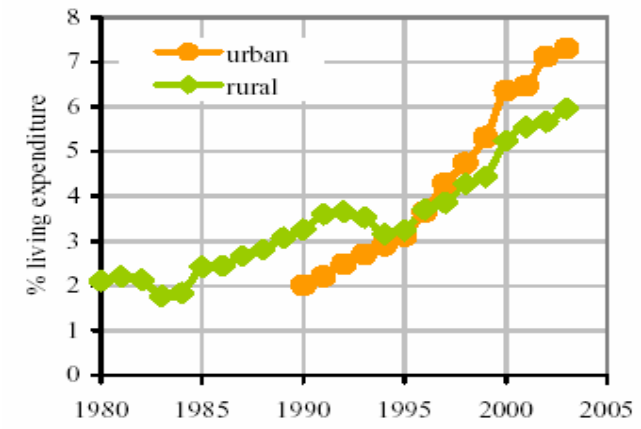
Table 7: Recurrent Health Expenditure by Source of Finance

Year	Per capita Expenditure (1980 Yuan)	Government Budget (%)	Social Expenditure (%)	Personal Expenditure (%)
1965	4.7	28	56	16
1970	5.1	27	57	15
1975	8.6	28	55	16
1980	10.9	28	56	16
1985	19.4	23	47	29
2000	95.5	15	24	61
2001	101.7	16	23	61

As cited in Zhang and Kanbur, 2003, Page no. 22, Table 2(adapted version)

The table shows declining government budget (28% in 1965 to 16% in 2001) and social expenditure (56% in 1965 to 23% in 2001) in medical care and increasing personal expenditure (16% in 1965 to 61% in 2001) over the years 1965-2001.

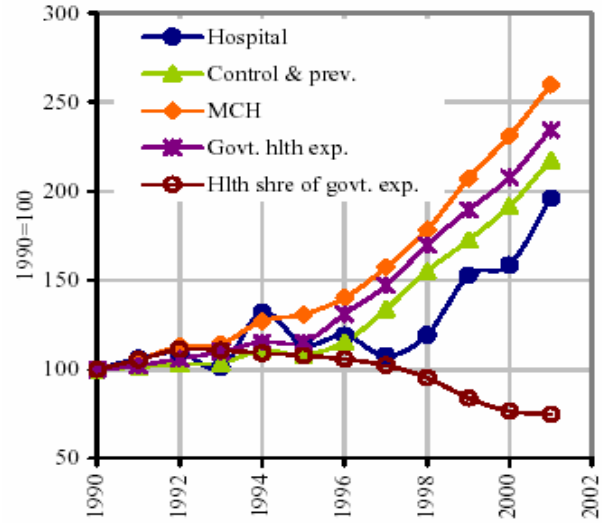
Figure 1: Out of pocket spending- an ever-larger share of household expenditure



Source: China National Health Economics Institute " China Health Accounts Digest", 2002.
as cited in Briefing Note No.3, 2005, Page no. 3

From the figure, one can see that private health spending rose as a share of the household budget dramatically during the 80's and the 90's especially among urban households. In real terms, private spending grew at average annual rate of 20% during the 90's whereas public spending grew at a more modest rate of 8% per annum (Briefing Note No.3, 2005). Also ratio of health expenditure per capita between urban and rural areas, which was 3:1 in 1981, had risen to 5:1 in 1992 (Hesketh and Zhu, 1997).

Figure 2: Declining Government health spending as share of total government spending



Source: China National Health Economics Institute " China Health Accounts Digest", 2002 as cited in Briefing Note No.3, 2005, Page no. 3

The figure above shows that government health spending has risen in real terms but has fallen as a share of total government spending in post reform China. By international standards, a country with China's per capita income should ideally spend around 2.4% of GDP on government health spending whereas it just spends 1.9% (Briefing Note No. 3, 2005).

Though there are many factors that determine a person's utilization of health services, cost is a very influential factor. The rise in the cost of care has coincided with **falling health insurance coverage.** Health insurance has almost disappeared in rural areas and it's under lot of strain in urban areas. In 2003, for a single inpatient, the cost was just under 4000 Yuan, which is equivalent to 43% of average income. For a person who is in the poorest fifth of the population, 4000 Yuan is equivalent to 200% of average income. This would have been less of a problem if households were covered by health insurance and costs did not have to be met out of pocket. (Briefing Note. 3, 2005)

It would be interesting to look at the shifts that have occurred in health insurance in post reform China. Chinese health care expenditures are financed very differently in rural and urban sectors and hence would be looked at separately.

In the pre-reform period in the 1960s and 1970s, a collective medical welfare system in rural socialist China, the **Cooperative Medical System (**CMS) was very successful. Most villages funded their rural CMS from three sources: a) **premiums** depending on the plan's benefit structure and the local community's economic status, 0.5 to 2% of a peasant family's annual income was paid to the fund; b) the **collective welfare fund** i.e., each village contributed a certain portion of its income from its agricultural production or rural enterprises into a welfare fund according to State guidelines and c) **subsidies** from higher-level government structures generally used for compensating health workers

and purchasing medical equipment (Liu, 2004). The original functions of CMS were: a) to collect premiums from the brigade, production teams and households; b) to **reimburse medical expenses** to members who sought services either in commune hospitals or county hospitals and c) **to train, recruit and monitor barefoot doctors** who were responsible for dissemination of health information, treatment and prevention of disease, maternal and child health services, immunization, prevention of infectious disease, isolation and disinfection, reporting of epidemic disease and carrying out the patriotic public health campaign. Thus, CMS was a form of **health maintenance organization.** As barefoot doctors were also involved in farming besides providing health services, some brigades gave them allowances when they were unable to complete their allotted farm work. In 1960, the Central Committee of the Chinese Communist Party affirmed the CMS as a suitable way of providing health services in rural areas. By 1979 about 90 percent of the rural population participated in the CMS (Chen et al., 1993). CMS could achieve **universal coverage of basic health** services in pre-reform period.CMS in China although based on principle of collectivism have functioned largely due to interest of state (Nayar and Razum, 2003).

With market oriented economic reforms in 1978, production system shifted from community to households, which resulted in the discontinuation of collective financing of health care. During the 1980's, participation in the CMS declined from 90 percent of rural villages to just 10 percent. Economic reforms changed the financing and incentives for individuals to participate in the CMS system. Barefoot doctors joined the rural enterprises in manufacturing production, participated in free-market retailing or engaged in more farming all of which provided higher earnings than they would have earned as barefoot doctors. There was no cash withholding system and no efficient channel to collect health and welfare funds for CMS operations. Also CMS underwent major changes after the reforms. In some places CMS stations are developing medical insurance programmes with the assistance of rural enterprises and some are changing to a type of system that covers medical care services but not drugs which constitute 90 percent of the costs of rural health stations. When the continuation of CMS was left for individuals to decide, that household that did not expect to receive medical services chose not to participate while families that joined the CMS expected to get their money's worth. If their expectations were not met, they withdrew from the insurance programme next year. Hence, lack of finances due to adverse selection or lack of support from a broader population base could lead to collapse of CMS (Chen et al., 1993). CMS survived only in richer coastal suburban areas and in prosperous model villages (Nayar and Razum, 2003). The table given below shows how the percentage of villages with CMS declined over the years in post reform China:

Table 8: The Percentage of Villages with CMS, 1958-89

Year	Percentage of villages with CMS
1958	10.0
1960	32.0
1962	46.0
1968	80.0
1976	90.0
1979	90.8
1981	58.2
1985	11.0
1987	5.4
1989	4.8

As cited in Acharya et. al. 2000, Page no. 233, Table 10.

Table 9: Declining subsidies to CMS in China, 1978-1988

Year	Subsidies to CMS (million yuan)
1978	39
1979	34
1980	26
1981	24
1982	29
1983	28
1984	29
1985	25
1986	28
1987	24
1988	22

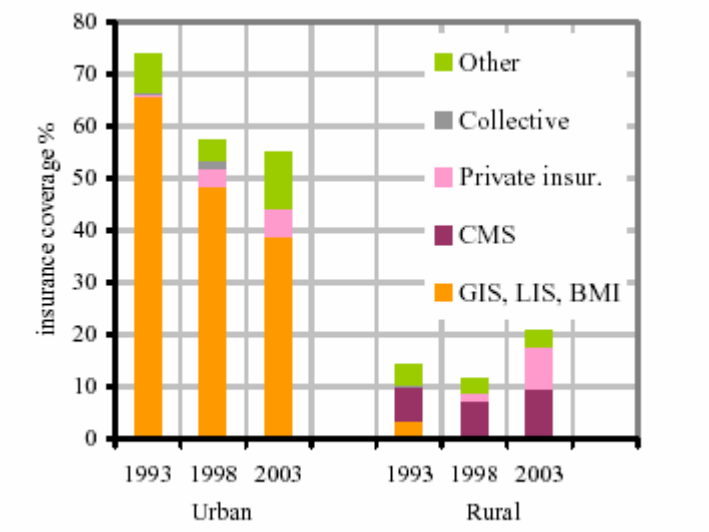
As cited in Acharya et al. 2000, Page No. 234, Table 11 (adapted version)

Now, there are attempts to revive CMS. However, revival is not based on earlier principles of collectivism. The generation of rural cooperative health care schemes has evolved into a medical insurance system under the guidance of health administrators and insurance companies. The focus is on village-based schemes with minimum external funding and no reimbursement of drug costs and payments for secondary and tertiary care. For sustainability, strong state support is required and cooperatives cannot be reduced to profit oriented curative institutions if they have to serve some purpose in the new economic scenario (Nayar and Razum, 2003). In 2002, officials launched experiments to create a very rudimentary financial safety net for health care. Government to provide equivalent of $ 2.50 a year to help cover a basic insurance plan for peasants who must match this with an annual $1.25 of their own. Because of their modest funding, these plans cover only inpatient care with a very high deductible and leave peasants without adequate primary care services and drugs (Blumenthal and Hsiao). **New Style CMS** (NCMS) is being piloted in China's more than 300 of China's more than 2000 counties and will implemented to the rest of the country by 2010. Contributions from households starting at 10 RMB per person and paid voluntarily will be supplemented by a 10 RMB subsidy from local government and by a 10 RMB matching subsidy from central government in the case of households living in the poorer Central and Western provinces. It would operate at the county level like the old CMS. However, the question is if 30 RMB is sufficient especially when 104 RMB was spent per capita on medical care in rural China in 2002 (Briefing Note No. 3, 2005).

The **Government Health Insurance Scheme** (GIS) and **Labour Health Insurance Scheme** (LIS) had played a very important role in providing China's urban working population with health protection. Both systems also extended coverage to dependents although reimbursed at 50%. (Grogan, 1995). For state owned enterprises, the government has launched series of urban reforms since late 1980s. The central theme is to transfer welfare provision obligations like health care and housing from enterprises to social insurance agencies and individuals and this might have made marginalized groups more vulnerable to sudden shocks and catastrophic illness (Zhang and Kanbur, 2003). In response to escalating costs, the Central Government instituted a countrywide co-payment policy under which provinces are allowed to make GIS covered individuals responsible for paying a part of their health care expenses. One example brings out the irony of such reforms. In Baoji, Shaanxi, a middle income city, government workers had to bear 40% of outpatient cost and 10% or more of inpatient costs as compared to Shanghai, a high income city where workers had to pay 10% of outpatient costs and no out of pocket expenses for inpatient care (Grogan, 1995).

By end of 2003, most cities in China established **Urban Employee Basic Health Insurance Scheme** (UEBHIS), which pools some elements of risk for all urban workers including both public and private sector employees. Self employed and rural industrial workers can buy the programme but are not required to enroll. Workers covered by UEBHIS receive only a basic set of health services defined by an **Essential Services List** and **Essential Drug List** issued by the government. Workers' dependants including their children used to receive partial coverage by GIS and LIS, but are now excluded. Also Chinese government is encouraging growth of **commercial health insurance market** and by 2002, about 8.6 per cent of population was covered by it whereas 19 percent of Chinese urban population was covered by UEBHIS. The UEBHIS programme is financed by compulsory premium contributions from employers, which is 6 percent of employee's annual wage, and employees, which is 2 percent of their annual wage. Retired workers do not have to pay premiums while their former employers have to contribute 8 percent of the employee's wage. The total premium contributions are divided into two parts i.e., individual medical account and social risk pooling. From the employee's wage 3.8 percent goes into individual medical account, which enrollees can use only to pay for outpatient health care expenses in public hospitals or for purchasing drugs in drug stores selected by government. If the enrollee has used up the money in the individual account in one year, he/she has to pay subsequent bills out of pocket. If the money remains unspent, it automatically gets transferred to the next financial year. The remaining 4.2 percent of the wage goes into social risk pooling which covers partially or fully inpatient medical expenses. The social risk pooling limits payment for each enrollee to four times the average annual wage of workers in that city. The expenses above the ceiling can be covered by complementary insurance schemes or have to be paid by the patient out of pocket or by purchasing commercial health insurance. Essential Drug List and Essential Services Lists have been developed for **cost containment.** The Essential Drug List is divided into two parts i.e., Drug List A and Drug List B. Drug List A is prepared by Central Government and the local government does not have the authority to adjust it and the medical expenditure of enrollees who use the drugs in Drug List A is paid by the UEBHIS. The local government has the power to expand or reduce items in Drug List B by up to 15 percent. The medical expenditure of Drug List B is divided proportionately between enrollee and the scheme (Sun, 2005).

Figure 3: Declining Health Insurance Coverage in China

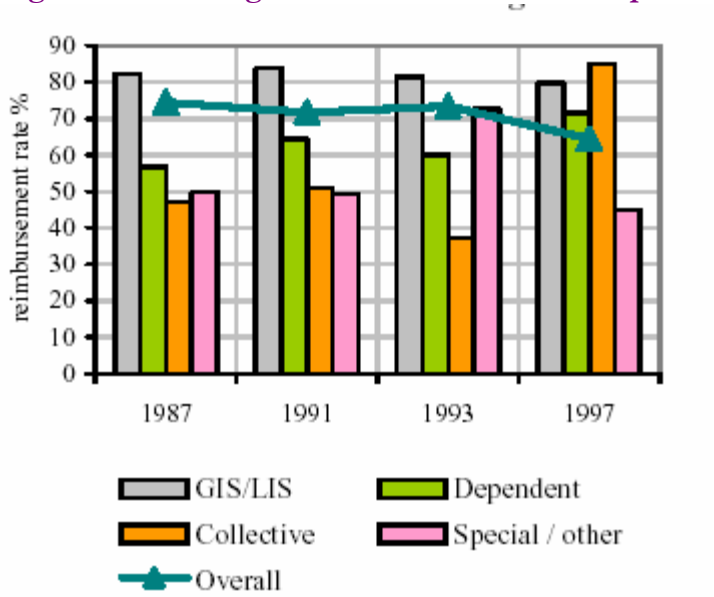


Source: National Health Survey as cited in Briefing Note No.3, 2005, Page no. 3

In urban areas, coverage in government schemes steadily declined during the period 1993-2002, falling below 40% in 2003 and 12 % among the poorest fifth urban population. For rural areas, the coverage improved between1998 –2003 and this could be attributed to CMS and commercial insurance schemes (Briefing Note No. 3, 2005).

The other important dimension as far as insurance is concerned is not only the numbers of people who are covered by insurance have been **falling** but also the **depth of coverage** has also been declining in post reform China (Briefing Note No. 3, 2005). Full reimbursement of medical expenses has become a rarity. Coverage for dependents is exceptional. One third of the state enterprises are running at loss and unable to reimburse cost and hence workers are effectively uninsured (Hesketh and Zhu, 1997).

Figure 4: Declining reimbursement rates for inpatient care



Source: China Health and Nutrition Survey as cited in Briefing Note No. 3, Page no.4

There is a wide rural-urban disparity as far as health care coverage is concerned and the inequality is on the rise since the introduction of market reforms.

Table 10: China's Health Care Coverage in 1998 (Yuan per capita)

	Cities	Countryside	Total
Totally public paid	16.0	1.2	5.0
Labour related	22.9	0.5	6.2
Semi-labour related	5.8	0.2	1.6
Insurance	3.3	1.4	1.9
Cooperative	4.2	6.6	5.9
Self-Paid	44.1	87.4	76.4
Other	3.7	2.7	2.9

Source: China Health Yearbook 1999 (Ministry of Health, 1999, P 410 as cited in Zhang and Kanbur, 2003.

The rising cost of health care, falling health insurance coverage coupled with introduction of user fees at the secondary and tertiary level of care further shifted the responsibility for health care to the individual which earlier had been collective responsibility.

After the introduction of market reforms, government funding to public institutions was reduced and Centre granted **local governments more fiscal responsibility** to improve their incentives to develop the local economy through taxation. Many local governments in poor regions cut spending on social development and let individuals share more health and educational expenses (Zhang and Kanbur, 2003). Central government drastically reduced its ability and commitment to redistribute health care resources from wealthy areas to poor areas (Blumenthal and Hsiao, 2005). Central government funding for healthcare reduced drastically and it contributed less than 1 % of total health expenditure, providing some capital grants to hospitals and subsidizing preventive services in poorer areas. Only 20-30% of hospital expenditure was granted and the shortfall had to be generated through user fees (Hesketh and Zhu, 1997). The kind of price regulation system that the government has imposed, had unintended consequences. To ensure access to basic care, government tightened controls over amount that publicly owned hospitals and clinics could charge for routine visits and services such as surgeries, standard diagnostic tests and routine pharmaceuticals. However, it **permitted to earn profits from new drugs, new tests and technology** with profit margins of 15 percent or more (Zhang and Kanbur, 2003). Western drugs can be charged at a mark up of 15 % and Chinese drugs at mark up of 25 %. The profits can directly go to the doctor or institution. Because of this, there is **massive overuse of drugs** and drug bill is estimated to account for 50% of all health care costs (Hesketh and Zhu, 1997). There is another factor that is associated with over prescription of drugs. Before 1980, Ministry of Health at national level formulated policies and established targets and the lower level had to meet these targets. In 1985, a national policy called the **"director responsibility system"** was introduced to increase the autonomy of health institutions. Directors were given the authority to recruit health staff according to hospital needs and to reward, punish and even dismiss health staff based on their performance. Three types of financial rewards were used- **bonus system, director's fund and floating salary.** Under the bonus system, 30 % of surplus funds generated could be shared amongst health staff on monthly basis. Director's fund was financed from up to 5 % of the surplus and this could be used for providing extra individual bonus to staff secretly using a red envelope. In floating salary, the floating component is performance related and normally associated with service provision like number of patient consultations or drugs prescribed and the managers had the freedom to decide the structure of salary. Ultimately, the floating salary had to be cancelled as doctors over prescribed in order to make money from sale of drugs (Liu et al., 2006). Some examples of problem of excess drug use would help in understanding how markets operate within public health system. Though many health workers know about the use of oral rehydration solution for diarrhoea, intravenous infusions and antibiotics are widely used though not needed. Hospital outpatient departments have infusion rooms where mild complaints are treated with intravenous fluids. Also huge profits are made from high technology investigations. Fees for Computed Tonography, Magnetic Resonance Imaging, laboratory services, ultrasonography, intensive care and renal dialysis are extremely lucrative. Full neonatal intensive care costs 1000 Yuan per day at Hangzhou Children's hospital whereas in the same area, the average monthly income is 600 Yuan. As most of the work based insurance schemes excludes children, such type of care is accessible to a small segment and removal of babies by parents who cannot afford care is not very uncommon (Hesketh and Zhu, 1997). A study aimed at measuring unnecessary care in 1999, found that 20 % of expenditures associated with treatment of appendicitis and pneumonia were clinically unnecessary. In a study of village clinics in 2003, it was found that only 0.06 of drug prescriptions were rational. In case of Tuberculosis, a study in found that providers deliver additional care along with the free DOTS package as that generates additional revenue. Patients were treated longer than six months and were provided non-standard tests and medicines along with those in DOTS package. The revenue generating activities have displaced more important health interventions such as basic preventive and curative care, public

health and out reach programs (Briefing Note No. 3, 2005). The Jiangxi study showed that hospitals from which state subsidy has been removed became dependent on medicine sales and increasing itemization of treatment to recover costs. The insurance status of patient influenced length of stay in the hospital and levels of payment. Uninsured patients had a shorter stay and were charged more for items of treatment (Zheng and Hillier, 1995). In China, even **immunization is not free** of cost in China and it is the only country in Western Pacific region, which is dependent on patients for financing childhood immunizations, and hence many avoid getting their children immunized.

In China, 44.4% of total health expenditures in 2001 were for pharmaceuticals. A case study in two Shadong hospitals to find out the impact of China's retail drug price control policy on hospital expenditures revealed that control of retail prices, implemented in isolation, is not effective in containing hospital drug expenditures. Utilization, more than price was the main determinant of expenditures. Hospitals could shift to more expensive drugs not covered in the price control list. Hospitals could increase drug utilization to maintain their overall revenue. Corruption in drug purchasing and prescribing within hospitals by doctors to get financial incentives from pharmaceutical companies can contribute to increasing costs. Also while implementing price regulation, complementary actions were missing such as setting criteria for drugs to be included on the price list, evaluation and price setting for new drugs and indications for their use. The study found that very high proportion of expenditures on cerebral infarction cases were for Western drugs without adequate evidence base of safety and efficacy (Meng et al., 2005).

Due to reduction in governmental support for health care, most Chinese health facilities were privatized forcing them to rely more on sale of services in private markets to cover their expenses. Public hospitals also have come to function much like for profit entities (Blumenthal and Hsiao, 2005). Many township hospitals could not cope with the economic reforms and had to close down or reduce the number of staff and beds. Between 1980 and 1987, number of township hospitals decreased by 15 % and the number of township level beds by 17%.

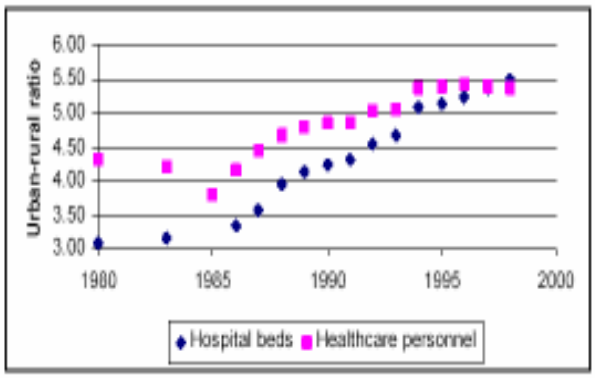
Table 11: Health care in China, 1952-1998

Year	Hospital beds/1000 (City)	Hospital beds/1000 (Rural)	Health care personnel/1000 (City)	Health care personnel/1000 (Rural)
1952	1.46	0.08	2.71	0.95
1978	4.70	1.41	7.50	1.63
1985	4.48	1.50	7.81	2.06
1998	6.08	1.11	9.16	1.71

Source: Comprehensive Statistical Data and Materials on 50 years of New China (China State Statistical Bureau, 2000) as cited in Zhang and Kanbur, 2003, Page no. 18 (adapted version).

The number of hospital beds /1000 population decreased from 1.50 to 1.11 in rural areas from 1985 to 1998 and number of health care personnel/1000 population during the same period decreased from 2.06 to 1.71 in rural areas (Zhang and Kanbur, 2003). Because of relaxation of regulations on the salaries of health staff, individual facilities motivated physicians by linking pay to performance. This led physicians move from low-revenue rural areas to high revenue urban ones as better financed facilities have attracted better trained physicians by offering more lucrative compensation packages. Many facilities with poor revenue generating potential collapsed leaving their clientele with less access to care. These may have contributed to **worsening of staffing disparities** between communities (Akin et al., 2005).

Figure 5: Urban-Rural ratios in hospital beds per one thousand people and health care personnel per one thousand people



Note: The vertical axis measures the urban-rural ratios of hospital beds per 1000 people and health care personnel per 1000 people. (As cited in Zhang and Kanbur, 2003)

To fill the gap, the **government authorized private medical practices** in rural areas and hence increasing number of people have to pay fee for service (Zhang and Kanbur, 2003). Xinxiang, a city in central province of Henan has engaged in the biggest sell off which has led to lot of controversy. In 2004, it sold majority control of all of its five main hospitals to a single state owned pharmaceutical company i.e., China World best Group. The Shanghai based company was happy to have guaranteed outlet for its drugs. Following this, the Shanghai government banned further deals between drug companies and hospitals (The Economist, 2004).

Now the question, which is very pertinent here, is what has been the impact of such reforms on accessibility to health care and health status indicators.

Table 12: Reasons for Non-Admission to Hospitals (percentage)

Reasons	Rich Counties	Intermediate Counties	Poor Counties	All
No bed available	9	3	2	3
Expense	36	51	63	54
Time	29	10	11	13
Declined admission	14	15	13	14
Others	11	21	11	16

Source: Household Survey as cited in Tang Sheng lan et al, Financing Health services in China: Adapting to Economic Reforms, Research Report 26, Institute of Development Studies, Sussex, 1994, Page 107.

The table shows that expense is one of the main reasons for non-admission to hospitals in China and poor counties are more adversely affected.

In 2001, a survey of residents in three representative Chinese provinces, half of the respondents said that they had foregone healthcare in previous 12 months because of cost (Blumenthal and Hsiao, 2005). Of those interviewed in the 2003 National Health Survey, 50 % (increased from 36%in 1993) said that they had been ill in the previous two weeks and yet had not sought care. In the survey, 30%

of respondents said they had not been hospitalized despite having been told they needed to be and among those who went to hospital, nearly half got them discharged against their doctor's advice and the reason being cost of care. Of those who said that they needed to be hospitalized but did not, three quarters of them were in rural areas and 85% among the poorest fifth of the population cited cost as the reason. And then there are people who seek treatment but get into financial difficulties as a result. In the National Health Survey of 2003, 30% of poor households said that health care costs were reason they were in poverty (Briefing Note No. 3, 2005).

Table 13 :Immunization Coverage in China, 1980-2002

Immunization Coverage	China			
	1980	1990	1995	2002
Child immunization rate, measles (% of children ages 12-23 months)	…	98	83	84
Child immunization rate, DPT3 (% of children ages 12-23 months)	…	97	84	90
Child immunization rate, BCG (% of children ages 12-23 months)	…	99	92	77
Child immunization rate, Pol3 (% of children ages 12-23 months)	80	98	94	79
Child immunization rate, HepB3 (% of children ages 12-23 months)	…	…	…	79

Source: World Bank Data 2002 (http://devdata.worldbank.org)

The table clearly shows that immunization coverage has deteriorated in China especially for BCG.
When World Health Organization ranked public health systems of 191 countries in 2001 based on fairness of access to health care and fairness of contributions to cost, China was placed at 144 behind some of Africa's poorest countries. India was placed at 112 (The Economist, 2004).
In 1960s to 70s, China achieved annual reductions in under five mortality in excess of 6 % which was much above rates achieved by Indonesia and Malaysia. But in the 1980s and 90's, while Indonesia and Malaysia achieved yet higher rates of reduction, China's rate fell (Briefing Note No. 3, 2005). Infant Mortality Rate (IMR) leveled off in the 80s. IMR in rural areas was significantly higher than in cities and the gap widened from 1.5 in 1981 to 2.1 in 1995. Ratio of female to male IMR increased from 0.9 to 1.3 between 1981 to 1995 and this can perhaps be attributed to family planning policy and preference for son (Zhang and Kanbur, 2003). There has also been **resurgence of some infectious diseases** like schistosomiasis, which was nearly controlled in the past. Decentralization and under financing of public health services have significantly affected China's ability to mount on effective, coordinated response to potentially pandemic infectious illnesses which was evident during the SARS epidemic. Also there are rising concerns about China's ability to contain its growing epidemic of HIV infection and associated outbreaks of multidrug resistant Tuberculosis especially in rural areas(Blumenthal and Hsiao, 2005). However, deteriorating health status is not just result of structural changes in health services but a consequence of changes in larger socio-economic and political sphere.
In India, one of the most important consequences of health sector reforms was a **massive cut in health sector expenditure.** Public health expenditure in India has declined from 1.3% of GDP in 1990 to 0.9% GDP in 1999 This is as against 12% of GDP as recommended by Bhore Committee in 1946. There was a steep fall in central grants to the disease control programs during early 90s.Central grants for disease control programs fell from 41 percent in 1984-85 to 29 percent

in 1988-89 and further to 18.5 percent in 1992-1993. During 1992-1993, some cutbacks were restored through World Bank Loans for specific disease programmes and this was mainly for AIDS control and there was a marginal increase for tuberculosis and blindness control programs. During 1993-94, there was a marginal increase for malaria but other communicable diseases registered a decline. In this period the outlays for curative services had stagnated and even declined for some states. Restoration of cut backs for communicable diseases was done when there was outbreak of several epidemics, the important ones being the plague epidemic in Surat and malaria in Western Rajasthan. Governmental infrastructure was inadequate to address the crisis and private hospitals refused to treat patients. The plague epidemic brought out the indispensability of public hospitals (as cited in Baru, 2001). Though the infectious diseases remain the main cause of mortality, investments increased only for selected programmes. Not only the secondary and tertiary unit lacked resources but Primary Health Care Centres also suffered. It did not receive adequate finances and there was dearth of staff. The disparity between rural and urban service provision sharpened in the 90s and the vertical Family Welfare Programmes dominated basic services (Qadeer, 2000). Compared to urban areas the ratio of hospital beds in rural areas is 15 times lower, the ratio of doctors is almost 6 times lower and that of government spending 7 times lower. As the cut backs extended to social sector as whole, there was loss of intersectoral support. **Decreased subsidies to public distribution** systems especially food rations, education and transport made the poor more vulnerable. In rural areas, sickness has become one important factor for indebtedness. Over 40% of hospitalized Indians borrow heavily or sell assets to cover expenses. Over 25 % of hospitalized Indians fall below the poverty line because of hospital expenses.

Privatization became the hallmark of reforms in India. Along with privatization of medical care, public health services like water supply, sanitation and sewerage treatment facilities are also getting privatized. As has been shown earlier that existence of private sector is not new in India and public-private mix has existed since a long time. But what is typical of reforms is now **public sector hospitals are opened up for private investment** and user fees have been introduced further marginalizing the poor section of the population. The increased role of private sector in provision of medical care in the absence of any kind of public regulation, regular service evaluation and quality control can be disastrous. Retreat of public sector would also create havoc for national disease control programmes. For example, in case of National Malaria Control Programme, the irrational use of drugs for resistant parasites and use of different drug regimes by practitioners and treatment without diagnosis have posed challenge for malaria control. In tuberculosis control, 80 regimes were prescribed by 102 private practitioners and generally more expensive than the most expensive standard regimes (as cited in Qadeer, 2000).

In analysis of privatization in health care, role played by large financial capital needs to be recognized. Large financial capital is largely confined to the pharmaceuticals, medical equipment and insurance industries and these operate globally. The impact of these industries was visible in Indian case during the late 1980's and 1990's and especially during the mid to late 1990s when government offered **reduced import duties for medical equipment**. The impact of liberalization of the pharmaceutical industry is starkly evident in **spiraling costs of drugs**. Also the list of drugs under price control has been reduced from 378 to 73 and prices of drugs have increased drastically (Qadeer, 2000). Between 1980 and 1995 the 778 drugs selected for a study had a 197% overall increase. The sharpest increases averaging 336% were evident for anti cancer drugs many of which are imported and also for those drugs, which have a near monopoly. Several drugs that have to be taken over long periods of time, such as those for thyroid disorders had increases over 500 %. The prices of non-essential drugs like balms, laxatives, food products, nutritional additives also increased (as cited in Sen et al., 2002). One major reason as to why the government has failed to regulate

prices and production of drugs adequately is overt and covert resistances from the drug industry initially comprising of transnational corporations and later Indian firms and wholesale and retail traders (Sen et al., 2002). The Indian generic companies particularly the larger ones are investing in new drugs and promoting generic exports especially to developed countries. Since mid-90s some Indian companies have started Research and Development for new drugs but they are targeting not the neglected diseases but diseases of the developed countries (Chaudhuri, 2005). The big business houses owned by non-resident Indians have been entering the medical market in a big way with active cooperation from Indian State as medical care market provides a very safe and easy source of making profits where consumer (patient) is highly vulnerable to the manipulation by providers of medical care. Not only the cost of care has been increasing at an exorbitant rate but also it is becoming more and more irrelevant to the health needs of the country. Majority of people suffer from diseases like TB, Malaria and other communicable diseases, which do not need sophisticated medical technology either in diagnosis or in treatment. The changing nature of medical care is more in favour of **private capital accumulation rather** than addressing health needs of the population (Kethineni, 1991).

Privatization has also indirectly affected health sector by transforming self-sufficient food economy to cash crop producing one, which undermines food security systems (Qadeer, 2000). Privatization raises some important concerns about accessibility, universality and equity in health care. There are concerns about quality and standards of care, of hygiene as well as over prescribing. Private sector often discharge their patients early in order to maximize patient turn over and increase intervention to earn profits. It is only during the first few days of hospitalization that a hospital makes profits on beds after which profit margins begin to decline. Hence, private hospitals tend to discharge patients earlier than public hospital even if it is not in the best interest of patient (Baru et al., 2000). Often privatization is justified as there is a myth that private sector provides better quality care. This myth was shattered when cases of medical negligence in private hospitals were brought to light under the Consumer Protection Act, 1986. Also there are serious methodological problems in evaluation and in drawing comparisons of efficiency and quality of public and private medical institutions (Baru, 2001).

The increasing cost of medical care has made it difficult for those who most need the help to access care.

Table 14: Reason for no treatment, India, 1986-1996 (National Sample Survey Organization 1998)

Reason for no treatment	Rural (%)		Urban (%)	
	1986-1987	1995-1996	1986-87	1995-1996
No medical facility	3	9	0	1
No faith in medicine	2	4	2	5
Long waiting	0	1	1	1
Financial reasons	**15**	**24**	**10**	**21**
Illness not "serious"	75	52	81	60
Other reasons	5	10	6	12
Total	100	99	100	101

(As cited in Sen et al., 2002, Page no. 306, Table 11.10)

Seeking health care is becoming increasingly difficult for poorer class. Compared with 1986-87, the proportion of those who were unable to access care because of financial constraints increased significantly in both rural and urban areas in 1995-1996. Also the proportion who said that no medical facility was available also increased over the same period in both urban and rural areas.

Consequently, the proportion of those who did not consider their health problems to be serious enough also declined thereby indicating difficulties in access to health care (Sen et. al., 2002).

Table 15: Average expenditure on medical care, India, 1995-1996 (NSSO, 1998)

	Rural		Urban		Urban: rural ratio 1995-1996
	1995-1996	Change % 1986-1996	1995-1996	Change % 1986-1996	
Outpatient care					
Public sector	129	77	166	124	1.29
Private sector	186	142	200	150	1.08
Total	176	132	194	146	1.10
Private: Public ratio	1.44		1.20		
Inpatient Care					
Public sector	2080	549	2195	470	1.06
Private Sector	4300	486	5344	343	1.24
Total	3202	436	3921	320	1.22
Private: Public ratio	2.07		2.43		

(As cited in Sen et al., 2002, Page no. 303, Table 11.8)
Urban-Rural ratio measures urban-rural differential in average expenditure and Private-Public ratio measures private-public differential in average expenditure.

Compared with mid 80s, costs of both outpatient and inpatient care rose in rural and urban areas. Between 1986-1987 and 1995-1996, private outpatient costs went up by 142% as against 77% in public sector in rural areas. In urban areas, private inpatient costs increased by 150% as compared with 124% in public sector. The rural-urban price difference for outpatient care rose from 1.04 to 1.10 during the same period. From the table, spiraling costs of inpatient care were particularly evident in institutions in the public sector in contrast to private sector in both rural and urban areas. What is worth noting is costs of private outpatient care and of public inpatient care went up in comparative terms, which is a double burden for the poor (Sen et al., 2002).

All the health sector reform projects of World Bank emphasize on introduction of user fees, which in turn would be a major source of revenue for renovating public hospitals. These measures have failed either to augment services to the poor or to introduce greater efficiency. In some states like Punjab in India, the utilization levels fell in hospitals after introduction of user fees.

Health indicators in India reveal that the health of Indians are poor as compared to health of people in China, and most of the diseases responsible for mortality and morbidity are diseases of poverty and lack of access to sanitation and safe drinking water and these are exacerbated by poor health services. However, in China the improvements in health indicators have almost stagnated in post reform era and in some cases have even deteriorated.

Table 16: Health Status Indicators in China and India, 1980-2002

Health Status Indicators	China				India			
	1980	1990	1995	2002	1980	1990	1995	2002
Life expectancy at birth, total (years)	68	69	70	71	55	59	62	63
IMR (per 1,000 live births)	49	38	37	30	113	84	74	63
Under-5 mortality rate (per 1,000)	64	49	46	37	173	123	104	87
Adult mortality rate, total (per 1,000)	…	…	143	…	…	…	224	…
Survival to age 65, male, (% of cohort)	…	…	…	72	…	…	…	62
Survival to age 65, female, (% of cohort)	…	…	…	79	…	…	…	66
Tuberculosis prevalence (per 100,000 people)	…	…	…	88	…	…	…	214
Tuberculosis incidence (per 100,000 people)		116	111	103	…	168	168	168
Tuberculosis death rate (per 100,000 people)				21	…	…	…	35
Tuberculosis treatment success rate (% of registered cases)			96	93	…	…	79	87

Source: World Bank Data 2002 (http://devdata.worldbank.org)

Conclusion

The State's approach to health improvement had been remarkably different in the liberated China and independent India. Different political ideologies informed the nature of state in these two countries. While China resorted to radical socio-economic restructuring to break the linkage between landlessness and poverty, land reforms in India were half hearted and failed to create an equitous base. China in the beginning laid greater emphasis on strengthening preventive care at the primary level and then building institutions for delivery of medical care and provided the necessary medical infrastructure at the primary, secondary and tertiary levels. In India though there was a great deal of rhetoric on primary health care but emphasis was on building hospitals at the secondary and tertiary levels. Between 1940's and 1960's, China's health status indicators improved dramatically while India's achievements were modest. (Acharya et al. 2000). China was able to make significant health improvements in a short span of time in pre-reform period by addressing social roots of health and ensuring comprehensive, universal health care to all whereas India failed to address class, rural-urban and gender differences in accessibility to health care. Improvement of health indicators does not depend only on health services but also on equitable economic policies, issues of production and distribution of food, reasonable wages, social security etc. The Chinese State had a strong political commitment to foster all round growth. In pre-reform period in India, unlike that of China, one can find the existence and growth of heterogeneous and unregulated private sector in medical care, inequalities in access based on class, gender and geographical location.

At the onset of reforms in China, a remarkable degree of social equality had been achieved and a substantial programme of basic health catered to almost entire population (Acharya et al., 2000). With China's transition to socialist market economy in 1978, the health services have undergone many changes. There is now decreased reliance on state funding, decentralization of public health services, increased autonomy of health facilities, increased freedom of movement of health workers

and decreased political control (Bloom and Xingyuan, 1997) Evidences show that there is growing inequality in access to health services with increasing costs of medical care, increase in out of pocket expense, declining health insurance coverage, decreased government spending, increased commercialization of health services, introduction of user fees and increase in drug prices. The revenue generating activities have displaced more important health interventions such as basic preventive and curative care, public health and out reach programs. Health indicators have stagnated in the post reform period and in some cases have deteriorated. For example, in some poor areas, Infant Mortality Rate has increased and there has been resurgence of some infectious diseases such as schistosomiasis. The reversal in health outcomes cannot be explained just by structural changes in health services but are linked with larger socio-economic and political factors.

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 inequitous base and they were initiated against the backdrop of poor human development indicators (Acharya et al., 2000). The main components of health sector reform in India are cuts in health sector investments, opening up of medical care to the private sector, introduction of user fees and private investments in public hospitals and purely techno centric public health interventions. There were massive cuts in health sector expenditure as a result of which not only secondary and tertiary units suffered but Primary Health Care centres also suffered. Because of cuts in expenditure, national health institutes have lost their autonomy and their planning priorities and research agenda are donor driven and not necessarily reflective of country's actual health needs. There is loss of intersectoral support to health. Subsidies to public distribution system especially food rations declined (Qadeer, 2000) Cost of drugs have increased and the government has failed to regulate the prices due to overt and covert resistances from powerful drug industry comprising of both transnational and Indian firms. Changing nature of medical care is more in favour of private capital accumulation rather than addressing health needs of the population. Health sector reforms have become instruments to promote markets rather than health. Even in public sector, private interests are increasingly accommodated.

The rising role of markets in the health sector has raised some important concerns regarding equity, comprehensiveness and universality of care. There are issues of quality and standards of care as well as over prescribing of medications and diagnostic tests for generating revenues, which might have adverse impact on health. There is an ideological shift from viewing health as a need to viewing health as consumption. But health should not be viewed as any other commodity as in case of health, market principles fail. The quantity of health care demanded does not necessarily reflect consumer's utility function, but the doctor's preference for a reasonable income and the asymmetrical relationship between a doctor and a patient with unequal power distribution and access to information renders the patient vulnerable for exploitation. The excessive drug use in China is a case in point. 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. China can be taken as a test case for stating that increasing role of market in the health sector leads to inequalities in access to health care and negatively affects health indicators. The role of state in providing comprehensive, universal and equitable health services to all needs to be reiterated in this present neo-liberal era.

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