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Health System Issues, Challenges, and Options: Reflections on India and China

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Abstract
India and China, the two countries which together represent almost half of the global population and their health systems could determine the destiny of more than 2 billion population. Starting with almost a common stage during early 20th century started moving in two different directions in social, economic and political strategies in reconstructing their nations. The paper tries to position Chinese health services *vis-a-vis* Indian health services in terms of broad issues related to financing, provision.

Keywords: China, India, health care financing, provision challenges.

Introduction

1. Background

The health systems of India and China are very interesting cases not only because of their ability to influence the health outcomes of a large majority in the world due to their huge populations, but above that their stories present a fair amount of evidence on "what to do and what not to do" in health services. India's health system has been running through rough weather for quite some time and at this moment, calls for radical progressive transformation, if it is to offer a good deal of welfare to its population. Soon after Independence, the national planners committed themselves to develop the country and its people through a socialist framework and health had to be an obvious component in it. The post-independent plans and policies on health care were much influenced by visionaries like Bhore whose committee on Health and Development in India made primary care approach the bedrock of Indian health care system, and the public sector was visualized keeping these ideals in mind. The committee laid down the principle that access to primary care is a basic right and ability to pay or any other socio-economic considerations should not be barriers in accessing care. The country has made tremendous progress in health outcomes in terms of increased life expectancy at birth, reduced IMR, MMR and death rates, etc. However, the achievements are not so significant once we look through a comparative lens. The perceived needs and demands have been undergoing tremendous changes while the resources needed to finance them are greater than ever before. The rate of progress is such that almost every day another new drug or treatment, or a further advance in medicine and health technology, is announced (WHO 2000). For a state that promised universal health care through the public health care delivery system, India has allocated only a meager fraction of the public resources for health care. The country's health system evolved with ambitious plans; however, the resources were no adequate enough to fulfill even the minimum commitments made in the initial plans. The more worrying aspect has been that, rather than heavily increasing the public health resources, it came down substantially in successive plans. It has already been mentioned that it is high time health care assumed priority in the agenda of policy makers which should be reflected through substantially increased allocation for health care sector, monitoring the performance of the public and private health care providers, the changes in the different access and utilization of care by the different socio-economic groups.

2. Chinese health system: As for China, its health system during Mao's rule served as a model for developing and low-income countries for providing egalitarian and low-cost health care to a vast majority of population. The period (1950-1970) was characterized by significant achievements in population health indicators despite how-income levels, Primary health care being the cornerstone of the health care delivery system helped China to attain better health indicators by the early 1970's. An ideology of equity for all citizens, and the near universal availability of adequate food, education, housing, jobs, and accessible and affordable health care services contributed to this achievement (Xu & Yang 2009). The achievements had been far beyond what could be expected when the stage of economic development was considered (World Bank 1993). However, China fell into a market regime since late 70s and the accepted ideology during the first phase of the reform, was "planning as a principal agent and market as a supplementary part" was reversed. The post reform period witnessed profound changes in the organization and delivery of rural health care services in China. The concomitant economic changes that followed the reforms, changes in the political structure and the internal problems of the Cooperative Medical Services contributed to the rapid decline of the system. There is hardly any disagreement among the scholars on the argument that economic reforms with its unquestioned belief on the market has not had a positive impact on the equity aspects of health care in most of the countries. The present paper is an attempt at understanding the Indian health care system better which had travelled a lot, but failed to make significant achievements. The paper is organized as follows. First, it discusses very briefly on Chinese health services, before going in detail towards the issues and challenges faced by the Indian health services. The following sub-section discusses some of the issues related to financing, provision etc with an emphasis on urban India. China has taken radical steps in the development of preventive medicine, public health and socialized services with a higher degree of success, while India lagged in many of the aspects. The basic structure of the health system that evolved during the era of command economy consisted of a comprehensive health insurance and health delivery system mainly funded by the state and organized along an administrative hierarchy. Cooperative medical services, which operated under the collective communes, provide services like primary, preventive and some curative care. The cooperative medical care services were organized into a three-tier structure comprising of the bare foot doctors at the primary level, township health centers at the secondary level and county hospitals at the upper level. Maoist model of medicine relied on political mobilization and patriotic health campaigns in support of public health/community medicine approach of health care. In rural areas there were mass mobilization and active participation of people and communities in improving environmental sanitation, immunization and prevention of diseases. The political economy of the authoritarian regime coupled with powerful bureaucratic control that mandated access to low-cost health care, controlled the training and job assignments of medical personnel, and rendered many of the public health programmes to be highly effective in achieving their objectives. However, since the reforms in early 80s, decline of the cooperative medical system, which had provided cost effective health care to a vast majority of rural population. The later disappearance of the collectives, led to the closure of welfare funds, the main source of financing for the CMS. However, since there is another paper in the same session which discusses rather elaborately the Chinese health care delivery system in term of its functioning and performance in the equity and efficiency dimensions, the discussion on China is confined.
3. Indian health landscape: Soon after the nation achieved Independence from the British Empire, the country's policy makers especially Jawaharlal Nehru had ambitious plans for the development of the country's future which was much evidenced in his speeches in the Constituent Assembly and in his revelations to the public. He acknowledged health care as a major component in 'eradicating poverty, inequities and diseases. The Indian National Congress was fully in favour of providing free care to all the populations by the state. Each Five-Year Plan reiterated the government's intention to provide quality health care at the lowest possible cost and a community centered health care. Though each plan and committee regretted or criticized the inability of the government in providing care to all, there was hardly any attempt to understand the factors for the failure. Rather than having a proper plan on health care, what we had was adhoc committees and some guidelines which were not clear on their objectives. Some for the other factors responsible for the failure of the Indian health services to me it closer to the population were.
    a. Health care was a state subject as per the Constitution and an absence of a strong national policy emphasizing the importance of health care led to differential importance attached to health care in many states and was reflected in varying allocation of health care finances in different states leading to wide inequities in the distribution of public health care. The initial conditions of many states were very poor in terms of health outcomes and declining health care system worsened the situation further.
    b. The development strategy of the national government was heavy-industrialization oriented, which demanded huge number of resources which might have reduced the allocation for health care. The First Plan gave 3.3 percent of the Plan resources to health care and unfortunately, it had never gone up from the initial mar and now, is hovering around one percent of the Plan funds (Government of India, 2002). Rather than increasing the distributional equity among the population, it has increased inequity due to less employment elasticity of the production
    c. The state has never attempted fully to intervene in the private health services not only the hospital sector, but also in the other critical inputs sectors like pharmaceutical industry, medical equipment industry etc.

d. The human resource policy including medical education, role of media in the post –Independent India needs a critical review in enhancing the role of state inn providing the kind of services the population wanted. For example, a review of articles on health by Amartya Sen (2000) reveals that health care issues were highly unrepresented in the new writings. All these point to the general feeling that health care is getting individualized with health of an individual as a private responsibility with less role for any social organization, which is generally not a desirable trend for the health of the population. With this brief introductory discussion on Indian health services, we may move forward to the country's current practical issues in health scenario.

The Indian healthcare scenario is often dubbed as pro rich and pro urban as majority of the health care delivery institutions, both public and private are concentrated in the urban area. The burden of health care in India is inversely related to economic status of the household and the poorer households are found to be victims of inefficient health care system (Gumber, 1994). It has eaten into their already thin household budget though out-of-pocket payments made for treatment as well as through inability to earn during the period of illness. India with its highest levels of private financing of health care especially through out-of-pocket expenses worsens the inequity in access to health care seeking. While private household out-of-pocket expenses form more than 80 percent of the total health expenditure in the country, the role of government expenditure is limited to less than 17 which is one of the lowest in the world. The role of private health insurance is 0.16 percent of the population and confined mostly to urban areas. The private health insurance does not have a solid ground in Indian health scenario because of the low size of the market primarily contributed by low market size, inadequate coverage, high premiums, lower awareness etc. Data reveal that regressiveness is the highest for out-of-pocket payment and it is hardly possible to make an impact on poverty reduction without addressing the ill health financing issues (GoI 2002).

India's health care system, in the present look, essentially a market-based one where diagnoses and drugs are treated much like any other commodity (Dreze and Sen 2002). A brief look at the international health system reveals that India's health care delivery system is the most privatized one with minimum collective responsibility, and it is important to note that even the so-called capitalist industrialized countries have heavy state involvement in the functioning of their health services. The public involvement has to be very high in the country specially to combat communicable diseases where private sector is hardly interested due to what is called "market failure' in economics literature.

Further, one of the grave problems in the present health care arena is its failure to control communicable diseases, despite the availability of cost-effective and relatively simple technologies. These pre-transition communicable and infectious diseases, whose treatment and prevention have a very high degree of positive externality still constitute more than half of the disease burden (as measured by DALYs) in the country. When the country started implementing measures to reduce mortality and enhance life expectancy at birth etc, the challenges thrown up by the ongoing health transition has important implications for the public heath structure and population health in the country. The three important constituents of the transition –demographic, epidemiological, and social changes-possess the capacity to change the outcomes of health actions, changes the requirements of the system, raise the financial burden of treatment, and increase pressure on the health system to deliver satisfying care to the clients. Ageing is the inevitable outcome of demographic transition with the share of elderly constituting are increasingly proportion level. The epidemiological changes bring in more of the so-called Group-II diseases whose treatment and management are costly and need long term care. Social transition regarding the quality of care, which further contributes to the rising expectation of the population regarding the methodology of treatment especially through enhanced quality increases the cost geometrically. The changes in demographic pattern have a great implication on cost of medical care in the sense that the elderly does exhibit a higher stock of morbidity. The exorbitant costs of treating non-communicable diseases including cardio-vascular diseases, diabetes, neoplasm, neurological disorders etc further strain the system and make huge devastation on the population. The fresh challenges including HIV/AIDS, resurgence of diseases which were earlier thought to have been eradicated, drug resistance to some diseases etc add to the woes of the health sector in the country.

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