

The State of Health Services in China and India in
a Larger Context

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Abstract: In this paper the problems of health services in China and India are related to some structural features of the two economies.

China and India have had a remarkable period of economic growth over the last quarter century, and as a result there has been a significant decline in mass poverty in these two large poor countries, more dramatically so in China. But this impressive economic growth and decline of income poverty have not been adequately reflected in some general features in the lives of the poor, particularly in the crucial matter of health. There are some egregious 'failures' of both market and government in the sphere of health services in all countries, but they have been particularly acute in China and India. We shall discuss this problem in the larger context of the political and economic structure in the two countries, and show that the structural deficiencies from which the problem arises are similar as well as different in the two cases.

In some broad aggregative measures of health outcome the Chinese performance has been much better than India's, and it has been so for several decades. For example, life expectation at birth now in India is what it used to be in China in the early 70's; in infant mortality by 1975 China achieved a rate which India did not reach even in 2000. To this we may add that of India's under-three children as many as 46 per cent are underweight, compared

to China's 8 per cent. Under-five child mortality rate in India is more than twice that of China. There are, of course, some differences in initial conditions between the two countries. India being in general nearer the tropics than most of China, one expects a larger incidence of certain diseases in India, and conditions of vector control may be more difficult, other things remaining the same. According to WHO estimates for 1998, the burden of infectious and parasitic diseases (measured in terms of DALY's—disability-adjusted life years—per capita) is 7 times as high in India compared to China. This may be partly the result of differences in physical and climatic conditions. But only partly, as this is also partly an outcome of relative policy deficiency. Socialist China had a much more vigorous policy of public health and sanitation than India, and also a larger army of paramedics pressed into basic public health service in the villages. By the middle 70's China had a rudimentary system of medical insurance (called "cooperative health services") that covered the overwhelming majority of rural people, something that did not exist in India. Also, the Chinese government showed an ability to mobilize campaigns for preventive health care and against

public health threats that were impressive by most developing country standards.

In contrast India after Independence never had any system of public health and sanitation anywhere on that scale. There has been no systematic planning and delivery of public health services (as opposed to curative medical services) or sustained large-scale disease control. As Dasgupta (2005) points out, in India "there is strong capacity for dealing with (disease) outbreaks when they occur, but not to prevent them from occurring. Impressive capacity also exists for conducting intensive campaigns, but not for sustaining these gains on a continuing basis after the campaign. This is illustrated by the near-eradication of malaria through highly-organized efforts in the 1950s, and its resurgence when attention shifted to other priorities such as family planning." This situation about public health and preventive care is not entirely unconnected with the political-economy factors being quite different in India compared to China in the early socialist decades. With the advance of antibiotics the elite in India felt less threatened than in the past by the spread of communicable diseases among the poor, leading to a policy de-emphasis on environmental hygiene,

and they succeeded in diverting public funds to high-end curative treatment in big urban hospitals, away from rudimentary but effective and widespread health services in the villages of the kind China used to have.

But in the last quarter century of economic reform there has been a sea-change in public health policy in China. With de-collectivization of 1978-79 the rural health services collapsed. The paramedics who used to be paid in work points at the production brigade and team levels now lacked a systematic method of compensation. Soon the total number of paramedics became less than a quarter of what it used to be in the 70's. By mid-1980's the "cooperative health services" covered less than 10% of the rural population (and the latter mostly lingering in the better-off coastal areas). In general with the collapse of local public finances, particularly in remote rural areas, fewer resources were devoted to public health. There was a decline even in curative services; the total number of hospital beds per thousand rural residents in 2003 was about half of what it was 20 years back. Yet these 20 years saw phenomenal economic growth in China. While the basic indicators of public health kept on improving, the pace was slower than before, and

worked particularly badly for rural girls. For example, between 1981 and 2000, while infant mortality for boys went down from 40 per thousand to 25.8, that for girls went down much slower, from 38.1 to 36.7.

China essentially moved in this period from one of the most impressive basic public health coverage systems to a largely privatized (or privately financed) system, particularly in rural areas. In the cities, formal sector employees have some form of health insurance, but there too over time premiums and fees paid by patients increased considerably. The poor had to bear the brunt, as even in the cities most of them are in the uncovered part of the population, migrants and informal sector workers. Yip and Mahal(2008) point out that 76% of the lowest-income quintile urban individuals do not have health insurance; the corresponding percentage in the lowest-income quintile rural individuals is 80%. This has implied that many sick people do not seek medical care, largely on account of financial hardship; Yip and Mahal cite data that in 2003 nearly half of those reporting an illness did not seek outpatient care. Those who do, spend an inordinate proportion of their income on health care; according to their data, the poorest quintile individuals

in rural areas spend as much as 27% of their income on health care, and in the poorest urban quintile it is 11%.

This large change in the public funding basis of health services in China is linked with a systemic problem relating to decentralized development. China is often cited as a glowing example of industrialization under decentralization. Regional economic decentralization provided autonomy and incentives, and in the 1980's and 1990's local industries flourished under the control of local governments and collectives. The so-called township and village enterprises (now largely privatized over the last decade) provided leadership to the phenomenal industrial growth in China over the last quarter century. Beyond a minimum amount of taxes for the higher-level governments, the local governments were allowed to keep the residual surplus, with all the positive incentive this provided for encouraging local enterprise and making money. There was also the pressure that failing enterprises will not in general be bailed out by higher-level governments. This combination of incentives and pressure worked in many localities, particularly those with better connections for market and finance. But one side effect of economic decentralization is acute

regional inequality. Coastal China surged ahead, and local governments there flush with profits from the enterprises under their control could buttress the social services, as their funding source from the communes disintegrated all over the country. But the interior or agriculture-dominant provinces and remote areas, where these enterprises were few and profitable ones fewer, were largely left to their own devices when it came to funding social services. Then the fiscal reforms of 1994 centralized revenue collection and allocation, and many local areas were left with unfunded mandates for basic social services including health. The fiscal reforms of more recent years clamped down on some of the arbitrary fees and taxes that many local governments had imposed on the local population, leaving them more financially strapped. An indicator of increasing regional disparity in provision of health care can be gauged from the fact that in 1985 the total number of technical medical personnel per thousand people was somewhat lower in city than in county; 20 years later, it was more than twice in city than in county. It is also no coincidence that, as Yip and Mahal(2008) estimate, the crude measures of inter-provincial inequality (such as the coefficient of variation) in aggregative health outcomes like life

expectancy at birth or infant mortality increased in 20 years since 1980.

While China moved away from an egalitarian and impressive basic health service of the socialist period, India's remained dismal and inequalitarian all through. Only about 15% of the people in India have any health insurance (primarily through their employers), and the share of out of pocket spending in total health spending exceeds 70%, which is higher than in China (though it has increased faster in the latter country). Appearances to the contrary, health care in India is predominantly private (which is largely unregulated). Household survey data suggest that 85% of all visits for health care in rural areas, even by the poorest people, are to private practitioners. While the poor quality of service in public clinics and hospitals (and absenteeism by nurses and doctors) often drive patients to private doctors (some of them quacks or crooks) in India, in China the high fees charged in public health clinics (and the latter's concentration on revenue-generating activities) in effect turn them into for-profit private providers. As Yip and Mahal(2008) point out, in India unlike China at least the public facilities receive the bulk of their

revenues from government subsidies and they provide their (often paltry and poor-quality) services at low cost to those who are too poor to afford the more expensive private care (although rampant corruption renders the public service provided not entirely free).

In both countries doctors often over-medicate and refer patients to unnecessary diagnostic tests, driving up health costs in general. This is part of a general market failure in health care, where the decider (the doctor) is not the purchaser (the patient). In poor countries with little information and education the problem is exacerbated as the patients themselves sometimes show preference for unnecessary antibiotics and steroids, which the quacks oblige them with. In both countries the more important problem is a governance failure. The public health delivery system is afflicted by poor provider incentives, coupled with low accountability to the patients.[For an elaboration of these issues in the context of India, see Hammer, Aiyar, and Samji (2007)].

First of all, the medical personnel are paid a fixed salary independent of the number of patients or of their visits, so they have no economic incentive to serve them.

In China, some of their non-fixed salary is in terms of commissions on drug sales, with effects on over-prescription. Secondly, there is little monitoring or punishment for laxity in service. Thirdly, the poor have very little organized 'voice' in sanctioning the errant provider. In the otherwise vibrant democracy of India, in most areas the state of local democracy is not strong enough to keep public service providers accountable to the local citizens. Periodic elections provide a rather blunt instrument for keeping public officials in check, and in any case the electoral agenda are full of multiplicity of pressing issues of which poor health service is only one among many. Besides, politicians find it easier to claim credit for inaugurating a big hospital or installing new equipment there than for regular maintenance of services or public sanitation and vector control. In China the channels of local accountability are even weaker. In both countries local social groups and NGO's provide some accountability pressure in localized pockets.

In both countries there is now a renewed effort on the part of the government to press more resources into and improve the delivery of public health services. The

Chinese program seems more ambitious, in attempting to provide a partially subsidized universal basic health care, and they have more budgetary resources to devote to this. But in both countries the governance and accountability issues mentioned earlier will not be resolved easily. In India the weakness of local democracy coupled with a corrupt and inert bureaucracy dissipate many a well-intentioned policy measure from above. In China how effective and adequate the actual implementation of the ambitious program will be remains to be seen. Over the last several years the constant chanting of the 'harmonious society' mantra by the central leadership has not always succeeded in reining in local officials from their hitherto single-minded, frantic (and lucrative) pursuit of income growth often at the expense of social welfare. Besides, the fundamental problem of equity and quality of social services remains when both the bureaucracy and the provider are bound to act according to their self-interest if their incentive system is not restructured, and when the intended beneficiaries are not well-informed about what is best for them and often lack the 'voice' or power to sanction even when they are.

References

M. Dasgupta, 2005. "Public Health in India: An Overview", World Bank Policy Research Working Paper no. 3787, World Bank, Washington D.C.

J. Hammer, Y. Aiyar, and S. Samji, 2007. "Understanding Government Failure in Public Health Services", *Economic and Political Weekly*, 42(40), pp. 4049-57.

W. Yip, and A. Mahal, 2008. "Health Care Systems of China and India: Performance and Future Challenges", *Health Affairs*, July/August 2008.