SELECTED SUMMARY

Privatisation and health care in China

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China is home to one quarter of the world's population, and increasingly its 1.3 billion people have flocked into highly prosperous cities like Shanghai and Beijing. China's gross domestic product (GDP) has grown at 8 per cent for 25 years, making its economy among the world's largest. Yet, the 900 million rural population lives in abject poverty. In the 1980s, abandoning Mao's socialist and collectivist strategy of central governmental control with social equality, the Chinese privatised and decentralised health care, resulting in huge disparities between urban and rural populations.

This report reviews the status of the Chinese health care system and looks at the results of privatisation and how China's leaders are trying to remedy the problems.

The recent history of China's health care system — 1950 to 2002

After the Chinese Communist Party took control of China in 1949, they created a health care system for its peasant population. The government owned, funded, and ran all hospitals. The private practice of medicine disappeared. In rural areas, the communes supplied social services including health care. Most public health services were provided through the Cooperative Medical System which operated village and township health centres staffed by barefoot doctors with minimal basic training in Western and traditional Chinese medicine. The results were spectacular. From 1952 to 1982, infant mortality fell from 200 to 34 per 1,000 live births, and life expectancy increased from 35 to 68 years.

In the early 1980s, the highly successful decentralisation and privatisation of the economy resulted in dismantling of its health care system. China reduced the central government's share of health care spending from 32 per cent in 1978 to 15 per cent in 1999, transferring this function to provincial and local authorities. This action favoured wealthy coastal provinces and led to growing disparities between urban and rural health care. The privatised health care facilities were forced to rely on the sale of services in private markets to cover their expenses.

The government continued tight controls over charges for routine visits and surgeries, standard diagnostic tests, and routine pharmaceuticals. However, facilities could earn profits from new drugs and tests. Hospital physicians received bonuses based on the revenue they generated through highly profitable new drugs and technologies. Sales of expensive pharmaceuticals and high-tech services skyrocketed with a rapid increase in health care prices. Health care became unaffordable for most Chinese citizens. With privatisation of the agricultural economy, 900 million poor rural citizens became uninsured. The barefoot doctors were forced to become private health care practitioners. Virtually unregulated, they abandoned public health services, which were now uncompensated, and switched to providing lucrative services for which they were untrained. These practitioners quickly found that selling drugs was one of the best ways to earn a living, and drug prices and sales exploded in rural areas as well.

China also decentralised its public health system and reduced central governmental funding for local public health efforts. To compensate, the central government granted local public health agencies the authority to make up for lost revenues by delivering personal medical services and charging for certain public health services, such as inspections of hotels and restaurants for sanitary conditions and of industries for compliance with environmental regulations. Predictably, local health authorities focused on revenue-generating activities and neglected health education, maternal and child health, and control of epidemics.

As expected, the urban consumer with three times the income of his rural counterpart fared far better. In 1999, 49 per cent of urban Chinese had health insurance compared to 7 per cent in rural areas. Rural communities depended on barefoot doctors who were not well trained. Therefore, villagers with serious illnesses frequently bypassed local facilities to seek care in urban hospitals, further increasing the financial burden on peasants.

These changes are reflected in health statistics. In 1999, infant mortality was 37/1,000 live births in rural areas vs 11/1,000 in urban areas. In 2002, the mortality rate among children under five years of age was 39/1,000 in rural areas and 14/1,000 in urban locales. Urban and rural maternal mortality rates in 2002 were 54 and 72, per 100,000, respectively.

The government responds

The government has tried to recreate an urban health care safety net through a system of mandated employer-financed catastrophic insurance, and medical savings accounts which require people to save money to pay for a portion of their medical expenses. Medical savings accounts cover initial health

care expenses up to 10 per cent of annual wages, after which the catastrophic plan takes over.

Some employers have refused to comply, claiming they cannot afford the contributions. Many urban dwellers do not work for organised employers. Companies form and disband rapidly to avoid paying benefits to workers. Dependents of workers may not be covered. An indigenous Chinese private health insurance industry sells health insurance to a wealthy minority that can afford it, and China is considering permitting foreign insurance companies to sell health care coverage as well. Whether the Chinese government will be able to cover the 51 per cent of urban residents who still lack protection against the cost of illness, and how it would do so, is far from clear.

In 2002, officials launched experiments to create a rudimentary financial safety net for rural health care. Thus, the government provides $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. With but modest funding, these plans cover only inpatient care without adequate primary care and drugs.

Clearly, government involvement is essential to ensure an effective health care safety net. China's leaders have begun to create a new health care system combining private and public provision of both insurance and services.

Commentary

Comparisons between India and China are inevitable: they became independent at about the same time; both started with comparable health statistics and over 80 per cent of their population lived in impoverished rural communities. However, the two followed different paths to development. By the 1960s, China had evolved an enviable health system. Yet, as the article above points out, a misguided leadership destroyed it overnight. India, on the other hand, has done little more than pay lip service to the concept of "health for all".

While the total health care spending in India seems adequate (6 per cent of GDP), central and state governments provide only 18 per cent of the total health care expenditure and 82 per cent comes from private sources (1). India's public health system consists of Primary Health Centres (PHCs) staffed by India's version of barefoot doctors –the Auxillary Nurse Midwife who staffs sub-centres and reports to a physician at the PHC. PHCs are plagued by understaffing, poor infrastructure, lack of essential drugs and equipment. Only 3 per cent of PHCs have the prescribed staffing, equipment and drugs (2). Thus, it is not surprising that, just as in China, peasants aware of the inadequacies of the PHCs, often seek care in urban private centres at a cost that leads to severe indebtedness and impoverishment (1).

With increasing migration of peasants to cities, urban slums have burgeoned. With inadequate safe drinking water, poor sanitation, overcrowding, poverty, and lack of access to preventive and curative health services, infant and perinatal mortality rates in urban slums approach those for the rural sectors (2).

In India, the private health sector provides more than 80 per cent of curative services for rich and poor; urban and rural alike. The private sector has grown without any direction or planning and without standards for quality or public disclosure on practices and pricing. There are large variations from state to state. In rural as well as urban areas, untrained providers offer a combination of systems of medicine. In the absence of formal studies on pricing, quality and appropriateness of care, it is impossible to draw any conclusions.

India's health care problems are so vast that one does not know where to begin. The in-depth World Bank report (1) lists recommendations to address every aspect of health care. The government of India's recent rural health mission of a trained village woman providing preventive and some curative services is a good start. The funding and supervision must reside with the gram panchayat to assure accountability. Similar services, linked to the local public hospitals, could be provided in urban slums as well. Contracting out of some public health services to private groups and non-profit organisations may cut red tape and enhance delivery of care while holding down costs (3).

A major effort is needed in the private sector to mandate transparency of fees, monitor quality and appropriateness of care and inculcate professionalism – that the practice of medicine is not merely a trade, and that the interests of the patient remain paramount.

India, just like China, needs to develop a form of public-private partnership for affordable insurance as well as develop a system to control costs without compromising quality and access to health care.

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