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HEALTH SERVICE SYSTEMS IN TRANSITION: CHALLENGES IN INDIA AND CHINA

Edited by
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Health Service Systems in Transition: Challenges in India and China

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Edited by
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List of Acronyms

AYUSH	Ayurveda, Yoga, Unani, Siddha and Homeopathy
BMC	Brihanmumbai Municipal Corporation
BOH	Bureau of Health
BMGF	Bill and Melinda Gates Foundation
BPL	Below Poverty Line
CGHS	Central Government Health Service
CHC	Community Health Centre
CHE	Catastrophic Health Expenditure
CMHIS	Chief minister's Health Insurance Scheme
CNHDRC	China National Health Development Research Centre
CPC	Communist Party of China
CSMCH	Centre of Social Medicine and Community Health
CT	Computerised Tomography
DANIDA	The Danish International Development Agency
DFID	Department for International Development
EC	European Commission
ESIS	Employee Health Insurance Scheme
FUSPH	School of Public Health, Fudan University
GAIN	Global Alliance for Improved Nutrition
GAVI	The Vaccine Alliance
GDP	Gross Domestic Product
GFATM	Global Fund (for the fight against) AIDS, Tuberculosis and Malaria
GOI	Government of India
GOM	Government of Maharashtra
GTZ	German Development Co-operation
HSDP	Health Systems Development Project
ICS	Institute of Chinese Studies
ICSSR	Indian Council of Social Science Research
ICMR	Indian Council of Medical Research
IMR	Infant Mortality Rate
JSA	Jan Swasthya Abhiyan (People's Health Movement)
MAS	Medical Assistance Schemes
MCA	Ministry of Civil Affairs
MHSDP	Maharashtra Health System Development Project
MMR	Maternal Mortality Ratio
MOC	Ministry of Commerce
MOCA	Ministry of Civil Affairs
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MOHRSS	Ministry of Human Resource and Social Security
MRI	Magnetic Resonance Imagery
NEML	National Essential Medicine List

NSSO	National Sample Survey Organisation
PMC	Pune Municipal Corporation
NBSC	National Bureau of Statistics of China
NDRC	National Development and Reform Commission
NGO	Non-governmental Organisation
NHFPC	National Health Family Planning Commission
NHS	National Health Service
NPM	New Public Management
NRHM	National Rural Health Mission
NRCMS	National Rural Cooperative Medical Scheme
OOP	Out-of-pocket
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PPP	Public-Private Partnership
RAS	Rajiv Aarogyasri Scheme
RCMS	Rural Cooperative Medical Scheme
RKS	Rogi Kalyan Samiti (Patient Welfare Committee)
RMB	Renminbi
RSBY	Rashtriya Swasthya Bima Yojna (National Health Insurance Scheme)
SFDA	State Food and Drug Administration
SHDRC	Shanghai Health Development Research Centre
SHI	Social Health Insurance
STCM	State Traditional Chinese Medicine
THE	Total Health Expenditure
UEBMI	Urban Employee Basic Medical Insurance
UHC	Universal Health Coverage
URBMI	Urban Resident Basic Medical Insurance
WHO	World Health Organisation

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1. Health Service Systems in Transition: Challenges in India and China

Madhurima Nundy

INTRODUCTION

Studying and researching different health systems and health service systems have gained importance in the last three decades with increasing globalisation and integration of the economic order. There has been a growing interest in comparing and contrasting health outcomes and interventions across developing countries. This was used by international organisations like the World Health Organisation (WHO) and the World Bank to showcase innovations and best practices as policy interventions globally. After the 1990s when health systems in developed and developing countries underwent reform, mainly through the introduction of market principles in public systems, there was concern about rising inequities in access and cost of services. This led to a growing interest in comparing country experiences of inequities, the determinants and interventions to reduce them. There was a growing recognition that health systems are shaped by economic, social and cultural histories. These influence the way the countries perceive, organise, and plan their health systems. They may have similar or different frameworks on delivery, financing, and coverage and these bring in the variations and similarities in the health systems. Such a perspective enriches us to identify the strengths and weaknesses of particular health systems, what policy interventions work and the context in which they work. This kind of academic engagement can lead to policy dialogues and designing of meaningful interventions.

This edited volume is an outcome of an International Seminar on *'Challenges to Health Service Systems in Transition: China and India'* held in Delhi on 10-11 March 2015, where public health scholars from both India and China participated. The papers have been updated to the present. This volume is not simply a culmination to the Seminar. It frames new research questions and expands areas for in-depth research around health service systems in India and China that would enable newer policy engagement and social action.

India and China have a global presence in terms of population size, economic and military strength. Both gained their independence at the same time and were poor in terms of economic development with high levels of poverty, undernutrition, high mortality and morbidity. The differences in political ideologies resulted in different trajectories for addressing these vulnerabilities. The outcomes of the different approaches resulted in dramatic improvements in undernutrition, mortality and morbidity in the case of China,

whereas, it was much more gradual in the case of India. The far reaching changes employed by China to deal with socio-economic inequalities through radical land reforms and the guarantees for livelihood, food and housing, that are important determinants of health, was reflected in the improvement of health status. India, on the other hand, did not address the question of inequality the way China did. As a result there were major differences in the health outcomes across both these countries. These socio-economic and political differences have shaped health service development in both countries. While up to the 1970s the pathway of health service development was divergent, in the post 1970s there have been some convergences. The convergence has largely been due to the ideas propagated under the umbrella of health sector reforms which was a global phenomenon. Many of the ideas and content of reforms were similar in nature while the spheres of engagement with the respective governments, bureaucracy and professional bodies between these countries have varied. China and India cannot be strictly compared as health sector reforms unfolded in different ways. The papers in this volume cover the landscape of changes that have occurred in the health sector with reforms in both countries. The contrasts that can be drawn from the two health systems of India and China would be of considerable interest.

China made impressive gains in health outcomes by the end of the 1970s and had created a strong base which got reflected in its human development indicators. Despite the hostilities China faced globally for closing its economy to the world, its remarkable development indicators by the late 1970s did not go unnoticed. China's model of barefoot doctors, the Cooperative Medical System and overall approach to health as central to development had a significant influence at the international conference convened by the WHO and UNICEF on Primary Health Care in 1978 at Almaty. India was signatory to this. Around this time, India was still struggling to build its public health system with dismal health outcomes which got reflected in very high infant mortality rates (IMR) and maternal mortality ratios (MMR).

Health sector reforms (HSR) of the last three decades have to be seen in the context of globalisation and liberalisation of economies. In the 1980s and 1990s, the health sector reforms were part of a larger restructuring of the economy in many middle and low-income countries. Several scholars have commented on the content and process of health reforms as encompassing both developed and developing countries and across political ideologies. They acknowledge that it is a global process informed by the principles of new public management (NPM), thus introducing, managed competition and internal markets to implement

reforms. Tritter *et al* (2010) have elaborated the process and transformation of health sector reforms into two phases. The first phase focused on introduction of commercial principles in the public sector in order to reduce costs and improve efficiency. There was also emphasis on the separation of preventive and curative services. While the role of the state would be more prominent in the case of the former, markets would have an upper hand in the case of the latter. This phase was reforming the supply side of public provisioning. The second phase focussed on the private sector as a revenue earner for the economy and hence saw its productive role.

In most European countries the content of reforms is characterised by the first two phases. However, in several middle income countries, one would argue that there is a discernible third phase. During this phase of reforms there is a continuation of the commercialisation of public institutions and simultaneously there is an expansion of the for-profit sector. In this phase there is a concerted move to attract global finance in health services.

HSR was therefore, a global phenomenon with a set of shared prescriptions that included restructuring public services through the introduction of market principles. Simultaneously, policies for promotion of markets in provisioning, research, medical technology and pharmaceuticals were encouraged. In the Chinese case it was the shift to market socialism and in India it was adopting the ideas of neo-liberalism. State retrenchment in social policy was one of the main reform steps in both countries that had an adverse impact on the health sector as well. There was clear indication that public systems were inefficient and ineffective and adopting market principles were necessary in public health services. The reforms were informed by ideas of commercialisation and NPM. They were introduced in middle and low-income countries by multilateral organisations mainly, the World Bank and bilateral organisations. The involvement of the multilateral organisations and the conditionalities in policy making and financing is evident in the case of India. In the case of China there was resistance to direct involvement of multilaterals in health services in terms of funding which was limited to some projects but many ideas propagated by the multilaterals and bilateral organisations were embraced by the CPC and introduced in public institutions.

In China, there was a limited role of the private sector but the public health service system became the site for commercialisation due to the dramatic withdrawal of government subsidies. The three-tier referral system that existed pre-1978 dismantled overnight with the onset of economic reforms. People were

no longer insured or covered for any episodes of ill-health. Due to the preoccupation with economic reforms, there was a complete neglect of the health sector.

The primary level of curative services were mostly dominated by private practitioners; and public hospitals at the secondary and tertiary level were autonomised to function as commercial entities where user charges were levied on medicines and use of diagnostics. There were perverse incentives given to doctors for generating revenue for the hospitals. India on the other hand had a privatised health sector at the primary and secondary level by the 1970s. This was largely due to the low investments made in the public sector that gave space for the private sector to expand. With the liberalisation of the economy in the early 1990s the private sector was given further impetus for expansion by subsidising land and import of technology. Unlike China, where the public sector started behaving like the for-profit, the public sector hospitals in India were not autonomised and were largely controlled, managed and funded by the government without profit motives but due to the underfunding of the public health service system, there was unregulated growth of the private sector.

In the late 1990s and early 2000s, as in India, China too was dealing with rising inequities in access to health care, with disparities in access across provinces, rural-urban areas and classes. The high out-of-pocket (OOP) expenditure that had peaked to 60 per cent of the overall health expenditure in 2002 was attributed to the profit maximising behaviour of the public hospitals. To improve access and universalise health coverage, China's reform step was to restructure its health financing in the early 2000s. It launched three insurance schemes for its rural residents, urban employees and urban residents, one after the other, in 1998, 2002 and 2007 respectively. These schemes were initially shallow with low coverage and high co-payments. China moved to a path of rectification by making amends to strengthen its public health system at the primary level, to expand coverage through insurance and to reform its drug policy in 2009. OOP expenditure reduced to about 34 per cent of total health expenditure (WHO 2014). These reforms came with its own sets of challenges that have received public and government attention.

To rejuvenate and rectify its public health service system, India launched the National Rural Health Mission (NRHM) in 2004 to strengthen systems especially rural health care services to reach out to the vast population that still had limited access to the health services. This included increasing communitisation processes for greater participation and accountability at various levels apart

from reforming financing in health care. The *Rashtriya Swasthya Bima Yojana* (RSBY), literally translated as National Health Insurance Scheme, that was introduced in 2005 was targeted for people below poverty line and was limited to hospitalisation which did not cover many catastrophic illnesses. The responsibility was on the state/provincial governments to implement the scheme. Several studies from across states in India have shown that despite its launch and the government projecting it as a successful scheme, the ground realities were very different. These studies showed that private hospitals empanelled by the government to provide the insured under RSBY were actually excluding many cases and people were still making high OOP payments (Baru 2015). Health insurance coverage in India is presently limited to only about 15 per cent of the population unlike China that boasts of 95 per cent coverage. In India, there is no universal insurance scheme that covers the population but a mix of several government and private insurance schemes across rural and urban areas and most of these cover only hospitalisation. OOP expenditure is still approximately 60 per cent of total health expenditure (WHO 2014).

The total expenditure in health as percentage of the GDP is 5.6 and 4 for China and India respectively for 2014. Out of this, the public expenditure as percentage of GDP is 3.1 for China which has been steadily increasing and a meagre 1.3 for India which has been static (World Bank 2014). It is in the latest National Health Policy of 2017 that the government shows a commitment of investing 2.5 per cent of GDP in health but that too by 2025. This data clearly shows that Indian state has invested very little in health and health is not a priority with the government. China on the other hand has made it a political mandate and is consistently making systemic amends with the objective of making health services accessible to its people.

Despite the initial reforms and subsequent reforms to address the gaps, inequities in access to health services still remain a challenge. There are private for-profit interests and a visible epidemiological and demographic transition evident in both countries to add to the challenges. The many dimensions of these inequities include the availability, accessibility, affordability and acceptability of health services. Several reforms are underway in both countries in the areas of financing, provisioning, human resources and medicines in order to mitigate these inequalities in the public sector. The next phase of reforms clearly gives a greater role to the for-profit sector in both countries in financing and provisioning. The for-profit sector has a significant presence in India while in China it is still small but is being allowed to expand cautiously by the government.

With this background, an International Seminar on *"Challenges to health service systems in transition: China and India"* was jointly organised on 10-11 March 2015 by the Institute of Chinese Studies (ICS) and the Centre of Social Medicine and Community Health (CSMCH), Jawaharlal Nehru University (JNU) and funded by the Indian Council of Social Science Research (ICSSR), New Delhi and was held at the Jawaharlal Nehru University, New Delhi. This edited volume comprises of select papers from public health scholars from China and India. It was for the first time that a seminar on this theme was organised in India. Chinese public health scholars were invited from the China National Health Development Research Centre (CNHDRC), Ministry of Health and Family Planning, Beijing; Shanghai Health Development Research Centre (SHDRC), Shanghai; and the School of Public Health, Fudan University (FUSPH), Shanghai. The Indian participants were from the Centre of Social Medicine and Community Health (CSMCH), Jawaharlal Nehru University, New Delhi; Institute of Economic Growth, Delhi; Public Health Foundation of India (PHFI), Delhi and the Institute of Chinese Studies (ICS), Delhi.

This edited volume brings together the major themes that were covered during the two-day Seminar and brings forth the challenges that both countries face as a consequence of the reforms. There are three themes covered – first one gives a broad overview of health sector reforms; the second theme draws a canvas of the public hospital reforms in both countries and the third theme covers financial reforms in the health sector with a focus on insurance.

UNFOLDING THE HEALTH SECTOR REFORM (HSR) STORY

The first set of paper brings together the broader trajectory of health sector reforms in both the countries.

Unlike China during the pre-reforms period, the Indian health sector took a different path. Even though there was considerable expansion of primary health care services, there was unregulated expansion of private sector as well. Ramila Bisht's paper on the overview of health sector reforms in India goes back to the history of health policies in India. She marks 1991 as the onset of economic reforms and the subsequent health sector reforms that were imposed by the World Bank. Bisht emphasises that the reforms of the 1990s was a radical shift from a public health model as envisaged by the Bhore Committee of 1948; the Almaty Declaration of 1978 and the Indian Council of Medical Research (ICMR)-Indian Council of Social Science Research (ICSSR) report on 'Health for All' in the early 1980s. A conscious market-driven strategy was opted for. The grounds

for bringing forth these reforms were already laid out by an underfunded public health service system and the presence of a large private sector. This paradigm shift saw changes at the national, state and local level policies in health.

Rama Baru discusses the ideological base of these reforms and what led to this global phenomenon. Her paper delineates the context, content and elements of these reforms and observes that the outcomes of reforms at all levels were a complex interplay of different agencies at global, national and local levels. The reforms have had similar elements but plays out differently in all countries with variations in pace and content. Baru further discusses the state-level experiences in India and variations in the content of reforms across these states. The reforms were brought-in by a fiscal crisis but there was no plan to guide them. These were initiatives that were mostly incremental and lacked a systemic perspective at the centre and the state level.

China's economic reforms beginning 1978 had an impact on all sectors including health. From 1980s to the early 2000s, China's focus was mainly on economic growth. The health sector did not receive much priority and was left to the local governments to be dealt with. The structure of health services that was created in the pre-reforms period got dismantled and institutions began charging fees from patients to generate revenue as government subsidies had reduced to 10 per cent of total costs by the early 1990s. The preoccupation with economic reforms resulted in a complete neglect of the health sector in the 1980s and 1990s. The inequalities in access to medical care especially in rural areas and breakdown of preventive services were stark by late 1990s and early 2000 when China was unable to contain the spread of SARS. Yip and Hsiao (2015) suggest that all through the reform process there has been a tension between two opposing ideological positions within Chinese academia, bureaucracy and the political class – pro-state and pro-market. The actual strategic implementation of health reforms started only in early 2000s with financial and institutional reforms. Shanlian Hu's paper on health sector reforms in China focuses on the major reforms that have been undertaken since 2009. This came about in response to some of the adverse consequences of the initial set of reforms that were launched 2003 onwards. There was a process of 'deepening health system reform' along with deepening of economic reforms. He covers the five major reforms undertaken in the health service sector that are also known as the 'pillars of reform' – multi-layer medical security system; establishing of a national essential medicine system; equality in public health services; improving medical service system and, public hospital reforms and

public-private partnerships (PPP). He spells out the reforms in each and the challenges that still exist. Of interest here, is China's reforms of rebuilding its referral system from primary to tertiary level that had broken down in the 1980s. Simultaneously, since 2013, China has been on a path of opening up the sector to private investors, and has set a goal that the private hospital services will increase to 20 per cent of the market share as compared to less than 10 per cent at present.

PUBLIC HOSPITAL REFORMS

The second set of papers looks at the public hospital reforms. Prachin Ghodajkar's paper gives a detailed account of the public hospital reforms and sets the socio-political and economic context in which these reforms came. Yingyao Chen and Ke Xiong's paper focuses on the aspect of development of hospital autonomy as one of the major reforms in public hospitals.

Both papers unravel the World Bank influence on health policies in more than one ways. Scholars who have studied the role of international institutions in shaping public policy in China say that the theory of external imposition does not fit well with China (Huang 2015; Baru and Nundy 2015). In the health sector, while the World Health Organisation (WHO), the World Bank and the Global Fund (for the fight against) AIDS, Tuberculosis and Malaria (GFATM) held influence in terms of policy inputs and also funding of projects, they could not dominate the policy discourse. This is clearly brought out by a study by Huang (2015) who writes that China never asked for structural adjustment loans from the Bank. The Chinese government was willing to cooperate with the Bank to improve their efficiency but were not willing to be dictated by them. While China took up the ideas and framework of the Bank propagated during the 1990s and implemented it in the public hospitals in 2000s, Indian health policies were dictated, driven and financed by the Bretton Woods institutions. China did not allow these impositions from the Bank and restricted their presence in terms of funding but there was a lot that permeated in terms of ideas generated by the Bank. This ideational influence of the Bank is quite evident in their health reforms.

Prachin Ghodajkar gives a detailed account of public hospital reforms in India. He presents the backdrop that sets the context of the reforms being introduced in the 1990s and thereafter. Quite early on, the decaying of public institutions had begun. By the 1970s there was stagnation in investments and the simultaneous growth of private hospitals was visible. The hope of a

universal, comprehensive and equitable health system post Alma-Ata declaration and progressive policies at the national level soon after were quickly pushed aside to give way to selective interventions and impetus to the private sector. The private sector was seen as a panacea to fill up the gap but the quality and efficacy of the unregulated sector was highly questionable. The hospital sector was declared as an industry in the later part of1980s, thus paving the path for further private sector growth once the reforms were announced. The structural adjustment policies brought reforms in public hospitals across states in India and ideas of NPM were incorporated into the institutions as a way of being cost-effective and efficient. There were cuts in health budget and user charges were introduced for all services. Many forms of partnerships mostly in the form of contracting-in of services were introduced. It also highlights the contractualisation of labour in hospitals that goes against the very culture and ethos of public institutions. The paper discusses all these components of reforms in detail and their outcomes on access and the implications of these on the idea of a public institution. There were some positives with NRHM in 2004 with strengthening the public hospitals and improving workforce skills and capacities at various levels but the reform agenda that had started continued even in this phase.

In China, public hospitals are central to people's lives and most visit a secondary or tertiary hospital for in-patient as well as out-patient services. Chen and Xiong's paper focuses on hospital autonomisation as a major reform in health sector in China and highlights five aspects of autonomy. Somewhere in this process of autonomisation the core aspect of the social function of a public hospital became peripheral to its function. It got subdued and received the lowest priority in the initial two decades of public hospital reforms. The focus was on creating ideal autonomised units that are revenue generating institutions. The framework of autonomising public hospitals mirrored World Bank's understanding on autonomisation where institutions function independently and even compete with each other.

The focus on social function was brought back to the core of reforms in 2009, as is also discussed by Hu, when newer set of reforms were introduced in public hospitals. This addressed the issue of perverse incentivisation linked to prescribing and selling of drugs. But the idea of creating efficient and autonomised institutes with new governance structures continues in this phase and these new reforms are being piloted in public hospitals of 16 cities. There is a clear separation intended between ownership and operations of a hospital that is seen as necessary to increase efficiency and cost-effectiveness. A lot depends on public hospitals in

China as 90 per cent inpatient and outpatient is still in these institutions, unlike India. There are also newer forms of engagement with private capital and the role of markets in public hospitals has increased since 2012 and this is a clear path the government intends to take. As further reforms are taking place in major cities in China, it would be interesting to unravel the hospital reform story in the coming years and understand the outcomes of a fragmented and corporatized public hospital system. On the other hand there has been a sense of urgency to strengthen the primary care services to decrease dependency on secondary and tertiary hospitals. Since 2016 the family doctor model is being piloted as a means of building back the referral system.

FINANCING HEALTH SERVICES

The third set and the final two papers are on the insurance schemes in India and China. Universal insurance has become synonymous to universal health care (in most instances it is understood as universal health coverage). Insurance has become a dominant mode of financing in most developing countries, though OOP expenditure is yet to reduce in many countries. The ideas of universal coverage have been propagated at the global level by multilateral agencies and donors and have gained momentum over the ideas of a national health service based on general taxation. The choices made in financing the health sector are political and reflects whether these policies are based on a sense of redistributive justice or are simply incremental.

Both countries have taken the path of insurance to universalise access. While China has been more determined and proactive to provide universal coverage in a little over a decade, in India it has been incremental. India has multiple insurance schemes and limited coverage and high OOP expenditure being the major proportion of financing.

Proportion of OOP expenditures is high in China but nothing compared to India. Is insurance the only way to universalise access? There are several fallouts of having an insurance model for universal health care. China has clearly made the decision to venture on that path, but the system is controlled and regulated by the government and that makes a lot of difference. India is attempting to go the same way but it gets more complex because of multiple players in the market and their interests. It must be understood that insurance schemes take care of only curative services and are cut off from the preventive services which fragments the system and goes against the principles of holistic comprehensive and universal public health care.

Indranil Mukhopadhyay writes about the state of medical insurance in India and its limitations in providing universal access. He shows the variations across schemes, from CGHS (Central Government Health Scheme for employees) to RSBY (for those below poverty line). The insurance schemes for the poor show poor financial risk protection where the coverage is only for hospitalisation. Mukhopadhyay argues that insurance cannot be the panacea to universal health care.

Xuefei Gu and Chaoqun Wang's paper gives the workings of the three insurance schemes in China and their challenges. They see this as a fragmented system of financing and regressive to some extent and propose clear strategies to integrate the insurance schemes in steps so as to aim for a universal insurance scheme that is equitable. The authors talk further on reforming the present insurance schemes and financing structures. They acknowledge that the present financing structures and multiple players have created an unequal system with different privileges and benefits across these insurance schemes. The idea of integrating the schemes is the best way forward but the authors clearly demarcate how this needs to be done so as to minimise the inequities that exist and to also contain costs.

China is taking the issue of inaccessibility of health services for migrants (population in unorganised employment) seriously due to low insurance coverage in this population. It has moved much ahead in providing financial protection for medical care and India is still implementing incremental policies that have led to further fragmentation. Mukhopadhyay's paper spells out this very dilemma. He questions the idea of insurance that is based on the idea of risk pooling and argues that the central attribute of a general taxation is also risk pooling. Insurance has also become a system of bringing in vested interests of private players to fund schemes. Through an analysis of many insurance schemes introduced by several state governments in the last decade as well as a National Health Insurance Scheme/RSBY, he shows that these provide basic coverage only for in-patient treatment. These are poor models and do not provide the adequate financial protection and OOP expenses have in fact not decreased over this period of time.

To summarise, the two health service system contexts are very different and have brought out different structures and forms of reforms. Despite the challenges, China has moved ahead in terms of health services infrastructure, access and outcomes in leaps and bounds. The challenge of universal access to equitable and comprehensive services still remains a concern as China ventures

on the path of 'deepening of reforms'. The larger ideas have been clearly dominated by the market principles in the context of market economies in a global world and ideas that are deliberated by global health agencies (multilaterals and donors), have influenced both countries but there are contrasts in the content and implementation. China has borrowed and adopted them to their context and not done away with government (central, provincial and local governments) control over policy decisions and implementation. India has compromised at various levels to clearly accommodate private interests and policies and plans from the 1980s followed by the structural adjustment programmes initiated by the multilateral institutions in the 1990s.

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2. Health Sector Reforms: A Paradigm Shift in Indian Health Care

Ramila Bisht

The Indian health scenario today looks far from promising. Improvements in some key indicators are consistently being outweighed by the failure to prevent thousands of preventable deaths, deterioration in the health status of vulnerable populations and persistent health disparities based on region, the rural–urban divide, class, caste and gender. India's health indicators are shockingly similar to those of low-income countries. India's IMR is 38 and an MMR of 174 which is one of the worst in Asia (World Bank 2015). There are disparities in these deaths which are higher in rural areas and in marginalised communities. These are sensitive indicators that reflect the state of public health service in India.

How did such a situation come to pass? Why do we continue to hold this poor track record? While there is no simple cause-effect relationship to explain this, and answers to these questions necessarily lie in the complexity of interacting factors, recent policy shifts and reforms in the health sector merit closer critical scrutiny.

As is well known, HSR were imposed on the Indian health system as part of a wider set of macroeconomic reforms in 1991. They marked a radical departure from the public health model of healthcare delivery that was pursued by a hitherto welfare-oriented state. The neoliberal ideology underlying the reforms ordained that notions of public welfare and of public financing of health be now abandoned and the state health system be replaced by a market-driven system.

This paper attempts to provide an overview of the HSRs that were initiated and the consequent paradigm shift reflected in the relevant national policies, programmes and systems. The most pressing concern is the health needs of the poorest and most deprived sections of Indian society. This is not an exhaustive survey of all policy and HSR documents. I have chosen those that I felt were important in shaping the trajectory of health services in India. I have also drawn from a rich body of literature that describes and analyses the HSRs in order to provide my interpretations.

Against the backdrop of pre-liberalisation India (1951–1985), this paper provides a critical overview of HSRs as they unfolded in India over three broad phases: 1991–2001, 2002–2010 and from 2011 to the present.

HEALTH CARE IN PRE-LIBERALISATION INDIA: A BRIEF OVERVIEW

The post-colonial health care system in India was shaped by nationalist thinking, which acknowledged the social roots of diseases and upheld the philosophy of free, basic provisions for all, as part of the larger Nehruvian vision of self-reliant socialist development. The Bhore Committee's landmark recommendations found political favour and provided the framework for the implementation of a publicly funded, comprehensive system of preventive and curative healthcare. The Committee emphasised the need for strong primary healthcare services, to be made available to everyone, 'irrespective of their ability to pay', and to be supported by secondary and tertiary levels of care (Government of India 1946).

The first two five-year plans embodied these wider notions of public health and focussed on the development of an extensive public health service system. Despite poor resource allocation, the post-independence period witnessed remarkable public health achievements, including the effective containment of communicable diseases and improvements in mortality indicators. However, India (unlike China) missed the opportunity to focus on community level preventive and promotive interventions, invest in the provision of universal access to water, sanitation, nutrition and education and leverage the strengths of indigenous medical systems to improve the delivery of health services. Many of the strategies adopted were, instead, centred on a vertical disease-control approach, which, though effective, ran contrary to the idea of an integrated health system.

The disjuncture between the Bhore Committee's path-breaking recommendations and policy planning grew wider in successive plans. What was worse – and well known – was the effective displacement of the public health agenda by the National Family Planning Programme in the late 1960s via the population bogey that was influentially raised by powerful international lobbies.

Following the Alma Ata Declaration in 1978 and the ICMR-ICSSR report on 'Health for All by 2000' (1980), the first National Health Policy (NHP) of India was enunciated in 1983. While reiterating a commitment to achieving the goal of 'Health for All' by the year 2000 through the provision of comprehensive primary healthcare services using a range of different strategies, it also stated that these should come at an affordable cost. Additionally, however, and ostensibly to reduce the government's burden, the policy called for the participation of voluntary organisations and private medical practitioners.

There was considerable expansion of primary health infrastructure and village level health services during this period. However, the anticipated financial repercussions of the primary healthcare approach and pressure from international aid agencies led the government to shelve the core prescriptions of NHP of 1983 and revert to verticality, in the guise of implementing a 'selective' primary healthcare approach.

The period also saw the unregulated expansion of the private sector and a steady erosion of drug price controls. In 1986, the hospital sector was declared an industry and hospitals registered as public trusts were given tax benefits and subsidies, enabling rapid and phenomenal growth.

The public health agenda was repeatedly frustrated by financial shortages as budgets consistently fell short of the desired mark, and continued to hover around 1.3 per cent of the GDP till the 1980s. Further, urban medical services suffered from an elitist bias created by upper class domination of medical education and the medical profession.

Barely a few years after Alma-Ata declaration and NHP 1983, a firm ground was laid for the far-reaching reforms that were to follow.

THE FIRST PHASE OF HEALTH SECTOR REFORMS (1991–2001)

By the time global economic reforms made their formal entry into the Indian health sector, the private sector, which was to function as the central anchor-lynchpin of reforms, had been well established. The trend towards privatisation of healthcare was aided considerably by industrial policy reforms, viz. subsidisation of the medical equipment industry and deregulation of the pharmaceutical industry.

The final blueprint for HSR was provided by the 1993 World Development Report titled 'Investing in Health', which was prepared by the International Monetary Fund (IMF), the twin organisation of the World Bank (World Bank 1993). Even prior to that, in 1992, the World Bank had produced a document titled 'Financing for India's Health Sector'. Given the paucity of public resources, the strategy followed by the World Bank was to direct government resources towards the provision of vital clinical services while the private sector could look after discretionary services. What largely went unnoticed, however, was the role played by the Fund-Bank package itself in ensuring the insufficiency of public resources.

This line of reasoning helped mask the World Bank's strictures against government spending on the social sector as well as against increasing taxes levied on the private sector and keeping the most lucrative part of health services in the private sector. In this atmosphere of trade liberalisation, fiscal austerity being practiced by the government, tax and tariff reduction and the general impetus to private foreign investment, the paradigm was sought to be shifted firmly and decisively in favour of the private sector, with the transformation of health care from being a public good to a private good. 'Public' initiatives were increasingly confined to sporadic efforts (approved by the World Bank's health plan) towards population control and controlling tuberculosis, sexually transmitted diseases and so on. No norms or concrete measures were spelt out for the creation of minimal facilities or the accreditation of private hospitals and clinics.

These developments signified that the reins of defining India's health problem and the scope of its health programmes now lay in the hands of international powers.

The impact of all these measures on state health services and the poor was swift and lethal. Severe cuts were made in state health budgets. The declining share of health in the government's revenue expenditure since the1980s dipped to 1.4 per cent of the GDP at the start of the 1990s and stagnated at around 1 per cent until 1994–1995. It further fell to 0.9 per cent in 2002, leaving primary health care reeling under the impact (World Bank 2014).

The direct consequence of low public investment was stagnation in the growth of public health infrastructure during the decade of 1990s. A large number of public primary health facilities became non-functional, and with cuts in supplies and material, what was left was a mere skeletal structure. Ironically, at a time when the World Bank brought out a document titled 'Better Health Systems for India's Poor' (Peters *et al* 2001), the ground reality was that people were being forced to opt for private health care or to pay for public services. The user fee regime initiated in 1997, even for basic essential services, was now fully operational.

As the public health system collapsed, the period between 1980 and 2004 saw an eightfold increase in the number of private facilities. The number of public facilities merely doubled. This period also witnessed private sector resources being harnessed for public health via PPPs. The fund-starved state

began to hand over the lucrative secondary and tertiary health services to the private sector, showering it with more incentives such as tax breaks and subsidies. The private sector was allowed avenues for uninterrupted expansion in the form of land give aways in metropolises (prime land to the tune of Rs 6.5 billion by the close of the 1990s) and a wide berth when it came to regulations. Coupled with the strides being made in medical technology, this led to an unprecedented widening of its reach in health care, especially in the area of diagnostics. The year 1995 saw additional deregulation of drug prices, leaving only 76 drugs on the controlled list. Given that the private sector is largely propelled by the profit motive, health care costs rose to prohibitive levels, as is evident from the steep increase in the per capita household expenditure on inpatient care between 1986-87 and 1995-96 - more so in public than private hospitals. This effectively ended the role of public hospitals as primary providers of inpatient care. Meanwhile, outpatient care remained largely in the hands of private players. Around the same time, the insurance sector also began to be liberalised. Given the rising costs it is no surprise that the 1990s witnessed household impoverishment due to OOP health expenditures on an unprecedented scale, especially in rural areas. The phenomenon had worsened by 2004-05 (Berman *et al* 2010).

The National Health Policy was updated in 2002, when it was decided to increase government expenditure on health to 2 per cent of the GDP. Given that merely four of the 17 goals of the original policy had been achieved thus far and existing health planning strategies had proven ineffective, the aim was to strengthen the state's commitment towards health issues. The private sector was given prominence, particularly in the case of citizens who could afford private health services. The policy sought to introduce public-private collaborations, make vital drugs available at the level of primary health care, achieve an increase in the number of licensed medical practitioners and decentralise functioning through Panchayati Raj Institutions. The government, however, was very selective when it came to implementation.

THE SECOND PHASE (2001–2010): RENEWING THE PUBLIC WHILE STRENGTHENING THE PRIVATE

Here, I focus on the emergence of the NRHM, a key development that attempted to revive the public health system. NRHM signified the return of sorts to a public health agenda and discourse, though the events that followed proved otherwise.

Rejuvenation of the public system was sought in a changed political context with a new government at the centre in the year 2004. These altered circumstances triggered a renewed state effort to respond to the basic unmet needs of common people who were disillusioned by the elitist, shallow notions of 'India Shining' that had been trumpeted by the previous government. Public health issues were reinstated on the national agenda as part of a Common Minimum Programme that was devised to relieve rural distress. The need was sorely felt to temper the harsh effects of rising health expenses.

These developments culminated in the formation of NRHM, which was implemented in 2005. Notwithstanding its articulated re-orientation to the old integrated model of public health, the approach adopted was much too circumscribed in terms of scope and coverage. It aimed to replace the provision of comprehensive services with a package approach and introduced a range of new concepts that served to promote private interests and management styles.

Health reforms after 2005 have been characterised by a certain dualism, which is also evident at the policy level. While there has been a renewed commitment to strengthening public health systems, the government has also been encouraging private players to develop infrastructure and services by providing them with incentives. Initiatives to improve public health care systems have tackled infrastructure, provision of untied funds, skill enhancement training for medical practitioners and the formation of a body of health workers called Accredited Social Health Activists (ASHAs), as well as attempts to bolster traditional medical knowledge. Meanwhile, the presence of private players is being encouraged especially at the secondary and tertiary levels, though in a largely haphazard manner. The government has also sought to engage private players through the PPP mode. There have been changes in the insurance sector as the government seeks to provide and diversify health financing, which is a departure from its previous role as mere provider of health services. Schemes such as the RSBY and *Janani Suraksha Yojana* (Security Scheme for Mothers) have been steps in this direction. Together with the priority being accorded to the Reproductive and Child Health Programme (RCH), these developments have led to some infrastructural growth in the form of recruitment of personnel, improved access to health services, evident from a sharp rise in the number of institutional deliveries and out-patient attendance. Overall, however, such improvements have been scattered and uneven, and much remains to be desired.

CONTINUED EXPANSION OF PRIVATE INTERESTS IN HEALTH

At the turn of the century, an estimated 1.3 million private health providers were catering to rural and urban India, most of which were small or medium sized. However, there have been some shifts in private healthcare ever since. In metropolitan cities, the considerable corporatisation as well as consolidation of private health enterprises has conferred an automatic advantage to bigger hospitals. Moreover, given the ever-increasing focus on technology in health care, medical bills are skyrocketing. Given the trend of private players making inroads into new spheres, it is safe to say that it is private healthcare that largely represents India's health sector.

Another such sphere is health insurance, which was largely dominated by public enterprises up to around 2005-06. Today, in a reversal of this trend, it is being aggressively promoted by private players as a solution for increasing access to health care by the poor. In fact, this development is being further aided by the central government as well as many state governments through their new insurance schemes specifically targeting low-income sections of the population. With technical support from the World Bank, GTZ (German acronym for German Development Co-operation) and other international agencies, these schemes are made possible by tie-ups with a list of accredited facilities, the majority of which are private enterprises. Beneficiaries of the scheme are entitled to reimbursement of family medical bills up to a certain amount, usually for access to inpatient services, with the additional incentive of cashless transactions.

Another important development in this regard, post 2008, is the growing role of private corporate donations - the most influential being Bill and Melinda Gates Foundation (BMGF) - and global health initiatives like the Vaccine Alliance (GAVI), Global Alliance for Improved Nutrition (GAIN) and the GFATM. These are largely targeted towards monitoring and checking the growth of some identified diseases, thereby undermining the NRHM approach which is more holistic.

RECENT DEVELOPMENTS IN HEALTH SECTOR REFORMS (2011 TO PRESENT)

Post 2005, India has been committed to the agenda of universal health coverage (UHC) and has supported worldwide efforts to push its importance as a goal. As a direct consequence of this, a High Level Expert Group was formed by the

Planning Commission in 2010, which suggested a comprehensive structure to achieve the goal of providing holistic health services to the entire population (Planning Commission of India 2011). Unfortunately, however, this twin agenda has been undermined in the Twelfth Plan, which has only made partial, half-hearted attempts at implementing UHC in India. Several of these measures have been viewed by some as more an attempt to appease voters than exemplifying India's commitment to UHC, for instance, the move to distribute generic medicines free of cost through the existing public system as well as the expansion of government health insurance schemes which are often scattered and financially draining. In the absence of effective regulations and controls, the growing expansion of the private sector in Indian health care is going unchecked.

The Twelfth Plan is emblematic of a larger move towards greater private involvement in the Indian health care system and a shrinking space for the public sector, which has been reduced to providing basic services like immunisation, antenatal care and health education since these do not quite fit in with the private sector's more lucrative ambitions. Widening the scope of insurance schemes like RSBY that are financed by the government could potentially lead to a disproportionate focus on costly secondary and tertiary health care while overlooking primary and ambulatory care, thereby resulting in a piecemeal approach. There is a clear lack of political interest in strengthening India's public health care system. The federal budget allocations of the current Plan are sufficient indication of this dangerous trend.

CONCLUSION

The paper has shown how following the broad logic of economic reforms, HSRs ushered in an era of state withdrawal from public health care, which, while permitting a rapid and aggressive expansion of the private sector in the organisation and delivery of health services, made health a paid service and shifted the onus of health care on the individual user. Private interests, operating at various levels and in multifarious forms, not only gained ascendance but have fundamentally altered the health system, both public and private, as also older paradigms of health care. In this context, sporadic policy initiatives that have sought to revive the public and primary health care systems with the aim of redressing the health woes of the ultra-poor have also failed to deliver.

Ever since the mid-1980s, when HSR took off in the country, the public health sector has traversed a difficult path. After a phase of severe budget cuts in the 1990s the state attempted to take middle ground in a bid to soften the hard blows it had dealt out to the poor. However, we find that due to contradictions in state policy and practice, even those limited initiatives to redeem pro-poor systems are now being shot down by frugal budgets. Moreover, inefficiencies in implementation have come to chronically plague the system. Through all this, the old malady of 'funds needed but not provided' continues. Government expenditure on health has not risen significantly while public infrastructure has stagnated and this is the most damaging policy impact of HSR.

HSR reduces the state's role as non-provider, regulator and key legitimiser. The state also takes on new roles as purchaser, financer and guarantor of private care. Meanwhile, the private sector continues to thrive on government largesse. HSR has continually accorded it with newer arenas of profiteering, including the marketisation of public services. Most of the private sector is clearly and primarily driven by profit; it is said to profit from ill-health. The adverse effects of HSR-driven privatisation are being felt not only by the poor but also by lower middle classes. They are the victims of this blatant commercialisation of health care, fraudulent practices and inflated bills, and are forced to throng the courts for grievance redressal. Yet public finances and resources are siphoned away to private players in the name of public interest.

Today a new National Health Policy is in place. Its proposals seem driven by the intention to more fully exploit the investment potential of the health sector. The draft policy, while claiming a commitment to strengthen primary health care and decentralising facilities for secondary and tertiary care, continues to privilege the private system as the main conduit of provisioning services. Given the neo-right leanings of the current government, the institutional mechanisms of 'strategic purchasing' might well facilitate monopolistic tendencies of the corporate sector.

The paradigm shift in health care, with the transition from the public sector to the private sector, does not place the two sectors in a complementary relationship. They rest on opposing, contradictory principles. The new paradigm seeks to erode the familiar notions of and principles underlying public health: from a comprehensive, integrative health model of free, universalistic service to a selective, fragmented and targeted approach. As a result, the public sector, too, is being partially privatised and marketised, and this is the biggest anomaly that is transforming the character and ethos of the public health system. This new

paradigm, positing false choices and false complementarity, seems ill-suited to achieve the desired outcomes of public well-being and health.

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3. Ideology and Health Sector Reforms: A State-level Analysis[1]

Rama V. Baru

The process of health sector reforms (HSR) is well entrenched across both developed and developing countries. The elements that are included within HSR are similar but the experience of reforms across countries has been varied. In India HSR has included several components and have addressed various levels and sub-systems of the health service system and the national health programmes. In this paper we provide a brief overview of the ideological and historical context within which the reforms were initiated globally and in India. This is followed by an analysis of the role of funding agencies in articulating these ideologies through specific projects as a part of the loans to the health sector. The influence of HSR is not merely confined to structural changes in the financing and provisioning of health services but has influenced technical aspects as well. The discussion then focuses on reforms at the state level that are driven by the government and those that are externally funded.

CONTEXT OF HSR

HSR is a feature of the 1980s and 1990s. It is a global phenomenon and is not merely a technical intervention or a value neutral process. HSR is very firmly rooted in the neo-liberal ideological framework and based on some shared assumptions that expenditure on public systems are wasteful; public systems have been inefficient and ineffective; markets need to be given greater prominence and market principles can be introduced in public systems to make them more efficient. The ideological base of HSR has been widely written and commented upon by several research scholars across different countries (Qadeer *et al* 2001). The ascendancy of the neo-liberal ideology is attributed to the world recession as a result of the oil shock during the mid-1970s and later the crisis and collapse of the socialist countries. In addition the welfare state was facing a crisis in terms of under-investment and problems of bureaucratised systems that were rigid and unresponsive to people's needs and expectations. It is this larger context that provided a convenient handle for an ideological position that questioned the legitimacy of the state and proposed that markets are more efficient and effective for delivering health services. It was indeed a fact that public health service systems were affected by growing demands, rising costs

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and organisational structures that were hierarchical with little room for responding to felt needs. Given the labour-intensive nature of the public health services the number of personnel employed by them was large and in most countries a substantial amount of the budget was spent on salaries. These issues were well acknowledged even before the onset of the crisis and it was widely acknowledged that the health services across the globe needed reform. The debate was ideologically divided with those who viewed health as a developmental issue where the state was a key player and others who visualised a reduced role for the state and a key role for markets. The Alma-Ata document on primary health care in 1978 had come up with a design where health was seen as interrelated with development and also how health services should respond to the felt needs of the people (WHO 1979). This global policy initiative was recognition of the failure of a purely technical approach to health issues with excessive emphasis on drugs and medical care for handling infectious diseases and other health concerns. The experiences of China, Soviet Union and other socialist countries that had addressed the basic needs of their people and had placed a great deal of emphasis on providing basic services with a well worked out referral system provided a contrast to the experiences of many European and developing countries who had mainly invested in medical care with focus on secondary and tertiary rather than primary levels of care. The Alma-Ata document provided a design whereby inequality, poverty and development were the core concerns that demanded the state to play a central role in order to ensure that the basic needs of the population were met.

The realisation of these issues was essentially political in nature and in many developing countries it had the potential to question their inegalitarian societies. This was clearly perceived as a threat by who felt that they would lose rather than gain from this initiative. Key among these were the pharmaceutical and related companies that were dependent on the large markets of ill-health in the developing countries. The Indian government that was one of the signatories of the Alma-Ata document set up a committee to review health services and provide an alternative approach to achieve 'Health for All' (ICSSR/ICMR 1981). Therefore, if one sees reforms as bringing about change in the health service system it is important to state that there were initiatives both at the global and national levels. These were driven by values like equity, universality and comprehensiveness, but there were resistances to these approaches from within countries from sections of the ruling classes, elite, professionals and the pharmaceutical industry. At the global level sections of the American political and professional class saw the Alma Ata document as promoting socialist ideology, which directly challenged the interests of the pharmaceutical industry. These various factors affected the implementation of this approach for any meaningful reform of the health sector.

The crisis within socialist countries further weakened the defence of this approach and resulted in the strengthening of greater faith in markets rather than the state. The anti-state and pro-market stance that informed the HSR agenda of the 1980s and 1990s is clearly articulated in its definition and content.

CONTENT AND ELEMENTS OF HSR

HSR was initiated during the 1980s and 1990s with the basic tenets of improving efficiency, effectiveness and quality of care in health services. These reforms placed a strong emphasis on restructuring public health services by contracting out of ancillary services, scaling down manpower and decentralisation. In addition, reforms often presume a more dominant role for the private market in finance, provision, technology and research of health care (Berman1995). During this period HSR tended to emphasise restructuring the role of the state for selective financing, provisioning and regulating health services.

Given these set of assumptions the elements that constitute HSR are related to financing, provisioning, personnel and management. In all these elements the emphasis is on efficiency, efficacy and quality of services. Therefore initiatives are taken to reduce public spending and ensuring expanded role for markets. As a result privatisation is at the core of HSR. There are several forms of privatisation and these include:

- Privatisation of ownership, which means that the ownership of facilities and service units is shifted from the public to the private sector. This may happen by sale of shares, voucher privatisation (as in the Central and Eastern European countries), transfer to management or employees, direct sale, etc.;
- Privatisation of responsibility, by formal transfer of responsibility for the service to a private organisation, transfer to users via abolition or reduction of service, liquidation of state-owned enterprises, liberalisation and reduction of planning of the sector;
- Privatisation of provision through contracting-out, leasing, operating concessions, management contracting, purchasing of private goods and services;
- Privatisation of finance through higher co-payments and user charges, or by shifting to private health insurance funds, private capital for public infrastructure investment, joint ventures with private enterprises; and,

- Privatisation through the introduction of markets (for example, competitive tendering between in-house and external contractors), creation of markets by splitting purchasers and providers or introducing greater choice for patients. (PSI1997: 8)

Different countries have adopted combinations of approaches as a part of HSR and these are seen in terms of specific initiatives that include privatisation through the introduction of user fees, contracting-out of services and decentralisation.

An analysis of the experiences of both developed and developing countries shows that it is this set of elements that have been broadly incorporated in HSR initiatives. These sets of elements have been the dominant paradigm that has guided HSR in both developed and developing countries during the last two decades. In developed countries like the UK and Canada there have been efforts to expand the space for private insurance and introducing market elements such as managed competition as was the case in the National Health Service reform in UK. It is often argued that this may lead to improvements in service quality and efficiency but result in increasing pressure on health care staff and management. In developing countries several of the initiatives mentioned above have been implemented either by national governments themselves or through the conditionality tied to loans that they borrow from the World Bank. It is well acknowledged that the Bank has emerged as the single largest financier of the health sector. Other multilateral and bilateral agencies largely support the ideological basis of HSR. The Bank has played a significant role in designing and prescribing policy changes in the health sector incorporating the basic tenets of HSR. The other agencies also accept the tenets but some of them are concerned about equity and the access to the poor. Over time even the Bank has incorporated these concerns in its agenda for developing countries.

EXPERIENCE OF HSR

HSR can be viewed as a complex interplay of the prevailing ideological climate and a number of actors that shape the process of reforms. This would include actors at the global, national and local levels but who are not clearly equal players in determining the process of reform. This is because power and its articulation at all levels are complex and unequal. Therefore one would see the content and process of reform as an outcome of a 'complex process that involves the interaction between global agencies, both bilateral and multilateral that promotes ideology; the national context that creates spaces for the articulation of this ideology and the health service system implements the reforms' (Baru and Nanda 2004). Available evidence suggests that the experience of HSR presents a varied picture both in terms of pace and content. These variations are dependent on the history of nations; the fiscal and infrastructural state of public

health services; the growth of markets in the health services; and resistance to reforms from civil society (Baru and Nanda 2004; Twaddle 2002). There are a group of countries, especially from Latin America and Africa, that are not only the first generation of reformers but their pace of reforms has been extremely rapid with little resistance either from the political class or the civil society. Erstwhile socialist countries from the eastern European region and Soviet Union have privatised their health service systems over a relatively short period of time, resulting in a number of problems.

The Indian experience is different in that some of the elements of reform were already in place even in the early 1980s. Therefore privatisation of health services at the tertiary level and state subsidies for tertiary private sector were initiated during the 1980s, much before the Bank started loaning to the health sector in India. During the 1990s the Bank did assume a greater role for deepening these reforms with the elements of HSR that were in-built into the various projects supported by the Bank in several states. These projects included strengthening primary level care, RCH project, communicable disease control and the state health systems project. The state health systems project focused on strengthening for secondary-level of provisioning. It is important to study in some detail the variation in the experience of these reforms across individual states since it comes under the jurisdiction of state governments.

CHARACTERISTICS AND EXPERIENCES OF HSR AT THE STATE LEVEL IN INDIA

In almost all Indian states elements of HSR have been initiated but there are differences in the content and extent of reforms. In India, states can be broadly classified into two categories with respect to HSR. The first category consists of states like Tamil Nadu, Madhya Pradesh, and Gujarat that have initiated certain elements of reform without external assistance. The second category consists of others like Andhra Pradesh, West Bengal, Orissa, Uttar Pradesh, Karnataka, Maharashtra and more recently Tamil Nadu who have sought external resources to initiate certain elements of the reform or augment the reforms with funding from multilateral and bilateral agencies.

Tamil Nadu, Gujarat, Rajasthan and Madhya Pradesh belong to those states that have initiated reforms related to drug procurement and supply, contracting out, PPPs, levying user charges and issues related to personnel. There are several forms that HSR have taken in different states and these include:

- Contracting-out of non-clinical services in hospitals to private agencies.
- Community health financing initiatives (as a part of alternative strategies for devolving the responsibility for paying to households).

- Devolving financial and administrative responsibilities to panchayats.
- Reform initiatives at the primary level have come largely through national programmes many of which are funded by multilateral and bilateral agencies.

Tamil Nadu was one of the first states to set up a drug procurement and supply corporation called the Tamil Nadu Medical Supplies Corporation. Karnataka, Orissa, Rajasthan and several other states have now adopted the design of this innovation. The reform process in Himachal Pradesh, Haryana and some of the newly formed states has been partially supported by agencies like Department of International Development (DFID), European Commission (EC) and the Danish International Development Agency (DANIDA).

FINANCING

This includes mechanisms to augment finances for the health sector, like introduction of user fees; setting up of *Rogi Kalyan Samiti* (RKS) (Patient Welfare Committee) in Madhya Pradesh, Medical Relief Society in Rajasthan and *Aspatal Kalyan Samiti* (Hospital Welfare Committee) in Himachal Pradesh. All these work on the same principle and are restricted to secondary and tertiary levels of care. The RKS in Madhya Pradesh set the trend for other states to follow. It was first started in a tertiary teaching hospital in Indore and then expanded to districts and even Community Health Centres (CHCs). Initially there was a great deal of euphoria based on the Indore experience where members of civil society contributed to the RKS. However, the experience has been far from even across the state. The Madhya Pradesh experience was a model for several other states and prominent among them are Rajasthan and Himachal Pradesh who have set up similar bodies for augmenting resources at the secondary and tertiary levels.

Rajasthan MRS was initiated in 1995 and was seen as a means to get additional revenue that could be used by hospitals through decentralised decision making. A separate management structure consisting of a committee consisting of official and non-official members of state, regional and district level was constituted. Its functions include providing services and using the additional resources to provide facilities like toilets, medical supplies and other amenities.

The information on how these societies are functioning and how they have improved the effectiveness of hospitals is not clear.

PUBLIC-PRIVATE PARTNERSHIPS

Handing over Primary Health Centres (PHCs) and urban health centres to Non-governmental Organisations (NGOs): There are examples of contracting out of PHCs to NGOs from Andhra Pradesh, Karnataka, Gujarat, and West Bengal. In Karnataka, two PHCs were contracted out to NGOs and the experience was a mixed one. Gujarat was among the earliest states that had experimented with contracting out PHCs to NGOs. In 1984 the state government had handed over several PHCs to Society for Education Welfare and Action (SEWA)-Rural wherein the government provided the budgetary support for the staff salaries and supplies. The NGOs had to utilise their own resources to procure any additional supplies and pay the salary of the personnel. An evaluation of these various experiences shows that the NGOs in Gujarat have faced a number of difficulties but have tried to overcome them. There are only five NGOs in Gujarat who are involved in this scheme (Arya and Mandwal 2006). In other states the government-NGO partnership has not worked out because the latter find it difficult to run the PHCs on the budget prescribed by the government.

Decentralisation*:* There are varied experiences of decentralisation across states but in most of them it is for getting additional resources. There is mainly de-concentration of services with inadequate financial devolution to the panchayats. Decentralisation then forces communities to augment resource by tapping the community. Kerala is the only state where health care institutions up to the district level have been handed over to the panchayat. In Himachal Pradesh, panchayati raj (decentralised form of government) institutions have introduced *Parivar Kalyan Salahkar Samiti* (family welfare consultant committee) at three levels of the panchayati raj system. These *samitis* have representatives of the panchayat institutions at different levels and their functions are related to family welfare activities. Except for Kerala where decentralisation has involved personnel under the panchayats' supervision, this has not happened in other states (Kumar 2003).

HEALTH PERSONNEL

Several states have introduced changes in the appointment and training of personnel. Some states have been appointing doctors on a contract basis in order to overcome the shortage of personnel in rural areas; at the peripheral level they have undertaken training for multi-skilling of paramedical workers. In Rajasthan they have started appointing even staff nurses, lab technicians and Auxiliary Nurse Midwives (ANM) on contract basis. During the 1990s the trend across several states was shortage of paramedical personnel due to non-recruitment and a freeze on training of these workers. As a result there was and continues to be a serious move to encourage community health workers on a voluntary basis or by giving honorarium. It is the poorer states, where there is

both fiscal and personnel shortage, that there is a serious move to hire medical and paramedical personnel on a contract basis. Human power is the backbone of the health services, therefore reducing investments will have negative consequences for delivery.

CONTRACTING-OUT OF ANCILLARY SERVICES

All states have contracted out non-medical services like laundry, security and in some cases the catering services as well. While we do know that this process has been in place for some time now there is little evidence regarding its effectiveness in terms of cost and quality.

REGULATION OF THE PRIVATE SECTOR

Several states like Rajasthan, Himachal Pradesh, Tamil Nadu, Andhra Pradesh and Maharashtra have introduced bills to regulate the private sector. In addition, the movement to check the mushrooming of diagnostic centres for sex determination has resulted in legal provisions for registering such institutions.

In Himachal Pradesh there is a bill called the Himachal Pradesh Paramedical Council Bill 2003 whose objective is to maintain a state register of paramedical practitioners, register them and also prescribe a code of ethics for them.

Reviews of the various elements that are broadly included under the rubric of HSR across states do show similarities. At present there is some rudimentary information regarding the initiatives that have been taken but little in terms of systematic documentation, analysis and lessons learned from some of these initiatives. The Bureau of Planning within the Director General of Health Services in the Ministry of Health and Family Welfare had initiated two meetings where state health secretaries shared their experiences and subsequently they also initiated studies on specific themes. There is a need for systematic studies to be done in order to document the process and outcomes of these initiatives. From the available information it is apparent that the reform initiatives have been largely driven by fiscal crisis and do not seem to have a plan that guides this effort. They appear more like a number of initiatives that are incremental in nature that have been cobbled together at different points in time. Thus, the process of reforms at the state level clearly shows the lack of a systemic perspective to reforms. Some states are reforming secondary and tertiary levels of care and primary level is being dealt with separately. Others are focusing only on procurement and dispensation of drugs and many of them on decentralisation. In the case of states supported by international agencies it is a project approach hence there is little coordination across projects. While there is some data available on the process of reform there is little or no data to assess the impact of these reforms on the health service system or the communities.

TABLE 3.1-STATE-WISE REFORM INITIATIVES IN THE HEALTH SERVICE SYSTEM

PROVISIONING AND SUPPORT SYSTEMS

Gujarat

- Creation of block health office and grouping of CHCs
- Establishment of quality control centres and blood transfusion network

Rajasthan

- Drug policy and procurement system
- Jan Mangal Scheme and BPL Medicare Card Scheme
- Contracting of ancillary services

Uttaranchal

- Integration of health and ICDS programme
- Fixed day schedule for health service delivery
- Drug procurement policy
- Contracting of ancillary services

Punjab

- Development of disease surveillance system
- Performance and quality indicators for hospitals and improvement of laboratories
- Revamping of primary health services and development of referral system
- Contracting of ancillary services
- State health systems strengthening at secondary level

Madhya Pradesh

- Revision of building construction rules
- Effective Operationalisation of First Referral Units (FRU)
- *Rogi Kalyan Samitis* at secondary and tertiary levels

Andhra Pradesh

- State health systems strengthening at secondary level
- Development of disease surveillance
- Primary level strengthening
- Contracting of ancillary services

Orissa

- State health systems strengthening at secondary level
- Drug procurement policy
- Contracting of ancillary services

Himachal Pradesh

- *Aspatal Kalyan Samiti* established for secondary level care

Uttar Pradesh

- State Health Systems Development Project for secondary strengthening

Tamil Nadu

- Drug procurement and supplies
- Strengthening and reorganisation of primary health services

HUMAN RESOURCES

- Appointment of staff on contractual basis (most of them)

CAPACITY BUILDING

- Course in anaesthesia (Orissa, Rajasthan)
- Internship training for better community health orientation (Orissa)
- Contracting appointments of medical and paramedical personnel (Orissa, Gujarat, Rajasthan, Andhra Pradesh)

REORGANISATION OF MEDICAL AND PARAMEDICAL PERSONNEL

- Cadre of para medical ophthalmic assistant (Gujarat)
- Formation of district cadre for paramedics (Gujarat, Orissa, Andhra Pradesh)
- Promulgation of bill to register practitioners and establishments (HP)
- Redeployment of staff (Tripura)
- Integration of ISM medical officers for national programmes (MP, Uttaranchal)
- Mandatory pre-PG rural service (Orissa)
- Transfer policy for MO in remote areas (Uttaranchal)
- Delegation of powers to medical officers (Gujarat)
- Multiskilling of health personnel (Rajasthan, Orissa, Uttaranchal)

Sources: Bureau of Planning and Ministry of Health, September 2003; Nandraj 2003; M. Gupta 2002.

INTERNATIONAL AGENCIES AND PROJECT-DRIVEN REFORMS

As discussed earlier there are some elements of HSR that are directed by the state and others that are either partially or entirely funded by multilateral or bilateral agencies. During the 1990s the World Bank emerged as the single largest agency for foreign assistance to the health sector in India. It essentially gave 'soft loans' to the health sector with its own conditionalities. The other agencies were the EC, DFID and others like DANIDA, Swedish International Development Agency (SIDA) and GTZ. Typically the World Bank and most other

agencies have a project approach to funding and are dealing with different levels and aspects of the health service system. The major projects funded by the World Bank include the state health systems development project for secondary-level strengthening, primary health care project, RCH project and disease surveillance and monitoring project. This section examines the process and experience of state health systems development project but recognises that other projects like the RCH project and primary-level strengthening project have incorporated several elements of the HSR agenda.

The secondary-level strengthening started in 1995 with Andhra Pradesh, West Bengal, Punjab and Karnataka. Subsequently Maharashtra, Orissa, Uttar Pradesh and most recently Tamil Nadu have also got loans for the state health systems development project from the World Bank. These projects provide loans for civil works, medicines, equipment purchase, training and research.

A recent evaluation of the World Bank of the first set of states provides some insights into the areas in which reform was initiated and while it states that it is 'satisfactory' it raises some significant issues for sustainability of these reforms. The objectives of the state health systems project were to: (i) improve efficiency in the allocation and use of health resources through policy and institutional development; and (ii) improve performance of the health care system through improvements in the quality, effectiveness and coverage of health services at the first referral level and selective coverage at the primary level to better serve the neediest sections of society. The project focused on the first referral level because several reviews of the trends in expenditure across levels of care observed that a disproportionately high proportion of the expenditure was on the tertiary level care. This was at the expense of first referral facilities and the fact that health facilities at the primary and first referral hospitals in the states continued to face operational deficiencies due to inefficiencies. A weak primary and first referral hospital system results in an overload on the tertiary sector - a trend seen across states.

If one reviews the outcome indicators for assessing the improvement after implementation of the health systems project they include:

- Increase in out-patient and in-patient care
- Shortening of average length of stay
- Increase in bed occupancy
- High bed turnover rates

These were to be achieved with better infrastructure and modern technology.

A preliminary review done by the World Bank of the four states, viz., Karnataka, Punjab, West Bengal and Andhra Pradesh that have completed the project raises a number of issues that need to be studied. The investment in the secondary level of care is seen as contributing to national policy objectives such as reduction in IMR and MMR, population stabilisation and controlling disease burden. This kind of a formulation assumes that more investments in hospitals alone can impact these indicators significantly. The experience of mortality declines and population stabilisations clearly indicate that the process is indeed a complex process and health institutions are just one of the inputs to affect it. There is a need to recognise that this project basically is focusing on hospitals and therefore how the impact on health status is going to be established is unclear.

Even for other inputs like user fees, PPPs, the role and quality of private services, impact of these projects for strengthening referral systems from primary to secondary, commitment to increase investments in health and ownership of these reforms at different levels of services, etc., need to be studied and evaluated. The evidence is either scanty or lacking as a result of which there are only a few descriptions of these projects that do not lend themselves to detailed analysis. However, each of these inputs raises a number of questions that need further exploration as discussed below.

Introduction of user fees and the exclusion of the poor from paying for services have been important areas for policy debates. The real question is to what extent have these projects been 'pro-poor'? Has access to health institutions improved for them and what is their perception of it? A number of these states had initiated PPPs in the health sector. There is inadequate evidence regarding the nature and experience of these partnerships in terms of its strengths and weaknesses. Linked to this is the performance of the private sector itself and to what extent these projects have addressed the regulation and quality monitoring in the private sector.

Administratively a separate governing board was created that included high-level representatives from different ministries that were associated with the project. This board was empowered to make major policy decisions and develop a broad policy outline for the project; approve the annual budget; authorise major project revisions as necessary; ratify decisions made by the steering committee (in Karnataka); formulate rules and regulations; and undertake an annual review of project implementation and monitor overall project progress (World Bank 2005). Here, again there are questions regarding what the interaction of the board is with the existing administrative structure? What is the extent of interaction between the two? Do they effectively work parallel to each another?

For the states that have completed the projects the issue of financial sustainability is critical. This essentially means that state governments have to increase their allocations for health. The recent evaluation by the Bank has raised this as the most important issue for future sustainability. While most state governments showed strong commitment and political support for HSR, experience showed that the area of public financing for health was a little weak. This was a serious issue for the future of the projects.

SYSTEMIC CRISIS AND NATIONAL RURAL HEALTH MISSION (NRHM) AS COURSE CORRECTION

By the early 2000s the crisis in the health services was being reflected in poor programme outcomes in several states. There was growing concern among the international community and national programmes for poor coverage in many states and districts. The RCH programme recognised the need for strengthening public health services to achieve better coverage, monitoring and surveillance of programmes. During the same period the evidence of a weak public service was denying access for curative care and high OOP expenditures. Clearly, there was a systemic crisis in the health services and the pressure for addressing this was coming from diverse quarters. A left centrist coalition in 2014 brought the need for equity in health access into the Common Minimum Programme. This also provided an opportunity for academia, civil society, political parties, donors and the health ministry to dialogue for a course correction. A broad based platform of all the above mentioned actors deliberated on a design for revitalising the health services. Many of the elements had already been laid out in the RCH-II document, but many changes and additions were made by civil society organisations, the representatives of the Peoples Health Movement globally and *Jan Swasthya Abhiyan* (JSA) at the national level[2]. Many rounds of negotiation and discussion gave rise to the architecture of the NRHM which was a centrally sponsored initiative with a focus on 'Empowered Action Group of States' and selected districts. The NRHM was seen as the resuscitation of the public sector and it met with differential success across states. The NRHM brought about systemic changes in the availability of finance, human resources and supply of drugs. It also brought in systems of accountability through ideas of communitisation, setting up of Village Health and Sanitation Committees at the grassroot level and introduced the Accredited Social Health Activist (ASHA) as the link worker between the community and the health service system. While one could argue about the effectiveness of these various measures, there is no doubt that it energised the public health services although differentially across

[2]This section is based on my participation and involvement in the several rounds of meetings in the run up to the blueprint for NRHM and as co-convenor of the sub-committee on Public-Private Partnerships in the NRHM

states. After the fall of the Congress government, the idea of NRHM was considerably weakened due to reduced financial support. It then went through many changes and became more opaque in terms of engagement with the varied actors who had so vibrantly engaged with the shaping of the idea and contents of the NRHM. Clearly, health is no longer a political priority of the Modi government. While some may argue that an increase in the recent budget is a sign of a turnaround, there is no clear indication of how and where the money will be spent.

DISCUSSION AND CONCLUSION

Health sector reforms are not technical initiatives but are informed by diverse ideological positions. There have been debates at the global level regarding the need for reforms even before the current wave of HSR. The Alma Ata declaration on primary health care was embedded and informed by the importance of development and concern for persisting poverty and inequalities within and across societies. The primary health care approach thus recognised the relationship between ideology, politics and health; therefore it was challenged by those who saw it as destabilising the *status quo.*

The debate for the need to reform the health sector continued and although the primary health care approach was considerably weakened with the selective primary health care approach, nevertheless several developing countries continued to use the former as a design that could ensure a more universal, comprehensive and universal health services. During the late 1970s there was an assertion of the neo-liberal ideology that sought to limit the role of the state and create greater spaces for markets, which was informed by the assumption that the latter is more efficient than the former. These ideas took root and informed the course of HSR in both the developed and developing countries. The negative experience of the early reforming countries put the pro-market lobby slightly on the defensive and a 'selective role' for the state was entertained in policy debates.

The experience of HSR across and within countries shows variations. In some countries many of the elements of HSR have been introduced as a result of a fiscal crisis and are incremental. The process of reform has been supported by the World Bank's lending to the health sector across several developing countries. Therefore one needs to make a distinction between countries that have been influenced by the ideology of HSR in general and others who have introduced it with Bank support. In the Indian context, elements like privatisation and even some user fees in the public sector were in place even in the 1970s and 1980s. Other elements like contracting-out and decentralisation were introduced as means of cost recovery across several states. Those states that have been implementing Bank's health projects, viz., RCH health project,

primary-level strengthening project, secondary-level strengthening project and so on, have elements of HSR built into them. The available evidence on the experience of user fees across Indian states shows variation. States like Madhya Pradesh, Himachal Pradesh and Rajasthan showed an increase in revenue with the introduction of user fees. Punjab showed an overall increase but there were tremendous variations across district hospitals-some had very low recovery rates. It is clear from all states that the revenue from user fees is only an additional income and not a substitute for public financing. There is concern about what introduction of user fee is doing to access for the poor and the very poor; however the evidence is insufficient to come to any meaningful conclusions.

A number of initiatives have been tried for PPPs but the evidence is presenting a mixed picture. There is little that can be generalised since it is specific to the institutions that are in partnership, the programme for which the partnership has been entered into and the kind of terms and conditions for these partnerships. This means that how replicable and upscalable these initiatives are at different levels is an open question. Although some states have included regulating the private sector as an important element of HSR, the pace, direction and content have been wanting. The focus has largely been on regulating provisioning and not adequate attention has been paid to private interests in medical, paramedical education as well as technology and drugs. There are too many well-entrenched and conflicting interests that have to be addressed by state governments in order to be effective. Any amount of reform of public sector without addressing the private sector will be ineffective in the long run. A number of these states had initiated PPPs in the health sector. There is inadequate evidence regarding the nature and experience of these partnerships in terms of its strengths and weaknesses. Linked to this is the performance of the private sector itself and to what extent these projects have addressed the regulation and quality monitoring in the private sector.

For states like Karnataka, West Bengal, Andhra Pradesh and Punjab which received loans from the Bank for strengthening their secondary level care, the financial sustainability of these reform initiatives is of real concern especially when these governments continue to be in a fiscal crisis (GOI, 2004). This paper has attempted to provide an overview and put together some evidence on the process of reforms. This exercise has shown the enormous gap in evidence and the need for systematic research at the level of the states to enable richer analysis. There are ideological and methodological issues that inform the process and outcome of HSR, therefore researchers in this area need to acknowledge them rather than view the HSR initiative as a value neutral process.

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4. Overview of Health Care Reform in China: Experiences and Lessons

Shanlian Hu

A new initiative of health sector reform in China was started in 2009. Great achievements have been reached in the reforms of four systems, i.e. health insurance, public health, medical service and pharmaceutical supply (Communist Party of China Central Committee 2009) since the 1990s. The paper will illustrate the progress of China's health care reform in the last six years. There are lessons to be learnt from the holistic design, implementation and the experience of health care reforms that one could learn from and adopt elsewhere in the world.

BACKGROUND

China is a large developing country with 1.3 billion population which has a five-tier system of governance - from central, provincial (municipal) to city, county (district) and township level. It has a highly decentralised health financing, health service delivery, medical insurance schemes and essential medicine policies. From the governance point of view, health system in China is very complicated and segmented. National Health and Family Planning Commission (NHFPC) is the leading Ministry of Health. Besides, National Development and Reform Commission (NDRC) has the responsibilities to invest in health care and set price for medical services and pharmaceuticals. The Ministry of Finance (MOF) is in charge of the government health budget, financial input and subsidies. Ministry of Human Resource and Social Security (MOHRSS) manages medical insurance schemes, reimbursements and payment system. The Ministry of Industry and Information deals with the productions by the pharmaceutical industry. The Ministry of Commerce (MOC) takes care of drug supplies, medical devices and equipment distribution and wholesale and retail business. The Ministry of Civil Affairs (MOCA) administers medical aid for the poor and nursing care for the elderly. In addition, the State Food and Drug Administration (SFDA) Bureau is responsible for quality supervision and drug approval, which is independent from NHFPC. Each stakeholder has its own role and responsibilities for the health system development and reforms (WHO 2015). Therefore, a multi-sectoral approach and the concept of health in all policies is necessary to achieve positive outcomes from the health sector reforms (WHO 2014). Policy conflicts will usually occur when the master health reform plan does not take a multi-sectoral approach and is not designed properly.

The National Health Accounts in 2013 showed that the total health expenditure was 3166.1 billion RMB. The share of total health expenditure in GDP was 5.57 per cent. The total health expenditure and pharmaceutical

expenditure per capita was 2327 RMB and 893 RMB respectively (CNHDRC 2013). About 38 per cent of total health expenditure was pharmaceutical expenditure. The health sector reform in China in 2009 was announced in five areas. These were the following: (1) speeding up the development of medical security system; (2) promoting equalisation of public health service; (3) improving health service system in grass-roots facilities; (4) establishing a national essential medicine system; (5) piloting public hospital reform. By the year of 2020 it is targeted that China will establish a basic health care system providing universal coverage for a safe, effective, convenient and affordable health service (CPC Central Committee 2009). The multiple health demands of the urban and rural populations will be met and the health status of the population will be further improved through medical security system.

MULTI-LAYER MEDICAL SECURITY SYSTEM IN CHINA

There are three basic medical insurance systems operating before 2016. These are - Urban Employee's Basic Medical Insurance (UEBMI), Urban Resident Basic Medical Insurance (URBMI) and the Rural Co-operative Medical Scheme (RCMS). These three insurance schemes are the major arrangements and cover majority of the population. The upper layer of insurance schemes contains supplementary insurance for catastrophic illness for enterprise workers, subsidies for civil servants and private medical insurance. The bottom layer of insurance schemes contains urban and rural social medical assistance system for the impoverished, which plays the role of a safety net.

In general, the contribution of UEBMI is based on the payroll tax at a range between 8 to 13 per cent of the salary, which differs across provinces (MOHRSS 2013). Usually, the employees pay 2 per cent annual salary or wages and the employers pay 6 per cent from employees' annual salary or wages. The total contributions are divided into two parts, i.e., 3.8 per cent payroll tax is used to establish a medical saving account for outpatient care payment and the remaining contributions (4.2 per cent) are a pooled fund for inpatient care and catastrophic illness.

Table 4.1: The Average Contribution Level in Different Medical Insurance Schemes

Type of Medical Insurance Scheme	The Average Contribution Per Person Per Year in 2015 (RMB)
Urban employee's basic medical insurance	1960
Urban resident basic medical insurance	500
Rural cooperative medical system	500

Source: MOHRSS 2015

As of December 2014, 283 million urban employees and 315 million urban residents were enrolled to the UEBMI and URBMI, respectively. These are administered by MOHRSS. The beneficiaries of RCMS have expanded to 835

million population, which is administrated by NHFPC or the Ministry of Health. The total number of insured has reached to 1.31 billion populations. The coverage rate in 2014 was nearly 98 per cent (MOHRSS 2014).

In July 2015, the State Council made an announcement towards preventing financial loss caused by catastrophic medical expenditure in the families (MOHRSS 2015). In 2017, it is said that a comparative catastrophic medical insurance will be established, which will reimburse at least 50 per cent of the medical bills. A certain amount of medical insurance surplus funds from urban and rural basic medical insurance scheme will be transferred to the catastrophic insurance scheme. In principle, the government will select some commercial insurance companies to run the catastrophic insurance schemes. In the process, business tax, insurance supervision charge and insurance guarantee fund will be waived for those private companies who are selected to run the scheme (MOHRSS 2015).

In the beginning of 2016, to ensure equity and acceptability, the urban and rural resident basic medical insurance schemes were merged together and have now become an unified urban and rural resident basic medical insurance (MOHRSS 2016). Government subsidised every insured person, 80 RMB per year in 2009; it was increased to 380 RMB in 2015. The URBMI will gradually be based on equal insurance contributions, reimbursement and payment standards. The funding would be deposited in a special account, divided into two separate revenue and expenditure sub-accounts. At the same time, the operational entity, human resource and information will be merged as well. To make it unified and stronger, the medical insurance fund will be pooled at city level, or even at provincial level in some provinces.

Coordination between the different medical insurance schemes, such as basic medical insurance, catastrophic medical insurance, medical aids, disease emergency fund and private medical insurance, is of utmost importance.

The drug items covered by employee medical insurance scheme are more than 2100. The number of drugs being reimbursed has increased by over 13 per cent since the 2009 reforms.

Table 4.2: Medical Insurance Drug Reimbursement List in 2009

	No. of Drugs	No. of New DrugsAccepted	Growth Rate (%)
Chemical medicines	1164	137	13.3
Traditional medicines	987	117	13.4
Total	2151	260	13.7
Class A	349	53	11.8
Class B	1802	207	

Source: Hu 2013

All drugs in class A are fully reimbursed by health insurance. The drugs in class B will be available on co-payment at 15 to 20 per cent of the drug price.

The issues that still exist in medical insurance schemes in China are: (1) The medical insurance of 150 million peasant workers who migrated into urban areas, cannot be transferred; (2) since the contributions are collected based on the jurisdiction, beneficiaries cannot get the reimbursement, when seeking medical service outside the area; (3) high OOP payment i.e. more than 30 per cent still exist; (4) the medical insurance schemes have to be sustained and are facing the challenge of an ageing population and cost containment.

NATIONAL ESSENTIAL MEDICINE POLICY

In 1977, China introduced the basic concept of essential medicines adapted from the WHO. The first essential medicine list was issued in 1982, which contained 278 chemical drugs. It was only in 2009 that the essential list of medicine was again revised and reformulated. Government issued an implementation guideline to build up a comparative and effective system of administration, including the cycle of selecting essential medicines, listing of formulations, drug production and provisioning, quality assurance, bidding and procurement, rational use, price supervision, reimbursement in medical insurance, monitoring and evaluation (Hu 2013).

The purpose of the essential medicine policy is to ensure access, safety and rational use of essential medicines and release the burden of pharmaceutical costs for the patients. All government-run primary health facilities use essential medicines. Other medical institutions also use them to some extent. All pharmacies should be equipped to sell the essential medicines and thereby improve reimbursement in medical insurance schemes.

Table 4.3: The Number of Items in National Essential Medicine List (NEML)

	2009 Version NEML No. of Essential Medicines (%)	2012 VersionNEML No. of Essential Medicines (%)
Chemical and biomedical medicines	205(66.8)	317(61.0)
Chinese traditional medicines	102(33.2)	203(39.0)
Total	307	520

Source: Hu 2013

The issues in the National Essential Medicine System are as follows: (1) The number of essential medicines in the NEML is unable to meet the demands of drug utilisation in health institutions. If each province lists out more essential medicines in their provincial essential medicine list, it would not only cause confusion with the hospital formulary, but would also influence on the authority of NEML; (2) All essential medicines have to implement the zero mark-up

policywhere no profit is made by selling these drugs at hospitals, but there is not enough government subsidies to resolve the gap between drug revenue and expenditure (Mao and Chen 2015); (3) The zero mark-up policy cannot be implemented in village health posts and private clinics because they are independent entities and not part of the system; (4) The procedure of bulk procurement and bidding system of essential medicines need to be standardised. This means using a double envelope tender system, first tender comprehensively evaluating a company and then the second tender quoting the drug price (Chaudhury 1996) This system would include signing the price-volume agreement, price reduction and negotiation (MOHRSS 2015).

EQUALITY IN PUBLIC HEALTH SERVICES

In China, government gives subsidies for implementing some basic and special public health service programmes. The subsidy was 15 RMB per capita in 2009 which was increased to 40 RMB in 2015.

The basic public health service provisioning includes 12 categories. They are electronic health record, health education and promotion, expanded programme of immunisation, health management in children, pregnant women and elderly, chronic disease management (hypertension and diabetes), expanded management of mental illness, prevention of infectious diseases and emergency public health event, physical identification of elderly and children, occupation health and supervision. Till now, hypertension management programme has covered 86.27 million patients and diabetes has covered 24.9 million patients.

Some special public health service programmes have covered about 200 million population. The programmes are - Hepatitis B vaccination for those under 15 years, screening of breast and cervical cancer in rural women, folic acid prevention in prenatal period in rural women, treatment of cataract for rural poor, elimination of the coal-type endemic fluorosis in six provinces and the project of improving water quality and lavatory in rural areas. The life expectancy at birth in 2014 has increased by a year since 2010 (General Office of the State Council 2015).

Table 4.4: The Progress of Maternal and Child Health Programme

Indicators	2008	2014
Hospital delivery (%)	88.6	95.8
C-section rate (%)	27.2	36.4
Hypertension management (%)	64.6	76.6
Control blood pressure (%)	—	65.9
MMR (per 100,000)	34.3	21.7
IMR (per 1,000)	14.9	8.9

Source: Ministry of Health 2009, 2015

IMPROVING MEDICAL SERVICE SYSTEM

The total number of medical institutions was 928,358 in 2013. The medical institutions are composed of hospitals (2.66 per cent), urban CHCs (3.66 per cent), rural township health centres (3.98 per cent), clinical centres (19.82 per cent) and village health post (69.86 per cent).

Table 4.5: Patient Flow in Health System at Different Level

	Outpatient Flow	Inpatient Flow
	Percentage(%)	Percentage(%)
Urban hospital	36.8	70.6
CHCs	8.8	2.0
Township health centres	16.3	27.4
Village health post	29.9	--
Clinical outpatient centre	9.0	--

Source: Ministry of Health 2015

In China, more than one third of outpatient and 70 per cent inpatient flow is to urban secondary and tertiary hospitals. In rural areas 46 per cent of outpatients and one third of inpatients are taken care by the county hospitals, township health centres and village health posts. At present, there is no gatekeeper system that exists. In order to establish a hierarchical medical system, it is important to allocate more resources to the grassroots health facilities so as to encourage patient flows to the primary health care institutions.

Along with the universal coverage of medical insurance schemes, the health utilisation has increased dramatically. In 2014, the annual number of outpatients was 7.8 billion and the number of admissions to the hospital increased to 20.5 million cases (Ministry of Health 2015). The annual average growth rate was 7.5 per cent for ambulatory visits and 9.6 per cent for hospitalisation.

Table 4.6: The Number of Outpatient and Inpatient in China (1985-2014)

	No. of Outpatient(100 Million)	No. of Inpatient (Million)
1985	24.11	4.3
1990	25.59	5.1
1995	21.90	5.0
2000	21.23	5.3
2005	40.97	7.2
2010	58.37	14.2
2014	78.0	20.5

Source: Ministry of Health 2015

Another significant phenomenon is that the trend of pharmaceutical expenditure has changed significantly. In the last two decades, hospitals used to be the main channel for sale of drugs. Nearly 70 per cent of the pharmaceutical expenditure occurs in the hospital outpatient department. Earlier, only 5 per

cent of the medicines were retailed from the pharmacy. Now the proportion of pharmaceutical expenditure in the pharmacies has increased to 30 per cent. This means that the patient can take the doctor's prescription to get the medicines from outside the hospital, as many drug stores have been designated by the medical insurance authority. The drugs sold by these drug stores can get reimbursed from medical insurance schemes. If patients suffer from mild infections, they buy drugs over-the-counter from pharmacies (CNHDRC 2013).

Table 4.7: The Trend of Distribution of Pharmaceutical Expenditure (in Percentage)

	Outpatient Department	Inpatient Department	Retail Drug in Pharmacy
1990	69.7	25.7	4.6
1995	60.0	30.8	9.3
2000	54.8	31.2	14
2005	46.1	32.5	21.4
2008	40.9	34.7	24.4
2009	40.9	36.9	22.2
2010	39.1	36.5	24.5
2011	38.5	35.8	25.7
2012	34.4	35.2	30.4

Source: Ministry of Health 2012

PUBLIC HOSPITAL REFORM AND PPP

Although most hospitals in China are government owned, government input only accounts for 10 per cent of total hospital revenue. Public hospital requires financial surplus through increasing the volume of medical services by means of insurance compensation. Public hospital reform is the most difficult task in the whole health sector reform. In 2014, 1033 county public hospitals were part of a national pilot study for comprehensive reform. The 15-20 per cent drug margin policy has been eliminated in these county hospitals. The financial balance will be maintained through cost accounting, adjusting medical service price and increasing government input. Meanwhile, the payment system is being reformed in hospitals and community health centres that includes global budget control, case payment and capitation that means a doctor is paid by the number of people staying the area.

Government has the responsibility for hospital construction, investing in equipment and diagnostics, supporting hospital information system, capacity building of key clinical specialties and improving the quality of medical service. Public hospitals need to pay attention to their efficiency, quality, cost containment and improve the internal management. Doctors are now encouraged to do multi-site practice, including private practice (Ministry of Health 2014).

Government financial support to public hospitals is still very low. At present, public hospital reform has many existing issues, such as lack of integrated services, irrational patient flow, and the price of medical services that needs to be adjusted in order to compensate for the real cost. After delinking the surplus between drug revenue and expenditure, hospitals are not able to make any profits and on the other hand patients still complain of higher costs when seeking medical care.

Going by the workload between public and private hospitals, the public sector dominates medical service. Even in urban China, 75 per cent outpatients are distributed in the government-run community health centres, only 25 per cent outpatients are treated in the private sector.

Table 4.8: The Workload between Public and Private Sectors (2012)

	Public Sector	Private Sector
No. of Outpatient (%)	90.05	9.95
No. of Inpatient (%)	89.03	10.97
No. of providers (%)	57.76	42.24
No. of beds (%)	86.01	13.99

Source: Ministry of Health 2012.

Table 4.8 shows that although 40 per cent medical providers are in the private sector, most are clinics, small group practices or small scale private hospitals. The private sector is underdeveloped in China. Only 14 per cent beds are in the private sector and only 10 per cent patients receive care in the private sector.

Recently, the State Council published a policy to promote private health sector development (General Office of the State Council 2015). The main measurements are to control the scale of public hospitals and encourage doctors to practice in multiple sites. Government will ease out the entry barrier of private hospital investors, and give a tax waive. It will also give the private sector some place in regional health planning. Patients who seek treatment in private hospitals can also get reimbursed from health insurance schemes. There are several other partnership models that are underway in different provinces.

CHALLENGES OF HEALTH CARE REFORM

Along with the universal coverage of basic medical insurance schemes, the health demand and utilisation increased dramatically. A hierarchical and referral medical system has not been established yet. The family doctor model is being piloted since 2016 to introduce the gatekeeper system and curb the irrational patient flow of patients to tertiary hospitals. On the other hand, the grassroots health facilities are underutilised at the primary level. It reflects the low efficiency of limited health resource allocation. Even if the medical insurance

coverage is high, the benefit package is not wide enough. Patients still have to pay more than 30 per cent medical costs OOP (China Health Insurance Research Association 2013).

China is facing an epidemiological and demographic transition. In Chinese society, 9.4 per cent population are more than 65 years old. The total prevalence rate of chronic disease is about 20 per cent. The number of diabetes and hypertension patients is increasing annually. For instance, China has the highest prevalence rate of diabetes in the world. 10 per cent adults above 18 years of age suffer from diabetes, 10.5 per cent male and 8.3 per cent female. The total number of diabetes patients is estimated beyond 114 million (WHO 2015).

There are several reforms being brought in human resources. Due to the high workload and low salary of medical professionals, the remuneration of doctors, nurses and pharmacists will be raised through performance-based payment reform. Organising a resident doctor training programme is a new initiative in human resource development. Rebuilding patient-physician trust in China is a very important component of the public hospital reform given the growing violence against health care professionals.

CONCLUSION

China has made great achievements in reforming the health service system in the past 6 years (Yip et al 2012). The main experience is the government commitment to health in all policies. Providing the basic health service, strengthening the grassroots health facilities and building up a new mechanism of reform will be the key principle and action. China's health system is segmented; health reform cannot be accomplished without a multi-sector approach. The health service reform cannot be done by the health sector alone, without the involvement of the different stakeholders, such as NDRC, Ministries of Finance, Human Resource and Social Security, Commerce, Civil Affairs, Industry and Information, SFDA and so on.

The roadmap to the universal health coverage requires having a master plan and holistic approach. From the provider side, China needs to have performance-based financing, integration of health service and PPPs. From the demand side, China needs to have population-oriented and patient-centred approach, a good relationship between doctors and patients. A feeling of optimism and sense of having gained from the reforms will hold the key to the direction and future of the health sector reforms.

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5. Reforms in Public Hospitals: The Indian Case

Prachin Ghodajkar

INTRODUCTION

To understand reforms in public hospitals in India it is important to understand the place of hospitals in health service system and its historical evolution.

Modern medicine entered in India during British rule, initially in the form of private practitioners and later through state run institutions. Modern medical care was primarily for British citizens and for the army, with a limited access to Indian elites. Health care institutes through state and provincial governments started emerging in late 19th and early 20th century in the form of maternity health unit, peripheral health centres and medical colleges.

EARLY YEARS OF OPTIMISM AND EXPANSION: 1950 AND 1960

The economic depression of the 1930s and the Second World War of the 1940s played an important role in making health services one of the important elements of welfare to be provided by the state to all citizens, especially in Europe. The Beveridge Committee's recommendations for building the National Health Service in the UK made an impression on a newly independent India, attempting to build its health services.

At the time of Independence different developmental visions for the country were discussed. After Independence, the government officially accepted the recommendations of the Bhore Committee. The Committee had suggested a three-tier model of providing comprehensive health care services to all the citizens of the country irrespective of their ability to pay. The model comprised of 75 bedded hospital at the primary level serving a population of 20,000; 650 bedded hospital at secondary level serving a population of 600,000 and 2,500 bedded hospital at the district headquarter serving a population of three million (GOI 1946).

Bhore committee's model of health service delivery was indeed hospital based involving basic doctor as a key person. Following the recommendations of Bhore committee, the decade of 50s and 60s saw a rapid expansion of hospitals and medical colleges as these were supposed to act as training centres, to provide all the necessary health related human resources needed for the country. In 1951, there were 2694 hospitals in the country and 117,000 beds

(hospital and dispensary beds combined). In 1956, hospitals increased by 20.15 per cent and medical colleges also doubled but this rapid expansion was very inadequate in comparison to what was required (GOI 1962).

At the end of the first decade a committee was appointed to assess the progress made on the implementation of Bhore committee recommendations and suggest future course of action. The Committee headed by Mudaliar submitted its recommendations in 1962. It highlighted the problems of shortage of resources-material, monetary and human resources and poor referral services. The Committee pointed out the poor quality of care being provided in the public sector hospitals. There was shortage of essential drugs and medical equipment. Proper referral system was not present, resulting in minor ailments being treated at higher levels such as at the district hospitals and medical colleges resulting in overcrowding. These overcrowded institutes lacked the quality in care that was provided. Smaller hospitals also faced shortages of resources-human, money and material. The evident inefficiency of health services was highlighted (GOI 1962).

The Committee recommended consolidation of the health services rather than expansion. It suggested organisational improvement to increase efficiency. The committee went on to indicate, against the principles laid down in Bhore committee recommendations that free medical care service was not possible (GOI 1962). It proposed possibility of exploring insurance based model of health services and of levying user fees for the services provided in order to generate resources. It also suggested that district hospitals should become the hub of medical care network in the entire district. It suggested the strengthening of bed capacity by allocating bed for different medical cases. For large rural areas it suggested expanding the mobile team of doctors to provide services.

DECADE OF STAGNATION: 1970S

There was a global economic recession during the 1970s. Health care costs had become an important concern even for developed countries. In the context of economic recession, questions were raised on the sustainability of a hospital-based and technology-centred curative medical service delivery models. This led to imaginations of alternative models of health service delivery. Primary Health Care declaration at Alma-Ata was widely accepted by the WHO member states. A comprehensive primary health care approach had highlighted the importance of a three-tier health service system. It was reiterated that primary level care service can function successfully only if they are backed by effective secondary

and tertiary level institutes. Recognising the skewed resource consumption it had suggested the augmenting of primary and secondary level care (WHO 1978).

Effect of global economic recession on Indian health services could be seen in the form of declining investments in health and slow growth of medical institutes. In 1973, there were 2769 (79.4 per cent) government owned and financed hospitals in the country with 230,161 (77.47 per cent) beds. From 1973 to 1980 private hospitals increased by 303 per cent and their bed strength increased by 95 per cent. Public sector hospital grew at lower rate, around 34 per cent and the bed strength increased by 43 per cent.

Public sector hospitals, especially district hospitals, sub-district hospitals and CHCs at the secondary level had different inadequacies especially of nursing staff, equipment, drugs, consumables and diet. Improving these hospitals was very essential as they were supposed to serve as referral centres.

POST ALMA-ATA: NEGLECT OF SECONDARY AND TERTIARY LEVEL FOR SELECTIVE PHC IN THE 1980S

The working group on Health for All in 1980 observed that, 'In spite of its best efforts and intentions, it would not be possible for government alone to provide all the financial requirements under the present state of country's economy, as such community must share some of the cost of health care delivery' (GOI 1981: 102). The group further suggested that hospitals should be turned in to hospital corporations in order to make them more autonomous and to ensure participation of urban community in hospital management. It suggested restricting the availability of medicines in all institutes above PHC level and stated that only basic medicines would be made available and rest of the medicines might be purchased by the patients. Fees for medicines, investigations and diet provided in the hospital were also suggested in addition to paid services for those who could afford, in the public hospitals (GOI 1981).

Thus, it could be seen that from the early eighties, small structural and organisational changes, community participation (both monetarily and in the management of the hospitals) and revenue generation by the hospital through fee for services were suggested. The secondary level institutes were resource starved and could hardly act as referral centres for the lower levels of health institutes. In this decade, the focus was on primary level care and there were restrictions on the expansion of public sector hospitals. At the end of this decade the public sector still had around 70 per cent of the total beds available in the country. The share of private sector beds had increased to 30 per cent. Private sector had slowly started to expand. It shifted from ambulatory

outpatient care to indoor care through small hospitals and nursing homes. Of the total hospitals, private sector had around 55 per cent hospitals. Much of this private sector providing in-patient care was providing services at the secondary level and small proportion at the tertiary level. Lack of investments in public sector hospitals, rising middle class, and urbanisation contributed to rise of private sector growth.

ERA OF STRUCTURAL ADJUSTMENT AND REFORMS: POST 1991

In 1991 India opened its economy in its attempt to deal with balance of payment crisis. This neoliberal turn of economy was guided and aided by the World Bank and IMF with the soft loans offered by these Bretton Woods institutes. Indian economy had to undergo major economic and other policy changes in order to get the soft loan. The soft loans came with the conditionalities, with reduced role of the government in welfare and government was to be seen as a steward of the ship where market was implicitly seen as the captain. World Bank's report on 'Investing in Health' in 1993 provided the blueprint for the proposed health reform strategies under the structural adjustment programme. The report proposed fundamental changes in health services structure and also in public sector hospitals in India with major role for private sector in providing health care especially at secondary and tertiary levels. Under the reforms the state was to act as a funder and purchaser of services, wherever required, instead of provider of services (World Bank 1993).

The decade of 1990s saw the stagnation of growth of public sector hospital and significant growth of the private sector.

HSR STRATEGIES AND ITS IMPLICATIONS FOR PUBLIC HOSPITALS

NEW PUBLIC MANAGEMENT

Health sector reform strategies rely heavily on principles offered by New Public Management (NPM), as can be seen from the experience of many developed and developing countries implementing them. NPM principles and strategies were used as tools for implementing structural adjustment programme and HSR. NPM emphasises on cost effectiveness and has a value for money approach. Application of NPM in public sector or in welfare services meant shifting the emphasis away from traditional public administration to public management. Decentralisation of management through autonomous agencies/bodies created within public services was one of the key shifts. These autonomous agencies/bodies served the purpose of management by the public and also

brought in devolution of budgetary controls (Roy 2007). NPM and structural adjustment policies complemented each other as these local autonomous bodies took over the roles and responsibilities that are actually state responsibilities. Thus, autonomous bodies helped the state to retreat and pushed communities to be responsible for their own health. NPM also meant incorporating practices of private sector to improve efficiency of public sector. The use of market principles, with its basic tenet being competition, was in the form of 'internal market mechanisms in public services' and 'managed competition'. The focus of NPM on cost effectiveness and efficiency translated in the form of output measurement and performance assessment, which are important activities under HSR and are usually governed by institutional economics. The economic considerations tend to prevail over public health and epidemiological consideration in such assessments.

CUTS IN THE HEALTH BUDGETS

The decade of 90s witnessed the huge cutbacks in already meagre health budgets. The health expenditure peaked in 1980s to 1.4 per cent of GDP. It then started slowly declining during this reform period throughout the decade 90s and early 2000s. Just before the launch of NRHM the health expenditure had plummeted to 0.9 per cent GDP. This was true for state budgets too. For example, for Maharashtra, time trend analysis of public health expenditure as a percentage of the state domestic product shows that expenditure had declined from 0.80 percent in 1980s to 0.60 percent in late 1990s and has actually stagnated at 0.60 percent for the initial years of 2000 (GOM, 2002). Total public health expenditure of Maharashtra was one of the lowest in the country

Apart from low budget allocation, there is another major problem of low utilisation of meagrely allocated funds. Underutilisation of fund was because of many bottle necks in financial flows, a large amount of funds was made available to various offices towards the end of the financial year. Poor fiscal management further added to the problems of financially deprived health services (Duggal et al 2004). Time trend of decade of 1990s shows consistent low capital spending on health. The implication of such a low capital spending had an implication of no new investments being made to upgrade or expand the public health services (Duggal 2003).

Outcome: Stagnant public services with rising costs of care for people/ shift in financial responsibility

Table 5.1*:* Health Expenditures in India as a Ratio to GDP at Current Prices (1980–2005)

	1980–81	1985–86	1991–92	1995–96	1998–99	2000–01	2004–05
Public							
% GDP	1.07	1.32	0.88	0.86	0.91	0.81	0.83
Private							
% GDP	3.88	3.45	2.60	2.94	4.09	4.46	4.67
% Hospitals	43		57	68		76	
% Beds	28		32	37		55	

Source: Jan SwasthyaAbhiyan (JSA),2006.

Budgetary cutbacks for health affected the health services system. There was stagnation in the expansion of health services, especially if seen in proportionate to population growth. There was stagnation both of quantity and quality of health services delivered. Acute shortages of health human resources at all levels of health service delivery, shortages of specialist and support staff lead to deterioration of quality of health services delivered. This neglect of public health services contributed to the expansion of private sector at secondary and tertiary level of health service delivery. Much of the growth in private sector was in urban areas. This contributed further aggravating the rural urban differences of distribution health facilities and beds.

One of the assumption behind cutting down of the health budget was to prevent wasteful or unnecessary health expenditure. However, a study on public hospitals in Bengal showed that 80 per cent of total hospitalised cases were emergency cases, indicating it was not unnecessary utilisation (Roy 2007). Health care utilisation patterns both for outpatient and inpatient health care services started to shift in favour of private sector, as people were almost pushed out of the government run hospitals. OOP expenditures for hospitalisation increased significantly, for both public and private hospitals.

PPP: PRIVATISATION OF THE PUBLIC HEALTH SERVICES

Privatisation of government health services and partnership with private sector in providing different types of health and allied services are important activities under HSR. Privatisation and PPPs unfolded in different forms like, contracting out of medical and other support services, selling or leasing of public hospitals to private sector, sharing of resources (human resources, material resources, technology and specialist), Build Operate and Transfer model for infrastructural development of large hospitals, partnering with voluntary organisations for increasing the outreach of health facilities and so on.

HSR strategies brought in on a large scale, a trend of outsourcing of management of non-clinical and support services in public hospitals. Outsourcing and getting this work done through contract based service arrangements was projected as strategy to increase efficiency and of reducing expenses. It was assumed that this kind of arrangement would improve quality.

In many states non-clinical supportive services like diet, laundry, sanitation, security, ambulance service in district hospitals, sub-divisional hospitals and in tertiary hospitals were outsourced. In due course of time diagnostic medical services – radiological investigations like Ultra sound, CT Scan and MRI and laboratory investigations were provided through different kinds of PPP arrangements. Some of these PPP were forged at the level of hospital, in others PPPs were between state and particular service provider, who was responsible for providing the service in all hospitals in the state or group of district.

In Punjab, X-ray and other diagnostic services along with maintenance services were outsourced. Proactive states like Punjab had even outsourced the clinical services like dental, psychiatry and skin. In some states PPPs had gone to an extent where public sector tertiary hospitals were handed over to private players to run. Karnataka government handed over one of its super-speciality hospital to the Apollo Group. Pune Municipal Corporation expanded one of its existing hospital constructed a new building by spending around Rs 30 million, and its capacity was increased to about 200 beds. Urban local bodies like the Pune Municipal Corporation (PMC) initiated the process of transferring the management of the newly constructed hospital to a private doctor. PMC with a contractual agreement with a private doctor handed over the newly constructed hospital along with free water supply and electricity supply and maintenance services for a period of 29 years that too without any rent. The agreement mandated the private doctor to provide certain basic services at the same rates being charged by the PMC, along with additional specialised services.

Maharashtra Health Systems Development Project II was started in the year 1999 with objectives of improving secondary hospitals i.e. community health centres, sub-divisional hospitals, district hospitals, and rural hospitals. The project contributed in up-gradation of these hospitals. The project helped hospitals to acquire new and hi-tech instruments and equipment. It also helped hospitals to upgrade and expand the services like adding extra speciality wards to hospitals like burns ward. Hospitals improved and expanded their infrastructure. Ambulances were purchased by the hospitals under this project.

The effect of the ethos of partnerships brought in by the project can be seen outside the state government owned public hospitals as well. By the end of over five years of project duration, 21 Brihanmumbai Municipal Corporation (BMC) hospitals were having some kind of PPPs. These partnerships were for range of services such as diagnostic services, especially high end diagnostics like CT scan, blood bank, dietary services and laundry services.

Outcome: Profit maximisation of private players at the cost of care delivery in public hospitals

The competition among the private players to take over the services of public hospitals opened by health sector reform strategies was expected to reduce the costs and improve the quality and in turn improve the efficiency. However experience shows that there was hardly any competition among private agencies to take over hospital services especially for diagnostic services like CT and MRI scans. There were not many takers of drug stores and ambulance services for some hospitals (Raman and Bjorkman, 2006).

Roy's study (2007) further shows that contracting out and selection of partners for PPP arrangements was not a transparent process always. Political influences, social connections, kickbacks affected the selection process. There were no fair competition and many selections were not based on comparison of costs, experience and standards. She showed that there was monopolisation of private players over hospitals. This control was achieved by the private players through extension of contract, by delaying the tendering process or through court cases. Long duration of work also had helped them to develop nexus within the hospital which acted in their favour.

Private players providing services in government hospitals under different PPP arrangement also did not improve the quality of those services provided. The natures of contract agreement were such that it ensured profits and flexibility to the private players but it did not ensure quality improvement for the public hospital. Contract agreements did not have clarity on keeping records of minimum human resources to be deployed, minimum wages to be given, purchase and use of the required raw material. Contractors were just required to take up the responsibility of services. Contractor exploited these loopholes to maximise their profits and delivered substandard services. In some instances, like the BMC hospitals managed to reduce the cost of dietary services provided in the hospital but at the cost of poor quality dietary services. These hospitals did not attempt to monitor quantity and quality of services provided (Bhatia and Mills 1997). Another study in BMC hospitals reports deterioration of sanitation

services. There were also discrepancies in amount and nature of chemicals and detergents used in the maintaining the hygiene of the hospital by the private player (Prabhakar 2006).

In public hospitals of Bengal, before outsourcing cooked meal service, there were eleven types of diets keeping in mind the nutritional requirements of different types of patients and their age group. After contracting out, six types of diet for adult and children were fixed. Patients had to be without food on the day of the admission. The special diets for the TB patients, post-operative diet, maternity cases and infant diets were also deleted. Tea or milk was not provided (Roy 2007).

CONTRACTUALISATION OF LABOUR IN PUBLIC HOSPITALS

A World Bank review identified different causes for underutilisation of first referral hospitals. Important factors identified included non-availability of staff (especially doctors). Apart from doctors other paramedical workers were also not available. Most of the posts of laboratory technicians, supervisory cadre were vacant. In places where posts were filled, then significant proportion of them was on deputation at higher level hospitals. Insensitivity of government medical personnel was another reason sighted for preference of private sector. Shortage of drugs and medicines at first referral hospitals was also important identified problem. It also studied private sector and reported that easily accessible services was main advantage of the private sector. Apart from being located in easily accessible areas, private sector hospitals were providing round the clock services, even the speciality services. Well maintained infrastructure and facilities, courteous behaviour of medical personnel were identified as the strengths of private sector hospital (World Bank 1996). It further highlights relevance of public sector but limits the relevance of it only for the poor and marginal. It stated that the private sector had low commitment to low-cost preventive care and that in the case of emergencies government hospitals were more efficient. Even with this evidence, they still recommended an enhanced role of the private sector to increase efficient services and contract out services to them by also bringing in contractual staff in public hospitals.

Cost cutting was an important objective of the reform process. The analysis of health care spending had shown that salaries contributed to almost two-thirds of the total expenditure on health. It was argued that as salaries component was eating up 70 per cent of the resources and affecting the inputs in other critical areas. Cost cutting in salaries was seen as an important avenue of optimising the resources. This was achieved through contractual human resources. It was assumed that in public sector hospitals poor service quality

was due to inefficient service delivery mechanism involving non-functional permanent workers. Contract based appointment was considered a way to deal with the 'non-functional' permanent workers.

Medical, para-medical and non-medical personnel in government hospitals were recruited through contract-based appointment. In some states specialists from the private sector were empanelled and appointed in government facilities with an honorarium. Anaesthetists were hired from the private sector. In Himachal Pradesh, contractual appointments were given to doctors and nurses. In Karnataka contractual appointment of doctors was decentralised. Government had stopped recruitment for the class IV employees (unskilled labour) and 30 per cent of the posts were kept vacant and the services they were providing were outsourced (GOI2004).

Outcome: Vulnerable health workers and undermining the ethos of care giving in public hospitals

Lack of clarity in contract agreements were used for exploitation of labour, especially those working on behalf of private players in public hospitals. Contract agreement did not specify work hours, salaries or the minimum manpower strength (skilled and unskilled) that the private agency should employ. This made private agencies less accountable to the public sector and allowed them to exploit the labour in public hospitals.

Apart from the exploitation and hiring of the workers by the private players, the public hospitals also started to hire health workers on contract. Many states stopped recruitment of new health workers of all types, paving the way for contractual hiring.

Health policy makers started the HSR by contracting out the services provided by group D workers who were the most vulnerable to private players. Sanitation workers in group D were mostly from lower castes. These workers were left to the mercy of private players who were more interested in earning profits than workers health. Significant proportion of posts of group D was kept vacant and then opened for private player to provide those services.

Health sector reform for hiring doctors, nurses, technicians, mostly from middle and upper castes, were channelised through contractual hiring by the public hospitals. So they were saved from the private contractors who were the middle men for hiring other contract workers.

Contractual workers did not have job protection and all other safety mechanism available for a regular worker. They did not have salary protection, increments and other retirement benefits. All the contract workers were paid a

minimum fixed consolidated amount per month as per the level of work. Contractual work arrangements were done in order to save money as salaries were shown to be eating up highest proportion of health budget. Roy's study (2007) shows that in secondary and tertiary level hospitals after contracting out diet, scavenging and security services, the reduction in salaries was only marginal because the investments were already at the lower levels and could not be brought down any further. In Nadia district, salary expenditure declined from 87 per cent to 82 per cent over 2002-03 to 2006-07. In another tertiary hospital the proportion of salary to total expenditure declined from 75.87 to 70 per cent between 2002-03 and 2006-07. Cost saving achieved through contractual working was very marginal (Roy 2007).

This marginal cost saving came with a cost of deterioration of work culture in public hospitals. After HSR led contractual hiring in a public hospital there were two kinds of workers doing the same job. Some doctors were permanent and some were on contract, this was applicable for all types of health workers. This affected their attitude and approach towards the work and in turn the work culture. Different job conditionalities for same job affected the working relationships among workers resulting in poor work culture.

REVENUE GENERATION AND USER FEES

User fees in government health services were introduced by some state governments in 1970s. The experience of cost recovery or revenue generation through user fees in 15 states had revealed that cost recovery had declined from 6.4 per cent in 1975-76 to 1.6 per cent in 1988-89, the average cost recovery being only 3.8 per cent of total (recurrent) health expenditure. Hence, the user fees levied on some services was not significant to make any impact on cost recovery. This became one of the main reform components in the 1990s.

User charge for services was supposed to serve the purpose of screening out the unnecessary use or minimising the moral hazard created by the free services. The findings from National Sample Surveys shows huge OOP expenditure on health (as people did not have choice but to spend in the context of poorly functioning and resource deprived government health services) was interpreted as people's willingness to pay for services. Since people were already paying for services in the private sector, user fees could be easily introduced in government hospitals. User fees were projected as one of the ways of community participation and making services accountable for users as they were paying for the services. These different rationales were used for introducing and expanding the scope of user fees. User fees were emphasised as a mechanism for cost

recovery and revenue generation in the Health System Development Project II (HSDP II). After HSDP II outpatient services, bed charges for inpatients, surgeries (major and minor), diagnostic services (both radiological and pathological), diet services were charged in government hospitals. In many states, user fee was revised, and paying beds were increased. The principle used in levying and expansion of user fee was that as the quality of services improves over time user fees can also be increased.

In Maharashtra, pre-reform cost recovery experience through user fee has been very poor. Revenue generated through user charges has been consistently less than two per cent of the total public health expenditure over a period of 1989-96. Maharashtra Health System Development Project (MHSDP) acted as catalyst for revising and expanding user fees in Maharashtra. Despite the poor experience of cost recovery through user fee, the government order on user fees of 1988 was revised after MHSDP. New guidelines were issued for charging user fees and utilising the revenue generated in all district and sub-district hospitals in Maharashtra. The revenue generated was collected in a consolidated fund which could be used only with permission of Medical Superintendent or civil surgeon.

There are inter-state differences in the implementation of user fees, retention by hospitals, utilisation pattern and exemption policy.

Outcome: Commodification of health in the name of revenue generation fees

The trend of revenue generation has continued. The experience of Nadia district hospital in Bengal shows that user fee generated very meagre revenue. The total amount collected through user fees was only 2.14 to 1.8 per cent of what was total expenditure of the district hospital 2002-03 to 2005-06 (Roy 2007). Thus, user fee contributed a miniscule amount to already resource deprived public sector health services. However, these miniscule financial gains were at the cost of reduced access and utilisation of public health services.

The National Sample Survey Organisation (NSSO) data shows that proportion of people not using any health care despite being ill increased. The proportion of those who did not access health services for financial reason was significant. NSSO in India indicates that between 1986-87 and 2004, the share of ailments not treated due to financial reasons has increased from around 15 to 28 per cent in the rural areas. According to the NSSO data, the share of outpatient visits to public facilities has dropped from 25 to 20 per cent and for inpatient visits from 60 to 40 per cent (Selvaraj and Karan, 2009).

Table 5.2: Proportion of Total Utilisation Accounted for the Poor in Andhra Pradesh

Services	2001–02 (% Before User Fees)	2003-04 (% after User Fees)
Inpatients	92	65
Outpatients	83	68
Surgeries	82	74
Deliveries	74	53

Source: JSA 2006

In some states this revenue generated made it to the state treasury, and was used by the state for expenditure of the state on different activities. However, some states kept some portion of revenue generated through user fees for hospital use.

The revenue generated was supposed to be used for recurrent hospital expenditures on consumables like drugs, reagents and other consumable items needed in the hospital. The revenue generated were miniscule but this strategy made important change i.e. it shifted the financial base of these consumable items of hospitals from general tax-based resource to user fees generated at hospitals. It has the risk of pushing the hospitals to prioritise monetary concerns over health needs of the patients and population.

The fundamental change that user fees brought is in the fact that it made health care a commodity which one had to buy by paying for it. Earlier also everyone was paying for health care services through direct and indirect tax based revenue system. However user fee made health care a commodity which one has to pay directly at the point of use. This defies the logic that health care is a public good. Wide spread practice of user fee even in public hospitals pre-empts the possibility of it being provided as a matter of right which society confers on to its members. It became commodity which one has to pay for with a clear understanding and practice that nature of care provided would differ based on amount paid for the services.

FORMATION OF AUTONOMOUS BODIES: PATIENT WELFARE COMMITTEES

Some of the developed countries like UK, with predominantly state provided health services, under their reform initiatives had made their public hospital autonomous entities in order to have competition among different hospital, and competition among general practitioners. Principles of NPM also necessitated shift from public administration to public management. Decentralised public management of NPM, for making public hospitals more efficient and cost effective, was deployed in India by forming autonomous bodies at public hospitals. In different states, autonomous bodies/societies were created. These

societies served the purpose of facilitating many new institutional arrangements of HSR. These societies started mainly with role of managing user charge collection. They were supposed help in improving the hospital service delivery. These autonomous societies were commonly called as *Rogi Kalyan Samitis* (RKS). Functions of the committees across the states did not reflect much difference.

Living up to the spirit of HSR and assumed inefficiency of public sector hospitals the societies played an important role in enhancing privatisation and PPPs with aim of improving functioning and quality of public hospitals. These committees played an important role in managing new institutional arrangements like contractual health workers, revenue generation through user fees, PPPs and so on.

In some states, RKS had authority and control over public sector assets like land of the hospital premises and hospital infrastructure. They used the hospital infrastructure and premise for commercial activity for revenue generation by renting out land for parking vehicles and by renting out hospital premise to run canteens. In Rajasthan, RKS outsourced services of diet, security, sanitation, and maintenance. In all the states, Samitis have received the power to raise finance through donations, loans from financial institutions, grants from governments and from donor agencies.

Outcome: Retreat of state through new institutional arrangements and financing methods

RKS played an important role in upgrading the hospitals with different types of diagnostic technologies as these were important sources of revenue generation. Upgradation of secondary and tertiary hospitals also served the agenda of technology transfer from developed countries to developing countries and of more business.

The experience of technological upgradation of hospitals along with fee for services, privatisation and PPPs implemented through RKS shows that RKSs did not act in favour of public or public hospitals. Diagnostics, especially the high tech and those requiring huge investments, that are needed more frequently and with high turnover were given to private players through PPPs, for example CT scan, MRI scan. Other high-end diagnostics requiring huge investments are needed less frequently and have less turn over, for example TMT,

echocardiography, colour doppler were provided through public hospitals at a regulated prices (Roy 2007).

In Maharashtra, the World Bank HSR project, MHSDP contributed in upgrading the secondary and tertiary hospitals with new technologies. However, rather than solving the existing problems created by a new set of problems in the health sector, there were advanced hi-tech equipment introduced but without the staff to operate them. In the context of declining budgetary allocation to health, maintaining these instruments and institutions was a difficult responsibility.

Autonomy with RKS for the public hospitals and principles of institutional economics to run these hospitals would delink these hospitals from other levels of care, especially primary level of care. Autonomous hospitals with financial pressure are less likely to act as referral centre for lower level of institutes.

PUBLIC HOSPITAL REFORMS UNDER NRHM

By early 2000s, stagnating health indicators, rising OOP expenditure, medical impoverishment had pushed Left parties backed government for economic growth with human face. The new coalition government from 2004 continued with economic reforms and structural adjustment policies but launched some programmes to tackle the damage caused by economic reforms. The NRHM was launched in 2005. The architectural corrections enshrined in the preamble of NRHM document primarily comprised of decentralisation, communitisation, organisational structural reforms inhealth sector, intersectoral convergence, PPP in health sector, mainstreaming Indian systems of medicine: Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH), induction of management and financial personnel into health care management and delivery system.

The key components of NRHM were: to strengthen public health facilities by defining and implementing Indian Public Health Standards, strengthening community health care through community level activists, PPPs, enhancing the role of Panchayati Raj Institutions and garnering community action for health, exploring new health financing mechanisms, decentralised district planning, medical education, and technical support for the mission.With NRHM there was a steady increase in fund release and expenditure, at both national and state levels. In monetary terms central spending in the eleventh plan period was 2.5 times and state spending increased by 2.41 times as compared to the tenth plan period.

The NRHM led to a significant strengthening of public health systems. It brought in a workforce of close to 900,000 community health volunteers. The NRHM deployed over 18,000 ambulances for free emergency response and patient transport services to over a million patients monthly. One of the major contributions of the NRHM has been the addition of 140,278 contractual skilled service providers as of 2012, to the public health services in the space of a mere six years. This includes 3083 specialists, 8230 medical officers, 32,915 staff nurses, 66,552 ANMs, 14,913 paramedics, 10,439 AYUSH doctors and 4,146 AYUSH paramedics. This figure has reached to 178,000.

One of the major activities under NRHM was training that aimed to increase the skill sets of existing service providers to enable provision of better quality of services. Some of the training programmes, known generically as 'multiskilling', aimed to address critical deficiencies in specialist skills or specific technical skills by imparting available cadre of service providers the skills usually in the domain of another cadre, for example, teaching medical officer the anaesthetic skills, or training health supervisors on microscopy. A huge volume of trainings for different cadres have taken place over the NRHM period.

NRHM in 11th five year plan (2007-12) trained doctors on Basic and Comprehensive Emergency Obstetric Care at various levels and about 10,022 number of doctors were trained on Medical Termination of Pregnancy at state and district levels. The number of doctors and nurses trained as skilled birth attendants was 60,571. A total of 267,377 doctors, nurses and Anganwadi workers received training on management of neo-natal and childhood diseases.

In addition to the increase in service providers, NRHM also deserves the credit for the induction of a number of non-clinical personnel such as programme managers, data managers, accountants and finance managers and other non-medical management related personnel who have played an important role in improving the quality of programme management.

Under NRHM by the year 2012 there was a 165.5 per cent increase in the total number of First Referral Units (FRUs) as compared to the baseline year of 2005. The total number of FRUs increased from 955 to 2,536. However, this was well short of NRHM targets. The skew in distribution of these FRUs is a greater concern. The high focus states which account for almost three fourths of all maternal deaths still have a 39 per cent shortfall.

One of the most important goals of the NRHM was improving quality of care in public health facilities. NRHM contributed to this goal in a number of ways, in addition to abovementioned expansion of services and increased human

resources it also included adoption of the Indian Public Health Standards.This defined not only the service package that each level of facility must provide, but also specified the minimum inputs required to ensure quality of care, in terms of infrastructure, equipment, skilled human resources, and supplies.Skill sets and Standard Treatment Protocols required for providing quality RCH services and training packages that would provide these skill sets were designed. NRHM also supported initiatives for building quality management systems. These range from formation of quality assurance committees which uses check lists and periodic monitoring visits to assess quality gaps, to more structured quality management systems leading to a third party audit and quality certification- either using ISO 9001: 2008 or NABH. Till date, 140 facilities have been certified by ISO, and 446 facilities are under process of certification.

NRHM continued the agenda of HSR but had brought many positive changes in health service delivery and health status indicators, though not very significant.

CONCLUSION

The damage caused by HSR is far reaching in the form of changed cultural ethos of medical practice where technology has become very central to health service delivery, profits and financial efficiency have become the guiding principles and rationality and ethical practice are no more valued principles. HSR has successfully managed to delink the secondary and tertiary levels from primary levels of health care delivery and give impetus to the private sector with more thrust on technology and specialisations.

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6. Public Hospital Reform in China: Review and Outlook

Yingyao Chen and Ke Xiong[1]

INTRODUCTION

The Chinese health service system has achieved a lot, but is confronted with great challenges. These health service issues are mostly related to the performance of public hospitals and public hospital governance structures and policies. The underlying reason may be that the government has granted public hospitals much autonomy since the economic reform and open policy of the 1980s.

The objective of the paper is to review the hospital autonomy policies in the context of economic reforms in China and to propose policy implications for the undergoing health care reform in China.

This paper employs a literature review of policy documents and conducts a secondary data analysis (mainly from China Statistics Yearbooks) to describe the development of hospital autonomy policies, their implementation, and their impact on the health system, including equity, quality and efficiency of care. This paper describes some of the public hospital reforms underway and aims to review the hospital autonomy policies in the context of economic reform, and proposes policy implications for HSR in China.

The paper outlines five aspects of hospital autonomy across different types of hospitals in China and proposes some policy recommendations to meet the requirements of 'sound' autonomy. This includes strengthening the government's role and responsibility for setting a national strategic vision on development of public hospitals; reaching the common goal and sharing responsibility among different functional government authorities at different levels; making use of insurance authorities to monitor health care costs, quality, efficiency and access to care; establishing effective governance structures for public hospitals; highlighting control of residual claimant and social function by effective governing approaches; inviting stakeholders (especially, patients) participation and re-piloting or re-implementing the separation of public and private or for-profit and non-profit hospitals.

In this paper we have reviewed literature on hospital autonomisation in China in the past 30 years, and analysed the development of policies related to autonomy and the impact on public hospitals. There are a few systematic studies available and these studies are focused on macro studies conducted on public hospitals.

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BACKGROUND AND CONTEXT

China is the largest developing country in the world. It is well known that the Chinese economy has had tremendous rapid growth since the implementation of reform and opening-up policies in the 1980s. In fact, economic growth has averaged 10 per cent over the past 30 years. China has become world's second largest economy. As the economy grew, Chinese citizens experienced growth in personal income and significant improvements in living conditions, but social problems also emerged and the growing inequalities across China became visible. Today, these social problems are hindering further improvement in people's living standard and their quality of life. The most outstanding problem for Chinese citizens has been the difficulty in accessing health services due to heavy OOP expenses that are incurred.

The Chinese health system has made a lot of achievements, but it is confronted with great challenges, such as the dual disease burden (communicable and non-communicable) along with a demographic transition, accumulated health service problems including high costs and unaffordability that has led to impoverishment. These health service issues are mostly related to the performance of public hospitals, public hospital governance structures, approaches and policies. The underlying reason may be that the government has granted public hospitals much autonomy since the economic reform and open policy of the1980s.

The government intends to restructure its health service system to address this problem. The goal of health care reform, that is underway in China, is to achieve universal coverage for essential health services by 2020. Public hospital reform is regarded as the most important and difficult area of healthcare reform. It is essential to review the public hospital policies and examine the consequences over the last 30 years, especially of hospital autonomy.

THE FRAMEWORK OF HOSPITAL AUTONOMY

Harding and Preker (2003) view hospital autonomy (HA) as a reduction in direct government (central health authority or government at different levels) control over public hospitals, and a shift of the decision making from the hierarchy to the hospital management team. The conceptual framework designed by Harding and Preker is a useful tool to analyse hospital autonomy. The framework proposes five dimensions to estimate the effect of autonomisation of different type of hospitals, including budget, autonomised, corporate and private hospital. The five dimensions are as follows:

a. *Decision rights* refers to giving autonomy in decision-making to the management who take critical decisions for allocation of resources for services, setting user fees, arrangements, scope of activities, clinical management, financial management and so on.

b. *Market exposure* means that hospital can earn some revenue from the market rather than getting it completely through direct budget allocation.

c. *The distribution of residual claims* reflects who would be the 'residual claimant' on revenue flows - the government (ownership), the public hospital or any other stakeholder.

d. *The structure of accountability mechanisms* means that hospitals having autonomy restructure accountability mechanisms given the new market pressures they would face, and reduce the traditional hierarchical control.

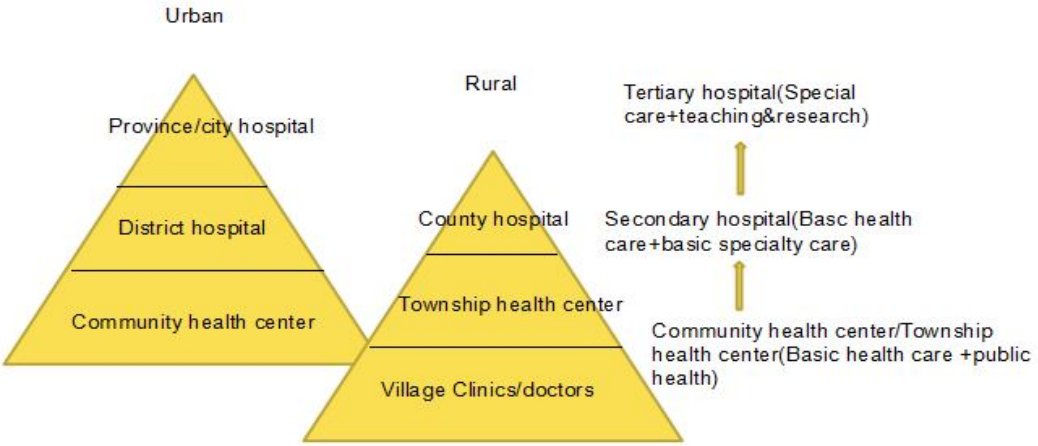
e. *Social function* is introduced to counterbalance the effects of highly powered incentives and to protect unprofitable services. Since the focus on management is on financial viability, they might decrease services that are not making enough profits, which must be checked.

STRUCTURE OF HEALTH SERVICES: SOME BASIC FACTS

SERVICE ORGANISATIONS AND DELIVERY

There are two structures of health service system - public-private mix and autonomous public hospitals. Due to lack of government support and cuts in health spending, public hospitals have had to survive on their own since decentralisation in the 1980s. Public sector dominates the market share, supplemented by the private sector. Therefore, there is competition within and between public hospitals and between public and private hospitals.

Fig. 6.1: Structure of the Urban and Rural Health Service System in China



In China, health service system includes several institutions at primary, secondary and tertiary level across urban and rural areas: clinics, community and township health centres, hospitals, centres for disease control, centres for mental health and so on (Figure 6.1). The idea of the primary level health care is to act as a gatekeeper, but such a function is yet to be implemented well.

NUMBER OF HOSPITALS IN CHINA AND TRENDS

The capacity of public hospitals to deliver services improved significantly through autonomisation, as observed by the growth in the number of hospitals from 1980 to 2014 (Table 6.1). The number of hospitals increased gradually, from 9,902 hospitals in 1980, to 14,377 hospitals in 1990, to 16,318 hospitals in 2000 and to 20,918 hospitals in 2010. The growth trend of general hospitals was similar. However, township health centres decreased from 55,413 in 1980 to 37,836 in 2010. The drop was in part due to the transfer of services to CHCs and urbanisation.

Table 6.1*:* Number of Hospitals in China: Trends by Type (1980–2014)

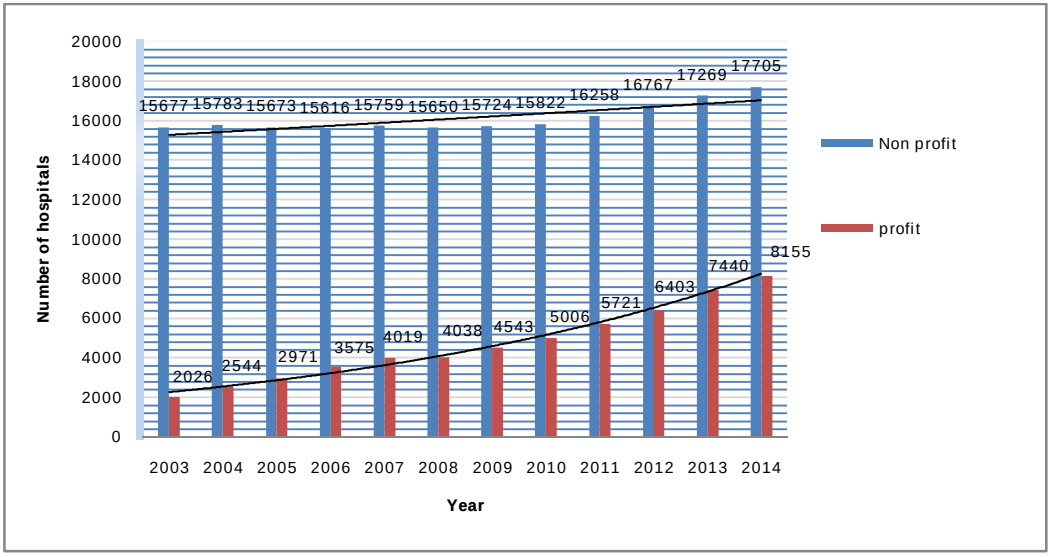
	1980	1990	2000	2010	2014	% Growth /Reduction (2000–2014)
Total Institution	180553	1012690	1034229	936927	981432	-5.1
Hospital	9902	14377	16318	20918	25860	58.4
General Hospital	7859	10424	11872	13681	16524	39.18
TCM Hospital	678	2115	2453	2778	3115	26.99
Specialised Hospital	694	1362	1543	3956	5478	255.02
Primary Medical Institutions	-	-	1000169	901709	917335	-8.28
Community Health Service Centre	-	-	-	32739	34238	-
Township Health Centre	55413	4779	49229	37836	36902	-25.04
Village Clinics	-	803956	709458	648424	645470	-9.02
Outpatient Department & Clinic	102474	129332	240934	181781	200130	-16.94

Source: Ministry of Health 2015

THE DEVELOPMENT OF PUBLIC AND PRIVATE HOSPITALS IN CHINA

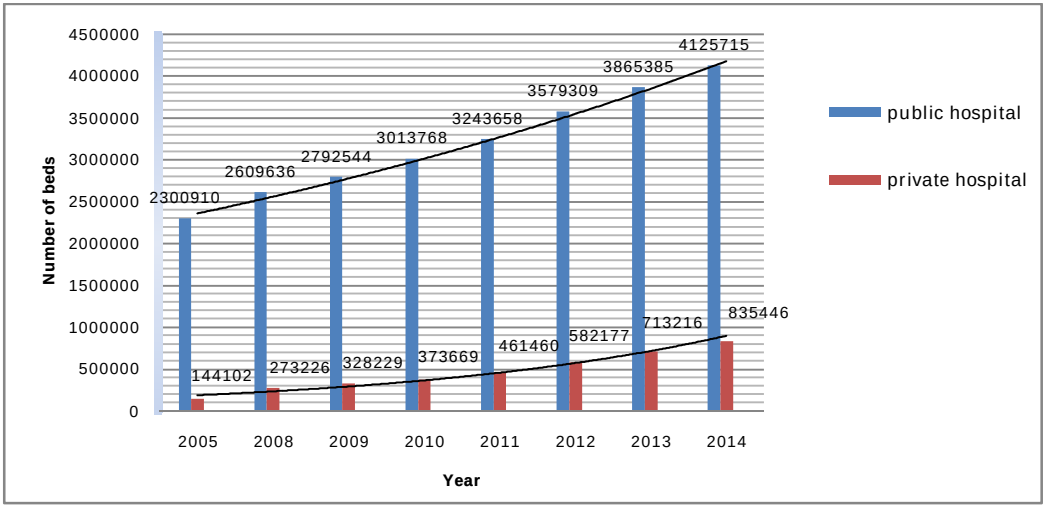
The growth rate of non-profit hospitals has increased by 12.9 per cent from 2003 to 2014. In contrast, for-profit hospitals have increased by 302.5 per cent (Figure 6.2). The growth rate of public hospital bed has increased by 79.3 per cent from 2003 to 2012. In contrast, private hospital bed has increased by 479.8 per cent (Figure 6.3).

Fig. 6.2: Growth of Hospitals by Ownership (Non-profit and Profit)



Source: Ministry of Health 2015

Fig. 6.3: Growth of Hospital Beds by Ownership (Public and Private)



Source: Ministry of Health 2015

INCOME AND EXPENDITURE OF GOVERNMENT HOSPITALS

From income and expenditure of government hospitals in 2014 (Table 6.2), we could observe that different level hospitals were able to cover their medical costs with income from medical services. The average surplus was 4 to 5.1 per cent by hospital levels. Total income reached to 664 million RMB, 102 million RMB and 11 million RMB for tertiary, secondary and primary hospitals respectively. Medical income share of total income was 91, 88, and 81 per cent respectively. Based on expenditure, medical expenditure occupied 85, 81 and 70 per cent, respectively and drug share of medical expenditure was 42, 42 and 45 per cent.

Table 6.2*:* Income and Expenditure of Public Hospitals by Level in 2014

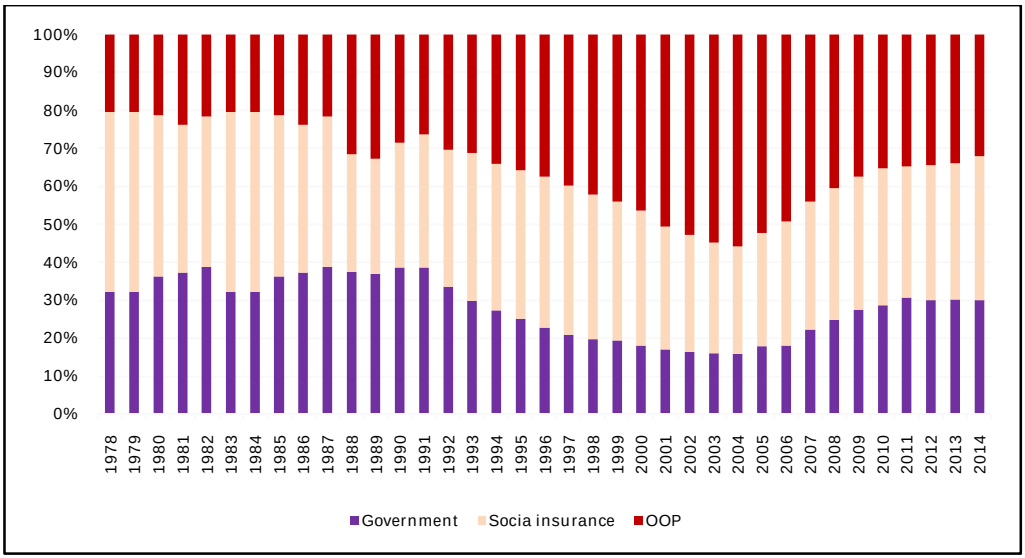
Indicator	Tertiary Hospitals	Secondary Hospitals	Primary Hospitals
Number of Hospitals	1833	5854	2630
Income Per Hospital (10,000 RMB)	66383	10153	1128
Medical Income	60658	8972	916
% of total income	91.38	88.37	81.21
Drug Income	25592	3771	429
% of medical income	42.19	42.03	46.83
Expenditure Per Hospital (10,000 RMB)	63152	9740	1085
Medical Expenditure	53540	7923	761
% of total expenditure	84.78	81.34	70.14
Drug Expenditure	22460	3319	345
% of medical expenditure	41.95	41.89	45.34
Surplus margin (%)	5.1	4.24	3.96
Medical Expense per Visit(RMB)	269.8	176.0	125.3
Medical Expense per Inpatient(RMB)	12100.2	5114.6	3737.1

Source: Ministry of Health 2015

TOTAL HEALTH EXPENDITURE'S STRUCTURE

Structure of total health expenditure has been changing in the last three decades. At the beginning of reforms and opening up, OOP share was 20 per cent, social insurance and government subsidies had 80 per cent share in expenditure. The developing trend was, OOP expenditure climbed up while government investment went down. In 2000, government had less than 20 per cent investment and OOP was 55 per cent. With the central government gradually putting people's health as priority, the government input was increasing and OOP decreasing (Figure 6.4).

Fig. 6.4: Health Financing Structure Change in China (1978–2014)



Source: Ministry of Health 2015

STEWARDSHIP SYSTEM IN CHINA

There are four-levels of administrative system in China from Centre to County. Many government agencies are at central government level, such asNDRC, Ministry of Finance (MoF), Ministry of Human Resources and Social Security (MoHRSS), Ministry of Health (MoH), SFDA and State Traditional Chinese Medicine (STCM), to name a few. In addition to these, associations also play roles. The focus is on licensure, safety, effectiveness, quality and pricing. Licensure involves many aspects, for hospitals and clinics, workforce, equipment, technology and so on.

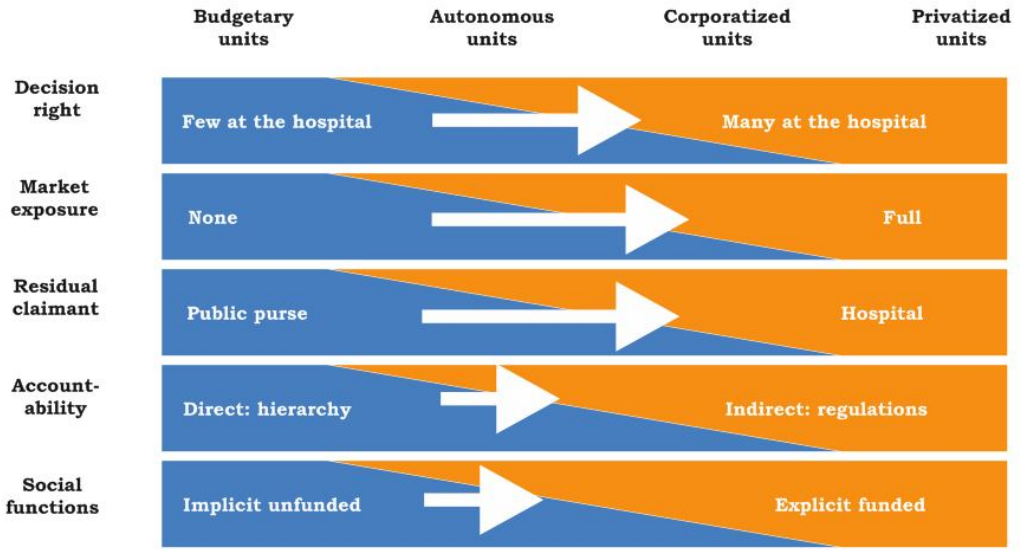
HOSPITAL AUTONOMY IN CHINA

Before 1979, public hospitals operated as departments of the government under a planned economic system. Essentially, they were classified as budgetary units. At that time, the government strictly controlled public hospitals through planning and budget allocation, and ensured that everyone could access the basic level of medical care at low cost, even in time of resource scarcity. It was a centralised and hierarchical system. Therefore, the hospital had to function with the budget allocated. While equitable healthcare provision fits in the context of general socioeconomic development, the capacity of the health system was too

weak to meet the requirements or expectations of patients. The development of hospitals was also hindered by shortages in health resources (doctors, beds, medical equipment and technology), limited financial capacity of the government, low efficacy of services, lack of vitality in health sector, and so on. Then, economic development became the governmental philosophy in China, and economic reforms focused on productivity and efficiency. This reform orientation was also applicable to health sector reforms.

With the resolution of the third plenary session of the 11th Central Committee of the Communist Party of China (CPC), policies emphasised reform, decentralisation and granting of more freedom to the local government from 1978. Chinese health authority paid more attention to market exposure, decision rights and residual claimant to public hospitals from 1980 to 1988 under the introduction of decision of the CPC central committee to reform the economic system. There was greater importance attached to accountability from 1989 to 1999 under the resolution of the 14th Central Committee of the CPC. In 2000, social function of health services was added when inequities in access to care were outstanding while public hospitals also had a strong incentive to improve their institutional efficiency.

Fig: 6.5: Qualitative Extent of Autonomy by Different Dimensions in Public Hospitals



Source: Jakab *et al* 2002

To get a clear understanding of public hospital autonomy in China, we have broken down the transformation into four time periods: beginning of HA (1979–1984); comprehensive development of HA (1985–1991); slowed development of HA (continuous development of HA) (1992-1996); accelerated changes in HA (1997-2008).

Nowadays, most public hospitals are autonomised units, a few are corporatised units or privatised units, and a few are budget units. Hospital reform is driven by policies from different levels of health authority. In terms of 'decision rights', public hospitals are a mixture of autonomous units and corporatised units; in terms of 'market exposure', they behave as corporatised units; in terms of 'residual claimant', they almost act as a mixture of corporatised units and privatised units; in term of 'accountability' and 'social functions', they perform as a mixture of budgetary units and autonomous units. In Figure 6.5, qualitative extent of autonomy is evaluated by Jakab*et al*.

EVALUATION ON PERFORMANCE OF HA

We conclude that the characteristics of performance of hospital autonomy are as follows:

CHANGES IN SERVICE DELIVERY AND HOSPITAL OPERATION

The capacity of services improved significantly from 1980 to 2010. The number of hospitals and hospital beds increased by 111 per cent and 183 per cent, respectively. With the dramatic increase in outpatient visits and hospital admissions, the revenues and expenditures also rapidly increased. Average surplus was 3 per cent from 2002 to 2010. Government subsidy indicated a rise of 6-7.5 per cent from 2002 to 2010. The expenses escalated, reflecting some evidence of expensive health care during 1990 to 2010. Average expense of outpatient visit increased from 10.9 RMB to 173.8 RMB and average expense of inpatient admission increased from 473 RMB to 6525 RMB (Ministry of Health 2015).

EVALUATION ON PERFORMANCE WITH INDICATORS FOR EFFICIENCY, QUALITY AND EQUALITY

Between 1990 and 2010, questions were raised around efficiency of health care. Average length of stay decreased from 14.1 to 9.7; bed occupancy rate increased from 88.2 per cent to 95.0 per cent; revenue per doctor per year increased from 47,000 RMB to 881,000 RMB. Quality of care had moderately improved (number and mix of qualified medical staff increased; adverse outcome rates decreased) but equity in access had deteriorated gradually at all levels. Public expenditure or government spending per patient by socio-economic category or insurance

status was decreasing, while mean OOP expenditure per visitor/admission by patient socioeconomic category was increasing. The observation by Liu *et al* (2008) below sums up the situation that existed till the mid-2000s.

"Overall, 16 per cent of urban and 20 per cent of rural residents reportedly had financial difficulties in accessing healthcare in 1998. Although urban rate of foregone medical care decreased to 15 per cent in 2003, the rural rate rose to 22 per cent in the same year, explained by 5 per cent increase in foregone outpatient care and 25 per cent rise in early hospital discharge from the rural rate in 1998. We also showed that the poorest income groups had not only a higher rate of foregone medical care than their better-off counterparts, but also a higher probability of attributing their decision to inability to pay. The uncompensated inequality in foregone health care and early hospital discharge due to inability to pay had increased for urban residents from 1998 to 2003, whereas it increased only for foregone outpatient care for rural residents during the same period." (Liu *et al*. 2008)

PRIVATE ENGAGEMENT WITH PUBLIC HOSPITALS

Autonomised public hospitals dominate the health delivery system, but there are newer forms of private engagement that have emerged in the last decade, such as contracting of diagnostic and clinical units; co-location of private services in a public hospital or clinical unit; privatisation of public hospitals; private sectors investing in public hospitals; government contracting of private providers to deliver primary and preventive services; government contracting with private management of public hospitals to operate public hospitals and so on.

PUBLIC HOSPITAL REFORM IN CHINA

The universal coverage of essential health services contains four systems and eight sectors. The four systems are: public health service system, medical security (insurance) system, medical service system and, pharmaceutical manufacturing and supply system. The eight sectors include: financing, supervision, information technology, human resource, operation mechanism, pricing mechanism, legislation and other sectors.

PRINCIPLES OF THE RECENT PUBLIC HOSPITAL REFORMS

The government promotes four principles for public hospital reform, namely 'four principles of separation', and they are separation of governance and service agencies, separation of governance and operation, separation of hospital and pharmaceuticals and separation of for-profit and non-profit.

PILOTING OF THE PUBLIC HOSPITAL REFORM

In some pilot cities, the roles and functions of public hospitals are clearly stated. Some of them have established a commission led by the Mayor or Deputy-Mayor, to address dispersion of responsibility and power between various city departments. Some of them reorganise the responsibilities and power of government departments, strengthening Department of Health to make health policy or regulations and creating a new agency to manage public hospitals. The decision-making power of individual public hospitals is controlled, weakening hospital development and strategic planning decision power (such as controlling number of beds aligned with regional health planning rather than expanding itself), strengthening human resource management decision power, and looking for some solutions to monitor use of surplus (residuals).

There are three models of public hospital stewardship system reform: a department within Bureau of Health (BOH); an independent agency under BOH and an outstanding agency beyond BOH. Model 1 is a department within BOH, for example, Weifang BOH, (Figure 6.6). The model 2 is an independent agency under BOH, for example, Wuxi BOH (Figure 6.7). The model 3 is an outstanding agency beyond BOH, for example, Shanghai Shenkang Hospital Development Centre (Figure 6.8).

Fig. 6.6: A Hospital Administration Department within BOH

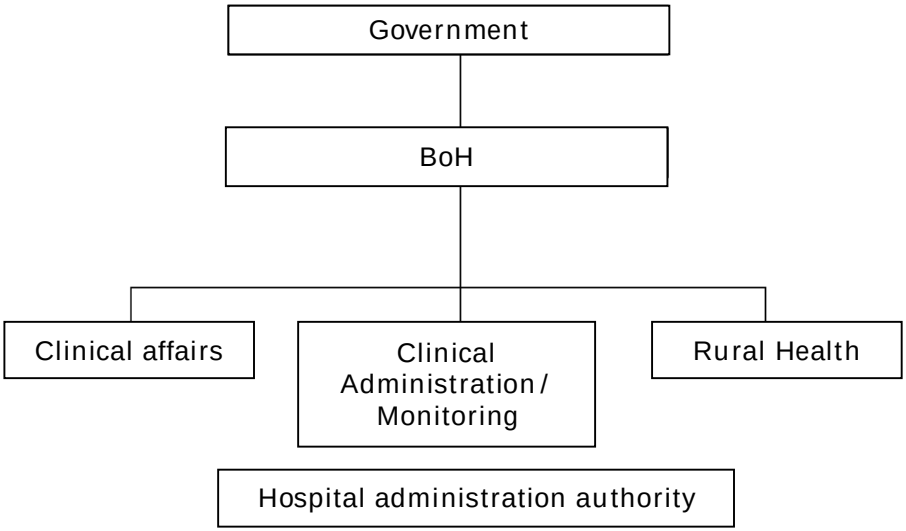


Fig. 6.7: An Independent Agency under BoH

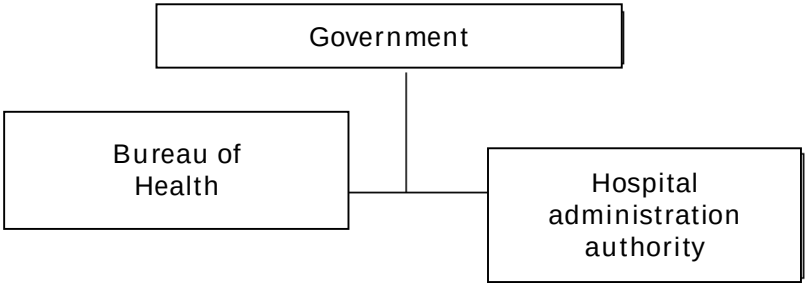
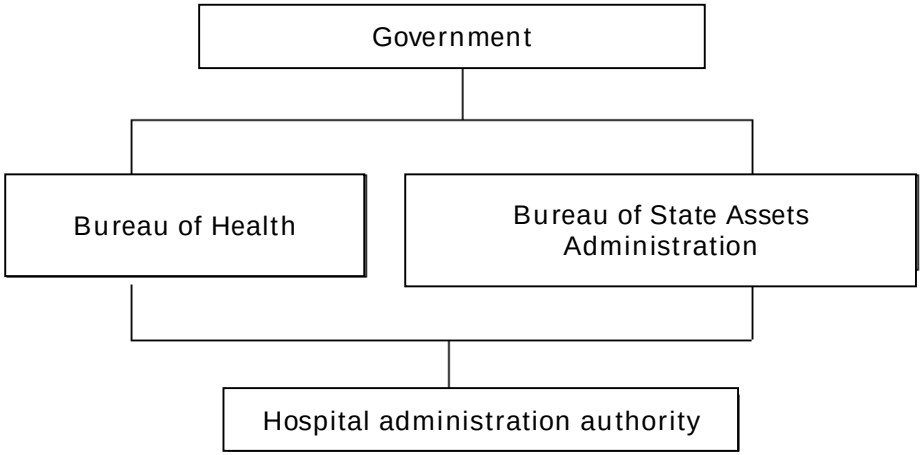


Fig. 6.8: An Outstanding Agency beyond BOH



COUNTY PUBLIC HOSPITAL COMPREHENSIVE REFORM

Comprehensive reforms in county public hospitals started in 2011, involving 311 pilot counties and 700 counties apart from the pilot counties. The main achievements were as follows: pharmaceutical zero mark-up policy was implemented; price for health services was adjusted; reimbursement mechanism was changed; hospital management was improved; government subsidy was increased in asset and hi-tech equipment; along with discipline development, human resource training, and subsidies for retired staff and preventive health services.

POLICY SUGGESTIONS FOR PUBLIC HOSPITAL REFORM IN CHINA

While reviewing 30 years of hospital autonomy in China, several experiences and lessons can be observed of health delivery development in the context of socio-economic transition. We employed the philosophy of 'crossing the river by touching the stones' and tried to achieve the goals of 'quality and efficiency' in order to improve the health system (Chen Yun 1995). We believe in comprehensive measures, such as government intervention, market mechanism and stakeholder participation that should be adopted to improve certain aspects of public hospital autonomy, especially, deficiencies in accountability and social functions, uncontrolled expensive medical costs, uneven medical quality and poor macro efficiency.

Some advice on policies should be emphasised in the future reforms to meet the requirements of 'sound' autonomy. To correct the imbalances among the dimensions of autonomy, i.e. accountability and social functions lagging behind other dimensions of hospital autonomy, some 'managed' strategies to control hospital autonomy are proposed below.

STRENGTHENING THE GOVERNMENT ROLE WITH RESPONSIBILITY FOR SETTING A NATIONAL STRATEGIC VISION ON DEVELOPMENT OF PUBLIC HOSPITALS

The government has the responsibility to mobilise and integrate resources to provide appropriate health services for all people. The Chinese government should put forward an explicit goal and strive to reach the objectives through planning and use of the market. A national strategic vision for autonomisation is necessary to reach the goal of providing quality health services with equity, appropriateness and efficiency by active public hospitals.

REACHING THE COMMON GOAL AND SHARING RESPONSIBILITY AMONG FUNCTIONAL GOVERNMENT AUTHORITIES AT DIFFERENT LEVELS

In China, the different levels of the government have different interests because of decentralisation. It is essential to coordinate different goals between the central and the local governments, and to set common goals for the health sector among different level of governments, including public hospital policies, financing, management, and autonomy. As discussed earlier in this paper, the incentives are different among different levels of government, and GDP is always the priority of the local government. Although public hospital autonomy is beneficial for the development of hospitals, misalignments often occur between the goals of the central and the local government, which are particularly

pronounced when it comes to financial allocation. It is proposed that a negotiation mechanism be introduced between governments to address the misalignments between different levels of the government and to provide fiscal subsidies for public hospitals. Meanwhile, an accountability mechanism for different levels of government should be explicit in the form of law.

MAKING USE OF INSURANCE AUTHORITIES TO MONITOR HEALTH CARE COSTS, QUALITY, EFFICIENCY AND ACCESS TO CARE

The government should make use of the power of the medical security system to control medical costs, to improve hospital efficiency and service quality. Looking at governance and power distribution among ministries and their interaction with public hospitals, it was found that different medical insurance schemes have a stronger financial relationship with public hospitals in the context of increased insurance coverage and expanded benefit packages. The third party for reimbursement mechanism has not played its governance role well, and has not cooperated with the Ministry of Health to raise the leverage of the public hospitals. There is a lot of room for health insurance authorities to improve the governance of public hospitals, including reimbursement mechanism design and selection, practice behaviour monitoring, cost-effective analysis of health care and so on. Improvements of the payment system would be conducive to explicit performance objectives of hospitals and would increase efficiency with monitoring and disseminating comparative provider performance information.

ESTABLISHING EFFECTIVE GOVERNANCE STRUCTURE FOR PUBLIC HOSPITALS

The establishment of a governance structure for public hospitals is important to improve accountability, and to prevent the adverse effects of hospital autonomy. Especially, direct intervention in hospital operation by the government should be reduced gradually. It could influence the improvement of accountability and address issues of capacity, responsiveness, efficiency and quality more effectively. It means that the accountability mechanism between the hospital, owners and regulators should be reshaped along with the governance structure. There are two structures for public hospitals: external hospital administration authority and internal governing board.

In recent years, Shanghai, Wuxi, Weifang and Beijing had piloted to reorganise the responsibilities and power of government departments, and to implement separation of governance and operation of public hospitals. They created a new agency under (or beyond) the health authority to manage and

operate public hospitals on behalf of the owner. Those changes improved the accountability mechanism between hospitals and payers, owners and regulators, and evidence demonstrated effectiveness.

HIGHLIGHTING CONTROL OF RESIDUAL CLAIMANT AND SOCIAL FUNCTION BY EFFECTIVE GOVERNANCE

The government and public hospitals must focus more on social responsibility. Public hospitals should be funded sufficiently by the government, either by the prospective budget or by reimbursement. The government should establish a long-term investment mechanism to ensure that hospitals perform social functions and implement social responsibility by providing equitable access to essential health care and appropriate quality of care. This would require not only direct investment from the government, but also social mobilisation by the government.

The government should also strengthen its supervision of the marketisation process of public hospitals and on controlling costs of basic health services, supervising rational utilisation of the medical insurance fund, improving access and performance for vulnerable populations and so on.

INVITING STAKEHOLDERS (ESPECIALLY, PATIENTS) TO PARTICIPATE

The participation of multiple stakeholders in the autonomisation of hospitals is helpful for accountability mechanism and social function of public hospitals. Transparency is a vital factor in enlisting participation. Patients are important stakeholders. The autonomisation of public hospital relates not only to the operation of hospital, but also to the health and service outcomes of patients. The process of autonomisation could result in rapid cost increases, inefficiencies, poor quality, unaffordable health care and an erosion of medical ethics, all of which can become potential threats to the health of the patient. For responding to the threats, the role of patients should be emphasised. Patients as stakeholders can play an important role in the operation of hospitals and the process of health service delivery.

RE-PILOTING OR RE-IMPLEMENTING THE SEPARATION OF PUBLIC/PRIVATE OR FOR-PROFIT/ NON-PROFIT HOSPITALS

There should be separate administration of for-profit and non-profit hospitals. Although the government established a management mechanism to manage the non-profit hospitals and for-profit hospitals on the basis of regulations in 2000, most public hospitals did not operate in accordance with requirement of non-

profit properties under the market environment. This could have been due to ambiguous definition of non-profit and undefined objectives of non-profit, so it is advised that the government should announce specific additional measures to improve supervision and implement different measures for non-profit and for-profit hospitals. For public hospitals that must behave as non-profit hospitals, these measures could include assigning health services for special people, taking responsibilities for part of the public health service, contributing to health personnel training and scientific development, setting health performance goals for hospitals and allocating subsidies for performance.

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7. Tax Financed Health Insurance in India: Illusion of Financial Protection

Indranil Mukhopadhyay

INTRODUCTION

Health financing in India is typically characterised by lack of financial protection. Financial protection can be achieved through progressive health financial arrangements which need to have three critical elements-risk pooling, pre-payment and cross subsidisation. Since there is an uncertainty of individual health care needs and there are risks and high costs of care associated with falling ill, if households are left to manage health care expenses, the consequences become severe - people forgo or delay care, die of avoidable deaths or face financial hardships associated with care seeking. Risk pooling and prepayments are effective means to protect people from disastrous financial consequences of illness, while cross-subsidisation brings in progressivity in financial arrangements. Risk pooling, which essentially means bringing people with various risks together is the insurance function. Financing mechanisms like social insurance or private health insurance are explicitly insurance based models where risk pooling is achieved through enrolment of people with varying risks into the scheme. Contrary to carefully constructed myth, where risk pooling is associated with formal insurance designs, like social insurance or private voluntary insurance; even general tax financed systems where health care is directly provided to all the citizens, risk pooling is a central attribute (Roberts 2008).

While tax funded health system has remained chronically underfunded in India, private sector flourished through proactive support of various forms from government, which were all banded under 'health sector reforms'. The essential feature of the reforms was to gradually withdraw the state from funding services other than a small group of services including preventive health care and immunisation (Ravindran 2010). The other element was promotion of private sector participation in the health sector, especially in areas which are comparatively more profitable like super-specialty hospitals; contracting-out clinical and non-clinical services and introducing user charges for various out-patient and in-patient services for the non-poor.

As a result people had to increasingly depend on private sector for utilisation of health care and bear health care expenses. It has been documented well in the past that overdependence on OOP expenditure in India is marked by high

inequity (Peters *et al* 2002; MOHFW 2005; Garg and Karan 2009; and Selvaraj and Karan 2009), which could result in catastrophic circumstances and impoverishment (van Doorslaer*et al* 2006; Selvaraj and Karan 2009 and Ghosh 2011). Since the middle of the last decade globally there has been a consensus of sort that health financing has to move away from household OOP expenses to various progressive forms, which would be essentially funded by government exchequer. Though there are various forms of financing systems, including tax funded and public systems providing 'Universal Health Coverage' in various nations, global institutions have been univocal in their efforts to push insurance based systems (People's Health Movement 2014).

SOCIAL AND TAX FUNDED INSURANCE IN INDIA

India's engagement with social health insurance (SHI) programmes goes back to the early 1950s. SHI was introduced with the launch of Employees' State Insurance Scheme (ESIS) in 1952 and the Central Government Health Scheme (CGHS) in 1954. While ESIS covers all employers with more than 10 employees in 'notified areas', and all employees with monthly salary of Rs 15,000 or less; CGHS on the other hand is available to all central government employees (both working and retired), and their families, and other representatives associated with the central government. As of 2014, ESIS alone had some 19.5 million workers and their families enrolled (ESIS 2014)[1]. Around 0.8 million more families are enrolled under CGHS (La Forgia and Nagpal 2012).

However, India has witnessed a plethora of publicly-financed insurance schemes being introduced both at the national and state level. *Yeshasvini* started as an insurance scheme for workers cooperative in 2003 in Karnataka, including all rural co-operative society members, members of Self-Help Groups / *Sthree Shakti* (Women's Empowerment) Groups and their family members (including joint family). The *Rajiv Aarogyasri Scheme* (RAS), the first of this class targeting below-the-poverty-line (BPL) population of Andhra Pradesh was introduced in 2007. It is interesting to observe that a scheme, which was originally planned to be focussed on BPL families, went ahead to cover almost the entire population of the state. The RSBY that was launched in 2008 is on the other end of the spectrum. It is also voluntary in enrolment, was initiated by the

[1] By 2009, ESIS had presence in 29 states, with 148 main hospitals and 42 annex facilities run by ESIS with total bed strength of around 28000. Moreover, there were around 1400 dispensaries and 8000 Medical officers and specialists enrolled across 783 centres. Some 50 million beneficiaries were covered, including 12.5 million workers from 0.39 million employers. (ESIS 2011)

Central Government (Ministry of Labour and Employment) as a national health insurance scheme targeting the BPL population. Other notable state sponsored schemes include Chief Minister's Health Insurance Scheme (CMHIS) in Tamil Nadu (2009) and *Vajpayee Aarogyasri* (2009) in Karnataka.

In this paper we would like to comment on the various aspects of effectiveness of tax funded health insurance programmes in the country, with special emphasis on financial protection as these schemes were essentially introduced to protect households from financial hardship.

RAPID EXPANSION

Coverage under tax funded insurance has increased from about 75 million people (roughly about 16 million family beneficiaries) in 2007, to an estimated 302 million people in 2010. RSBY alone currently covers approximately 41.3 million families across the country today (RSBY 2016), covering approximately a third of target population. In 2011, approximately 22.9 million families and 72 million beneficiaries were covered by the RAS scheme, which is about 85 percent of the total population of the Andhra Pradesh (*Aarogyasri* Health Care Trust 2012). Three giant schemes (RSBY, RAS in Andhra Pradesh and CMHIS in Tamil Nadu) have, in a span of 7-8 years, covered roughly 247 million or over one-fifth of India's population. By any standard this breadth of coverage is impressive, and occurred at a rapid rate within 7-8 years.

Except for ESIS and CGHS, the publicly-funded schemes provide only hospitalisation cover to the beneficiaries. In terms of benefit packages, there are sharp differences between the various schemes in accordance with their different priorities. While RSBY's package is modest, with a limited mandate which it had set itself, RAS in Andhra Pradesh and CMHIS in Tamil Nadu schemes are the most ambitious programmes. The differences in the programmes are reflected in tertiary care. For instance, in 2009-10 CGHS spent nearly Rs16,000 million on covering a population of three million in the country, whereas RAS, spent Rs12,000 million on covering about 85 per cent of the population of Andhra Pradesh, which had a total population of 84 million. Similarly, in 2009-10 the Tamil Nadu model covered only high-end surgical procedures for a 50 million population, with a total outlay of Rs5,173 million (PHFI 2011).

The major thrust of the current health insurance schemes is on inpatient care. In the commercial insurance sector, households and employers contribute to cover the costs of the premium, and in other schemes such as ESIS and

CGHS, contributions from employees and employers are collected. Therefore, the issues of prepayment and risk pooling, which are central to any health financing functions, are taken into account in these two programmes. Similarly, in all the other publicly funded schemes, the contribution is made by the government – central or state – depending on the scheme, and thus the entire burden of specialised hospital care for the covered population is borne by the government. In this case, the risk of making catastrophic payments for illnesses and the likelihood of being impoverished due to hospitalisation (surgical care) is reduced to some extent. But despite this, a huge burden is left to be borne by the households. In the case of RSBY, even hospitalisation relates only to secondary care, still leaving a huge burden on households, while state-based schemes ignore primary and secondary care completely.

LIMITED EFFECTIVE COVERAGE AND LACK OF FINANCIAL PROTECTION

Despite its intention to providing financial cushion to patients suffering from illness, the track records of such insurance models are poor in securing financial risk protection (Wagstaff and Lindelow 2008; Wagstaff *et al.* 2009). Such models are target-specific and designed to address low-frequency high-value hospitalisation expenses. Target-oriented approaches (BPL population) have never worked in the past due to several reasons. Identification of beneficiaries has never been so easy. The state of Andhra Pradesh, for instance, has rolled out insurance schemes for almost 85 per cent of the population, while in several states BPL population has been inadequately covered. Unfortunately, provision of health care has been turned into another poverty-reduction programme. While improving population health could have major dent on poverty, there are other key dimensions of health sector including providing financial risk protection. By providing financial risk protection to the BPL population, it is assumed that APL population does not face catastrophic payments and impoverishment. With only a thin line that separates BPL from APL, it is myopic to plan and make policies for BPL population involving health care.

Couple of studies have tried to measure impact of insurance on aggregate OOP expenditure by households at district level (Selvaraj and Karan 2012; Selvaraj *et al* 2015; Hooda 2015). These studies have categorised districts into two groups: districts with insurance coverage (intervention districts) and those without insurance (control districts) and compared the impact of insurance over a period of time. Evidences from these studies indicate that the share of

households' expenditure has increased sharply between 2004-05 and 2011-12[2]. For instance, between 2000 and 2012, in rural areas, share of health in household expenditure has increased from 6.05 per cent to 7.73 per cent. The real rise in OOP expenses of households' appears to be largely due to sharper increase in hospitalisation expenditure while outpatient and drugs expenditure have grown at a slow pace. Further, there is considerable increase in hospitalisation cost of the poorer sections, clearly demonstrating the limitations of the scheme in terms of effective financial protection (Selvaraj *et al* 2015). Similar findings have been observed by Hooda (2015). Households' OOP expenses, by all categories – inpatient, outpatient and drugs, were reportedly higher in intervention districts as against non-intervention districts, even before insurance schemes were introduced. This disparity continued to exist in the post-insurance years as well. However, it is apparent that the disparity in spending has relatively become significant in hospitalisation expenditure. As far as the share of hospitalisation expenses goes, it is not only relatively higher in intervention districts, but both intervention and non-intervention districts experienced rise in its share in the post-insurance years and intervention districts have experienced sharper increase

As far as headcount on catastrophic nature of hospitalisation is concerned, it accelerated in the post-insurance years, both in intervention and non-intervention districts. Catastrophic headcount across income/expenditure quintiles, both in the pre-insurance as well as in the post-insurance period shows a consistently higher burden in the intervention districts in comparison to the non-intervention districts (Selvaraj *et al* 2015). Further, the poorer income sections in RSBY and other state-based health insurance districts had indeed experienced a rise in catastrophic headcount, a conclusive proof that RSBY and other state-based health insurance intervention failed to provide financial risk protection. So, rising per capita health spending on hospitalisation and the associated increase in catastrophe headcount, especially among the poor

[2] The data source for this study is drawn from the unit level records of the Consumer Expenditure Surveys (CES), conducted by the National Sample Survey Organisation (NSSO), for the respective years. The two periods under study are quinquennial rounds of NSSO, where sample size is large enough, to capture the impact at state and groups of districts levels. For instance, the number of households surveyed during the period 2004-05 were 124,644 (79,298 rural & 45,346 urban households) and 101,662 households (59,695rural and 41,967urban) during 2011-12. The CES collects information on expenditure of households' consumption for about 350 items. This includes food and non-food items while the relevant non-food items that are examined here are institutional and non-institutional medical spending of households. However, there is no information on insurance coverage of households. For details of the method please refer to Selvaraj*et al* (2014).

population is reflective of continuation of the trend witnessed since the last two decades, with RSBY and state-based health insurance schemes making no impact of whatsoever.

All these previous studies have tried to measure the impact of the insurance programmes on households rather indirectly as there was no information on insurance coverage. The latest NSSO data provides us the opportunity to study the impact of insurance on households OOP expenditure (NSSO 2015). In terms of effective coverage, NSSO results show that only 12.8 per cent of households are covered under various state sponsored and social insurance schemes. Compared to government claim of coverage for some 300 million people, NSSO shows much lesser coverage in reality. This clearly points out that there is large gap in government statistics and independent evaluations; so far coverage under the scheme is concerned. These findings are in line with most other evaluations of government financed insurance schemes (Ghosh 2014; Nandi *et al*. 2014).

Several research studies have identified various gaps in RSBY implementation. These studies demonstrated the low levels of enrolment among eligible population barring few exceptions like Kerala. Furthermore, hospitalisation rates have also remained low for RSBY patients. The Ministry of Labour's own estimation suggests that average national utilisation rate increased slightly compared to NSSO (60th round) survey (PHFI, 2011). However, the same report recognises that there exists huge difference across states and districts with most of the hospitalisation happening in few states and fewer districts. Within districts, utilisation is concentrated in few villages. This clearly shows that RSBY is being used by those who already have better access and the most marginalised sections are being excluded further. The other possibility which remains to be verified is that even if poor people are reaching hospitals, they end up paying significantly. Studies have shown that awareness levels are really low among the enrolled people about different entitlements about RSBY (Ghosh 2014).

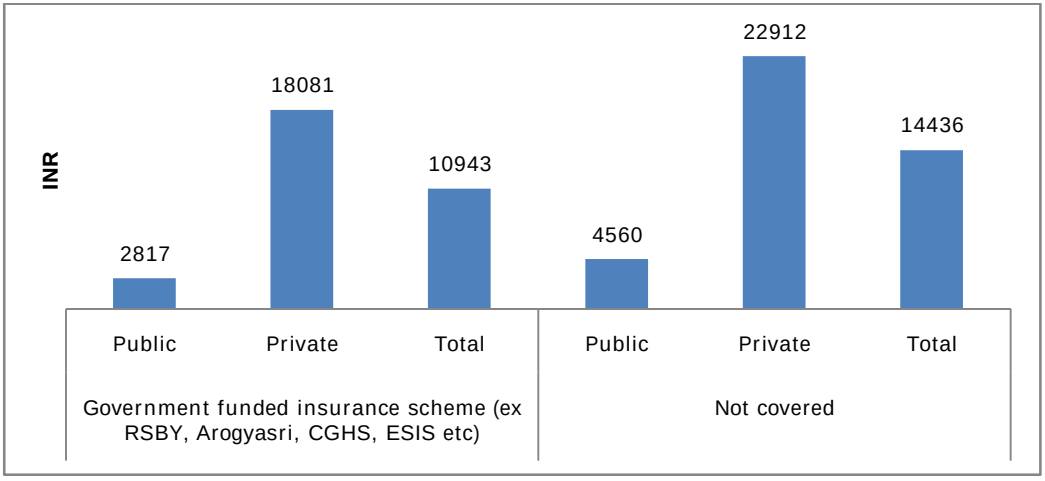
Table 7.1: Coverage of Various Insurance Schemes in India (in Percentage) (2014)

Type of Insurance Coverage	Rural (%)	Urban (%)	Total (%)
Government funded insurance scheme (Eg: RSBY, RAS, CGHS,ESIS etc.)	13.1	12.0	12.8
Employer supported health protection (other than government)	0.6	2.4	1.2
Arrange by household with private insurance companies and others	0.4	3.7	1.3
Not covered	85.9	82.0	84.8
Total (N)	100 (189573)	100 (143529)	100 (333102)

Source: NSSO 2015. 71st round, Author's calculation based on unit records

Furthermore, data clearly shows that there is very little financial protection provided by the state sponsored insurance scheme. As depicted in Figure 7.1, OOP per hospitalisation episode if there is no insurance coverage, is Rs 22,912 when private hospitals are accessed. Even if a person is covered by government insurance scheme one episode of hospitalisation costs Rs 18,081 thus, rendering the claim of cashlessness of these programmes into question. Even though costs in public sector is much lower compared to private hospitals, households end up incurring OOP expenses. It has to be noted however, that costs in public and private sector cannot be strictly compared as there are explicit subsidies in public sector. It has to be also noted that those who are covered under the insurance schemes are usually poor or vulnerable whereas proportion of the richer sections would be higher among those who are not covered. Though average expenditures do not capture the effect of class, diseases, location, all of which affect cost of care, a further disaggregated analysis is required to study the implications of insurance on financial protection.

Fig. 7.1: Average Per Episode Hospitalisation Expenditure by Coverage of Insurance Schemes and Type of Provider (INR)



Source: NSSO 2015. 71st round, Author's calculation based on unit records

DRAIN OF RESOURCES FROM PRIMARY CARE AND PUBLIC SECTOR HOSPITALS

In the Union budget of 2016-17, the Finance Minister proposed to expand the coverage of RSBY further, invoking the need to tackle catastrophic health care

spending. The Finance Minister's attempt to tackle catastrophic health events is laudable, but the proposed investment of Rs15 billion is clearly inadequate. There are roughly 110 million BPL families in India. Average premium under RSBY is around Rs 400-450, including the administrative expenses. Total money required for providing insurance cover up to Rs 30 billion (under RSBY) is Rs 50-55 billion. If the coverage has to increase to Rs 100,000, the premium has to also increase. Even if the premium doubles to Rs900 per family; around Rs100 billion would be required. Against this requirement, only Rs15 billion has been allocated, which is only 15 per cent of required amount.

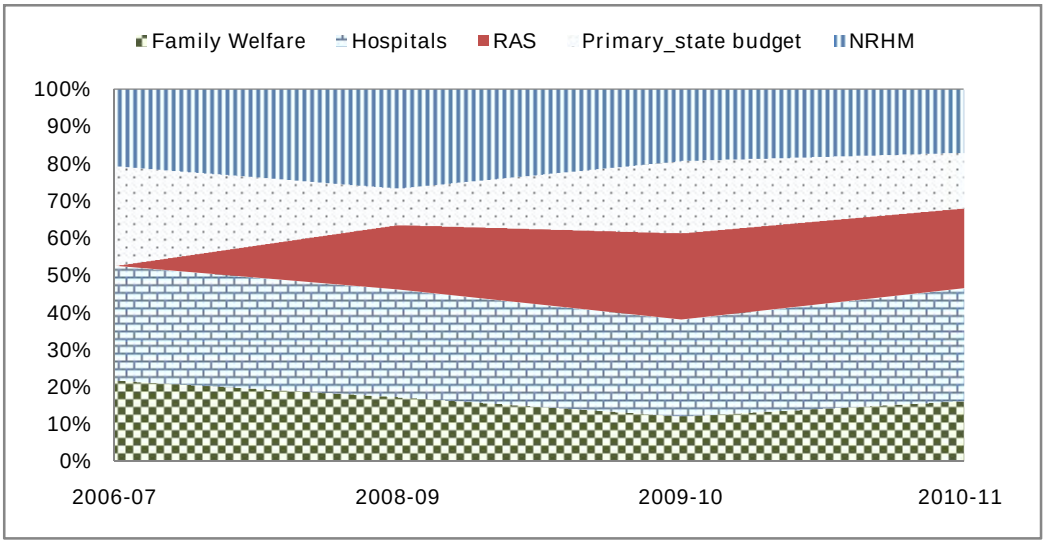
One important element of the government sponsored insurance schemes is they positioned public sector hospitals and private hospitals as competitors for insurance funds. While this can be seen as an opportunity for government hospitals to improve quality to attract more patients, in reality, this situation favours the private sector. It is important to note that competition between public and private sector is not at all fair. With little money spent on public sector hospitals in the country, apart from in-patient and out-patient care, public sector provides the entire spectrum of preventive care, shares overwhelming burden of end of life care and critical care, majority of institutional deliveries and entire medico-legal and administrative services (Sundararaman *et al.* 2016).

The experience of RAS in Andhra Pradesh shows that more than four-fifth of funds flow to private hospitals. As depicted in Figure 2 out of the total claims disbursed of the value of Rs 33.3 billion as much as Rs 27.16 billion have gone to private hospitals. Moreover, the growth of private hospitals, in part fuelled by the substantial insurance funds available, has increased their demand for skilled human resources. This private sector demand will likely add to the growing migration of skilled staff from government to private hospitals. Finally, there is also little harmony between state schemes and RSBY in terms of services and population covered. For instance, in states like Andhra Pradesh both the RSBY and RAS schemes are independently offered to the public. This raises obvious questions about wastefulness and efficiency.

In Andhra Pradesh, the RAS consumes around 20 per cent of the state's health budget (Figure 7.2). More than 55 per cent of funds are devoted towards secondary and tertiary care and RAS. The insurance route has exclusively focused on hospital services. Which route ultimately dominates will have

profound implications on the nature and delivery of health services in India. For instance, in Andhra Pradesh, which has been operating its insurance scheme since 2008, the government spends about three times as much on hospital services as it does on primary care. One can expect similar crowding out of funds for primary care as government insurance coverage expands and demands more resources to operate.

Fig. 7.2: Competing Priorities for the Andhra Pradesh Government



Source: Detailed Demand for Grants, AP Budget, various years

CONCLUSION

Despite the overwhelming evidence pouring on exclusions and lack of financial protection in state sponsored insurance schemes these programmes seem to be very popular among political classes. Several states have jumped in to the insurance bandwagon and introduced their own version of RSBY. The government has proposed to expand the insurance coverage. There is no doubt that household OOP expenditure can lead to financial catastrophe and impoverishment. This is a major issue and insurance cannot be the answer to impoverishment of 55 million people. Around 34 million is impoverished because they have to purchase medicines from the market. Outpatient care constitutes a

larger share of expenditure and causes impoverishment while insurance which caters to inpatient care constitutes a smaller part. Academicians from across the world have written about it. Government Commissions have noted it and advocated against expansion of insurance programmes. Such a step can only be explained by dogma in certain quarter of policy makers rather than any rational thinking. The recent National Health Policy, 2017 does not give any different view but advocates continuing with and expanding the public insurance schemeslike the RSBY where select benefit package is purchased from public and the private sector at the secondary and tertiary level.

The state has played a critical role over last three decades in the expansion of organised health care market in the country. Be it through provision of free land and electricity for setting up private hospitals; or systematic destruction of public institutions through chronic under-investment; or ensuring supply of skilled health professional to private sector through complete ban on recruitments in public sector; or through user fees and PPPs - health sector reforms have been used by the neo-liberal establishment to expand private sector in large metropolitan cities at the cost of public services. Government's persistence with insurance models epitomise the growing strength of for-profit sector which sees insurance as a vehicle to expand further in smaller towns and rural areas at the cost of public exchequer. Insurance programmes are seen as immense opportunity to 'commodify' and 'medicalise' the 'health market' in areas where the demand for health services remains low otherwise. Under the aegis of finance capital, governments are being called upon to expand their financing function so that the private provider and insurance market gets 'business', to survive and thrive, in the name of providing 'efficient' and 'quality' care.

Several key issues underlined above, calls for an urgent need to reverse this trend. An alternative pathway, based on the expansion of public provisioning and financing, rational use of technology and medicines, and expansion of preventive and curative services has been demonstrated in different parts of the world, including India. This is critical in order to protect public health system, to cap health care costs from escalating, to provide much needed financial risk protection, provision of rational care and, to improve health outcomes of the population.

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8. The Path to Integrate Chinese Urban and Rural Health Insurance Schemes

Xuefei Gu and Chaoqun Wang

FRAMEWORK OF CHINESE PUBLIC MEDICAL CARE SCHEME

Before the reform and opening up, China established a sound public medical care scheme. In rural areas, most farmers enjoyed RCMS, with coverage of over 90 per cent at its peak (Wang, He and Le 2005). In urban areas, enterprises established traditional *Laobao* or labour insurance scheme for their employees, and employees' dependents could get benefit equivalent to half of the workers' benefit. The local government would subsidise if *Laobao* funds of the enterprises were unable to make ends meet. Civil servants and workers in public sector enjoyed a national health scheme (NHS) which was funded by the government. However, the medical care of their dependents was covered in the form of mutual assistance.

After 1978, China shifted to a market economy from a planned economy. The traditional RCMS lost effective support of the institutional environment. There were less than 5 per cent areas retained under this scheme in 1985 and this situation lasted until 2003(Wang, He and Le 2005). In 2003, the central government decided to set up a NRCMS when OOP expenditures reached a peak and inequalities in access to health care was stark. NRCMS was called a mutual medical care scheme, which was organised, guided and supported by the government, voluntary participation by rural residents, funded by the individual, collective and government; and targeted at catastrophic diseases. The scheme aimed at covering all the rural residents by 2010. NRCMS adapts a combination method of individual contributions and government subsidies. All family members contribute fixed charges which are adjusted by the central government every year. The contribution accounts for less than 20 per cent of the total amount of funding. According to the National Bureau of Statistics of China (NBSC 2015), in 2014, 736 million people were covered by NRCMS, accounting for 98.9 per cent of rural household population. NRCMS receives guidance from MOH and has a county pooling level.

Due to the generous benefits of *Laobao* health care scheme and great importance given to social stability in the reforms period, Chinese government took a gradual reform path. In 1994, *Laobao* health care scheme in each company was gradually replaced by a new social health insurance called UEBMI

that nearly covered entire urban areas. UEBMI combined social pooling and individual account. At the same time, the urban unemployed residents were excluded from this scheme, and therefore, lost protection of any health insurance. In 1998, central government formalised UEBMI. The employers contribute at 6 per cent of the employee salary and employees contribute at 2 per cent of their own salary. 30 per cent of employers' contribution and all of employees' contributions were enrolled into employees' own individual account, used for paying outpatient and ambulatory cost while 70 per cent of employers' contribution were collected to establish social pooling funding, used for paying inpatient costs. In 2014, there were 283 million urban workers enrolled in UEBMI (NBSC, 2015). UEBMI receives guidance from the Ministry of Human Resources and Social Security (MOHRSS), and has a city pooling level. In recent years, nearly all the China's civil servants and workers in the public sector have transformed their insurance to UEBMI. Currently, only a few civil servants and teachers in universities in Beijing and other areas still enjoy NHS because of the slow reform process. In fact, the beneficiaries of NHS prefer UEBMI, because in the latter system, the insured can choose any one of the eligible medical institutions. But the beneficiaries of NHS have no choice and have to go to one of the medical institutions designated by the NHS. The NRCMS' operation and functioning has brought good reputation for government. Seeing its success, the central government decided to establish URBMIwho were not employed in 2007. URBMI adopted the same design as the NRCMS and the urban residents contribute less than 20 per cent of the total amount of funding. In 2014, there were 315 million urban residents enrolled in URBMI (NBSC 2015). URBMI receives guidance from MOHRSS and has a city pooling level.

In addition to the above schemes, Chinese government established medical assistance schemes (MAS) for rural residents in 2003 and for urban residents in 2005 in order to further protect the poor from high OOP. Although the medical assistance scheme for rural residents and urban residents receives guidance from MOCA, the two funds were separate. Chinese government intended to merge the two parts of the funds in 2015. In 2016, these two medical assistance schemes have been merged into one scheme.

Figure 8.1 shows the current basic framework of Chinese public medical care scheme. This includes NRCMS for rural residents, UEBMI for urban workers, URBMI for urban residents and MAS for the poor.

Fig. 8.1: Framework of Chinese Public Medical Care Scheme

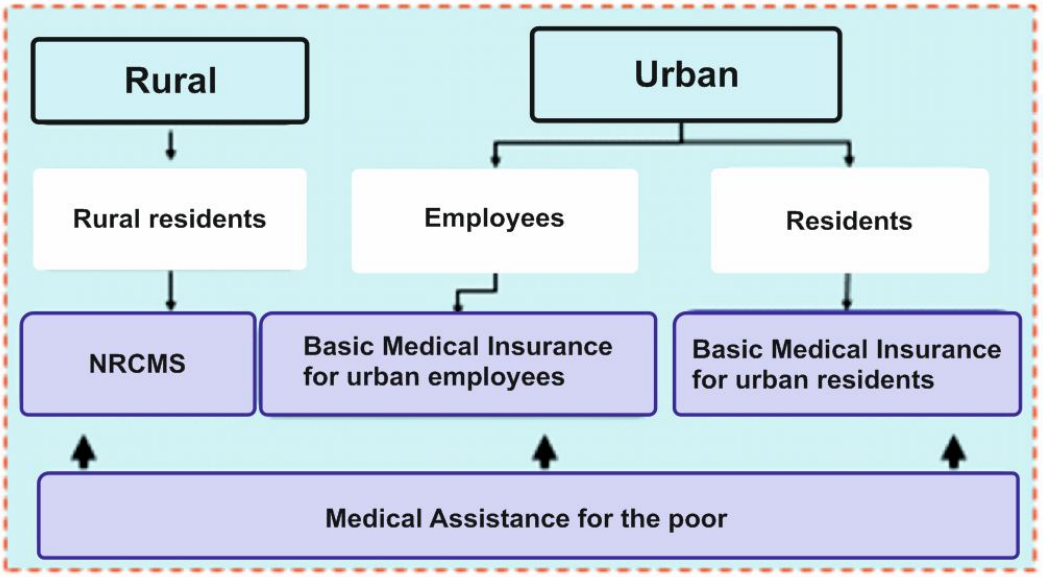


Table 8.1 shows the development trend of coverage of Chinese social health insurance schemes. Since 2000, the coverage expanded rapidly and achieved great achievements. In 2013, insured people even exceeded the total national population; the reason being that there were lots of insured people repeatedly enrolling in different social health insurance schemes. In 2013, it was estimated that there were more than 100 million insured people who repeatedly enrolled in different social health insurance schemes in China (Wang 2010).

Table 8.1: Coverage of Social Health Insurance Schemes in China

Year	Total Population (Hundred Million)	NRCMS (Hundred Million)	UEBMI (Hundred Million)	URBMI (Hundred Million)	Coverage Rate (Per cent)
2000	12.67	0.00	0.38	0.00	2.99
2004	13.00	0.80	1.24	0.00	15.70
2007	13.21	7.26	1.80	0.43	71.83
2008	13.28	8.15	2.00	1.18	85.33
2009	13.35	8.33	2.19	1.82	92.50
2010	13.41	8.36	2.37	1.95	94.61
2011	13.47	8.32	2.52	2.21	96.89
2012	13.54	8.05	2.65	2.72	99.07
2013	13.61	8.02	2.74	2.96	100.88
2014	13.68	7.35	2.83	3.15	97.44

Source: NBSC 2016; NBSC 2008.

FINANCING AND BENEFITS OF PUBLIC MEDICAL CARE SCHEME

FINANCING

Table 8.2 indicates that China's total health expenditure (THE) has been increasing rapidly since the reform and opening up in 1978. From 2000 to 2013, it increased six times. In 2009, which was the year when the new medical reforms were announced, the THE was only 1754.2 billion RMB, and in 2014, the THE increased to 3531.2 billion RMB (NBSC, 2015). The relative value of the Chinese THE was also rising rapidly. In 2014, it accounted for 5.55 per cent of gross domestic product (GDP) (NBSC, 2015).

Table 8.2*:* Total Health Expenditure and its Components

Year	Total Health Expenditure (Billion)	Government Health Expenditure (Per cent)	Social Health Expenditure (Per cent)	Out-of-pocket Health Expenditure (Per cent)	Health Expenditure as Percentage of GDP (Per cent)
1980	14.32	36.24	42.57	21.19	3.15
1990	74.74	25.06	39.22	35.73	3.98
2000	458.66	15.47	25.55	58.98	4.60
2001	502.59	15.93	24.10	59.97	4.56
2002	579.00	15.69	26.59	57.72	4.79
2003	658.41	16.96	27.16	55.87	4.82
2004	759.03	17.04	29.32	53.64	4.72
2005	865.99	17.93	29.87	52.21	4.66
2006	984.33	18.07	32.62	49.31	4.52
2007	1157.40	22.31	33.64	44.05	4.32
2008	1453.54	24.73	34.85	40.42	4.59
2009	1754.19	27.46	35.08	37.46	5.08
2010	1998.04	28.69	36.02	35.29	4.89
2011	2434.59	30.66	34.57	34.77	5.03
2012	2811.90	29.99	35.67	34.34	5.26
2013	3166.90	30.14	35.98	33.88	5.39
2014	3531.24	29.96	38.05	31.99	5.55

Source: The Chinese Statistics Yearbook 2015

The statistical calibres about the THE between OECD countries and China are different. According to source of financing, China's THE can be divided into three parts: government health expenditure, social health expenditure and OOP health expenditure. Table 2 shows the financing proportion of each part. The component on social health expenditure increased quickly in proportion, which reflected the achievement of Chinese social health insurance schemes.

Even so, there is a big gap between the financing capacities of the three major social health insurance schemes. Table 8.3 indicates each scheme's financing capacity in 2013. The per capita financing level of UEBMI equals to 6-7 times that of URBMI and NRCMS. It is evident that there are wide disparities among different social health insurance schemes in terms of benefit package.

Table 8.3: Financing and Reimbursement Level of NRCMS, URBMI and UEBMI

2013	NRCMS	URBMI	UEBMI
Insured People (Ten Thousand)	8.02	2.96	2.74
Fund Input (Hundred Million RMB)	2972.2	1186.6	7061.6
Fund Expenditures (Hundred Million RMB)	2909.2	971.1	5829.9
Per Capita Funds (RMB)	370.6	400.9	2577.2
Per Capita Reimbursement (RMB)	362.7	328.1	2127.7

Source: The Chinese Statistics Yearbook 2014.

BENEFITS

Both NRCMS and URBMI combine social pooling and outpatient pooling. Social pooling was used for paying hospitalisation expenditure and outpatient pooling was used for outpatient costs. For NRCMS and URBMI, the implementation of outpatient pooling is to expand the beneficiaries in order to enhance the scheme's attractiveness and reduce the financing cost. Social pooling funds of NRCMS and URBMI both define deductible lines and ceiling lines (which means that the funds only compensate the insured for a maximum amount), and do not pay for costs other than their benefit packages.

UEBMI combined social pooling and individual account. Social pooling was used for paying hospitalisation expenditure and individual account was used for outpatient costs and medicine expenditures. The money in individual account was only allowed to be used by the workers themselves, and not allowed to pay the medical expenses of theirdependents. However, in fact, individual accounts were often used for worker's dependents' expenses. In recent years, Chinese government recognised the shortcomings of individual accounts and planned to cancel it gradually. Social pooling funds of UEBMI also define deductible lines and ceiling lines, and do not pay for costs other than their benefit packages.

Overall, according to the 'Audit Report of National Social Health Insurance Funds', the actual reimbursement proportion of UEBMI, URBMI and NRCMS had increased to 64.10 per cent, 52.28 per cent and 49.20 per cent in 2011 from 58.91 per cent, 45 per cent and 24.80 per cent in 2005 (National Audit Office 2012). Thus, on the one hand, the enhancing of the financing capacity of health insurance schemes did not bring the equal decrease of OOP because of the rapid increase of medical expenditures at the same period. On the other hand, although there are big disparities among the three schemes in terms of financing level, the benefit gaps are not the same case. The reason is that workers' average medical expenditure is much higher than that of urban residents and rural residents. It means that there is a possibility of cross-subsidisation among the three population groups.

MAS has two main functions - one is to subsidise low-income groups; the other is to lower the threshold for low-income groups to obtain medical services

and enhance their benefits. We had talked about the deductible lines set by social pooling funds of three social insurance scheme.

From the perspective of benefited population and due to limited data, this paper only offers relevant data on NRCMS and MAS (Table 8.4). Number of beneficiaries of NRCMS includes two parts: outpatient beneficiaries and inpatient beneficiaries. Number of beneficiaries of MAS also contains two parts: subsidising urban residents to participate in URBMI or subsidising rural residents to participate in NRCMS; and directly paying poor urban and rural residents.

Table 8.4: Number of Beneficiaries of NRCMS and MAS

Year	Number of Beneficiaries of NRCMS (in %)	Number of Beneficiaries of MAS
2010	10.87	0.76
2011	13.15	0.85
2012	17.45	0.81
2013	19.42	0.85
2014	16.52	0.91

Source: The Chinese Statistics Yearbook 2015; Ministry of Civil Affairs.

CURRENT CHALLENGES OF CHINESE PUBLIC MEDICAL CARE SCHEME

The first challenge is that medical insurance fund expenditures increased too fast. Although financing level of social health insurance fund had a rapid growth, expenditure grew even faster in recent years, and expenditure exceeded revenue in many regions. With the decline in growth rate of Chinese economic and government revenue, the financing of UEBMI encounters bottlenecks; NRCMS and URBMI that mainly rely on government subsidies also face great challenges in terms of financing. However, China is vigorously pushing payment methods reform, aiming at controlling the excessive growth of medical insurance fund expenditure.

The second challenge is that China's OOP is still very high. Table 2 indicates that China's current OOP was 31.99 per cent in 2014 and its rapid decline trend had stopped since 2010. Due to the financing bottlenecks[1] of social health insurance, it is possible that OOP will rebound in the future. The high OOP payments had led to a high incidence of catastrophic health expenditure (CHE). According to an authoritative survey of many Chinese families across provinces,the CHE (refers to when household OOP expenses exceed 40 per cent of the total

[1]For the URBMI and NRCMS, the financing bottlenecks are that the two funds are financed mainly by government subsidies. But the increasing rate of China's economy had slowed down and the also the government revenues, so the subsidies from government would decrease. For the UEBMI, the financing bottleneck is similar to the URBMI and NRCMS because the economy would also affect the employment and wage.

household income) was12.2 per cent, 14 per cent and 12.9 per cent in 2003, 2008 and 2011 respectively (Meng, Xu, Zhang *et al* 2012). Thus, the social health insurance scheme did not effectively relieve China's incidence of CHE.

The third challenge is that the huge gaps exist between the three health insurance schemes. The result is that the medical service utilisation of the different groups differs greatly. This means there is serious injustice.

The fourth challenge is that there are 274 million migrant workers in China. Migrant workers refer to those groups who are agricultural registered permanent residents, but engage in non-agricultural industries in local areas or go out to work for six months or more. Migrant workers across counties refer to those people who work at counties beyond their household registration places. In 2015, there are 169 million migrant workers across counties (MOHRSS 2016). Although nearly all of them had joined in NRCMS, there are less than 20 per cent of them who have joined in UEBMI in the cities in which they work. This means that when they get sick, they would not receive treatment from the enterprise in which they were employed. It would also mean that even though they obtained medical services in employment locations, they would have had to go back to their rural registered places for reimbursement from NRCMS. In many cases, those migrant workers cannot get any reimbursement from NRCMS. Chinese government is committed to solve this problem in three years. According to central government's agenda, China will construct an information system to connect different provinces.

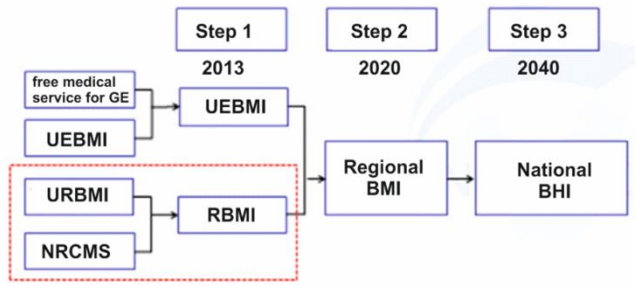
The fifth challenge is that China's public medical care schemes are administrated by different departments, including MOH, MOHRSS and MCA. These departments are different in terms of management philosophies, operation modes, benefit packages, reimbursement levels and payment methods, which make it difficult to make unified planning for health insurance schemes. Due to lack of uniform information scheme, the transition among different schemes is also very difficult.

The last challenge is that NRCMS and URBMI are voluntary insurance schemes at present. In the short term, this condition is not likely to change. However, voluntary insurance means that government needs to spend a lot of effort to attract people to enrol in the schemes. Earlier studies have shown that financing costs of NRCMS accounted for 10-30 per cent of the total amount of funding (Lin, Li and Li 2008). However, there is still lack of evidence on whether financing costs have reduced or not in recent years. It should also be noted that NRCMS has a county pooling level that is too small. Chinese government is now promoting pooling level to the city level for NRCMS.

PATHS AND STRATEGIES OF CHINESE URBAN AND RURAL SOCIAL HEALTH INSURANCE SCHEMES

Given this background, how should the urban and rural health insurance schemes be integrated to have a unified and equitable system? At present, the mainstream integration is a "three-step" strategy: firstly, merging of NRCMS and URBMI into a Basic Medical Insurance for Residence (RBMI); secondly, merging RBMI with UEBMI to form a regional Basic Medical Insurance (BMI); lastly, establishing a national BHI (Basic Health Insurance) (Zheng *et al* 2008; Qiu, Zhai and Hao 2011). The specific path is as shown in Figure 8.2. Researchers believe that the reasons in favour of the merging of NRCMS and URBMI are that they have similar financing levels, financial assistance and reimbursement rates. It will be much easier to merge NRCMS and URBMI into one (Cheng and Wang 2011). This practice will also make the RBMI a third-party purchaser to supervise the medical service providers (Deng and Zhu 2011). Moreover, it can resolve the problems of duplicate insurance, double subsidies and redundant constructions and so on (Wang 2010).

Fig. 8.2: Mainstream Suggestions for Integration of Existing Social Health Insurance Schemes



In January 2016, the State Council of China released a file named 'On the integration of urban and rural residents' basic medical insurance system'. This file demanded all provinces integrate NRCMS and URBMI before November 2016. At present, there are at least 18 provinces that have completed the integration.

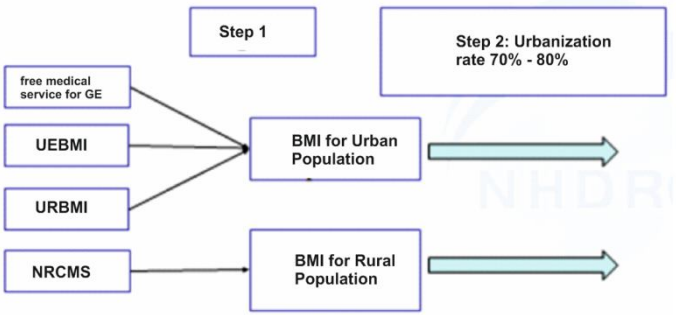
However, medical cost risks would affect the whole family rather than a single member of the family, so it is unwise to divide urban workers and urban residents into two separate health insurance schemes. China's current situation has shown that the benefit gaps among family members would induce moral hazards such as abusing of individual account funds. At the same time, there is a large gap between urban residents and rural residents in terms of income level, education levels and health seeking behaviour. They belong to entirely different groups. If we compulsorily incorporate the two schemes into one, rural residents may go to hospitals in the cities, which would direct the health

resources towards cities, or urban residents would occupy the funds that belong to the NRCMS, which would lead to reverse redistribution between urban residents and rural residents (Li Zhen 2012).

Therefore, this paper suggests that we should first integrate the UEBMI and the URBMI to establish an urban basic medical insurance (UBMI) which covers all the residents in cities. In the new UBMI, all employees (including migrant workers) compulsorily enrol in the UBMI and their dependents automatically enrol into the UBMI, but the dependents should also contribute fixed charges as before. In future, all urban families may contribute according to their total income. The government should subsidise continually for urban residents who are unemployed. The individual account of UEBMI should be abolished and retired workers of UEBMI who did not contribute to the UEBMI, should contribute to the UBMI. At the same time, the employers and employees should equally share the contribution rate, which means, that the contribution rate of both would be 4 per cent of the income.

The NRCMS should remain the same. The time to reconsider whether the NRCMS and the UBMI should be integrated will be once the urbanisation level reaches 70 per cent. Our suggested path of integration of social health insurance schemes is shown in Figure 8.3.

Fig. 8.3: Suggestions for Integrating Existing Social Health Insurance Schemes



So, how can these suggestions be implemented? Firstly, we must unify the management departments. Chinese central government had decided to unify the management departments of the three social insurance schemes in the near future, although whether the unified management department would be the MOH or MOHRSS or another new department is not clear yet. We believe that this will not be decided soon.

Secondly, the three social insurance schemes should be managed by the local government not by those who register households. At present, although the central government has abolished household registration scheme (known as the

hukou), the local governments still rely on household registration scheme to manage local population. In this situation, we recommend that all employees (including migrant workers) compulsorily be enrolled in the UBMI. This has many advantages, such as localised management and enrolment of migrant workers and their dependents.

Thirdly, the reform and promotion of benefits should be combined. The reform would make retired workers of UEBMI contribute to the new UBMI and abolish the individual account of UEBMI. These suggestions will reduce the benefit of the insured of UEBMI. Therefore, we should simultaneously implement outpatient pooling scheme to compensate these groups. At the same time, the government should be geared towards appropriately countering the resistance from those insured with UEBMI.

Lastly, the benefits promotion and the reform of payment methods should be combined. The reform of payment method should be hastened to decrease the health expenditure so as to maintain the financial sustainability of the new UBMI and the NRCMS. Nevertheless, cost containment of health expenditure must be one of the main issues to be taken up under the Chinese social health insurance in future.

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Notes on Contributors

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