Lessons India can learn from China

Washington: It was the 1960s, and China under Mao Zedong was battling to stanch the spread of schistosomiasis—a parasitic disease that can cause organ damage and, in children, impair growth.

Chinese peasants called it the big belly disease because it caused the abdomen to swell. The image of a schistosomiasis patient remains an enduring symbol of the lack of healthcare in rural China of the 1950s and 1960s.

After trying, unsuccessfully, to recruit doctors from the cities to move to the villages to control the disease, chairman Mao came up with a solution for the delivery of affordable and accessible healthcare in China. “Studying is a stupid endeavour for a doctor,” Mao declared bluntly in a June 1965 speech.

That statement led to the birth of China's cadre of barefoot doctors—an army of peasants with basic medical and paramedical training who treated common illnesses and provided basic preventive healthcare in the villages. They were so called because they worked without shoes in their paddy fields when they weren't tending to the sick.

Mao’s solution for rural healthcare was “inspirational” and “revolutionary,” said Judith Rodin, director of the Rockefeller Foundation, at the second global symposium of health systems research held in Beijing from 31 October to 3 November.

With urban-trained doctors refusing to settle in rural areas, the Chinese government recruited and trained a million barefoot doctors and sent them to the countryside, where they administered vaccines, taught villagers basic hygiene and gathered data on epidemics.

Some stayed on to become permanent village doctors. One rose to become China’s minister of health. He is Chen Zhu, who served as a barefoot doctor for five years before he was trained as a haematologist.

“The work of barefoot doctors was significant in reducing healthcare delivery costs in China. Even more radical was the shift in focus from curative to preventive healthcare,” said Winnie Yip, a professor of health policy and economics at the University of Oxford in the UK.

The barefoot doctors system was abolished in 1981 as part of economic reforms, Yip said. As China switched increasingly to a market economy, people were expected to pay for the services they received, including healthcare.

Despite gains made during the Mao era in delivering rural healthcare, China was the fourth worst out of 190 countries in terms of health equity the last time the World Health Organization (WHO) ranked health systems in 2000.

Over the past three decades, the cost of healthcare has escalated in China in line with an increased role for private healthcare. According to WHO, out-of-pocket expenses on purchasing healthcare in China currently stands at 50%, which is only second to India, where 70% of health expenses come from citizens' pockets.

Although the barefoot doctors phenomenon is a thing of the past in the country of its birth, the programme holds potentially valuable lessons in frugal healthcare for countries such as India that are setting health targets for the period beyond 2015, the deadline for the world to meet the UN’s Millennium Development Goals.

China and India together account for a third of humanity. And both countries have struggled with providing their people with universal health coverage defined in terms of financial protection and access, said Shanlian Hu, a professor at the school of public health at Fudan University.
in Shanghai.

“Both countries are currently experimenting with models of UHC (universal health coverage) and relying heavily on insurance and private sector to expand coverage,” Hu said.

On the basis of lessons learnt from the barefoot doctors programme, the Chinese government in the 2000s launched three schemes to extend healthcare and basic health insurance to its citizens which now cover 833 million people in the villages and 337 million in the cities.

The government-run rural health insurance scheme in China, which covered only 3% of the population in 2003, has now been expanded to cover 97.5%.

To be sure, the Chinese programmes have their shortcomings. “Although the coverage of government-run medical insurance schemes is very high in China, the benefit package is not reimbursed enough; the economic burden on self-payment is still very high, specially in secondary and tertiary hospitals,” said Hu.

According to Robert Hecht, managing director of US-based think tank Results for Development Institute, political commitment will be the most crucial aspect of India’s experiment with universal health coverage.

“China’s experience has many interesting positive lessons for India. First, where there is political will, insurance coverage can be expanded rapidly in just a few years, reaching hundreds of millions of people and reducing their financial risks,” Hecht said. “Experimentation in different cities and provinces can help to find best practice’ solutions that work and can be quickly spread across the country.”

Lastly, government-run and funded insurance programs can successfully pay for a mix of public and private clinics and hospitals, he said.

India’s attempt to make health an entitlement began with the National Rural Health Mission (NRHM), launched in 2005, which now accounts for 72% of the health ministry’s budget.

According to the Planning Commission, the health ministry spent ₹64,294 crore during the 11th Five-Year Plan (2007-2012), yet only 27% of the amount went towards public health infrastructure. In 2009-10, the total spending on government-sponsored health insurance schemes including the Rashtriya Swasthya Bima Yojana was ₹16,000 crore, covering only 243 million persons.

K.Srinath Reddy, who heads a high-level expert group on healthcare, attributes India’s failures in public health to lack of investment in primary healthcare centres.

“Our health indicators have lagged behind economic progress because we have a low level of public spending on health,” he said. “Current insurance schemes do not provide financial protection since they don’t predict out of pocket expenses, costs of drugs etc.”

Experts say India must not make the mistakes China did on health insurance.

“China has some cautionary lessons for India with regards to insurance. China’s way of reimbursing healthcare providers on a fee-for-service basis has led to cost escalation, which the government is now trying to control. Their insurance so far has been broad, covering more than 95% of the population, but not that deep, with some health services not reimbursed or only partly reimbursed, so some Chinese citizens still have to make large out-of-pocket payments,” says Robert Hecht.

The Chinese government has said it would address health insurance-related concerns 2009 by the time it rolls out healthcare for all its citizens by 2020.

According to WHO’s health financing expert Joe Kutzin, insurance will be the key to progressing towards universal health coverage for both India and China.

Careful attention must be paid to specific features of health insurance packages, such as government subsidies, to ensure that the poor are included in them, said Kutzin, or else “schemes can actually harm progress towards this goal.”

While the route to universal health coverage is being debated in developing countries, it is evident that the idea itself has taken hold.

Rodin of the Rockefeller Foundation cautioned that effective health systems and the concept of universal health coverage are political issues as much as they are technical.

“And there are too many countries where universal coverage has been stymied by self-interest and short-sightedness,” Rodin warned. “As much as we need health systems solutions, we also need political solutions. For universal health coverage, we need a movement. And that
movement is gathering momentum."