Regulating Health Care Markets In China And India

Regulatory approaches based on functioning local institutions seem to work best in both countries.

by Gerald Bloom, Barun Kanjilal, and David H. Peters

ABSTRACT: Health care markets in China and India have expanded rapidly. The regulatory response has lagged behind in both countries and has followed a different pathway in each. Using the examples of front-line health providers and health insurance, this paper discusses how their different approaches have emerged from their own historical and political contexts and have led to different ways to address the main regulatory questions concerning quality of care, value for money, social agreement, and accountability. In both countries, the challenge is to build trust-based institutions that rely less on state-dominated approaches to regulation and involve other key actors. [*Health Affairs* 27, no. 4 (2008): 952–963; 10.1377/hlthaff.27.4.952]

China and India are two countries whose economies are growing rapidly and where governments have found it important to stimulate reforms to strengthen their social sectors. In the 1950s and 1960s, both countries invested in largely public health systems. Yet both health systems have become highly marketized, although they have taken different routes. Both countries are now facing a crisis of trust in the health sector, attributable in part to rising expectations and concomitant failures in their health care markets.[1] Each country is tackling the issue of how to regulate its health care market differently.

■ **Views about regulation.** The traditional view of regulation is that it is a government function, dealing with the laws, orders, and rules placed by government on enterprises, citizens, and government itself.[2] A more holistic view incorporates roles of other key players in the formulation and implementation of regulations, which are continually under development, and where the interests and incentives of those involved in regulation matter greatly.[3] The key institutions in the regulation of the health sector include those involved in the production and distribution of health-related services and products (for example, health care providers, hospital and pharmacy owners, and professional associations); those financing health services (for ex-

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ample, state and nonstate health insurance organizations); the media; and organizations involved in accountability activities, including formal state and quasi-state regulatory agencies, the legislative and judiciary arms of government, and civil society organizations that seek to protect the interest of the public. The asymmetries in the relationships between these actors and the public, and their inability or unwillingness to disclose information, make health care markets unable to function efficiently on their own.[4] In particular, information asymmetry concerning the appropriateness of health care, its quality, its price, and its medical and financial effects on patients and their families make regulation both necessary and difficult to carry out. Because of the information asymmetry and the intensive and personal nature of the transactions involved, health care markets depend highly on trust-based institutions to function well.[5] Both China and India are struggling to develop effective trust-based institutions to make their markets support public policy objectives.

■ **Broad policy objectives.** The broad policy objectives that governments hope to achieve through regulation of their health care markets are quite similar and include the following concerns: (1) quality of care—are providers competent? Is health care safe? Is it effective? (2) value for money—is health care provided at a reasonable price? Is it cost-effective? (3) social agreement—is health care provided in a fair and equitable way, in terms of access and financing? (4) accountability—is health care provided and paid for in a transparent way that holds key actors responsible?

This paper examines the regulatory pathways taken by both countries, using the examples of front-line health care providers and health insurance to illustrate how key institutions are trying to address the main regulatory concerns of the health sector in each country.

Development Of The Two Health Care Markets

Neither country has an overarching strategy for regulating its health care markets. Both countries have left a high proportion of their health care financing to private, out-of-pocket payments, a sign that health care markets have been left to grow on their own, and have underused financing mechanisms to pursue regulatory objectives.[6]

■ **In China.** Health care markets have developed differently in China and India, which is an important reason for the different regulatory pathways they have taken. In China, they emerged within the state and Communist Party structures, as government health facilities came to rely increasingly on user charges. Strong civil society groups have not emerged as a regulatory force, and the health professions do not have a dominant role. During the Cultural Revolution, the regulatory powers of the medical profession were greatly weakened, and many nonprofessional people either became village-level "barefoot doctors" or provided health services as employees of rural health centers. The village doctors are slowly being replaced by a new cadre of village general practitioners (GPs), the unqualified hospital employees have largely

reached retirement age, and licensing for the health professions is emerging as an important regulatory strategy.

■ **In India.** In India, the government has drawn clear distinctions between the public and private sectors. Government has focused its concerns on delivering services through a largely underfunded public health sector. Untrained local practitioners and drug shop owners have grown into the dominant type of provider of outpatient medical care and are collectively known as rural medical practitioners, village doctors, quacks, and other names. These informally trained providers have largely been ignored by the central and state Ministries of Health. The Indian government has sponsored village workers, such as auxiliary nurse midwifes (ANMs), who have remained in the weak public system. The health professions have been powerful enough to prevent village doctors from becoming legitimized through civil society organizations or licensing arrangements. Instead of developing professional self-regulation, medical associations have acted more as unions seeking to prevent other competition than as organizations interested in promoting quality of care, although some recent exceptions are emerging to develop professional accreditation.[7]

■ **Concerns in both countries.** In both countries, the media have raised concerns about the public's being taken advantage of by unscrupulous health care providers. Although independent consumer associations are beginning to focus on protecting health care consumers in India, this is a new area of activity for them. The comparable institutions in China have also begun to deal with medical complaints since the late 1990s. Both India and China are seeing the increased involvement of courts in medical malpractice cases.[8]

The Chinese Experience: From A Rural Health System To A Market Economy

In China, the institutional arrangements that supported cost-effective health services with wide access during the command economy were no longer in place by the 1990s, and the construction of institutions appropriate to the emerging market economy was taking a long time.[9]

Rural health services have increasingly come to resemble a market for which the government is at an early stage in creating an appropriate regulatory framework. Government officials no longer influence the day-to-day management of health facilities, and health facilities compete for patients and revenue. Many local governments do not have the resources to monitor and regulate the health sector effectively, and health facilities have gained considerable autonomy, even as the number of private-sector providers is growing.

■ **Government powers and the deterioration of trust.** The government has retained many of its old powers. For example, it controls prices, keeping charges for consultations and hospital days low but allowing facilities to earn a surplus from drug sales and test fees. This has encouraged high levels of diagnostic testing and pharmaceutical use and rapid cost increases.[10]

"Most Chinese provinces have created a licensing system whereby village doctors are required to take annual examinations."

These problems have been reflected in low levels of trust in the health system. The Ministry of Agriculture opposed the introduction of compulsory rural health insurance, and farmers resisted joining voluntary schemes.[11] Newspaper articles have highlighted self-serving behavior by health care providers and published reports of physical violence against health workers.[12] The deterioration of trust culminated in highly public speeches in 2005 by the most senior political leaders, which emphasized the need for health workers to change their attitude toward the public.

■ **New regulatory approaches.** The government has been implementing measures to develop new regulatory approaches appropriate to the market economy since the late 1990s.[13] It began with procedures by the anticorruption department of the Communist Party to reduce demands by health workers for informal payments from clients and for kickbacks from drug wholesalers. It has also introduced measures to improve the quality of front-line health services and establish new rural health insurance schemes.

■ **Front-line providers.** During the 1960s and 1970s, China trained many so-called barefoot doctors to lead village-level public health activities and provide basic medical care. During the transition to the market economy, these cadres did not become government employees, and they have mostly earned a living by selling pharmaceuticals and charging for services. In some localities, local governments paid them modest fees for providing certain preventive services. The township health centers—the lowest-level government facility—also employed many poorly trained personnel during the Cultural Revolution of the 1970s, when the medical schools were closed. These health workers needed to develop their medical skills on the job.

Health facilities in poor localities struggled to generate enough revenue to pay salaries to their qualified and less skilled personnel. There were good moral and political reasons for retaining the people who began work when the training institutions were closed. Since the turn of the century, a growing number of these employees have reached retirement age, and the average level of training of rural health workers has risen. Newly appointed personnel are now expected to have at least minimum technical qualifications.

Quality of care. The health system has gradually established a regulatory framework to ensure a basic level of quality of service by village doctors. Most Chinese provinces have created a licensing system whereby village doctors are required to take annual examinations. Those who fail these examinations can lose their right to practice. Local health departments carry out periodic campaigns to close down clinics run by unlicensed personnel. In many places, the township hospitals organize regular meetings of village doctors, and doctors from township facilities may

visit villages to monitor their performance. Although these supervisory activities are included in the national policy, the actual practice is often limited by resource constraints.

Village doctor training. The level of training of village doctors is also changing. Many counties have established two- or three-year college courses for village doctors. One increasingly finds clinics staffed by young graduates, often married couples, whose practice resembles village-level general practice. The relationship of these practitioners with the public health system is still not clearly defined.

Rural public health services. There is a growing government interest in strategies for strengthening rural public health services by making better use of village doctors. There have been experiments with contracting village doctors to provide a set of defined services for an agreed-upon fee. One example has been the use of village doctors to identify people with hypertension and follow their treatment. The government is debating alternative strategies for reforming public health services, and new policy is expected soon, which may strengthen the role of village doctors.

■ **Health insurance.** Since 2003, the central government has begun to make substantial fiscal transfers earmarked for health services in poor counties. One noticeable feature of these transfers has been government's strong preference for demand-side arrangements, rather than the provision of budget support for government health facilities. This reflects a belief that measures are needed to make health facilities more accountable to the community. The most important such arrangement is the county-level voluntary health insurance schemes, known as the New Cooperative Medical Scheme (NCMS).

The government is also funding a health care safety net for the very poor, through the Ministry of Civil Affairs. The exact design of this scheme is in evolution. However, the most common pattern is for the government to pay eligible households' contribution to the NCMS and a proportion of their copayments.

In 2003 the government announced a policy in favor of the rapid expansion of the NCMS. The schemes have been structured as mechanisms for the provision of public finance to support health services. The central government allocates a fixed amount per beneficiary to schemes in the poorer counties, as long as local governments match this contribution. Households are also expected to contribute to the schemes. At first, the schemes reimbursed a modest proportion of the cost of inpatient care. The new program began slowly with a relatively small number of pilot schemes. The government soon accelerated implementation, and now most counties have a scheme. At the same time, the central government increased its contribution to schemes from 10 yuan to 40 yuan per beneficiary.

Government's focus during the early years of the scheme has been on the creation of institutional arrangements to ensure that the funds were used only for the purposes defined for the NCMS and that the systems of reimbursement were fair and widely seen to be so. The emphasis has been on financial audit and on winning public support for the reimbursement system. This was quite rational, given the

context, in many localities, of low trust in the accountability of local government.

The government anticipated the eventual need for the NCMS to address other regulatory issues. This has been done by establishing supervision committees on which all key government departments, the anticorruption office of the Communist Party, and the local representative bodies are included. Scheme managers already speak of the need to monitor for inappropriate charges by hospitals, and they have created local processes to review claims for reimbursement. These arrangements complement the role of county health bureaus in monitoring the achievement by health facilities of agreed-upon performance targets. Some counties have begun to experiment with alternative arrangements for the payment of providers, such as a fixed fee for treatment of a specific health problem. One can anticipate the emergence of a variety of issues, such as the overprescribing of drugs, the high cost of treatment of certain kinds of health problems, and potential differences in capacity to use services based on geographical location and household income. These schemes are establishing computer-based billing systems that record the details of treatment. This could eventually provide an important basis for these schemes to influence providers' behavior.

The impact of these governance arrangements will depend on the capacity of relevant managers to undertake their regulatory roles, the priority that local government leaders give to these schemes, and the degree to which the interests of beneficiaries, particularly the poor, are taken into account.

The Indian Experience: Growth Of The Private Sector

The most recent data in India indicate a rapidly growing presence of private-sector providers in both outpatient and inpatient markets. Private hospitals have grown to provide about 58 percent of rural and 62 percent of all urban hospitalizations in 2004.[14] The presence of private providers is more prominent in the outpatient care market, where about 80 percent of cases are treated, mostly by unqualified providers.

■ **Front-line providers.** The mechanisms to regulate the front-line provider market are quite blurry, although there are several key institutions that, taken together, could play a valuable role. They include (1) the Medical Council of India (MCI), which is responsible for giving recognition to medical qualifications, maintaining a registry of providers, maintaining standards for postgraduate medical education, and defining a professional code of conduct; (2) the Departments of Health in individual states; (3) associations of qualified allopathic practitioners (such as the Indian Medical Association), practitioners of Indian System of Medicines (ISM), and numerous associations of unqualified providers who practice modern medicine without recognized training; and (4) a judicial system that allows consumers to approach a consumer court to seek justice for medical negligence. On their own, none of these can effectively address India's key regulatory concerns.

Quality of care. The regulatory concerns regarding the quality of care of front-line

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providers is conspicuously underrated in India's health care system. Consequently, the inpatient care market experienced unregulated growth in private providers, which resulted in duplication of facilities in urban centers, variable quality of services in the absence of effective licensing and accreditation, and corrupt practices.[15] This is even more problematic in the outpatient care market, where most providers are seen to have a poor knowledge base and tend to follow irrational, ineffective, and sometimes even harmful practices when treating minor ailments.[16] The risk is further aggravated when many people do not even know that many of these providers are not qualified as physicians.[17]

The quality of noninstitutional care is crucial, yet it remains mostly out of regulatory domain. The MCI, for example, has a list of medical misconducts that can be brought before the council, yet it does not specify punishments. This makes the institution toothless, even against very serious grievances. Similarly, the associations of unqualified providers have remained ineffective bodies for self-regulation. Given the failure of these institutions, the Consumer Protection Act (COPRA) often becomes the only way for affected consumers to protect their interests. COPRA, promulgated in 1986 to protect the rights and interests of consumers, recognizes medical misconduct as an offense.[18] There are district, state, and national quasi-judicial bodies to redress such cases. However, even this instrument remains grossly ineffective against medical negligence, since (1) the redress process often becomes too lengthy for the common consumer; (2) the responsibility of proving negligence lies with the consumer; and (3) the services provided through the informal market and government providers remain in a gray area, because the "purchase" of services is hard to prove.

Value for money. The existing regulatory framework also does little to ensure value for money. Because there is no standard pricing policy in India, including minimal requirements concerning the disclosure of prices, there is huge variation in the prices clients pay for the same service. This is both unfair and inefficient. For example, according to a recently conducted facility survey, a cesarean section could cost anywhere between Rs 3,500 and Rs 50,000.[19] Given the large asymmetry in information, there is unbounded scope for supplier-induced demand and price gauging. The future challenge remains in (1) how to influence providers to follow a reasonably standardized set of procedures, particularly for major curative interventions; (2) how to reduce unsupportable price variations; and (3) how to limit inappropriate treatment practices.

Health care disparities. The issues related to social agreement revolve around the key question of equity in access and the impact of health care on socially disadvantaged populations. There is now enough evidence that the front-line market often

poses a prohibitively high barrier to access services from qualified private providers, forcing the poorest users to seek treatment from unqualified providers (for outpatient care) and public hospitals (for inpatient care). Since public hospitals function poorly in many areas, a large proportion (about 44 percent) of people below the poverty level have to seek admission in private hospitals and then bear a substantial financial burden for treatment.[20]

So far, regulatory institutions have hardly been successful in ensuring equity. The state governments are supposed to provide subsidized health care to the poor and vulnerable, but there is virtually no oversight at the ground level to ensure effective targeting. Private hospitals fail to provide care to the poor even when they receive subsidies from the government.

Accountability is also a serious matter of concern to policymakers. The dismal picture is reflected by the finding that more than one-third of the health enterprises in the country do not have any form of provider registration.[21] Registration is necessary but not sufficient to bring transparency into the system, since registered providers are not compelled by the regulatory system to divulge information on prices and procedures to clients. A natural economic consequence of such loose accountability is an oligopolistic market where providers feed on an implicit collusion and consequent exploitative price structure.

■ **Health insurance.** Regulating the market for health insurance is another important issue in India because of the lack of financial protection in health afforded to most Indians. The health insurance market comprises a mix of insurers providing mandatory social health insurance, voluntary private health insurance, and community-based health insurance schemes. Despite the presence of a variety of players, the market is still very small: only 3–5 percent of Indians are covered by any form of health insurance.[22]

An initial step toward regulating the Indian insurance market was to pass the Insurance Regulatory and Development Authority (IRDA) Act in 1999, which allowed the entry of the private sector into the Indian insurance market—including health insurance—and established a regulatory authority.[23] Before this act was passed, health insurance services were provided entirely by the public sector.

It is interesting to note that health insurance received no special reference under IRDA and was bunched with other nonlife insurance initiatives. This seems to reflect policymakers' inability to recognize the dynamic transformation of the health care market and consequent need for special understanding of catastrophic shock and its impact on health care consumers.

Quality of care. Does the existing health insurance regulatory framework help address the key concerns about quality of care? The social insurance schemes—for example, the Employees State Insurance Scheme (ESIS), targeted to all employees of factories employing twenty or more people—fare poorly on this aspect. There is a common concern that the quality of care provided by ESIS facilities is abysmally poor, which is evident from a very low bed occupancy rate.[24]

IRDA has outlined an elaborate framework to regulate the operations of private insurance companies and third-party administrators (TPAs). However, the direct impact of this effort on quality of care will remain insignificant unless it is coupled with a parallel initiative to establish a credible system of regulating providers, such as through universal licensure and accreditation processes. Without such institutions, the natural process of competition is expected to force each insurer to come up with its own accreditation policy and reimbursement procedures.

Value for money. The existing regulatory framework raises concern about the value for money spent on health insurance. The current trend in the Indian private insurance market is toward indemnity products, which usually pushes up the cost of care. Given that managed care systems can yield low-cost outcomes in comparison to traditional third-party models, the relevant issue for policymakers and regulators is to devise methods to promote the emergence of managed care models relevant to India.[25]

Equity in access. Can regulation in the insurance market help achieve better social agreement? The common perception is that market-driven risk pooling aggravates inequity in the health care market. By all probabilities, private health insurance schemes would exclude high-risk populations and contribute to inequity in health care. There is also a concern that private insurers insure a disproportionately large number of the people in economically well-off groups, leaving the worst-off to the public health care facilities.

It is encouraging that Indian policymakers have embarked on several parallel initiatives to make insurance more equitable. Some of the state-sponsored interventions are (1) launching special health insurance products targeted to the potentially excluded populations, such those below poverty, workers in the informal sector, and the elderly; (2) including an insurance component in the National Rural Health Mission (NRHM)—a nationwide comprehensive public program primarily to increase access and use of high-quality health services—to provide heavily subsidized insurance for rural residents; and (3) mandating private insurers to invest a part of their worth in designing and delivering appropriate products for the socially excluded.

Accountability. Accountability issues seem to have drawn keen attention from IRDA. IRDA's major concern was to ensure transparency in the operation of insurers and to protect consumers from the threat of "fly-by-night" operations. IRDA has wide powers to oversee the operations of insurance companies, which take the form of mandatory requirements for insurance companies such as auditing by qualified actuaries, periodic submission of reports, appointing directors or taking over management, requesting information, and even shutting down the operations of an insurance company through court orders.[26]

The above procedures may increase the accountability of insurers if they are actually applied, but will they make service providers more accountable? In a competitive environment, providers empanelled by an insurance company are ex-

pected to follow some transparent rules of the game. However, the accountability of the majority of providers who operate in the informal care market or in public hospitals remains unresolved, since there is scarcely any means of integrating these two sectors in the new insurance regime.

Key Gaps And Future Pathways

The story of how each country has tried to regulate the front-line provision and financing of health care has highlighted some key gaps in the approaches taken. In India, the largest set of providers and health transactions have been largely neglected by public policy and regulatory agencies, with the possible exception of the judiciary and consumer courts, which have played a limited role in influencing health care practices. The fact that most village doctors are the most common type of provider to the poor makes it more difficult to follow through the stated policy priority of reducing inequalities in health care without addressing these providers.[27] The gap in effective regulation has been exacerbated by the interests of the health professions, which have not focused on the key regulatory concerns. The fragmented financing system has also limited the ability of the state (or collective purchasers) to influence providers' behavior and reduce prices through strategic purchasing of health care.

In China, the key gaps include weaknesses in the regulatory capacity of local governments and in the degree to which they are answerable to the community, the limited (but rapidly growing) voice for consumers through the media or civil society, and the stunting of professional self-regulation. Health insurance is becoming increasingly important, but many issues remain to be addressed concerning differences in the benefit packages in localities at different levels of development and the problems associated with the very rapid rate of urbanization.

Although key regulatory gaps remain in each country, it is still worthwhile to ask, What can China and India learn from each other in how they regulate their health care markets? and, What can other countries learn from their experiences? In both countries, it is apparent that traditional approaches that depend exclusively on state-directed mechanisms are limited in their ability to regulate health systems that are pluralistic and marketized. What seems to work better are regulatory approaches that are based on institutions that are working locally. For example, local scheme managers in China are developing their own ways to monitor provider practices. In India, private hospitals are setting up their own accreditation schemes. All actors have potential to contribute to regulation and could be better incorporated. In particular, the health professions, civil society organizations, and the media could play stronger roles in both countries, even in the coproduction of service provision and regulation.[28]

■ **Potential in India.** Because of the strong media, active civil society organizations, and the rising expectations of a growing middle class, the prospects for engaging these actors in strategies to disclose information and hold providers accountable

for their actions has great potential in India. Rather than overly relying on its traditional role as an inspectorate, governments in India may be more effective by focusing on ways to facilitate the participation of these groups, including by making information and performance standards available for both public and private providers. Demonstrating a more serious commitment to health insurance would also provide better opportunities to align the country's health care financing with its stated goals of equity and poverty reduction, as well as to better influence providers' behavior.

■ **Prospects in China.** In China, the prospects are much greater for improving accountability through its growing social health insurance schemes (the NCMS and urban health insurance). However, the role of civil society organizations, representing the professions or the public, is very underdeveloped, and the degree to which schemes can be influenced to reflect the interests of their beneficiaries is uncertain.

Much is left unanswered about how these countries will be able to regulate their health care markets in the future. Priorities for the future should include in-depth analyses of how the new institutional models are working, preferably based on involvement of key actors. The most important tests for these institutional arrangements are whether they are able to build trust among these key actors, and how well they are able to protect the interests of the most marginalized segments of society.

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