Klaus J. Hornetz

Learning from the Neighbor?
Values, Ideologies and Political Economy of Health Care in China
Lessons to be learned for Kyrgyzstan

> *"Nationalization of medicine should not be understood in a vulgar sense, as a closure of private hospitals and prohibition of private medical practice; in fact, it means actual 'governmentalisation' [ogosudarstvlenie] of medicine; i.e. the state makes a pledge to provide everyone with free and qualified medical help immediately upon request. And it is only after that that all private entrepreneurial hospitals and commercial 'private medical practice' will disappear, as darkness flees from the light. (Semashko1919)*[1]

Introduction - Soviet legacy and transformation

The fundamental transformation of all countries of the former Soviet Union (FSU) over the last two decades have brought about significant change to almost all aspects of political, economic, social and cultural spheres.

Kyrgyzstan has been gradually reforming its health care system since the second half of the 1990s. Like all countries of the former Soviet Union, the country was confronted with the legacy of the bureaucratic and hierarchical "Semashko" Soviet model of health care, which had to fit into the needs of the planned economy.

The Soviet socialist health care model was centralized, integrated, hierarchically organised with the government providing state-funded health care to all citizens. All health services were owned by the state. All health personnel were state employees. Control of communicable diseases had priority over non-communicable ones. On the whole, the Soviet system tended to primary care, and placed much emphasis on specialist and hospital care. The Semashko model has been considered as a "coherent, cost-effective system to cope with the medical necessities of its own time".[2] *The health of the population in this system was defined as a public interest.*

The model of health care governance, delivery and financing deeply impacts on perceptions, attitudes and behaviour of the people. Combined with the manifestations of chronic scarcity in this system, besides poor quality of care, and sluggish scientific and technological development, the citizen becomes an dependent object rather than an autonomous subject of care. These roles are internalized by the population and ultimately lead to a 'delegation' of responsibility for health to the state. Such attitude is one of the fundamental legacies of the socialist system with which any later policy must depart from - as a political reality. Consequently the change of the political system implies changing roles of state and of the individual.

On the positive side, the system aimed for security, solidarity and equality, albeit at an extremely low level. The result is first of all comprehensive and effective systems of public (preventive) health services

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[1] *Cited after Olga Zvonareva, Evgeniya Popova, Klasien Horstman. Health, Technologies, and Politics in Post-*

[2] *OECD: The Social Crisis in the Russian Federation, p. 95*

which, by means of vaccinations and control measures, ensure safety against communicable diseases. On the financing side, the state effectively assumes the role of a comprehensive general insurance institution.

Such "Paternalistic security" and equal access to health care are significantly discredited by corruption and privileges. It was possible in this system, to obtain preferred care, treatment or e.g. more expensive medications, through personal connections, a high rank in the hierarchy, favors, or bribery.

Socio-cultural and economic tensions in transformation societies are evolving between people's (and decision makers) deeply rooted experience of all-caring authoritarian political systems on one hand, and of the opportunities and challenges of self-regulating market economies on the other. Such tensions, as we argue in this paper, critically influence the perceptions of individual responsibilities, autonomy, responsibility, solidarity mechanisms, expectation and aspirations of citizens and eventually the negotiation and formulating of social polices and organization building.

Market economy, new freedoms and modernization of state and society have generally positively impacted on the lives of citizens, At the same time access to health care, health outcomes and financial social and health protection have not kept pace with the overall transformation process. Health and social protection systems were slow to adapt to the rapid epidemiological and demographic change. Despite remarkable progress and positive sector reform results, health outcomes in these countries, including Kyrgyzstan, are still considerably worse than in other countries of similar economic performance. Gains in life expectancy for example in FSU countries over the past 20 years, including Kyrgyzstan, have been the lowest in the world. Instead of catching up with Western Europe, FSU countries have been falling behind.

Policy makers in Kyrgyzstan are well aware of these challenges. The reform agenda for the last 15 years addressed persisting health gaps and inequities in access and outcomes, rationalizing and diversifying the delivery systems, making better use of resources, improving quality, transparency and accountability, and transforming the Soviet governance, financing and service delivery models based on the values of a social market-economy, and an open transparent society.

Formulating, implementing and financing reforms, Kyrgyzstan, like other FSU countries, has received substantial technical and financial support from the international community. Shaping national service delivery and social health protection systems have largely been influenced by reform blueprints and system models from selected Western countries and the related paradigms of UN agencies and other multilaterals. While both countries departed from the fully-fledged Semasho model, the wealth of lessons learned from the political and economic transformation of Kyrgyzstan's immediate neighbor, the Peoples Republic of China are largely unknown to Kyrgyz social policy decision makers and to civil society. In this paper we attempt a brief historical and political economy analysis of the health sector and contrast health reform environments and drivers. We demonstrate similarities and differences, and reflecting on their historical, political, economic and socio-cultural roots.

Application of the Semashko System in China

> *'Tell the Ministry of Public Health that it only works for fifteen per cent of the total population of the country and that this fifteen per cent is mainly composed of gentlemen, while the broad masses of the peasants do not get any medical treatment. First they don't have any doctors; second they don't have any medicine. The Ministry of Public Health is not a Ministry of Public Health for the people, so why not change its name to the Ministry of Urban Health, the Ministry of Gentlemen's Health, or even to Ministry of Urban Gentlemen's Health'?*[3]

Since 1949, China has developed a health care system that was typical of the communist states of the time. High priority for social justice and the dominating role of the government in financing and providing social services, including health, were design principles. Private service providers and private ownership of health care facilities disappeared in the 1950s through complete nationalization. The government (national and local) owned, financed and ran all healthcare facilities from small community health centers in the countryside and clinics in the cities to large tertiary hospitals in urban areas. Doctors became employees of the state. The production-cooperatives in the countryside and the state production enterprises in cities were the main providers and financiers of services for workers and their families. Local governments financed the supply for all other parts of the population.

Most hospitals lacked high-tech equipment and new medicines because of very limited funding. At the same time, there was a considerable shortage of skilled workers. Despite these limitations, the Chinese health care system achieved tremendous improvements in health and health care into the early 1980s. Prevention and primary care had an absolute lead, while minor health care workers (I.e. 'barefoot-doctors') were the main contributors. Almost all citizens had equal access to the very simple health care system. Public health has achieved great success in controlling infectious diseases through immunization, improving sanitation and controlling common communicable diseases. The infant mortality e.g. fell from 200 to 57 per 1000 live births in three decades, and life expectancy increased from about 45 to 68 years.

In the late 1970s, China had a stagnant economy but a functioning healthcare system that was 'the envy of the developing world'. More remarkably is that these achievements were attained at a relatively low cost: total expenditure on health accounted for only 3% of GDP.

Despite all these achievements of the Semashko-type system, its legacy has been (and still is) weighing heavily.

> *"The classical socialist system is the ultimate manifestation of paternalism: the ideology and the practice of the system conflict strongly with... the idea of individual sovereignty. The communist party's philosophy is, "We will look after you. You will receive free health care. We, on the other hand, will decide what care you receive and how much of it." So one of the main characteristics of the classical Soviet model is a universal entitlement to free health care.*

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[3] *Mao Tse-tung. Directive On Public Health June 26, 1965. Source: https://www.marxists.org/reference/archive/mao/selected-works/volume-9/mswv9_41.htm*

...Patients have no freedom of choice …Chronic shortage appears in the health sector, just as it does in other branches of the classical socialist system. The mere fact that all citizens are entitled to free care engenders shortage. The phenomenon of "moral hazard" appears in an extreme form; patients have no incentive whatever to moderate their demands."[4]

As outlined for Kyrgyzstan above, the Chinese citizen had become a dependent object of paternalistic care rather than an autonomous actor. Both, the drastic change of the political system in case of the FSU countries or the initially uncompromising market transformation of China's economic policy reform imply changing roles of state and of the individual. Both political systems appear not having timely realized the weight and impact of this legacy on the way. Citizens were and still are coping with demographic and epidemiological transition of this time.

Applying the Free Market Model in The Health Sector

The extraordinary developments of key health indicators stagnated after the introduction of economic reforms. With the beginning of the successful transformation of the Chinese economy in 1978, the blueprints of market transformation were – from todays perspective un-reflected and naïve- extended to the health sector. Confidence in the regulatory capacity of the market and accepting inequalities in the spirit of Deng Xia'o Ping's "let some people get rich first" doctrine justified laissez-fair policies in the area of hospital autonomy, the drastic reduction of state funding to public health services, including those responsible for health protection, prevention and consumer protection.

Like all transition economies, China has been experiencing a fiscal crisis since 1978 when it came to liberalizing its economy. Government revenues as a percentage of GDP fell from 30% to 10% between 1978 and 1993. Subsidies to public health institutions fell from 50-60% at the beginning of 1990 to only 10% of the total revenue of the institutions. Coverage under all insurance schemes fell from 70% of the population in 1981 to 20% in 1993[5].

As a result, public health institutions covered the funding shortfalls with increasing patient co-payments, followed by a continuous increase in prices. Affordability of care became a major challenge for the less wealthy population group. Correction attempts, such as government price regulation, were poorly designed. They created irrational incentives for health services to increase medically unjustified services and overall diagnostic and therapeutic performance, adding to the cost increase.

These problems were compounded by the decline of the previously successful system of primary health care, especially in rural areas. Associated with this an increasing relocation of demand and supply to higher levels of care, also due to an increase in chronic degenerative diseases. The quality of care has fallen drastically, both in the curative area as well as in the area of prevention, epidemic control and consumer health protection. Combined with the collapse of rural and urban social security networks and ever-increasing prices for medical services, supply disparities between socio-economically defined groups have worsened further. The growing inequality and the loss of confidence and dissatisfaction of the population, which caused concern to the political leadership, were the consequences. The urban-rural differences in maternal mortality, for example, in 2002 were 65 and 28 deaths per 100,000 live births respectively. Out of pocket expenditure for healthcare rose from 21% in 1980 to 59% in 2000, resulting in an increasing number of families confronted by catastrophic household expenditure refraining from seeking health care, despite serious conditions.

Public health services were no longer able to cope adequately with "old" (tuberculosis, schistosomiasis) and even less with the "new" (HIV / AIDS and SARS) epidemics. In particular, the worldwide noticed loss of control of state services, which was perceived in connection with the SARS epidemic in

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[4] *Kornai,JÃnos & Eggleston,Karen, 2001. "Welfare, Choice and Solidarity in Transition," Cambridge Books, Cambridge University Press, number 9780521790369, December. Pg 135ff*

[5] *World Bank. 2003. World Development Report 2004. Making Services Work for Poor People. Washington, DC: World Bank.*

2003 and considered shameful by the leadership, was a major trigger point in the reform of Chinese pro-market health policies.

Re-Focusing on State Provision and -Financing

With the new Government since 2003, the country was seeking to overcome the contradictions between state ideology and growing inequalities. The new leadership departed with a different set of social values. They gave higher priority to equity in people's wellbeing between the rich and poor, and rural and urban residents. A health safety net was considered an essential necessity for people's wellbeing. The new vision of a "socialist harmonious society" has since dominated China's social paradigm, recognizing that China had to balance economic and social development. However, while President Hu declared the goal of the health reform to be "everyone has affordable access to basic health care, the roles of government and market have not been well defined. The SARS outbreak in 2003 was a dramatic wake-up call for the political leadership. Many politicians and academics attributed the failure of the system to respond to SARS to decades of failed policies marked by marketization and privatization.

The powerful National Development and Reform Commission 2009 summarized the situation in an -for the country very unusual - blunt statement: 'Health care undertakings are developing unevenly between urban and rural areas and among different regions; resource allocation is unreasonable; the work of public health as well as rural and community health care is comparatively weak; the medical insurance system is incomplete; pharmaceutical production and circulation is not well regulated; the hospital managerial system and operational mechanism are imperfect; government investment in health is insufficient; medical costs are soaring individual burden is too heavy, and therefore, the people's reaction is very strong'[6].

Scientific Socialism, Sustainable Development, Social Justice, a Humanistic Society, Increasing Democracy (client empowerment), and the Aim of Forming a Socialist Harmonic Society are at the heart of China's new development values. The gradual application of these principles to the health sector since 2003 characterize the reforms between 2002 and 2012: the provision of services, their funding and control by the state, qualitatively improved public services, the prioritization of prevention and primary care, the restructuring of public health, the dismantling of supply inequalities, a significant increase in public health care allocations investments and staff development, and the gradual development of social health insurance systems. Initially departing slow, the reforms gained particular momentum since 2009.

This progress did not come easy. Even within the rather authoritarian Chinese Government, various Ministries and Commissions pursued different and partly conflicting interests, adding to the influences by the mighty hospital provider group and the pharmaceutical industry. The decade between 2003 and 2012 saw an intense health policy debate. The Ministry of Health (MOH), representing the interests of public hospitals and clinics and physicians, joined forces with pro-Government scholars. The Ministries of Human Resource and Social Security (MOHRSS), representing the interests of now 10 Million health workers, supported the pro-market camp and lobbied for social health insurance to be administered by them. The National Development and Reform Commission (NDRC) and the Ministry of Finance are responsible for setting policy and funding priorities and allocating resources. They are the two most powerful ministries whose interests were to assure effective and efficient use of additional government funding. Both authorities had concerns with channeling new government funding directly to government facilities. The Ministry of Commerce, representing the interests of state enterprises and businesses, supported pro-market policies that designed to promote growth of healthcare industries and stimulate domestic consumption.

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[6] *National Development and Reform Commission 2009*

Formulating policy reforms in such environment require far-reaching consensus building. With the goal to reach such consensus, the Chinese government established an Inter-ministry Task Force since 2006, chaired by the powerful Minister of NDRC and the Minister of Health, involving all relevant (more than 20) Government agencies and charged it to develop a health reform plan under the guiding principle of a "socialist harmonious society." Consensus were reached regarding the central role of Government in safeguarding basic, primary and preventive health services and how these services should be organized. No consensus was reached regarding the delivery of hospital services. The debate still continues during the second decade of the new millennium.

In 2009, the Chinese government announced its health care reform with the goal 'to provide safe, efficient and affordable basic health care for all Chinese residents by 2020'. The reform affirmed the government's role in financing health care together with priorities for prevention, primary care, and redistribution of finance and human resources to poorer and rural regions. Five specific targets were defined, (1) expanding coverage to insure at least 95% of the population; (2) making public health services available and equal for all; (3) improving the primary care delivery system to provide basic health care universally; (4) establishing an essential medicine system to meet everyone's needs of essential medicines; and (5) piloting public hospital reforms. For implementation, the Government allocated substantial additional funds for the health sector. Up to 230 Billion US$ were committed for the period from 2009 – 2012). Half of these funds were scheduled to expand social health insurance, the other half for investments on health systems development, infrastructure, human resources and capacity development. By 2012, significant progress has been achieved, with the exception of target (5). The last decade, the country has been extending its health care networks reaching than 95% of its 1.3 billion people, a significant contributions to achieving the SDG Target 3.8 "Universal Health Coverage" far ahead of time. Lack of confidence in lower – level (basic) health services, resulting in health care seeking at higher levels of care, inappropriate prescription of medicines and yet the unresolved issue of sustainable hospital reforms are among the remaining challenges.

Pragmatic Ideologies: Promoting Provider Diversity and Public-Private Financing"

> *A healthy population is a key mark of a prosperous nation and a strong country. We will improve the national health policy, and ensure the delivery of comprehensive lifecycle health services for our people. We will deepen reform of the medicine and healthcare system, establish distinctively Chinese systems for providing basic healthcare, medical insurance, and quality and efficient healthcare services, and develop a sound modern hospital management system. We will improve community-level healthcare services, and strengthen the ranks of general practitioners. We will put an end to the practices of hospitals funding their operations with profits from overpriced drugs, and improve the system for medicine supply. We will, with emphasis on prevention, carry out extensive patriotic health campaigns, promote healthy and positive lifestyles, and prevent and control major diseases. We will initiate a food safety strategy to ensure that people have peace of mind about what they're putting on their plates. We will support both traditional Chinese medicine and Western medicine, and ensure the preservation and development of traditional Chinese medicine. We will support the development of private hospitals and health-related industries". Xi Jiping, 2017.*[7]

Since 2013, under the new Government led by President Xi Jinping, China is increasingly promoting provider diversity, again departing from the sole public sector service delivery model, encouraging private investments in health and strengthening Government's regulatory capacity. Maintaining equi-

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[7] *Secure a Decisive Victory in Building a Moderately Prosperous Society in All Respects and Strive for the Great Success of Socialism with Chinese Characteristics for a New Era Delivered at the 19th National Congress of the Communist Party of China October 18, 2017 Xi Jinping.*
http://www.xinhuanet.com/english/download/Xi_Jinping's_report_at_19th_CPC_National_Congress.pdf

table access in an environment of rapidly increasing of non-communicable, lifestyle-related and chronic diseases and -at the same time- safeguarding sustainability, are the key challenges for the decades to come.

Lessons to be learned for Kyrgyzstan?

These patterns will sound very familiar to policy makers in Kyrgyzstan. China's new health sector policy 2030 compares very well to Kyrgyzstan's Development Strategy 2040 and the Health Sector Strategy 2030. Kyrgyz planners and politicians are recognizing that – in the context of already overstretched public resources and growing out-of –pocket payments - the persisting focus on hospital care continues to fuel the cost spiral and threaten sustainability and equitable access. Prevention, strengthening of Primary Health Care and introduction of a People-Centered Integrated System of Care are the central building blocks of both the Kyrgyz and the Chinese health sector development vision. Given the difficult political economy of health reform, the multitude of interest and the yet unfinished agenda of transforming the paternalistic model, Kyrgyz implementers will face very similar challenges as compared to their Chinese colleagues.

The rich narrative of changes in values and ideologies, related reforms and the lessons learned in the FSU, Kyrgyzstan and China hold, as we argue, ample grounds for discourse and mutual learning, as both countries are charting a path toward a stronger health system by 2030, challenges ahead and shared visions provide rich opportunities for exchange. In our paper we present examples for such opportunities.

The design of People Centered Integrated Care Systems, closing the policy – implementation gap in Primary Prevention, - well phased- increasing of the role of private sector service provision and financing, strengthen national and local Government regulatory capacity, expanding access to hard-to-reach populations or dealing with the difficult political economy of health reform and stakeholder interests are examples for such mutual knowledge exchange opportunities. Given China's substantial pledged support to strengthen Kyrgyzstan's health care infrastructure, negotiating and embedding such investments in the wider context of health reform, would be another aspect adding value to this cooperation.

Klaus J. Hornetz
Email: daktari164@gmail.com
Skype klaus.hornetz
Wechat: Sleeplessinkunming

中国. 云南省. 昆明市
五华区华山西路
水晶宫国际公寓. 仁轩 6C