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Violence against Health Personnel in China and India: Symptom of a Deeper Crisis

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Several incidents of violence have been reported against doctors and other health personnel in China in the last few years that have received considerable media attention. These episodes seem to have increased in number in the recent past and include patients and/or their kin physically attacking doctors or other health personnel in some instances, to fatal blows in others. The majority of news items churn out immediate solutions like increasing doctor security (Xinhua 2015; Woodhead 2015) but very few deal with the fact that the attackers are victims in their own right and that there is a crisis in health services that needs to be addressed (Beam 2014).

Although it does not receive much media coverage here, violence against health personnel in India is commonplace. A recent study by the Indian Medical Association reveals that 75 per cent of doctors in India

have faced some kind of violence in the form of threats, verbal and/or physical abuse from their patients (Dey 2015; Pant 2015). On the face of it, the obvious reason for this kind of violence is attributed to patient overload in the public hospitals in both countries and the ensuing neglect in providing care. Unlike China, India has an extremely heterogeneous and unregulated private sector that resorts to frequent unethical practices (Nandraj 2015; Kay 2015) which invites hostility and mistrust from those seeking care. Many patients and their families clearly feel short-changed as a result of the experience with the institutions they come in contact with and there is a trust deficit between those seeking care and the health care institutions. This mistrust seems to prevail in both countries. The question is why violence, conflict and blatant outrage between health care personnel and patients have become a regular feature in recent times.

Over the past three decades, the Communist Party of China (CPC) as well as the Indian government has traversed the path to reforming the health sector especially in financing and provisioning. These reforms have resulted in systemic and structural transformations in health care. Both countries resorted to cutbacks in spending for the health sector in the 1980s and 1990s and gave space to market mechanisms. The idea was that this shift in policy would create efficient systems. While China made a shift to commercialising its public institutions, India expanded its market by giving space to private sector players in provisioning at the secondary and tertiary level as well as introducing some market principles in the public sector.

Commercialisation, profit-maximising motives, incentivisation and an underfunded public health system have had dire consequences on the overall functioning of the system

These shifts have been counterproductive to creating an efficient, accessible and equitable system, which was the main objective of the reforms. Instead, they have been successful in creating distortions and have been unable to create a system that reaches out to all irrespective of the ability to pay. Commercialisation, profit-maximising motives, incentivisation and an underfunded public health system have proved to have dire consequences on the overall functioning of the system. The violent attacks must be understood as a symptom of the reform process that has created gaps in services and inequalities in access across regions and income levels. It is imperative to look at the health service

system in its entirety in order to understand how fundamental principles of equity, access and quality of care have been compromised and why the systems that have thus been created are an exasperating experience for patients and a professional hazard for the medical profession.

Inequity in health financing

In China, the central government's share of national healthcare spending as a percentage of total healthcare expenditure fell from 36 per cent to 15 per cent between 1980 and 1999 (Rose-Ackerman and Tan, 2014). This led to people bearing most of the costs as local governments found it difficult to subsidise medical care. This was a dramatic shift from the pre-reforms period when out-of-pocket expenses were minimal. The cost of medical care that became the source of much discontentment with the people especially those in rural areas led to the successive introduction of three social insurance health schemes across China – for the rural population, for urban employees and for urban residents in the early 2000s.

The social health insurance models that China launched over the past 15 years have been seen as progressive due to the wide expanse in coverage that it has been able to attain. There has been much focus on the success of financial accessibility to health care services as out-of-pocket expenditures have reduced from before but it is evident that the financing structure has still been unable to address equity concerns. Although China proudly claims that 95 per cent of its population is covered, the depth of the insurance coverage is shallow and access to services is still a challenge. There is uneven distribution of benefits across the schemes and across provinces. The structure of the insurance itself is skewed with high co-

payments due to low coverage which essentially means that an individual pays a significant amount out-of-pocket. The rural health insurance scheme is the least progressive with low premiums and higher out-of-pocket expenditure. Reimbursement rates and specifics of the insurance plan seem to vary even within a province. Under the rural health insurance an individual on an average still pays over 55 per cent out-of-pocket while under an urban employee scheme an individual pays 30 per cent out-of-pocket (Tian, Zhou and Pan 2015, p. 63).

The people who are most affected in terms of financial access and are left out of what should be a progressive insurance system are the rural poor and growing number of urban migrants. While the *hukou* system may have been eased out over the years, there still exists discriminatory policy against the rural population. The existing *hukou* still results in unequal distribution of income, housing, food, education and medical services in contemporary China. While, there are pilot schemes now being introduced for migrants in the urban employment insurance scheme, these are few in number. There exists no mechanism for cross-subsidising as the three insurance schemes are three separate insurance pools managed by different ministries. The rural poor and the urban migrants who are more vulnerable to ill-health, therefore, face a greater financial burden when it comes to accessing medical care (Ying 2014).

The health financing structure in India too has resulted in significant inequities across states and income groups with the poor facing the greater burden without any coverage and the higher income groups mostly seeking private insurance coverage. Public investment in health care is a meagre 1.3 per cent of the GDP compared to a 3.1 per cent in China (World Bank 2015). The

percentage of out-of-pocket expenditure to total health expenditure amounts to more than 60 per cent in India.

China claims that 95 per cent of its population is covered by insurance but the depth of coverage is shallow. India, on the other hand has only 17 per cent of its population covered by any kind of insurance.

There is no uniform insurance scheme but a mix of public and private schemes and hence no scope for cross-subsidisation. Overall only 17 per cent have any kind of health insurance coverage (Mehra 2014). The much-hyped Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme) for those below poverty line has very limited coverage for hospitalisation. There is no financial security for catastrophic illnesses and out-patient services that are mostly sought in the private sector due to inadequate primary level public institutions (Nandi et al 2015).

Incentivisation, corruption and the culture of medical practice

In China, incentives for physicians in public hospitals were directly linked to the withdrawal of government subsidies during the 1980s that changed the structure of health financing. Hospitals that were made autonomous entities had to generate their own revenues. Patients who were insured before the 1980s under the collective structure had to now pay for visits to hospitals. Over and above they became victims of incentivisation where bonuses were given to doctors for prescribing drugs and diagnostics as these contributed to

hospital profits. Hospitals were allowed a 15 per cent mark up on drug sales. This period created structures that led to distortions and deep-rooted problems that China is still trying to grapple with and making attempts to reverse. The base salary of doctors in public hospitals is lower than many skilled workers and as of 2011, almost 80 per cent of the physician's income came as bonuses from profits the hospital made.

The rapid growth of technology has increased costs of care and has transformed the culture of medical practice.

These incentives were perverse yet legitimate and led to unethical practices and corruption. Doctors would try and accommodate many patients at a time to secure their income. Big pharmaceutical and medical diagnostic companies would give kickbacks to hospitals and doctors to prescribe their drugs and purchase their equipment. Suppliers paid higher bribes to secure their contract with the hospitals. Besides these, doctors in China are also known to take what is known as 'red envelopes' (*hongbao*) from patients who bribe them to 'ensure' better care (Woodhead 2014). So while the CPC has attempted to improve access by implementing new insurance schemes, the provisioning picture determined by the policy of incentives and behaviour of the providers work against the goal of improving access.

In China, the public sector hospitals have a lot to answer for, as they constitute 90 per cent of outpatient and inpatient load. In India, the patients have to deal with both – the underfunded public sector institutions and the diverse and unregulated private

sector hospitals; the private sector provides 80 per cent of the outpatient and 60 per cent of inpatient care (Sharma 2015). Unethical and corrupt practices are rampant in both. Here too, there are kickbacks that doctors in a private setting receive from pharmaceutical companies and diagnostic centres. The rapid growth in technology has increased costs of care and has transformed the culture of medical practice. The consequences are over-medicalisation and rise in irrational services that imply that people are paying for unnecessary services that are expensive. Privatisation and commercialisation during the reforms period have had a detrimental effect on access especially for the lower and middle-income groups who are mostly uninsured.

Apart from this, the general demeanour and attitude of doctors towards patients in many instances is condescending and one of disdain. There is enough evidence from India portraying abuse that pregnant women undergo during delivery and how patients from lower castes are subjected to discrimination and exclusionary practices by health workers. Undignified care amounts to denial of care and has resulted in a system that perpetrates and condones violence (Chattopadhyay 2015; Deshpande 2006).

The other aspect that gives rise to such a culture of medical practice is medical education itself. In India, the boom in private medical education in the last three decades has created its own mess on issues relating to licensing, high capitation fees, infrastructural deficiencies, low quality education and corruption in private medical colleges. The recent Vyapam admission and recruitment scam in Madhya Pradesh has revealed the extent of corruption to secure a seat in these medical colleges and the nexus between politicians, bureaucrats, businessmen, doctors and several other

actors (Baru and Diwate 2015). One can only wonder at the quality of doctors that emerge from such an education system and then enter hospitals to ostensibly serve the people.

Breakdown of primary level health care

In the first two decades of reforms, China faced a systematic breakdown of its referral system that affected its preventive services and primary level services the most. The three-tier referral system created under its Cooperative Medical System in the 1960s had become a model for health services across the world during the 1970s. The consequences that the dismantling of the referral system had was recognised during the outbreak of SARS in 2003 when the CPC acknowledged that the malfunctioning primary level institutions, breakdown in the surveillance and communication systems across institutions had led to a rapid increase in cases. The reforms period had focused mostly on the secondary and tertiary level institutions and these institutions had severed their connection with primary level institutions.

Though new reforms are making an attempt to restore the three-tier structure that existed during collectivisation, it has been unable to distribute people seeking care evenly across levels of care. The breakdown of the primary level institutions at the county and township level has put the burden on the secondary and mostly the tertiary level of care. Patients traverse long distances to access services for conditions that can be treated at the primary level. The overload of patients in tertiary institutions has compromised quality of care with long waiting time and short doctor consultations. The lack of focus on preventive services and

dearth of human resources at the primary level has created a top-heavy system.

In India, the referral system does exist in a notional sense but faces similar paradoxes as China. There is dearth of funding and human resources at all levels of public provisioning but this is worse at the primary level and hence, many people seeking care first approach the expensive private sector and if unresolved travel to tertiary level public hospitals in the districts or to bigger cities that witness very large volumes of patients.

Perpetrators or victims?

Over three decades of health reforms in both countries have led to several structural changes in the respective health service systems with severe long-term effects. In order to keep all the interest groups content the one whose interests have not figured as a priority is the one for whom these structures exist – the patient or the care-seeker.

The patients who are attackers are victims in their own right, of a system that perpetrates violence of a different kind, marred by poor quality of care, denial of care, high fees for service and corrupt practices.

Since 2009, China has acknowledged the distortions created in the health service system and is making an attempt towards rectification and systemic corrections. India has made no such move in the recent past and is regressing further to say the least. The slashing of public health budgets by 20 per cent reflects the direction of reforms under the present political milieu (Kalra, 2014).

Violence in any form is not justified. A rise in the reporting of violence and outrage that shows conflict and resistance between health personnel and patients in both China and India is indicative of deep crisis in health services. The patients who are attackers are victims in their own right, of a system that perpetrates violence of a different kind that is marred by poor quality of care, denial of care, high fees for service and corrupt practices. The health personnel are part of a system that is underfunded, behaves in a commercial manner and is fragmented in both countries. Reforms are meant to be transformative but a lot depends on the politics of interest groups and priorities made at the policy level that then determine the direction of reforms. There has clearly been an undermining of the primary health care goals of equity, accessibility and affordability.

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