REPORT OF SEMINAR

ON

"Challenges for Health Service Systems in Transition: India and China"

Date: 10-12 March 2015

Organized by

Institute of Chinese Studies, Delhi

and

Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi

Supported by

Indian Council of Social Science Research

Venue:

Lecture Hall 2, Convention Centre, Jawaharlal Nehru University, New Delhi

The two day seminar on the topic *Challenges for Health Service Systems in Transition: India and China* which was organized by the Institute of Chinese Studies (ICS), Delhi in collaboration with Centre of Social Medicine and Community Health (CSMCH), Jawaharlal Nehru University (JNU) was held on 10th and 11th of March 2015 in the Convention Centre at JNU. On the 12th of March there was a closed door meeting to discuss common areas of interest between and future collaborations.

This seminar was supported by the Indian Council of Social Science Research (ICSSR). Four public health scholars from China participated in the seminar. Prof.Hu Shanlian Director, Shanghai Health Development Research Center, Shanghai Health and Family Planning Commission; Dr. Song Daping, Associate Professor, National Health & Development Research Center (NHDRC), Beijing; Dr. Gu Xuefei, Associate Professor, NHDRC, Beijing and Prof. Chen Yingyao, Professor and Associate Dean, Fudan School of Public Health, Shanghai. The Indian delegates included faculty from the CSMCH, JNU; Institute of Economic Growth, Centre for Chinese and South East Asian Studies, JNU; and the Institute of Chinese Studies. About 87 scholars participated in this seminar over the two days.

Day One: Tuesday, 10 March 2014

Session I

09:30 – 10:00AM – Registration & Tea

10:00 – 10:30 - Session 1	**Inaugural Session**	
Opening Remarks	**Prof. Alka Acharya** **Prof. Ritu Priya**	Director, Institute of Chinese Studies (ICS) Chairperson, Centre of Social Medicine and Community Health (CSMCH), JNU
Introduction to the Seminar	**Prof. Rama V. Baru** **Dr. Madhurima Nundy**	Professor, CSMCH, JNU Associate Fellow, Institute of Chinese Studies (ICS)

The introductory remarks were given by the Heads of the collaborating institutions and the objective of the Seminar and the two day program was introduced by Prof. Rama Baru and Dr. Madhurima Nundy.

Over the last three decades India and China have been facing the challenge of rising inequalities in access and cost of health services. The many dimensions of these inequalities include the availability, accessibility, affordability and acceptability of health services. Several efforts 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. While the Indian health sector is still grappling with how to ensure universal access, the Chinese have expanded insurance coverage for medical care. Through this strategy China has achieved nearly 95 percent coverage however there is variation in the benefit package across rural-urban, provinces and income groups. Inequities therefore still exist. The other major area of concern is the public-private mix in health services in both these countries. In both countries the public institutions have been reformed with introduction of market mechanisms like user charges and a variety of public-private partnerships. These measures have also contributed to growing inequities in access and cost of care. The 'for profit' sector has a significant presence in India while in China it is still small and being allowed to expand cautiously by the government.

This Seminar was structured keeping these challenges in mind and invited scholars from the public health field from both countries to present their views on the various aspects of health services during the reform period.

Session 2

10:30- 12:00PM Session 2 Overview of Health Reforms – India and China **Chair: Keshav Desiraju, Secretary, Consumer Affairs, (Former Health Secretary)**	
Prof. Hu Shanlian	**An Overview of Recent Health System Reform in China** *Director, Shanghai Health Development Research Center, Shanghai Health & Family Planning Commission*
Dr. Ramila Bisht	**An Overview of Recent Health Sector Reforms in India** *Associate Professor, CSMCH, JNU*
Discussion	

Prof. Hu Shanlian presented the Chinese experience with health sector reforms and focused on the recent reforms that started in 2009. These reforms were launched to address the inequities that resulted from the previous set of reforms from early 2000s. China has a five-tier organization system - central, provincial (municipal), city, county (district) and township is in charge of health system development and reform - from National Health and Family Planning Commission (NHFPC) to local level HFPC. Health financing, health service delivery, social medical insurance schemes and essential medicine policies are highly decentralized. Health indicators are good with Infant Mortality Rate at 10.3 and Maternal Mortality Ratio at 24.5. The share of total health heath expenditure as percentage of GDP is 5.57 per cent. In 2009, five reform pillars were introduced: speeding up of the medical security system; promoting preventive public health services; improving primary level health service

system; establishing national essential medicine system; and piloting new reforms in public hospitals. Some of the challenges mentioned were: an ageing population of about 10 per cent; transition in disease patterns where the prevalence rate of total chronic disease is about 20 per cent; along with the universal coverage of basic medical insurance schemes, the health demand and utilization increased dramatically; there was an irrational patient flow reflecting the low efficiency of limited health resource utilization; out of pocket expenditure (OOP) was still over 30 per cent. By the year of 2020, China aims to establish a basic health care system providing universal coverage of safety, effective, convenient and affordable health services for the population

Dr. Ramila Bisht presented the Indian story of health sector reforms. She gave an analysis of the health sector in India. With the advent of neo-liberal policies, there have been a lot of disparities in the delivery of health services in India. Private health sector has been gaining dominance over the years. The only answer to the prevailing problems is a universal public health system with government intervention to balance the increasing trends in inequalities. There cannot be a convergence between the public and the private sector because market principles cannot be applied to gain equality in the health of the population. There is a need to look for factors that triggered the launch of National Rural Health Mission and Universal Health Coverage which need to be carefully analyzed.

The **discussion** centered mostly on questions related to the Chinese health reforms. The Chinese health sector in the recent decade has shown increasing disparities in the utilization and distribution of health services which is being highlighted by the large scale inequalities portrayed by the health outcomes of the population. Health care reform did improve the health care utilization but the huge disparities have increased in the recent past. The migrant population suffers the most because of the restrictive *hukou* system.

Chinese health sector is dominated by public sector and the number of private sector is fairly low as compared to India. But the disparity in the health sector was shown by the rising out of pocket expenditure (OOP). The recent reform policy that started in 2009 seeks to reduce the OOP to less than 30 per cent by 2022.

There is a social security system in China to protect the population from health expenditures through the insurance mechanism. All public hospitals are part of the social insurance but not all private providers are part of social insurance. In a recent order, to earn more benefit the doctors in the public hospital are given the autonomy to work in the private sector as well.

Due to the problem of an ageing population, the Chinese government has formulated a new policy whereby a single child of a family can have two children. Pollution has become a major problem in China in the recent years and this problem has been taken on as a top priority by the government. Though maternal and child health has improved in the recent years due to the change in policies, the

C-section rates seemed to be increasing which poses a threat to the health status of the female population. Since the public hospitals in China function more like private sector with kickbacks from the pharmaceuticals and generating revenues through user fees, the government has adopted policies for rational use of technology. The insurance system is the major payment provider of health in China. The important debate that needs to be considered is whether the only way forward towards universal health coverage (UHC) is insurance and whether India should be following a similar model.

Session 3

12:15 - 1:45PM Session 3	**Challenges for Equity in Access to Health Care and Response of the State** **Chair: Prof. Mohan Rao, JNU**
Prof. Ritu Priya	**Challenges for Equity in Access to Health Care and Response of the State in India** *Professor, CSMCH, JNU*
Dr. Song Daping	**Health Justice: An Examination of the Healthcare Delivery System in Rural China** *Associate Professor, National Health and Development Research Centre (NHDRC), Beijing*
Discussion	

Prof. Ritu Priya presented on the challenges for equity in access to health care and response of the state in India. The transformation that the Indian health care experienced should be studied basing on the historical developments since the 1940`s. The important question that should be asked is what constitutes health care, who gains and how priority is structured that would take into account the power play within the health care system. The challenge faced by the health care after Independence was huge with high levels of poverty and very poor living conditions. The health coverage was minimal with high socio-cultural diversity. The Bhore Committee report focused on comprehensive healthcare with about 15 per cent of budget allocation but what had happened over the twenty year period was an allocation of only 4-5 per cent. The whole idea of formulating UHC is centered on the politics of making unaffordable health seem affordable through insurance. Euro-American model of healthcare was adopted by the Indian health sector. The present public health system is facing lots of challenges with unequal distribution and very poor services. The government has been trying to develop the rural healthcare system but no attention has been given to regulate the large expanding private health care industry. Health care in India is being dominated by modern science and technology. This neo-colonial hegemony in knowledge, technology and systems design since post-

Independence seamlessly created conditions for globalization and health sector reforms to be implemented. 'Equality' is a political term connoting social democracy; equality of opportunity. It has got displaced during the 1980s and 90s by the apolitical term 'Equity'.

Dr. Song Daping gave a detailed view about the function of the healthcare delivery system in rural China. With thirty years of health reforms, the Chinese health system is still faced with bottlenecks where there is misallocation of health resources; weak protection against catastrophic health expenditures and an extremely tense doctor-patient relationship and a strong anti-doctor public opinion. In China most of the health service expenditures are paid by the people although there is system of social insurance. People pay in case of chronic illness as there is ceiling limit so poor people are forced to seal their asset to seek tertiary level care. The patient load at the tertiary level is huge so there is lot of patient dissatisfaction and the attitude of the doctor is seen to be problematic. Media highlights a lot on the worsening patient-doctor relationship. Hence there is a huge problem of hatred towards the doctor by the people. China is dreaming of sustainable, affordable, equitable and comprehensive health care. This requires a certain level of GDP to provide as seen in other countries such as Europe.

The **discussion** centered on the question whether an equal and affordable health delivery system is a dream and only a mirage shown to people to follow the current exploitative system of health care which is counterproductive to health and wellbeing. There is need to question such a dream rather than following the mirage. The questions on the issues of the health status of the ethnic minorities were also raised. There are social problems in terms of education and lack of access to other social services in the minority population across the provinces in China but for health care there is no problems that arise for ethnic minority. For example, the biggest ethnic group is Tibet so there is a separate health delivery system and program for Tibet. About private health sector in China, there is some growth of for for-profit corporations as a part of joint ventures and partnerships with the public sector. Overall, health market in China is weak so there is no strong private hospital and private insurance.

Session 4

02:45– 4:15PM Session 4	**Health Coverage for Reducing Inequities in Access: Some Challenges** **Chair: Dr.Sheela Prasad, Economic Advisor, MoHFW**
Prof. Indrani Gupta	**Health Coverage for Reducing Inequities in Access in India** *Professor, Institute of Economic Growth, Delhi*

Dr. Gu Xuefei	**The Path to Integrate Chinese Urban and Rural Health Insurance Schemes** *Associate Professor, NHDRC, Beijing*
Discussion	

Prof Indrani Gupta gave a detailed presentation on the challenges around health coverage in relation to access to health services in India. In India the major reasons for poor health outcomes is accessibility, availability and affordability of quality care which has led to high out of pocket spending. OOP expenditure has been increasing in the recent years as shown by a number of studies. Health coverage is comprehensive for organized sector as compared to unorganized sector. Most of the insurance schemes offer coverage for hospitalization but very little coverage is offered for out-patient care. The centre and the state both spend on health coverage with the number of spending larger by the centre. There are four essential components needed for UHC: financing from government revenues; removal of financial barriers like user fees; ensuring large risk pools and compulsory pre-payment. The Indian government is moving towards UHC through formulation of different health programs like National Health Assurance Mission. There has not been any increase in the health care spending by the government.

Dr. Gu Xuefei presented on the health insurance schemes in China and the challenges. Premium of insurance is increasing so the economy will have to be sustainable and there are different insurance plans for urban resident and rural farmers. There is planning for increasing premiums in five year plans. Difference between different provinces is very low as coverage is 98 percent. Even though the schemes are voluntary, coverage is high as there are very high incentives for participation in schemes but it is not 100 percent and migration and the *hukou* makes it tough to provide insurance to all. Premiums are different across the three schemes but coverage is same because there is political commitment for insurance scheme. In the rural insurance scheme, 1/3rd premium is paid by central government and another 1/3rd by local government and 1/3rd by farmer. So there is lot of incentive for farmer to join the scheme.

The **discussion** for this session revolved around the Chinese health insurance scheme and how the government has been trying to solve the problem of unequal distribution of health resources through the approach of insurance scheme. There is no debate in China on whether insurance system is the best policy to attain universal health coverage. In China insurance is a political mandate and therefore not much debate around whether that is the best way to universalize access to health care. In China, the private sector health insurance is a mere 8 per cent because social insurance developed very

rapidly in China. For UHC there is a need for standard treatment guidelines and protocols. China has such guidelines and protocols across all providers.

Session 5

4:30 – 5:30PM Session 5	**Open Session**
Moderator: Prof. Imrana Qadeer, Visiting Professor, CSD	

The open session was moderated by **Prof. Imrana Qadeer**. In India, policies are being worked out based on neoliberal context unlike China. India shifted from welfare capitalist society to neoliberal society. China is different as it went through a social revolution and has given lot of positive results as compared to India. China reacted differently from the threat of the neo-liberal world and focused on protective measures. China has a strong ideological commitment. Public health is politics and how that politics unfolds is the issue in every country and its impact on the health service system and health status of people needs to be understood. China has now different challenges as the base is much stronger than India. Presently, even in China, the health sector is controlled by professionals which is a problem. These professionals are going out to international institutions and coming back with new set of ideas even in China.

The term UHC is rooted in the European experience. It came in early 1920s and 1930s with colonialism and accumulation that led to development. So these countries could afford to do UHC and do prevention such as immunization along with curative services. Prevention in India demands looking at nutrition, sanitation, housing, water supply etc. but UHC in India is only medical care. In India poor health cannot be openly denied, India moved from NRHM to UHC as a policy which does not openly deny the poor health but at the same time promotes commercialization and privatization of the health sector.

<u>Day Two: Wednesday, 11March 2014</u>

Session 6

10:00 – 11:30 Session 6	**Market reforms in Public Hospitals: India and China**
Chair: Dr. Madhurima Nundy, ICS	
Prof. Chen Yingyao	**Public Hospital Reforms in China** *Professor and Associate Dean, Fudan School of Public Health, Shanghai*
Dr. Prachin Ghodajkar	**Market Reforms in Public Hospitals in India** *Assistant Professor, CSMCH, JNU*

Discussion

This session focused on the issues involving market reforms in the public hospitals in both the countries in a large scale. The content and forms of these reforms have been different. India ventured into market reform in 1990 because of structural adjustment polices introduced by World Bank and China reformed its public hospitals with the onset of economic reforms and open door policy in the 1980s. In China the reform was more dramatic since the referral system dismantled with decollectivization. The main aspect of reforms in China was decentralization and this resulted in reduction in government subsidies. Hospitals, hence, started generating revenue by selling drugs and diagnostics thus every hospital was responsible for its success and failure. The term 'reform' is a big word which can be interpreted in various ways. China interpreted it differently compared to India.

Prof. Chen Yingyao presented the Chinese experience of public hospital reforms. In China there is no formal referral system. Patient seeks care at any level of care which they prefer but this also results in increased patient load at the tertiary level. So government in China is implementing polices to guide people back to primary and secondary level from tertiary level of care. In the insurance system in China the reimbursement system is such that people end up paying more at tertiary level compared to primary or secondary level centers. At the primary health center, the cost of care with insurance and incentive is zero. But all levels of care have their own budget and revenue system and since the primary health center has no financial incentive it does not provide services. So it has been recommended to provide incentive component along with budget to reduce load at tertiary hospital.

Dr. Prachin Ghodajkar gave insights into the public hospital reforms in India. he emphasized that market reforms in hospitals started early with the introduction of structural adjustment programs in the early 1990s. User charges and user fees were introduced around this time. In the later stages, partnerships with for-profit sector led to commercialsation of many services and medical impoversishment.

The **discussions** mostly centered on the different types of reforms that both the countries experienced especially the change in the function of the public hospitals in China. In India there is a high level of poverty along with inter and intra state regional health variations. Similarly in China there are variations in provinces in terms of OOP and other basic services although the Human Development Index is low. Medical tourism is developing industry in India which is catching the attention of policy makers. Medical tourism industry in China is perceived as a source to generate revenue and contributing to GDP. So there is a focus of developing this industry.

Medical education in China is very interdisciplinary as the graduating doctors are not only taught medicine but also courses of humanities and public health education. Such interdisciplinary education

improves the doctor and patient relationship. Basic salary of doctors in China is according to their degree and position in the hospital. In China the doctors are like a civil cadre in public health institutions which are bound by rules and regulation. Other part of the salary is a performance based where there is a comprehensive performance evaluation system which includes patient satisfaction, drug use, papers published etc. The total salary is moderate. There are plenty of medical colleges in China attracting Indian students but the percentage of Indian student in top ten medical colleges is very low. Social status of Chinese doctor differs between young and senior doctors. A young doctor has to spend a long period of education including PhD and 2-3 years of residential program to reach at senior level. So the life of a young doctor is very challenging compared to a senior doctor. The Chinese story of public hospital reforms is very interesting as public hospitals become autonomized unlike Indian reforms where market principles enter the public system but are less radical. In the period of 80s and 90s when inequality increased there was some kind of financial support which was provided to the public through insurance schemes. In 2009, the five pillars of reform were introduced one of which looked at the social function of hospital to address access to all.

The boundary between secondary and tertiary is not clear and it depends on different hospitals and institutions and kinds of services provided. Each level of care has their own package of services and performance and evaluation system. Reform document in China is a long and comprehensive document and implementation of it in reality is questionable. Even the general public is not fully aware of reform policies and its component. At the same time policy implementation is a big challenge in China. The insurance system in China is very comprehensive as people have many types of insurance such as safety insurance, medical and hospital insurance. Even a person without insurance can seek care and it is the duty of public hospitals to provide basic services and reimbursement of care from its funds. In China there is a policy for private sector regulation along with this there is a recent policy to increase growth of private sector and push reform forward in the form of public private partnership and increase competition between public and private hospitals.

In China systemic corrections were made to make reforms more comprehensive and address the previous gaps. In India NRHM was introduced in 2005 and architectural corrections were made in the public health sector to improve access for rural people but market reforms are very much prevalent and were introduced during the new set of reforms and convergence is still a distant dream.

Session 7

11:45 - 1:15PM Session 7 State and Civil Society: The Case of the Social Sector **Chair & Discussant: Dr. Hemant Adlakha, Professor, SLL & CS, JNU**	
Dr. Madhurima Nundy	**Social Unrest and Resistances: State and the Social Sector in China**

	Associate Fellow, ICS
Discussion	

Dr. Madhurima Nundy presented on the protests and resistances in China today and how people and social sector interact with the state by taking example from three main issues of focus in China today – migrants, environment and HIV/AIDS. There has been a preoccupation with the role of 'civil society' in China in recent times but these have mainly looked at whether civil society is autonomous and whether it is a means to political transformations in a 'non-democratic' society. The conclusion generally drawn from such a framework is that the Chinese state is either a 'corporatist state' that is controlling or one sees an emerging civil society that is in its nascent phase. The macro-level analysis fails to bring forth the dynamics between state and society at various levels, the spaces of negotiations and probably the nature of Chinese politics itself. She focused on the local dynamics and how state at the local level responded to protests and the social sector. There are multiple layers and spaces of engagement and one might observe that the State at different levels permeates through these spaces in order to control as well as collaborate. It dominates to gain control over social forces but there is a constant interplay between state and society.

Dr. Hemant Adlakha also made a brief presentation on 'China's search for a distant civil society'. He raised questions on what the China model of civil society encapsulates? He spoke of Chinese NGOs and the difficulty in finding the right term that fits the idea of a non-governmental organization. He gave a brief overview of the quantum of NGOs in China and their origins. He also discussed the US grants that come to NGOs and amount of grants distributed issue-wise.

The **discussion** was around the functions of the NGO`s in China. In China voices against capital punishment and for unregistered children are mostly raised from grassroots NGOs run by activist or university scholars or teachers. There is a big role of social media in China particularly after the 2008 and 2013 earthquake in reaching out to government and pressuring government to take actions. Civil society as a term is not used and discussed in China. China has its own unique civil society driven by the communist party model not imitating the western concept of civil society. There is no political or theoretical debate around civil society in China. In other words in China government is ready to listen to people concerns. Issues raised under such protest are taken on board and in the past many corrections and polices are implemented. Protests are majorly on issues regarding forced evictions or land grabbing, migrant issues and environmental concerns. But the question is that to what extent protests are allowed in China. A lot of funding for health sector in China comes from American Foundations such as BMGF for HIV/AIDS and family planning. Rockefeller Foundation has a hundred year association with China. In China, the role voluntary sector needs to be understood

within the context of the country as there are strong and effective NGO`s and government organized NGOs.

Session 8 and 9

2:15- 3:45PM Session 8 **Transnational Actors and Commercialization** **Chair and Discussant: Prof. Chen Yingyao**	
Prof. Rama V. Baru	Professor, CSMCH, JNU
Dr. Madhurima Nundy	Associate Fellow, ICS
Session 9 Open Discussion: 3:45 - 4:30PM	

The last session on "Transnational Actors and Commercialization" was chaired by Prof. Chen Yingyao. **Dr. Madhurima Nundy** gave a systematic review of all the transnational actors that have influenced health policies in India and China. These actors were categorized as: Multi-lateral organizations; Bi-lateral organizations; American foundations; for-profit private equity and consulting groups.

Prof. Rama V. Baru presented the three phases in the commercialization of health services in China and supported it with evidence from the in-depth interviews conducted during the field visit to China. The first phase included the change in the status of government institutions to State owned Enterprises (SOEs) in the 1980s. In the second phase beginning in the early 90s, the Ministry of Health emphasised the principle of decentralisation of power and transfer of profits in the hospital sector. By the late 1990s, there was a third phase when several local governments started to experiment with autonomization giving rise to a plurality of management models, incentive and governance structures. The oldest hospital chain promoted by an American company, Chindex, started trade in medical equipment in the 1980s. They set up the United Family Hospital during the 1980s. They have sold most of their shares recently to a Chinese pharma company, Fosun. According to an interviewee, efficiency in public hospitals was fairly high but there was still a shortage of medical services. The National Health Policy was working at two ends by building more government hospitals and expanding private hospitals. The human resource availability is an issue as the private sector expands. Doctors of long experience and repute are in government hospitals. Recently, the government has introduced a rule whereby doctors in government hospitals have to apply for permission to work in private hospitals. Government doctors enjoy a high status, good salaries and also have access to government funding for research. The economic reforms of three decades have resulted in the growth of a large middle class that is driven by consumerism in China.

This session extended to an **open discussion** on issues raised over the two days and other important aspect of the health sector that may have gone amiss. In China problem related to health delivery is of supplies which are not enough to meet the people needs. Efficiency is very low and there is need to improve the productivity and efficiency. The philosophy of government is economic development first and later on social services development. There is region-wise stratification and huge differences between upper, middle and lower class in terms of income. There is a large middle class including working class. Rich are very rich and there is difference in lives of rich and middle class with quarantine settlement in different parts of China. There is high level of poverty in China with differences in provinces and quality of life is not equal. There is a section of population in China buying private insurance. So there is a need to look at how the Chinese society is transforming in terms of classes and what are the consequences for health outcomes.

There is rapid aging in China which is changing the demography in China and it is a big issue. There is a need to explore elderly care economy. In the context of the one-child policy many elderly live alone and find it difficult to care for themselves. Community based care has emerged in cities where people are appointed to check on elderly and provide them with food and assistance when needed. The policy makers have anticipated this change in composition and have long-term care plans with innovative technology and services for aging people in community health centers and hospitals. Eighty or ninety per cent of elderly should be taken care by home care, 7 percent by community services and 3 percent should be taken care by hospitals eventually.

Discussions also extended to other issues that pose as a challenge to the health service system. Mental health is a big challenge in China. There is a consumer grievance mechanism in China for malpractices for citizens in public sector and private sector. There are a lot of channels for addressing the grievances; there is services satisfaction survey for inpatient and outpatient people. There are boxes in different places to address complaints and communist party officials who are in the hospital board look for malpractices.

There were questions around Traditional Chinese Medicine (TCM). There is one agency in China for TCM and there is a lot of encouragement by government for TCM industry development. Each county has a TCM hospital and the doctor’s practice is based on modern and TCM drugs prescription. For management of hospital sometimes private agencies are involved but public capacity to manage hospital is sufficient. More than 95 percent of medical devices are imported in China. The major issue is to create a balance between private market and the public health sector.

The two day seminar came to an end and a vote of thanks was extended to all Chinese and Indian presenters, Chairs, the faculty from both organizing Institutes, volunteers who helped organizing and ICSSR who provided the funding for the Seminar.

Day Three: Thursday, 12 March 2014

On day three there was a closed door meeting with Prof. Hu Shanlian and Prof. Chen Yingyao along with the faculty of the health unit at ICS and CSMCH, JNU. Areas of common interest were marked out for the purpose of taking collaborative work forward. The areas of interest for Fudan has been listed as Health Policy and Management and Global Health; from the Indian scholars the areas of interest listed varied from communicable diseases, elderly care, traditional medicines and urban health.

This was followed by a meeting with the Rector to see ways of formalizing the collaborations.

Members present at the meeting:

Prof. Sudha Pai, Rector, JNU
Prof. Varun Sahni; Chief Advisor, International Collaboration, JNU
Prof. Rajib Dasgupta, Chairperson, Centre of Social Medicine and Community Health (CSMCH), JNU
Prof. Rama V. Baru, Centre of Social Medicine and Community Health, JNU
Prof. Alka Acharya, Director, Institute of Chinese Studies (ICS), Delhi
Dr. Madhurima Nundy, Associate fellow, Institute of Chinese Studies, Delhi
Prof. Hu Shanlian, Director, Shanghai Health Development Research Centre (SHDRC), Shanghai
Prof. Chen Yingyao, Vice Dean, Fudan School of Public Health

The objective of the meeting with the Rector and the Chief Advisor, International collaboration was to arrive at a Memorandum of Understanding between JNU and the Fudan School of Public Health, Shanghai. Following a fruitful discussion it was agreed that :

- There will be an Agreement of Cooperation (AoC) between School of Social Sciences and the Fudan School of Public Health. The AoC will be drafted between Fudan and JNU. The AoC would broadly cover three areas of collaboration – Research; student exchange; teaching and field visits.
- A separate AoC will be drawn between the four partners i.e. CSMCH, JNU; ICS, Delhi; Shanghai Health Development Research Centee and Fudan School of Public Health. This will be a Forum for Comparative Health Studies. This AOC will include student exchange; an annual workshop; joint projects.