The art of medicine

Learning from others

See Comment page 181
See Series page 252

"Is there anyone, in the five parts of India, who does not admire China?" asked Yi Jing in the 7th century, on returning to China after being in India for 10 years. Yi Jing spent his years studying, among other subjects, ayurveda (the science of longevity) at the famous Indian university in Nalanda (an institution of higher learning that is being re-established right now as an international university, on the initiative of a number of Asian countries, including India, China, Japan, Singapore, among others). Yi Jing's cheerful assessment might have been overly optimistic about Indian open-mindedness, but comparison of China with India was not only a common pastime then, it gets a lot of attention today. And rightly so.

What, however, goes wrong in the current obsession with the India–China comparison is not the relevance of comparing China with India, but the field that is chosen for comparison. Now that the Indian economic growth (that is, the growth of gross domestic product, or the GDP), seems to be hovering around 8–9% per year, there is a lot of speculation—and breathless discourse—on whether and when India may catch up or surpass China's over-10% growth rate. Despite the interest in this subject, comparable to that in a horse race (the betting comes from the West as well as Asia), this is surely a silly focus. This is so not merely because there are so many elements of arbitrariness in any growth estimate (the choice of prices for weighting is only one of the problems), but also because the lives that people are able to lead—what ultimately interests people most—are only indirectly, and very partially, influenced by the rates of overall economic growth.

Jonas Bendiksen/Magnum

By contrast, in his 7th-century comparison, Yi Jing concentrated directly on human lives, particularly health and longevity, in China and India. He gave the first systematic comparative account of medical practices and health care in these two countries (perhaps the first such comparison between any two countries in the world) in 691 AD. The ex-student of Nalanda asked what China could learn from India, and what, in turn, India could gain from China. Comparisons of that kind remain relevant today.

In our times, China went towards a massive expansion of public health care shortly after the revolution. Through a governmental commitment, China came close to having universal coverage (even though the health care was sometimes quite primitive), and by 1979, at the time of the economic reforms, China had already raised its life expectancy at birth to the impressive figure of 68 years. India had less political commitment on this, and life expectancy there lingered around 54 years—a shortfall of 14 years. India's very incomplete network of health facilities contributed to restraining longevity. Even though the public hospitals were mostly free, they were fewer and far between.

Then, in 1979, China carried through its market-oriented economic reforms on a massive scale, with tremendous success in some fields, particularly in dramatically raising the rates of growth, first in agriculture, and then in industry. Unfortunately, the market orientation was far less useful in health care, since it led to the replacement of universal health insurance through the states and the communes by private insurance that had to be bought in the market, which the vast majority of the Chinese did not buy and could not afford, despite rising incomes. China's lead over India in life expectancy shrank sharply in the period that followed the Chinese reforms.

By the beginning of the 21st century, the gap in life expectancy between China and India had shrunk by nearly half (from 14 years to 7). Since I visit China often (mostly to Peking University), I was excited to see that the Chinese authorities were gradually appreciating what had been lost. They started rising to the challenge of reintroducing, through one means or another, health insurance for a larger and larger proportion of the people. As things stand now, China has a considerably higher proportion of people with guaranteed health care than does India. The gap in life expectancy is now around 9 years (with China at 73·5 years and Indians still confined only to 64·4 years), and although there are many factors behind this contrast, the issue of health-care coverage is clearly central to the difference.

What makes good health so problematic for so many people in India? There are many issues to consider here,

including general economic and social inequality, which is large both in India and in China. However, the China–India contrast points immediately and directly to one important policy factor, namely coverage. If a significant proportion of people are left out of ongoing health facilities for one reason or another, the health of the people will clearly suffer. The point is so obvious that I would be shy about making it, except that after living in the USA for many years, it is clear to me that even obvious issues in health care need not be easily grasped.

Having universal coverage through a public commitment does have costs, including public costs. The proportion of national expenditure on health that is met by the government is 26% in India and 45% in China. Or, to look at a related contrast, while government expenditure on health care in India is only around 1·1% of its GDP, it is around 1·9% in China. One need not be a genius to see that if the government of a country is ready to spend more on health, it could expect better results in terms of the health of the people. This contrast has many correlates, and as has been brought out by a recent study done by WHO, led by Sudhir Anand, India lags behind China in the availability of a trained workforce for health care in nearly every category.

One of the more plausible justifications for a pro-growth strategy of economic development is that the public revenue in the hands of the state expands with economic growth—and sometimes expands considerably faster than the GDP itself, as it definitely has in India. This gives the government a huge opportunity to expand its public expenditure, including that on health. To some extent this has happened in India, but not nearly fast enough, and the proportion of the GDP going into health care is still significantly lower than in many countries with similar income per head.

One result of the relatively low allocation to public health care in India is the development of a remarkable reliance of many poor people across the country on private doctors, many of whom have little medical training, if any. Since health is also a typical case of "asymmetric information", with the patients knowing very little about what the doctors (or "supposed doctors") are giving them, the possibility of fraud and deceit is very large. In a study conducted by the Pratichi Trust—a public-interest trust I had the opportunity of setting up with the Nobel money that happened to come my way some years ago—we found cases of exploitation of patients' ignorance of what they are being given to make them part with badly needed money to get treatment that they often fail to get (we even found cases in which patients with malaria were charged substantial sums of money for being given saline injections). There is very definitive evidence of a combination of quackery and crookery in the premature privatisation of basic health care in India. This nastiness is the result not only of shameful exploitation and rudderless medical ethics, but ultimately of the sheer unavailability of public health care in many localities around India.

However, India is a diverse country, and the situation is quite different in those regions where public health care is active and large, and where private health care only supplements—and adds to—what is publicly available to all. The best example of this in India is in the state of Kerala that has close to universal coverage for public health care. The good impact of that on the health of the population in Kerala is supplemented by near universal literacy, especially among the young. Not surprisingly, Kerala has a life expectancy that has been comfortably higher than in China.

I end by commenting briefly on the role of public discussion in advancing good health. Thailand has made huge use of what they call the National Health Assembly, in which there are open discussions on what problems the public faces in health care and in related fields and also on how they can be removed. This has gone with the progress made in Thailand in introducing universal public health care, and it has been nicely supplemented by feedback from the people, with considerable gain in efficiency and reach. As a functioning democracy, India can learn from others on how the public can be engaged in advancing the health of all. There is a huge role for the media and for political leadership, of all parties, in advancing this important national cause, in making the best use of the facilities provided by democracy.

As it happens, some of the real progress that has happened in recent years in India has come from public discussion—and agitation. This applies, for example, to the delivery of cooked midday meals in schools, and selected interventions in child development in preschool institutions. These new changes have had positive effects, even though their use is uneven across the country, and has to be expanded and improved. China does not yet have either of these important instruments of basic health care, but they could be important for China too, since China—despite its high average performance—does have identifiable gaps (the existence of which has been pioneeringly studied by the China Development Research Foundation). China too may have to learn from others to eliminate the resisting pockets of deprivation. India faces, of course, a much larger task.

Learning from other countries remains as important today as it was in Yi Jing's time, almost 1400 years ago.

Amartya Sen
Thomas W Lamont University Professor and Professor of Economics and Philosophy, Harvard University, Cambridge, MA 02138, USA
asen@fas.harvard.edu