HEALTH AND SOCIAL CARE FOR AGING SOCIETIES : CHINA AND INDIA

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PRESENTATION AT THE MEETING ON 'HEALTH IN ALL POLICIES AND SOCIAL DETERMINANTS OF HEALTH OF THE GLOBAL NETWORK FOR HEALTH IN ALL POLICIES, TAMPERE, FINLAND.

SEPTEMBER 5TH AND 6TH 2023

OUTLINE OF PRESENTATION

- Introduction to India and China in Asia
- Demographic and epidemiological profiles
- Varied levels of socio-economic development and political trajectories
- Interventionist welfare state in India and guarantees approach to welfare in China
- Neoliberalism and reshaping of role of market and State- liberalization of economy in India and market socialism in China
- Commercialisation of health services and social care in India and China
- Incremental approach to planning for health services and social care for older persons
- Efforts at integration for continuum of care in China

DEMOGRAPHIC AND EPIDEMIOLOGICAL CONTEXT FOR OLDER PERSONS: INDIA AND CHINA

- India is ranked as low middle income country with a population of nearly 1.5 billion.
- Around 7 percent of the population are older persons aged above 65 years.
- The public expenditure on health as percent of GDP is low -3 percent
- India has a targeted, means tested, public insurance scheme
- China ranks as a middle income country with a population of 1.4 billion
- Around 14 percent of the population are older persons aged above 65 years
- The public expenditure on health as percent of GDP is 5.6 percent
- China has a near universal public health insurance scheme

EPIDEMIOLOGICAL PICTURE

- For older persons the picture is similar in India and China – dominance of non communicable diseases and a range of cognitive related conditions (Chatterji et al, 2008)
- Challenges for multiple morbidities and syndemic complexes that require both health and social care (Chatterji et al, 2008)
- Increased rates of hospitalization that puts pressure on the health services
- The fragmentation of health and social care creates stresses for older persons (Baru and Nundy, 2019)
- Community based services are essential for continuum of care (Baru and Nundy, 2019)

SOCIO-ECONOMIC DEVELOPMENT; POLITICAL REGIMES AND WELFARE POLICIES

- Both India and China as nation states in 1947 and 1949
- Divergences in terms of political ideology and welfarism
- India – liberal democracy; mixed economy and interventionist state for welfare
- China- Communist party; State led economic growth; post 1978 shift to market socialism
- China and India show variation in human development indicators
- Pre 1978 – the ideology of welfare was divergent but post liberalization there is convergence with commercialization of the economy and social services (Baru, forthcoming)
- Tripod model of welfare for older persons in both countries- family, public, for profit and non profit private sector

ORGANISATION OF HEALTH SERVICES - CHINA

- Health services in China – Strong public funding but provisioning is commercialized (Baru and Nundy, 2020)
- Post 1978 – health sector reform led to autonomisation of public hospitals financially and administratively
- Public hospitals behaved more like private entities
- Near universal hospital insurance
- Growth of for profit institutions; insurance schemes; public-private partnerships
- Inter provinicial variation in service provisioning and widening of socio-economic inequalities in access for older persons
- Rise in Out of Pocket expenditures
- Some provinces have insurance schemes for Long Term Care and catastrophic expenditure for older persons

SOCIAL CARE FOR OLDER PERSONS -CHINA

- Public Insurance schemes for older persons- from community based to long term care (Baru and Nundy, 2019)
- PPPs in provisioning of these services (Baru and Nundy, 2019)
- Increased focus on strengthening primary level services
- Long term care in PPP mode-local and provincial government initiated
- Several models of PPPs
- Market for retirement communities and long term care has expanded to address the needs of older persons (Baru et al 2021)

HEALTH SERVICES IN INDIA

- Weak public spending and with a large private sector
- Inter regional variations in distribution and quality of public and private services
- Post liberalization there is a growth of large private sector across the health system
- Targeted public health insurance programmes
- High out of pocket expenditure – a social gradient is seen in the OOPs
- The access to care for older persons is fragmented and they incur high OOPs
- The poor among older persons are covered by public health insurance
- A significant proportion are not covered either by public or private insurance

PUBLIC-PRIVATE MIX IN HEALTH AND SOCIAL CARE –INDIA AND CHINA

- Post liberalization has seen a public-private mix in health and social care
- There is better regulation and accountability in China compared to India
- There are more mature PPPs in China especially in urban contexts than India (Baru et al – forthcoming)
- Segmented market for supported living and long term care for older persons in both contexts
- The middle and upper middle classes have several 'for profit' and 'non profit' arrangements for care in urban areas in India and China
- These are models that are based on ability to pay- with engagement of international capital from Singapore, Taiwan and Australia

SOCIAL INEQUITIES AND CHALLENGES OF ACCESS FOR OLDER PERSONS

- Changing family structure and out migration of the younger population places heavy demands for care of older persons
- In India and China there are variations in the experiences of older persons along the lines of class and gender
- Older persons living alone is a major concern in both countries
- Lack of adequately skilled human resources for care giving is of concern.
- In India certification and licensing is absent that raises questions around quality of care
- The upper middle classes in both countries are able to hire domestic workers who double as care givers
- The family care givers and domestic workers are not skilled to care for older persons
- Initiatives to train family and domestic care workers are now being piloted in Hong Kong (SAR) (He et al 2023)

CHALLENGES FOR INTEGRATION FOR CONTINUITY OF CARE FOR OLDER PERSONS:INDIA AND CHINA

- Financing and governance - Multiple actors and agencies; fragmentation of authority, hierarchy and power.
- Provisioning – public and private mix
- Human resources – availability, training and quality
- Regulation- fragmented and for profit sector's resistance to regulation
- Importance of a combination of self regulation and state led regulation