Chapter 6

International Prospective of Health Insurance
A Human Rights Perspective on Health Systems

“All human rights are universal, indivisible and interdependent and interrelated. The International community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of National and regional particularities and various historical, cultural and religious Backgrounds must be borne in mind, it is the duty of the States, regardless of political, economic and cultural system, to promote and protect all human rights and fundamental freedoms.”

-Vienna Declaration and Programme of Action, World Conference on Human Rights.

The Universal Declaration of Human Rights from 1948 expresses the norms and the demarcations of human rights. To make a solid foundation to all human rights is that all human beings are born free and equal in dignity and rights. Respect for the individual and the prohibition of any kind of discrimination are the cornerstones in all human rights work. Human Rights include civil, cultural, economic, political and social and rights. They are internationally agreed principles protecting individuals and groups against actions that interfere with human dignity and fundamental freedom as well as principles on entitlements to ensure the well being and development of individuals. Their strength is the common commitment by all ratifying states to respect, protect and fulfill them. Human Rights are developed in international fora, agreed on in international conventions and voluntarily ratified by states. Conventions are legally binding documents that the parliaments of the state parties have voted to ratify and implement.¹

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1. The Universal Declaration of Human Rights from 1948.
Their fulfillment is the responsibility of the national governments. The need for international co-operation for the implementation of the rights is underlined, especially in relation to the possibilities for lesser developed countries to fulfill their obligations. After adopting the declaration on human rights in 1948 it was agreed that also a legally binding document on human rights should be developed. Cold war pressures led to the development of two separate tracks with civil and political rights and social, economic and cultural rights evolving in isolation from each other and sometimes even in conflict with each other. One track emphasized individual freedom and independence; the other underlined the responsibility of the State to cater for its citizens. Two different Covenants were developed (1966) one on civil and political rights and one on social, economic and cultural rights. The end of the cold war and the global conferences of the 1990s laid the political and normative basis for bridging this unfortunate gap. The Declaration from the World Conference in Vienna in 1993 underlines that all rights are universal, interdependent, indivisible and mutually reinforcing. Respecting, protecting and fulfilling human rights, is striking a balance between them all. ²

A healthy population is the original wealth of the any country. This is the systems of healthy country to providing adequate living conditions, access to potable water, necessary nutrition and accessible and acceptable health services governments fulfill their human rights obligations and contribute to the dignity and well being of the population. A healthy population is the contributes to productivity, development and participation in economic development.

2. Declaration from Vienna 1993
A healthy population is the original wealth of any country. This is the system of healthy country to providing adequate living conditions, access to potable water, necessary nutrition and accessible and acceptable health services governments fulfill their human rights obligations and contribute to the dignity and well-being of the population. A healthy population contributes to productivity, development and participation in economic development. And this way to increases the possibility to improve living-conditions and underlying determinants for health as well as creating funds for health services. Health and well-being are basic to the enjoyment of other human rights such as education, freedom of speech, free movement, work etc. Access to health services and rehabilitation is especially important for people who without the input of health promoting activities would not be able to enjoy their basic rights in society, such as people with disabilities, people who have been abused and people with chronic disease.

A human rights related to health sets the focus on basic principles of human Rights, such as non-discrimination, participation, transparency, responsibility and interdependence. The documents of the International human rights give a standard framework of long term for analysis and action. Human rights clearly defines for every individual in the society, people hold some rights as the right to health, while the state has the obligation to respect, protect and fulfill the rights of its citizens. The state can use legislation, law enforcement, administrative systems and regulations, services, information and education as means to fulfill their obligations.³

³ Birgitta Rubenson, ‘Health and Human Rights’ SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY, Department for Democracy and Social Development Health Division HEALTH DIVISION DOCUMENT 2002:2A.
In planning, programming, supervising and monitoring the basic principles of human rights have to be developed and considered. Every human being has the same right to health without discrimination. To ensure this, a rights-based approach means that target-groups have to be analyzed and disaggregated to discover their different needs and abilities. Gender, age, socio-economic background and other characteristics need to be considered and respected. Every human being has the right to decide about his/her own life and to participate in public decision-making. For this to be possible access to information is crucial, both at an individual level and in society at large. People have the right to information about how to stay healthy and patients have the right to information about their ill health and available treatment. The community needs to be informed and given opportunity to influence how health services are developed, but also how to protect health by affecting underlying health determinants. The state parties have the obligation to respect, protect and fulfill the human rights of their citizens. They are responsible to their citizens for the way in which they strive to fulfill their obligations. For citizens to be able to follow and understand the process decision-making and activities have to be transparent. The different rights are interdependent and the realization of one right, for example the right to health depends on the level of realization of other rights such as education, housing, nutrition or security. Health is concerned with protecting and preserving the health of the people as a collective. It involves curative services, prevention of diseases and promotion of a healthy life. This may include restrictions on behavior and choices of the individual both for his own and the community’s benefit.4

4. Ibid,
Key rights related to the implementation of the right to health include:

– The right to non-discrimination
– The right to information and participation
– The right to privacy, physical integrity and confidentiality
– The right to education
– The right to a healthy environment and an adequate standard of living
– The right to work and to just and favorable conditions of work
– The right to social security

Human Rights have implications for public health and health services in many ways. They recognize the right of the individual to access to health services and the obligation of the government to fulfill this by making health services available to all. They include underlying determinants for health, as the right to housing, food, water, healthy occupational and environmental conditions etc. They are important in guiding how public health activities are implemented, so as not to violate the rights of the individuals. By offering adequate health services human rights will be protected and promoted in the community and by respecting human rights principles in the health services dignity and well being of the individual can be restored. Everybody should have access to affordable, adequate health services and to living conditions and information adequate for protecting health and preventing disease. Everybody should be treated with dignity, without discrimination, irrespective of health problem and possibility for Cure. Confidentiality and physical integrity should be respected. Adequate health systems promote human rights by protecting and promoting good health and by restoring health, dignity and well being.\(^5\)

\(^5\) Ibid,
"The States Parties ... recognize the right of everyone to ... just and favorable conditions of work which ensure ... safe and healthy working conditions...; ... the right to ... an adequate standard of living ...; the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken ... to achieve the full realization of this right shall include those necessary for: ... the reduction of ... infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the creation of conditions which would assure to all medical service and medical attention in the event of sickness."

--International Covenant on Economic, Social and Cultural Rights, Articles 7, 11, and 12

The “right to (highest attainable) health” expresses the right the individual has and the obligation of the state to guarantee this right. Health services should be provided equally to all persons within the jurisdiction of the state and nobody should be denied the right as a result of discriminatory regulations and practices.

"States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health...."

--Convention on the Rights of the Child, Article 24

The Convention on the Rights of the Child underlines that illegal residency is not an acceptable cause for exclusion. But it is not enough, not to deny anyone access to health services. A human rights approach requires that the
government takes active steps to guarantee accessibility especially to marginalize and vulnerable groups, who otherwise may have no access. The realization of “the right to health” requires setting priorities, developing functional and just systems for financing, for balancing the freedom of choice and the responsibility of the individual for her/his health and the need for restrictions and regulations to protect and promote public health. The Alma Ata declaration from 1978 set the standard for how governments should develop health services for all. The services should be accessible and acceptable to everyone. They should be both curative and preventive and available to all at a cost the country and community could afford. The declaration underlines the importance of community participation and information. The individual has the main responsibility for his/her own health and the right to adequate information to protect and promote health. Communities should be supported in developing and running basic health services and supplied with necessary goods and personnel. Realizing the right to health involves both a focus on how the health system is organized and how it is financed. For everyone to have the right to health, the health system (every aspect that aims at improving the health of people) should be accessible to all. Special attention needs to be given to people living in remote areas, people belonging to marginalized groups (ethnic, religious minorities), displaced people and illegal residents (immigrants, refugees, slum-dwellers). The government has a special responsibility to make health available to these groups, whose health status is often poor. In planning and programming for improvement of underlying determinants and services the special needs and wishes of the respective groups need to be investigated and respected. Also the special needs of women, youth and children need attention. The financing of the health system is a problem for all countries. Health service costs
increase constantly as new medication and new treatments are introduced. Financing can be organized in different ways, through taxation, through an individual or employment related insurance system, through user fees or a combination of them. Whichever system is chosen it is the responsibility of the government to monitor the effects for all sections of society, so that everyone has access to affordable services. Human Rights in the health services refer to how health services are provided and how patients, citizens experience the services. Human rights are often violated in the health services. Patients are dependent and insecure in the situation and know little about their rights. It is easy for health personnel to misuse the position. Withholding information and denying the patient the right to participation in decisions about treatment and care is common. The right to privacy, confidentiality, physical integrity and individual autonomy are also often violated. It is the obligation of the government to institute clear rules and regulations to protect patients and to monitor compliance. These rules should be the same for public and private institutions. All the countries have our own constitution and have a provision for all people, but at a time of renewed interest in the international human right to health, it is useful to identify and examine the provisions of the constitutions of the world regarding health and health care. These provisions indicate a national commitment towards the assurance of access to high quality and affordable health care for all peoples.

6. Birgitta Rubenson, ‘Health and Human Rights’ SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY, Department for Democracy and Social Development Health Division HEALTH DIVISION DOCUMENT 2002:2A
In addition, such constitutional Provisions may be important factors in the international campaign to promote the recognition and implementation of the international human right to health domestically throughout the world. 7

The study of the international health care system inevitable reveals stark and intriguing contrast which have act their roots an individual country’s unique set of economic and social values.8

**Health care of China**

China has a vast populated country in the world. China has announcing ambitions health care in 2009 . china has made big and bold strides in providing its people with equitable, accessible and affordable health care over the past three years. In 2009 to 2011 the investment in the health care sector totaling $124 billion between these periods this is the highest investment in health care in china’s history most appreciable thing is the 95 percent population of china is now covered under the health insurance. In this way nation increase budget for health expenditure this way reduced individuals ‘out of pocket’ expenses this things an encourage population to take medical insurance. China’s ministry of health (MOH) designed a frame work that covers a number of key reforms areas, including information system, pricing and payment structure, drug quality supervision, primary care and public hospital reform. Among these components public hospital reform has been identified as one of the top priorities9

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8. Ibid,
Health care reform of China mainly focus on seeking medical care is difficult and expensive. The reform of the provider payment system is a means to achieve the end goal of expanding access to affordable health care by unifying the way the government reimburse hospitals and improving resources allocation in public hospitals. China's three year reform plan, launched in 2009, marked the first phase towards achieving comprehensive universal basic healthcare for reform: accelerating the expansion of the basic health insurance system; establishing a national essential drug list system; improving primary healthcare services; promoting the equalization of basic public health. Of the five priorities announced in 2009, expansion of health insurance coverage stands out as all its citizens by 2020. The government and healthcare organizations have also set up clinical registries and mechanisms to evaluate a range of issues, from quality and safety to efficiency and performance, laying the groundwork for more solid healthcare infrastructures in the future. While the recent reforms seem successful, it is clear that the Chinese healthcare system faces several challenges in the future. Although the government is constantly trying to adapt the system to the needs of the population and to improve performance, problems concerning misuse of antibiotics, drug quality and supply, as well as hospital accreditation, are officially recognized. Looking ahead, the Chinese healthcare system faces a substantial increase in demand. The one child policy has led to a rapidly ageing population that will demand more healthcare resources, and with a rapidly growing middle-income class, demand for quantity as well as quality of healthcare is likely to increase.\textsuperscript{10}

\textsuperscript{10} Ibid,
Such an increase in demand can hardly be met directly by the public healthcare system.

As a result the government is encouraging private investments in the construction of new hospitals and other care facilities and there is a robust combination of public and commercial insurance schemes for people to choose from. China is still at the outset of reforming its healthcare system and its implementation is likely to be an arduous challenge. The reform plan has important implication not just for China’s healthcare system, but also for society at large. This report examines a range of topics, including insurance systems currently in place in China, hospital reforms, how healthcare is financed, maintaining quality of care and how these various indices should be measured. The major components of China's healthcare reform plan include; the expansion of basic medical insurance programs and creation of a rural cooperative medical system that already today enroll more than 90 percent of urban and rural residents; establishing a national essential drug system that encompasses drug selection, production and supply, clinical applications, and medical insurance reimbursement; establishing a competent, primary medical care service infrastructure composed of rural township centers, village clinics and urban community healthcare centers, including a dual-direction referral system between community healthcare institutions and hospitals and, finally; equal access to basic public health services by both urban and rural residents. Pervading all of this are the roles of both public and private institutions and how this balance is to be maintained as China continues to build its healthcare system.11

Emphasis has also been put on improving care at all levels of the system by addressing various problems such as abuse of antibiotics and intravenous drugs, drug quality and Safety as well as hospital accreditation. The government and healthcare organizations have set up quality registries and mechanisms to evaluate a range of issues, from quality and safety to efficiency and performance, laying the groundwork for a more solid healthcare infrastructure in the future.\textsuperscript{12}

The healthcare system in China refers to the healthcare system transition in modern China. China's government, specifically the Ministry of Health of the Council oversees the health services system, which includes a substantial rural collective sector but little private sector. Nearly all the major medical facilities are run by the government. China's healthcare reform history has seen an increase in quality after 1949 with the establishing of the Cooperative Medical System, and a collapse in healthcare with economic reforms post-1980. Recent reforms include the New Rural Cooperative Medical System, health insurance reforms, the World Bank Health VIII project, and the Healthy China 2020 project, but challenges still exist in providing universal healthcare access to all of China, most notably the rural sectors. In view of China managing major health system reform against a background of rapid economic and institutional change, the Institute of Development Studies, an international research institute, outlines policy implications based on collaborative research around the Chinese approach to health system development.\textsuperscript{13}

\textsuperscript{12} Ibid,
\textsuperscript{13} Lesson from the Chinese Approach to Health Systems Development Institute of Development Studies (IDS) In Focus Policy Brief Issue 8, June 2009
A comparison of China's healthcare to other nations shows that the organization of healthcare is crucial to its implementation. There exists some degree of disorganization and inequity in access to healthcare in urban and rural areas, but the overall quality of healthcare has not been drastically affected.\textsuperscript{14} Certain incentives, such as adjusting prices of medical equipment and medicine have helped improve health care to an extent. The largest barrier to improvement in healthcare is a lack of unity in policies affecting each county. The Institute of Development Studies suggests testing innovations at local level, encouraging learning from success, and gradually building institutions that support new ways of doing things.\textsuperscript{15}

\textsuperscript{14} Ibid,
\textsuperscript{15} Hsiao, William. (1995). The Chinese health care system: Lessons for other nations journal=Social Science and Medicine, 8, 1047-1055
Canada Health Act
The 1984 Canada Health Act articulates the five fundamental principles of the Canadian healthcare system: public administration, universality, portability, comprehensiveness, and accessibility. The model of the Canadian healthcare ensures that its population will receive to all necessary services like medical, hospital and physician services. Possessing a single-payer national health insurance system, Canada combines publicly funded, mandated universal healthcare with largely private delivery mechanisms. The nature of the Canada’s care health system is the decentralized nature of its government; it has ten provinces and three territories are constitutionally accountable for funding, managing, and delivering they manage all the health services. the national government play a regulatory role by way of its ability to manage the federal funding to provinces when provinces/territories fail to comply with certain federally-defined criteria Canada's healthcare system was ranked 30th by the World Health Funding and administration responsibilities are decentralized within the Healthcare delivery occurs mainly through private providers who work either independently in solo practice or as part of a group practice. Hospitals have traditionally been not-for-profit entities, with most being in the public sector Canadian health system, as each province/territory administers its own insurance plan on a not-for-profit basis for residents who have lived in the area for over three months The role of the federal government is to provide oversight and regulation of the provincial/territorial governments.16

16. Jessica A.hohman, international health care system primer”, the American medical student association 1902 association drive Reston, VA 20191-more see in – www.jrf@amsa.org.
The power of the federal government stems from its ability to withhold federal funding for healthcare. Healthcare delivery occurs mainly through private providers who work either independently in solo practice or as part of a group practice. Hospitals have traditionally been not-for-profit entities, with most being in the public sector.\textsuperscript{17}

Guaranteed insurance plans are provided by the Canada health act. In this act has to proper insurance plans health insured services provide by hospitals and medical practitioners or dentists. Canada provide to their Canadians have free choice and few financial barriers to high quality healthcare in their country. Despite the generally good healthcare access overall for most Canadians, there do exist inequities in access for low-income Canadians and those living in rural areas, where there are fewer providers and healthcare facilities.

\textsuperscript{17} Ibid, Jessica A.hohman, international health care system primer”; the American medical student association 1902 association drive reston, VA 20191-more see in – www.jrf@amsa.org.
Swedish Health Care

Sweden first began to establish broad access to healthcare after 1946, when the Social Democratic Hansson government set up a system in which all working Swedes contributed to and were covered by social health insurance, comparable to the 1911 National Insurance Act reforms in the UK. However, since at the time not all Swedes were covered and out-of-pocket health costs remained high for some, in 1969 the Social Democratic government of Tage Erlanger put Swedish healthcare through further reforms that rebased their system predominantly on general taxation financing and direct public provision of health services, Sweden’s citizenry is served by a national health insurance (single-payer) system, in which the government is the primary reimburse (payer) of healthcare. Conceptually, Sweden’s healthcare system is relatively decentralized, with the main duties of healthcare administration and financing falling under the jurisdiction of individual county councils; the role of the central government is to use federal taxes to fund the councils. Ranked 23rd of 191 countries for overall performance, 10th for level of responsiveness, and 4th for level of health attainment by the World Health Organization (WHO). Together, the Ministry of Health and Social Affairs and these various agencies provide a clear national framework for healthcare in Sweden and set basic uniform standards that must apply across the country, in order to ensure strategic oversight and a sense of the national within the localist system.  

18. Ibid, Jessica A. Hohman, international health care system primer”, the American medical student association 1902 association drive reston, VA 20191-more see in – www.jrf@amsa.org.
The system of the Swedish health care is a socially responsible system with an evident public commitment to ensure the health of all citizens. Three basic principles are human dignity, need and unity, and last is cost and effectiveness is purporting to apply to health care in Sweden. The principle of human dignity means that all human beings have an equal status and equal entitlement to dignity, and should have the same rights. The principle of need and unity means that those in greatest need take preference and priority in medical care. The principle of cost–effectiveness means that when a choice has to be made between different health care options, there should be a reasonable relationship between the costs and the effects measured in terms of improved health and improved quality of life. The main aim of health care in Sweden is to provide effective, reasonable health care to their citizens.

19. Ibid, Jessica A.Hohman, international health care system primer”, the American medical student association 1902 association drive Reston, VA 20191-more see in – www.jrf@amsa.org.

20. Elliot bidgood, health care system: Sweden and localism an example for the U.K? OCT 21-2013
United States Health care

The United States economy is the largest in the world, and its gross national income per head is among the highest in the world. The United States has a federal system of government, with substantial authority delegated to its regional governments – the 50 states – and a historical unwillingness regarding central planning or controls either at federal or state level. The United States health-care system can be thought of as multiple systems that operate independently and, at times, in participation with each other. Powers in the health sector are divided between the federal and state governments. For example, states fund and manage many public health functions, pay part of the cost of Medicaid and shape its organization within that state, and set the rules for health insurance policies that are not covered by self-insured employer plans. On the other hand, products such as pharmaceuticals and medical devices are regulated at federal level. Regulations to achieve objectives of quality, access and cost control in health care may be set by public or private entities, at any or all of federal, state or local levels. However, there is relatively limited planning in terms of regulation, with little coordinated system-level planning in the United States in comparison to other countries, although incentives are sometimes used (for example to promote service provision in underserved areas) United States public health is decentralized, with the main locus of power at the state level. The actual public health structures at the state level vary significantly; in some states, public health functions are further decentralized (e.g. to county level).  

At federal level, the United States Public Health Service brings together

21. KAO-PING CHUA “, overview of the U.S health care system”.2005-2006 AMSA  
eight federal public health agencies (including the Centers for Disease Control and Prevention, the Food and Drug Administration, and the National Institutes of Health). Federal, state and local public health services have been underfunded, and tend to be driven by immediate concerns; for example, as concerns rose over terrorist attacks in the United States, much of the public health funding and services switched to terrorism preparedness, leaving holes in other areas of public health. The United States health system has both considerable strengths and notable Weaknesses. It has a large and well-trained health workforce, and a wide range of High-quality medical specialists, as well as secondary and tertiary institutions, a robust health sector research program and, for selected services, among the best medical outcomes in the world. But it also suffers from incomplete Coverage, underinsurance, and inadequate care for the uninsured. Additional problems include health expenditure levels per person that far exceed all other Countries, poor results on many objective and subjective measures of quality and outcomes, an unequal distribution of resources and outcomes across the country and among different population groups, and lagging efforts to introduce health information technology. It is difficult to generalize about the United States health-care system and, accordingly, hard to draw overall conclusions about its performance. In some respects it is unquestionably among the best in the world, yet in other respects there are significant shortcomings. One factor that sets the United States apart from its counterparts is the more limited government involvement. Historically, there has been distaste for central planning, lack of control over the dissemination of medical technologies, reluctance to take advantage of the

22. Ibid,
potential bargaining power afforded through large government insurers, lack of centralized prices and prospective budgeting and, most importantly, the absence of guaranteed insurance coverage. There is general agreement among those on the left and the right that reforms are necessary to control spending. There is less agreement on whether there is a quality problem, nor much agreement on the need to provide coverage for the uninsured. In spite of these disagreements and because of the adoption of the Affordable Care Act in 2010, the United States is facing a period of enormous potential change. Whether the ACA will indeed be effective in addressing the challenges identified above can only be determined over time. Such changes in healthcare delivery will take a great deal of time. The ACA addresses major challenging issues such as geographic variation in the use of services and a bias towards subspecialty rather than primary care services, but mainly through small programmes and pilot studies. The types of changes needed in health-care delivery are unlikely to result from legislation. Rather, they need to be innovated and supported by both the public and private sectors as each grapples with the cost, quality and access issues they face. They also hinge on changing individual and provider behaviors. Americans face an even more fundamental challenge: the lack of effective dialogue, much less consensus, on how to improve their health-care system. There is very little agreement among the Democratic and Republican parties on the solutions to problems and, with a few exceptions, little in the way of working towards common solutions. Such a climate tends to result in stasis, slowing down the country’s ability to further innovate and improve the system. 23

23. Thomas Rice • Pauline Rosenau Lynn Y. Unruh • Andrew J. Barnes, Health Systems in Transition United States of America Health system review Vol. 15 No. 3 2013
Comparison of Healthcare in India vs. China

compare the health systems of China and India the world’s two most populous countries, each of which is undergoing dramatic demographic, societal, and economic transformations—to determine what approaches to improving health in these two countries do and do not work. In particular, compare the health systems of China and India along three dimensions: policy levers, intermediate outcomes, and ultimate ends. Policy levers are policies or behaviors that affect the financing, organization, and regulation of health care. Intermediate outcomes are the efficiency, quality, and level of access to care. The ultimate ends of a health care system are to promote better health, reduce the financial risks associated with medical care, and increase consumer satisfaction. Both China and India have achieved substantial gains in life expectancy and disease prevention since independence; these gains are more substantial in China. However, both countries’ health systems provide little protection against financial risk, and patient satisfaction is a lower priority than it should be. These countries have define priority areas, to reform health system help improve the performance of each community of the health system.24

China and India are similarly huge nations currently experiencing rapid economic growth, urbanization and widening inequalities between rich and poor. They are dissimilar in terms of their political regimes, policies for population growth and ethnic composition and heterogeneity.

This review compares health and health care in China and India within the framework of the epidemiological transition model and against the backdrop of globalization. It identifies similarities and differences in health situation. In general, for both countries, infectious diseases of the past sit alongside emerging infectious diseases and chronic illnesses associated with ageing societies, although the burden of infectious diseases is much higher in India. Whilst globalization contributes to widening inequalities in health and health care in both countries--particularly with respect to increasing disparities between urban and rural areas and between rich and poor--there is evidence that local circumstances are important, especially with respect to the structure and financing of health care and the implementation of health policy. For example, India has huge problems providing even rudimentary health care to its large population of urban slum dwellers whilst China is struggling to re-establish universal rural health insurance. In terms of funding access to health care, the Chinese state has traditionally supported most costs, whereas private insurance has always played a major role in India, although recent changes in China have seen the burgeoning of private health care payments. China has, arguably, had more success than India in improving population health, although recent reforms have severely impacted upon the ability of the Chinese health care system to operate effectively. Both countries are experiencing a decline in the amount of government funding for health care and this is a major issue that must be addressed.\textsuperscript{25} India has the largest democracy in the world. Its media is vibrant and free, since independence in 1947, the life expectancy at birth has more than doubled, to 66 years from 32, and per-capita income (adjusted for

\textsuperscript{25} Ibid,
inflation) has grown fivefold. In recent decades, reforms pushed up the country’s once lazy growth rate to around 8 percent per year, before it fell back a couple of percentage points over the last two years. For years, the economic growth, India’s rate ranked second among the largest in the world’s economies, after the China, which it has consistently trailed by at least one percentage point. The hope that India might overtake China one day in economic growth now seems a distant one. But that comparison is not what should worry Indians most. The far greater gap between India and China is in the provision of essential public services a failing that depresses living standards and is a continuing stretch on growth. Inequality is high in both countries, but China has done far more than India to raise life expectancy, expand general education and secure health care for its people. India has elite schools of varying degrees of excellence for the privileged, but among all Indians 7 or older, nearly one in every five males and one in every three females is illiterate they do not aware about health and health care facilities. India may be the world’s largest producer of generic medicine, but its health care system is an unregulated mess. The poor have to rely on low-quality and sometimes exploitative private medical care, because there isn’t enough decent public care. While China devotes 2.7 percent of its gross domestic product to government spending on health care, India 26 allots 1.2 percent. India’s underperformance can be traced to a failure to learn from the examples of so-called Asian economic development, in which rapid expansion of human capability is both a goal in itself and an integral element in achieving rapid growth.