

PERSPECTIVE

Tide Turning: China's Health Care Policy in Transition

转型趋势：处于转轨期的中国医疗保险制度

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Summary

This article systematically reviews the historical process of China's healthcare system reform, and provides his perspective on the future reform direction. The author examined the unintended consequences of China's market-oriented healthcare reform since the collapse of the socialized health system in 1979, including the sharply decreasing health insurance coverage, diminishing public health prevention services, increasing healthcare costs and worsening inequalities, resulted from the reduction in public health expenditures. In response to the collapse of universal health system, a new Urban Basic Medical Care Insurance System for Staff and Workers (UBMCI-SW) was started in 1993 for urban employees; the New Rural Cooperative Medical System (NCMS) was reestablished in October 2002 for the rural residents; and various forms of medical care insurance schemes were established starting in 2007 to provide coverage for the elderly, children and migrant farmer labors. China has achieved a significant success in restoring its universal healthcare system in one decade, in spite of the limited health services and scope of illness coverage. Witnessing the currently heated debate over whether the future reform direction should focus on marketization or public welfare, Dr. Guo believes that the reform-minded China's new government will increase public expenditure and focus more on the welfare function of healthcare system.

郭保刚博士系统地回顾了中国医疗卫生体系改革的历史进程，并提出他对中国医改未来走向的见解。他详细阐述了自从1979年市场主导的医疗改革取代了集体经济下的公共医保模式，由于政府在医疗卫生领域公共开支的减少所产生的不利社会影响：包括医保覆盖率急剧下降、公共卫生预防服务的减少、医疗费用的升高、以及不断恶化的医疗服务公平性问题。为了应对全民医保制度瓦解的不利影响，中国政府于1993年起致力于建立城镇职工基本医疗保险制度（UBMCI-SW），于2002年10月起重建新农村医疗卫生合作体系（NCMS），并于2007年开始提供了一系列的医保措施以覆盖老人、儿童以及城市务工人员。尽管现阶段医保提供的医疗服务和覆盖的疾病种类有限，但中国成功地在短短的十年间重新建立起全民医保制度。关于未来医改要着重于市场化还是强调其社会公益性的激烈辩论，郭保刚博士认为富有改革精神的新一届中国政府将增加在医疗卫生领域的开支，并强调医疗卫生体系的社会公益性。^{*}

Since 1979, China has attempted to use market mechanisms to restructure its outdated health care system and improve its coverage and delivery systems. In the urban areas, the government introduced many new market-based reforms in an attempt to streamline the health care industry and slow down the escalating costs of providing health care. Health insurance reforms introduced built-in incentives for consumers to reduce unnecessary utilization of health services. The hospital reform reduced government subsidies and put the burden of institutional finance on hospitals.

These market-oriented reforms have resulted in a major overhaul of both health care finance and delivery systems. While the welfare functions of health services are phased out gradually and public

^{*} This bilingual summary was prepared by Zongshuan (Jack) Duan, MPH Candidate.

expenditures on health care dropped substantially in relationship to the overall government expenditure, there were some improvement in efficient health care services and resource allocation. However, the market reforms also resulted in some unintended consequences. As the burden of health finance was shifted to consumers, health care was once again beyond reach for more and more people, especially the urban poor and rural farmers. Health care, together with housing and education, has become new “three mountains” that put tremendous amount of pressure on people’s livelihood. Many Chinese have begun to develop a negative view about these reforms and started challenge the market approach that has been implemented so far. Where is China headed from this point? How to improve efficiency while ensure access and equitable distribution of health resources? China is once again at a crossroad.

Since the beginning of the new millennium, China’s health care reform has undergone a new transition. The focus of the latest reform is designed for increase public expenditure on health care; broaden access to health service, and improve basic health service and health care delivery system. In one way or another, it is an affirmative action to provide remedies to the unintended consequences of the market-oriented reforms.

The Problems

When China began its ambitious economic reforms in 1978, the health-care system crumbled as governments at various levels no longer guaranteed the health care insurance coverage. The reduction in public expenditures resulted in diminishing public health services and prevention. Emphasis in investment in high technology and facilities reduced the available resources for services and treatments. With the dismantlement of People’s Communes, rural cooperative health care insurance coverage dropped from 90 percent in the pre-reform era to just about 10 percent in 2005. Almost all village clinics were contracted out to individual doctors or sold to private practitioners. In urban areas, employees no longer received health care for free. Urban economic reforms created many new groups of labor forces who were outside the traditional urban health insurance schemes, such as the laid-off workers, the employees of privately owned businesses, and the migrant farm laborers. In just a decade, the near universal health coverage disappeared in China.

Meanwhile, health-care costs increased at an alarming rate. Total health-care spending rose by 28 times between 1978 and 1997, much faster than the inflation rates during the same period. Health care wastes and overutilization were widespread among insured public employees. While their numbers were declining steadily, the resources the state provided for their coverage continued to rise uncontrollably, despite the overall decline of government spending in total health expenditure during the same time. According to a report of the World Health Organization (WHO) published in 2000, based on the statistics of 1997, China ranked 144th in the overall health system performance, and 188th in fairness in financial contribution (among the 191 member states).¹ China’s own data suggested that the ratio between urban and rural public health resource allocation was 7.4:1.²

China’s own official national health survey conducted in 2003 confirmed the worsening inequality in health care. Due to the high cost and diminishing insurance coverage, more than one-third of people who were sick did not go to doctors for treatment, and 13 percent of these sick people were not treated at all. More than 80 percent of government health spending went to urban areas, and 80 percent of public spending went to major health care institutions. All together, only 20 percent of the population benefited from public health insurance programs. Even in the cities, health care inequality was also evident. By 2003, more than 76 percent of urban low-income families had no health insurance coverage at all. Uneven distribution of healthcare resources resulted in some disturbing statistics. While 90 percent of pregnant women of low-income families in urban area still received some level of prenatal care, and 85 percent of them delivered their babies in a hospital, only 75 percent of pregnant women of low-income rural families got some

prenatal check-up and only 45 percent of them gave birth to their children in a hospital.³ As a result, the infant mortality rate between rural and city was 2:1 before 2001.⁴

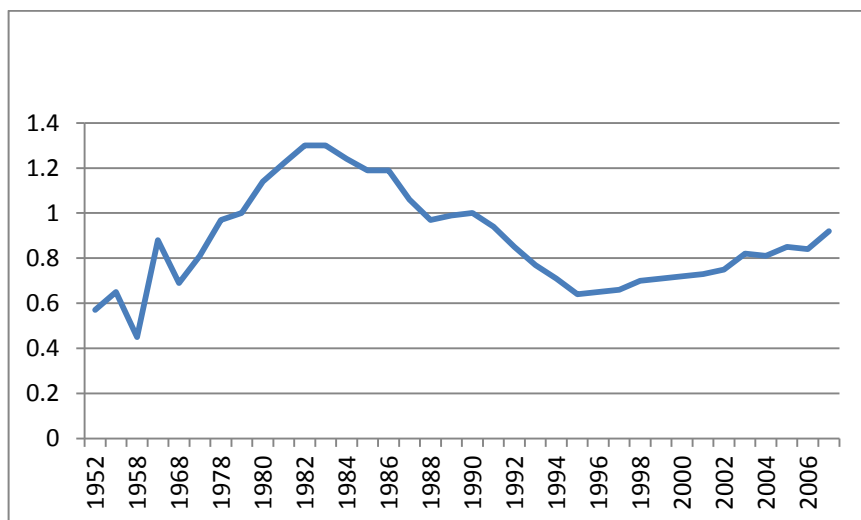


Figure 1 Government Health Expenditure as Percentage of GDP

Sources: Du Le-xun, Zhao Yu-xin, and Liu Guo-xiang, "Reflection on 60 Years of Development of Government Health Investment and Total Health Expenditure Accounting in China: Respect and Prospect," *Chinese Journal of Health Policy* 2, no. 10 (October 2009), 19, Table 2.

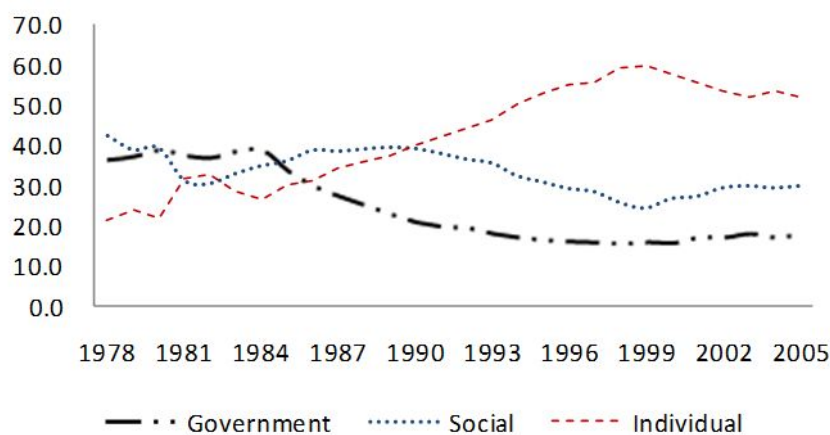


Figure 2 Percentage Share of Health Care Expenditures (units: percentage)

Sources: MOH, 2007 Health Care Statistics Yearbook.

Additionally, with the diversification of the employment system, the labor forces became more and more mobile than ever, and most of the 140 million migrant rural laborers, and millions of self-employed small business owners and their employees in the new economy went uninsured in 2001. Only 30.2 percent of urban employees were enrolled in the urban employee medical insurance.

Figure 1 reflects the changes in public health spending between 1952 and 2007. Between 1952 and 1982, public spending on health care rose significantly, but declined for the next twelve years. The out-of-pocket individual expenditure increased threefold. The trends began to move up again after 1996, but at a much slower rate. The public complaints about the rising costs of health care

were largely a result of the decrease in public spending on health care. The profits of health institutions went up, but at the expense of equity and accessibility.

Figure 2 shows that the percentage of government contributions to health care declined steadily in the 1980s. Individual contributions now make up more than half of all health care expenditures. The unwillingness of the government during this period to share the costs of health care is in sharp contrast with many of its neighbors. In Japan, the percentage of public financed health care is 81.5 percent.⁵ The direct impact of the shrinking public health spending is the increased financial burden on health care consumers, and makes health care one of the new “three mountains” on top of every family.⁶

A New Beginning

In response to the crumbling national health insurance system, the central government started to work on developing a nation-wide new employee medical care system in the 1990s, although incremental and small-scale health-care reforms began as early as the 1980s. These reform experiments were designed to incorporate various market mechanisms into the health care system. The main concern was to cut down health care costs and to make the industry more efficient and more profitable.

The nationwide drive for health care reform was initiated in 1993. A new urban basic medical care insurance system for staff and workers (UBMCI-SW) would be based on the concept of social risk-pooling in which work units would no longer be providers of free health care, and employees must bear some of the costs.⁷ Under the new system, a participant’s medical costs will be covered by two separate medical accounts. An individual employee contributes 2 percent of his/her wages or salary to his or her individual medical account. The participant can use this balance to pay for outpatient services and medications. Employers contribute 6 percent of the sum of their employees’ total wages or salaries to the general medical trust fund, but 30 percent of the employers’ contributions will be allocated to employees’ individual accounts.⁸ The general medical trust funds are currently pooled at the city and county levels, primarily to pay for employees’ in-patient and major health services.⁹ City or county governments will provide operating budgets and personnel to collect, manage, and run the general trust accounts as well as the individual medical accounts. The government agencies will negotiate with health-care providers on the terms, coverage, and reimbursement of health-care services. This new system was initially experimental in many cities, starting in 1994.¹⁰

The government launched a nation-wide campaign in 1999 to promote the new system.¹¹ The initial goal was to enroll within one year all urban employees and all who were self-employed. However, inexperience and bureaucratic red tape hampered the implementation process. By 2008, about two-thirds of the urban labor forces are covered by the UBMCI-SW (see Figure 3). By 2012, 82 percent of urban employees have been covered. At the same time, to reduce the burden of enterprises, over 7,000 enterprise-owned and -operated hospitals and health-care facilities have been turned over to local governments.¹² The separation of health insurance and service functions from enterprises paved the way for building a modern enterprise system.

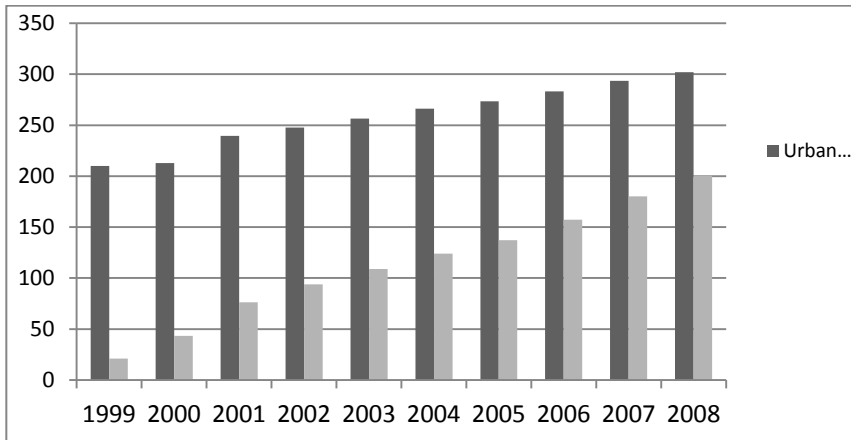


Figure 3 The Growth of Urban Basic Medical Care Insurance Coverage for Staff and Workers (1999–2008) (units: millions)

Sources: National Bureau of Statistics of China, *China Statistical Yearbook (1999-2008)*, <http://www.stats.gov.cn/>.

The new health insurance program consolidated the old public insurance and labor insurance schemes into a single employee medical insurance program, covering employees in all types of enterprises, governmental institutions, and semi-official social groups in urban areas. Employees of private-owned and foreign-owned companies, which now consisted of the majority of urban labor forces, became eligible to enroll in the system. The coverage also included laid-off workers (6 million) and retirees (37 million).

The rural-urban divide created the most unfair allocation of health resources. The lack of adequate access to quality health care systems has resulted in higher infant mortality, higher death rates of pregnant women, and lower life expectancy. With the collapse of the rural cooperative health care system, farmers became very vulnerable to sickness. Many fell into poverty because of chronic or major illnesses.

To address this issue, the government decided in October 2002 to reestablish the rural cooperative health system.¹³ However, since the rural collective is gone, there is no public financial support to sustain the system. The government eventually decided to use public funds to fill the vacuum. The sheer size of the rural population demands a substantial amount of resources to be allocated to cover the 900 million plus rural population.

The effort to restore the cooperative health care system actually began in 1993. In 1994, the Ministry of Health (MOH), Ministry of Agriculture (MOA) and the World Health Organization (WHO) launched an experimental project on a new cooperative health care scheme. The experiment was carried out in fourteen counties and cities. It was not until 1997 that the MOH decided to promote the new system nationwide.¹⁴ However, the new system asked local people to organize the system and relied mainly on individual contributions to support the system financially. By 2002, less than 10 percent villagers had signed up for the system. Most farmers were unable to shoulder even the modest cost of the program.

Since 2003, the government has changed its approach. In the new program promoted after 2003, the government organized, guided, and supported the system. In only five years, the rural cooperative health system has achieved universal coverage in rural areas. This is truly remarkable achievement. The public contribution to the program's finance certainly played a major role in the rapid expansion of the program. Participation in the new program is voluntary. Their contribution would be put in their individual account, and would be used to pay for outpatient visits. The state

and collective contributions would be put into a pooled account to help pay for the cost of the treatment of major illnesses. In 2006, the central government decided to increase public financial support in order to increase the program's coverage. The central government and local governments would each double their contributions to 20 yuan for each participant. In another words, the government now will pay 60 percent of the total cost of insuring each rural participant. In 2008, these contributions were doubled again, with the state and county governments each contributing 40 yuan to each insured and the each participant would pay 20 yuan annually.

Compared to the urban health insurance plan, the benefits of the rural program are still very limited. It only pays for 50 percent of the cost of hospitalization initially (now it is about 60 percent). For doctor's visits, a patient can only be reimbursed for 7–8 yuan per visit. The annual maximum of patient reimbursement for doctor's visits varies greatly from county to county. Some limit annual individual reimbursements to 140 yuan, while other set it at 400 yuan.¹⁵ One direct result of the new insurance system is the increase of the rate of health services utilization. Farmers are more likely to visit a doctor in case of an illness. For in-patient services, the system encourages patients to seek services at the township level. According to the 2008 National Health Survey, only one-third of rural patients received reimbursements for out-patient services; 85 percent of farmers who received in-patient services were reimbursed, and reimbursement was only 34 percent of their total expenses for their hospital bills.¹⁶ In 2012, the rural health insurance scheme has increased its coverage to 98 percent of rural population. The total government contribution to each enrolled farmers have increased to 240 yuan, and the projected reimbursement will increase to about 70 percent.

With the rapid expansion of the employee insurance scheme and the rural cooperative health insurance scheme, most of the working-age populations are now covered. However, some groups of the populations are still left out. One is the elderly who are not part of the retirees of state-owned enterprises. The second group is the children, and the third group is the family-operated small business owners and their employees. The final group is the 140 million migrant farmer laborers. State-owned enterprises generally allowed coverage to the family members of an employee, but usually at half the cost.

Table 1 Social Insurance Composition of Residents (units: percentage)

Item	Total		Urban		Rural	
	2008	2003	2008	2003	2008	2003
Basic Medical Insurance of Employees Government Insurance Program	12.7	8.9	44.2	30.4	1.5	1.5
Basic Medical Insurance of Resident	1.0	1.2	3.0	4.0	0.3	0.2
New Rural Cooperative Medical Scheme	3.8	--	12.5	--	0.7	--
Other Social Insurance	68.7	--	9.5	--	89.7	--
No Social Medical Insurance	1.0	12.0	2.8	15.2	0.4	10.9
	12.9	77.9	28.1	50.4	7.5	87.3

Sources: National Survey on Health Service in 2003 and 2008; Statistical Summary of China's Health Care from MOR (2009), Ministry of Health, <http://www.moh.gov.cn/>.

To provide health insurance coverage for these groups, starting in 2007, various forms of medical care insurance schemes were established. The goal was to create a mandatory urban resident insurance by 2010. Like the rural cooperative health care scheme, the government would provide sizeable subsidies to individual participants. Under the new program, an adult would pay a monthly premium of 100 yuan with a state subsidy of 50 yuan. Children's cost was 30 yuan a month with 50 yuan state subsidy. For the disabled, the premium was only 40 yuan with 110 yuan state subsidy. The insurance would only cover major illnesses and urgent care on an outpatient basis or inpatient hospitalization. The annual deductible was quite high, ranging from 540 to 980 yuan per illness. The co-payment ranged between 20 percent and 50 percent. Most of the services were limited to community health centers. Referrals were needed to go to a regional hospital for further treatment.

Maximum insurance benefits ranged between 16,000 to 20,000 yuan annually.¹⁷ The main beneficiaries of the new resident-based health programs were children under age of eighteen, including students in technical schools. By 2008, there were 116.5 million people enrolled in the new health insurance system. The new system was also extended to migrant laborers. About 42.5 million or one-third of migrant labor forces had enrolled in the program by 2008.¹⁸ Table 1 is the summary of the enrollment status of employees and residents in various medical insurance schemes.

It is undeniably a major success for China to restore its universal health care insurance system in such a short of period of time. Although the financial benefits are still limited to providing basic services and coverage for major illness, the access to health care has been improved significantly in the last decade.

The Debate and the Future Direction

During the last two decades, there was a series of heated debates on the direction of health care reform. Generally speaking, there were two groups in the debates. The pro-market advocates were in favor of marketization of health care industry. The opponents of this approach insisted on the welfare and social functions of health care, and demanded an active role for the government to ensure adequate access to health care and services.

The effort to turn hospitals care institutions into self-sufficient economic entities in the 1980s forced hospitals to increase their charges and fees, causing the loss of accessibility to health care. Health ethics was compromised due to rampant corruptions, such as doctors taking bribes from patients and drug companies, prescribing unnecessary medication and technology usage, and making false advertisements. As a result, the relationship between doctors and patients was at all-time low. In 1993, the vice minister of the MOH, Yin Dakui, openly opposed to the marketization of health care. He argued that health care was a public product serving the public interest and it should have an important role in ensuring social justice and fairness.

On July 29, 2005, the Development Research Center (DRC) of the State Council shocked the nation by releasing its final report on China's health care policy reform. It claimed that, taken as a whole, the market-oriented reform in health care was unsuccessful, and the reform had contributed to the escalating costs of and difficulties in access to health care.¹⁹ This negative assessment triggered a new round of debate on health care reform in China and paved the way for the second round of health care reform that was unveiled at the end of 2008.

The year 2005 was a turning point in China's health care reform. Once again, attention was shifted away from pushing for further marketization and focused more on fairness issues. In September 2006, the State Council put together a new health care reform coordination committee, which consisted of eleven ministries and agencies of the State Council. The committee engaged in extensive debates on ten different reform plans submitted by various agencies.

On October 14, 2008, a new comprehensive health care reform proposal was published for public comments. It targeted 2020 as the date for the establishment of a comprehensive system of basic health care, which included public health, health services, health insurance, and pharmaceutical supply sub-systems. It emphasized the public service functions of health care system, and the dominant role of the government in providing health care financing and services. It promised to increase the share of health care spending in the government's total expenditures and to provide budgetary support for all public health care institutions so that they do not have to rely on incomes generated through charges on in-house pharmacies and prescribing unnecessary procedures and medical tests. It moved away from the market fundamentalist approach and brought pricing control back, especially for non-profit public hospitals. It called for increased governmental subsidies to participants of urban resident medical insurance and rural cooperative medical systems.

No significant new changes were made to the health insurance schemes that were put into place since 2002. Under the plan, the urban employee medical insurance system will be expanded to provide coverage for the uninsured, employees in the private sectors, retirees, and companies in economic hardship. The urban resident insurance program will extend its coverage for the elderly and the poor. The rural cooperative health system will be focused on improve its benefit level and coverage. It is hoped that eventually the three separated public systems will be unified. The government determined to strengthen areas that are the weakest in the current system, namely, public health, community health services, and rural health services.

In the wake of the global financial crisis of 2009, the State Council took a swift action by announcing a four trillion yuan economic stimulus plan. As a part of the stimulus package, the state issued its much debated ambitious health reform plan with a total projected 850 billion yuan investment to support these reforms. The following is some of the highlights of this plan:²⁰

- (1) Strengthen the health service delivery system. Under the plan, the state will invest significant amounts of money to modernize 2,000 county hospitals, 290,000 township health hospitals, 5,000 township health centers, 3,700 urban community health service centers, and 11,000 neighborhood health service stations. To improve the quality of rural health services, the government promised to offer trainings to nearly two millions doctors and nurses who worked in the rural health care system.
- (2) Promote equality in basic public health services. The government will provide free annual checkups for the elderly, wellness care for children under age three, prenatal and post-natal care and follow-ups for pregnant women, prevention and treatment consultation for people who have high blood pressure, diabetes, mental illness, and TB. The government will also provide free immunization and treatment for TB and AIDs, assistance to rural pregnant women to have hospital delivery,
- (3) Increase government-provided subsidies to public hospitals and eliminates surcharges on drugs imposed by hospitals. While the number of public hospitals will be reduced, some of the existing public hospitals will be privatized.

The State Council's decision to deepen health care reform has clearly redefined health care as a public utility and should be treated as a public product, managed and provided by the government. This decision represents a departure from the decades-long pursuit of market-driven health care reform, and a refocus on the issue of equity in health care. The goal is to achieve equilibrium between the need for efficiency and cost-control on the one hand, and universal access and quality service on the other.

China's health reform is struggling with different models. In the early days of the republic, socialized health care provided a universal health care system for the public employees in urban areas. During the reform era, the efficiency-oriented guiding principles pushed China toward a market-driven system similar to the United States. The reform since the 1990s has embraced a social insurance model similar to that of Germany and Japan. The recent reform initiative strengthened the role of the government in the new health care system and reestablished the public nature of the health care services. In the foreseeable future, we will continue to see more debates about the pros and cons of the two very different approaches. The health reform in the last decade has laid down a solid foundation for China new health care system. With reform-minded new leaders such as Xi Jinping and Li Keqiang coming into power, we have reasons to believe major steps will be taken to continue to increase public expenditure in health care, to make health care more affordable, to make more equitable distribution of health care resources, and to focus more on the welfare function of health care system.

*This paper is an abridged version of a chapter published in Dr. Guo's book *China's Quest for Political Legitimacy: The Equity-Enhancing Politics* (Lexington Books, 2010).

Notes

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- ⁶. The other two are education and housing.
- ⁷. CCP Central Committee, "Decisions on Market Reform."
- ⁸. It varies among different age groups. Younger workers will get much less from employers' contribution, while older workers will get more.
- ⁹. Although it is currently pooled together by cities and counties, it may go up to a higher level, such as provinces, in the future, according to an official document.
- ¹⁰. Commission on System Reform, State Council, "Decision on the Experiments of Employee Health-care System," Commission on System Reform Document No. 51 (1994); Office of State Council, "Decision on Expanding Employee Health-care Reform Trials," State Council, Document, No. 16 (1996).
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