Health sector reforms in China

Speaker: Ms. Madhurima Nundy

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Institute of Chinese Studies
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The presenter started with the broader notion of health sector reforms across the world. The reforms in the health sector started in the developed countries in the 1970s with the fiscal crisis that was a global phenomenon. This crisis resulted in the restructuring of the State in welfare services globally. The reforms focused on improving efficiency of public systems and included – improving the performance of civil service, decentralisation of power and resources, improving function of national health ministries, broadening health financing mechanisms, introducing managed competition between public and private sectors.

The presentation looked at the health sector reforms undertaken in China with the onset of economic reforms in 1979. It attempted to capture the shifts in the form and content of reforms in the last three decades and discuss its consequences for access and the overall health services system. According to the presenter, there were three phases to the reforms which were discussed in detail. But to put the reform story into context it was important that the pre-reforms story on the structure of health services be told.

The first 16 years of health sector development saw more focus on preventive services that took the form of patriotic health campaigns through mass mobilisations. In spite of these developments and interventions the rural population lacked basic health services. From the very beginning there was a distinct difference in the structure of rural and urban health services. The growth of hospitals was largely an urban phenomenon and the expansion of health services was only marginal during this time.

The socio-political changes during the Cultural Revolution resulted in a greater focus on rural areas and were reflected in the development of health services as well. Institutional growth at the secondary and tertiary level started in the 1960s. Existing public hospitals were strengthened and new ones were built. There was a referral linkage between the rural and urban areas. Around a third of the services were owned by the state and the remaining was collectively owned. A Cooperative Medical Scheme (CMS) was introduced during this time and was integrated with the collectives and a comprehensive structure was created at different levels. CMS was a unique kind of pre-payment plan (a kind of insurance) that was linked to the agricultural cooperatives and everyone was covered under this in rural areas. At the primary level, that is, at the brigade, the barefoot doctor became an important human resource in health and they were paid by the collectives based on the work points they earned.
On the other hand, in urban China, all the workers of public industries and urban collective industries were covered through the Labour Insurance Scheme (LIS). Their dependents were also covered. The

state functionaries received free health services under the Government Health Insurance Scheme (GIS). Both the schemes started in the early 1950s. The remaining residents were covered by poverty-aid programmes. During this period of the socially planned command economy, the state attained universal health coverage through its provisioning and financing systems across rural and urban China. Access to health services was not dependent on the ability to pay.

The three phases of reforms were then discussed. The first phase of reforms was the introduction of market principles in health services in the 1980s and 90s that started with the economic reforms of the late 1970s. It led to an almost immediate dismantling of the CMS in rural areas. The CMS collapsed and the three-tier network of rural health care weakened due to lack of funds from the state. Much of the financing was decentralised and left to the responsibility of the provincial and local governments. Health facilities that were the backbone of the rural health services accumulated deficits. There was emergence of private practitioners, private clinics and private pharmacies at the primary level. By the late 80s, less than 10 per cent of the rural population was covered by the CMS.

In 1989, State Council developed State Owned Enterprise reform by promoting various contracting systems for medical institutions. Public hospitals were allowed to earn profits from specialty medical services. Several of these initiatives introduced market principles in secondary and tertiary public medical institutions to make them financially self-sufficient. The rationale for these reforms was premised on the inability of the government to invest in health care. This was undertaken in order to augment financial revenues by introducing mechanisms like user fees, charging for drugs and diagnostics, contracting in, attracting private capital and opening tertiary care to markets. As a result, hospitals were now autonomous units within the health service system under the jurisdiction of local governments and were responsible for their success and failure. The process of this reform led to the 'autonomisation' of hospitals that was rationalised by the World Bank.

By the end of the 90s access to health services in China was exemplified by the phrase *kan bing nan kan bing gui* (getting medical care is difficult and expensive). High costs were frequently cited as one of the reasons for failing to seek care in the poor counties. There were financial barriers to access in-patient care and non-admission rates were higher in poor counties than in the rich ones. In rich counties it was seen that the hospitalisation levels were higher than the poor counties. In 1993, 58.8 per cent of the sick who needed hospitalisation could not get hospitalised due to economic reasons. This increased to over 65 per cent in 1998. So accessibility and utilisation of services was dependent on region and socio-economic status. By early 2000s, the nation that was a model for the Alma-Ata declaration on Health for All in 1978 was ranked 144 out of 191 countries in terms of fairness in financial contributions to the health sector by the WHO.

This phase was followed by the financial reforms of 2000s. The new leadership that emerged with the 16th National Congress Party in 2002 articulated the need for a 'balanced development'. The SARS debacle was a warning that all was not well with the health services system and there was acknowledgement by Party leaders that excessive focus on GDP was not the answer to overall development and hence a shift was needed towards a balanced development. At the policy level, the White paper on China's Social Security in 2004 and the eleventh five-year plan stated the importance of a comprehensive social security system. The key emphasis of the 17th Party Congress in 2007 was on social security for everyone especially those in the rural areas and the poor who had been left out of the development process. The outcomes of these deliberations resulted in the financial reforms in the 2000s and introduced health insurance schemes to cover all urban and rural population in phases. The financial reforms were undertaken in the last decade with the intent to universalise coverage and access to health services and to bring down out-of-pocket expenditure in health.

The features of all the current insurance systems were then presented. The first insurance scheme to be launched was the NRCMS (New Rural Cooperative Medical Scheme) under the Ministry of Social Security in 2003 as a voluntary insurance scheme for farmers and their dependents in rural areas. The premium is paid by three sources. The coverage of services varies across counties. Some counties provide reimbursements for out-patient, in-patient and some catastrophic cases while some just provide for in-patients and so on.

The basic medical insurance for urban employees, that is the Urban Employee Basic Medical Insurance Scheme (UEBMIS), is under the Ministry of Health and was launched in 1998 as mentioned. Those included are government employees; private non-business units; and employees in informal sector may choose to enrol. The employer contributes six per cent of the salary and the employee contributes two per cent. Enterprises can volunteer to be part of this system and once they participate then it is mandatory to cover all employees. The benefit package of UEBMIS includes both in-patient and out-patient services.

The basic medical insurance for urban residents (URBMIS) was introduced in 2007 and is voluntary scheme for urban students, children and non-employed residents. This is under the Ministry of Health. Contributions are collected based on household size, pooled at city level and subsidised by the government.

Supplementary medical insurance gives space for enterprises to offer supplementary medical insurance over and above the insurance provided. Civil servants and employees of public service units enjoy medical allowance systems and are covered under government medical insurance system.
Medical Assistance (MA) is targeted towards three groups and is under the Ministry of Civil Affairs. These are – *Te Kun* (extremely poor households), *Wu Bao* (households that receive five guarantees –food, health care, shelter, clothing and funeral costs) and *Di Bao* (households eligible for a new safety net programme and receive cash transfers). Revenue comes generally from government and donations from social sectors. Studies have shown that individuals apply for assistance once they have incurred medical expenses. There is a move towards increasing the number of groups receiving MA but a lot still needs to be improved in this scheme as experiences largely vary across provinces and so do coverage of benefits.

Including migrant workers in any of the health insurance coverage seems to have been the most challenging for the government. It has been difficult to cover them in any of the above insurance systems as membership in rural insurance would mean urban migrant workers visiting the rural institutions for treatment and urban insurance premiums are too high for small and medium enterprises where the migrants generally work.

Apart from all the above government initiatives there is a presence of few private insurance players. Private health insurance accounts for less than two per cent of the overall health expenditure and it serves seven per cent of the population. It provides supplementary insurance for hospitalisation and chronic condition and those insured are mainly the upper and middle class in the urban cities.

The presenter then discussed the consequences to the institutional and financial reforms. The trend towards *autonomisation* of institutions created many distortions. There is fragmentation of governance from administration. Health managers have become important because they are vested with powers to garner financial resources. Often this meant that they were wooing investments that would produce high returns. One of the most important policies of the public hospital reforms in China has been the shift from a centralised personnel system of employment to a contractual based one between the physician and the hospital. This is a clear shift from the pre-reforms where hospitals

were public service units where personnel were closely controlled by government. Hospital managers are granted with more autonomy over hiring, firing and promoting physician. They can also offer incentive contracts based on their performance. With deregulation there are many private players in medical care in China. This has resulted in competition with the public sector that has to function in a market environment. Therefore, the supply side has introduced more high technology, medicines and procedures that are available at a price and this has resulted in overmedicalisation, irrational practices and rising costs. As a consequence of the market environment in which the public hospitals behave like any for-profit institution, costs of care have risen and so have inequities in access. The large development gap between urban, rural and coastal inland China also mirror the state of health services system in these regions. Spending on health is higher in regions that are developed. The referral system that was the strength of the health services system in the pre-reform period has completely broken down due to the move towards autonomisation. While pilots on creating a system of referral is on in some provinces it is too early to say whether these would be successful and be replicated to other provinces. But what has actually been most neglected is the primary level of services. This has had consequences for comprehensiveness of services.

In China, while breadth of coverage is almost universal there is much to be achieved in terms of the depth and the height of coverage. Coverage is very shallow and a sustainable financing mechanism is yet to be implemented. In spite of large coverage of population there are several issues that need attention in terms of rising costs of health care, incomplete coverage of services, low reimbursement rates and out-of-pocket expenses that still exist. There are huge gaps between the costs and benefit packages across the three insurance schemes and there is a need to reach greater cross subsidisation across rural and urban and integrate urban and rural insurance systems. Although the central and local governments have increased their funding the costs have escalated over the last decade.

Migrant workers are not completely covered as there are problems that arise due to their status. Their knowledge on insurance benefits is poor and information on benefits is withheld by employers. Many migrants are also illegal and they are undocumented and therefore do not qualify for UEBMI. Health care therefore becomes very costly for an average migrant worker. A 2012 study shows that ratio of out-of-pocket expenditure to total health expenditure and out-of-pocket to disposable personal income has not reduced. This consequence is typical of an insurance system based on market principles and low level of income distribution.

The presenter then went on to discuss new set of reforms that were introduced in 2009. While the CCP clearly spells out the need to focus on building the public health services system at all levels, these reforms also hint at greater private participation and many foreign investors see this is as an opportunity to invest. This has to be seen in the context of a changing demographic profile where the percentage of population above 60 years is increasing and an expanding middle class that has gradually started exiting from public services and the rapid urbanisation. The markets have been responding to this segment of the population.

There are several private players in China and some that are poised to enter. Some of these are foreign hospital groups from Singapore and Hong Kong. Global consulting firms like the BCG, McKinsey, PricewaterhouseCoopers and KPMG have set the roadmap for foreign investors to invest in health care.

The presenter summed up the presentation with drawing some comparisons of the reforms with India. In India the reform process has been gradual and introduction of market principles in terms of user fees, public-private partnerships but not as radical as China. In China, public hospitals function as

private entities even though ownership is public which was not the case in India. A notional referral system still exists in India that has completely broken down in China.

The resistance to radical reforms have slowed the pace in India and has not allowed public systems to behave like private entities. The voices of activists, academics, media, role of regional governments have been significant in curbing the fast pace of reforms. In China there is no organised movement voicing the concerns of the health sector but there is evidence of local resistances.

The discussion centred around questions related to access of health services to migrants, how China is coping up with non-communicable diseases, and whether there were health indicators to show that how much has been achieved from past to the present. There were several comments on how there is a move towards traditional medicine which would be an entire new area in itself; and the importance of looking at leadership and how health policies get formulated.