Health care Reform in Urban China

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If you just go through the figures – life expectancy, infant mortality, [and the] first three causes of death – without knowing which country it is, it would be very difficult to pick the country as China and almost impossible to pick it as a developing country. The top causes of mortality in the cities are the same as in developed countries: cardiovascular disease, cerebrovascular disease and cancer.

--- Dr. B. P. Kean, World Health Organization representative¹

There is no question that in a time when people are despondent about what’s happening in China, the health-care system really is a shining light from the Maoist era that continues to shine to this day. It’s a model for the developing world.

---- Gail E. Henderson
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I. Introduction

China has developed perhaps the largest national health care institutions’ network and the largest health care workforce in the world. Its achievement in health care has become an example to economically less advanced nations in the world.

The health care network in China is composed of: the well established Government Insurance Scheme (GIS, gongfei yiliao), the Labor Insurance Scheme (LIS, laobao), urban collective medical care schemes (chengshi hezuo yiliao), and rural collective medical care schemes (nongcun hezuo yiliao) plus widespread “barefoot doctors” (chijiao yisheng). These arrangements ensured Mao’s “prevention first” health policy. The Chinese peoples' health has been improving since 1949. It is a common acknowledgement that health issues have been priorities of the Chinese Government, especially during Mao’s era (Sidel and Sidel, 1977; Lee, 1982, New, 1986).

However, since the early 1980s, the Chinese health care system has encountered great challenges. Some came from economic reform, since the health care insurance system is intertwined with economic sectors. Other challenges resulted from the decentralization and privatization of the health system. The main challenge, though, was an increasing inequality in health care.

¹ New York Times, 14 April 1991 P. 8
² New York Times, 14 April 1991 P.1 and P. 8
Privatization and decentralization in China since the early 1980s have caused unequal access to the health care system. It is now a main factor shaking China’s social equity, which is the foundation of social stability in the socialist system. Therefore, there is an urgent need for both the Chinese government and Chinese people to find a better health care system that can provide everyone in society equal access, easy access, and better service.

This paper is intended to 1) present an overview of the Chinese urban health care system and its reforms in the past two decades; 2) discuss the pros and cons of the Chinese employment based health care insurance system, and 3) analyze the cost sharing health care insurance schemes, which has been introduced to the urban Chinese recently, and its impact to different social groups in urban areas, Shanghai in particular.

II. China’s urban health care system in Mao’s era

The health protection system for China's urban workers was established in the early 1950s. With a set of systematically planned and strongly enforced organizational principles, the Chinese government was able to use all its possible resources, effectively to provide health care in the context of prevailing political, social-cultural and economic conditions. It ensured maximum participation of the Chinese people in the delivery, and easy access to the health services. (Sidel and Sidel, 1977; Lee, 1982; New, 1986).

The health status of the Chinese people rose dramatically during Mao’s era. An ideology of equity for all citizens, and the near universal availability of adequate food, education, housing, jobs, and accessible and affordable health care services contributed to this achievement (Yang, et al, 1991). The health improvements in China resulted an interesting comparison reported by the New York Times (1991): “In Shanghai, 10.9 infants out of 1,000 die before their first birthday, while in New York City infant mortality is 13.3 per 1,000 live births. And life expectancy at birth in Shanghai is now 75.5 years, compared to a life expectancy in New York City of about 73 years for whites and 70 years for nonwhites as of 1980, the last year for which data are available.”

The Chinese health care system included a health insurance system and health delivery system.

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3 New York Times, 14 April 1991 P. 1
i. Health Insurance System

The establishment of primary health care networks in the community level was an early priority of Mao’s government. The government decided to have its health system integrated within the workings of its industrial and agricultural systems – instead of a national health insurance or national health system (Blendon, 1979). The system implemented was effective, given the fact that almost everyone in China belonged to specific work-unit (danwei).

The two primary components of health insurance in China are the Government Insurance Scheme (GIS), which covered government employees, retirees, disabled veterans, and university teachers, staff and students; and the Labor Insurance Scheme (LIS), which covered state enterprise employees, retirees and their dependents (i.e., immediate family members who were not covered by the GIS or LIS). Both of the health insurance schemes were financed by government budgets.

Only state enterprises (enterprises owned and managed by central or provincial governments) with more than 100 employees were required to participate in the LIS; smaller state enterprises and industries owned by district or street (county or town) governments could provide the LIS on a voluntary basis. Yearly, each enterprise would set aside a certain percentage of total wages as a welfare fund to finance health expenditures incurred by that work-unit's LIS beneficiaries. In the years from 1950 to 1980, the GIS and LIS played an important role in providing China's urban population with health protection, thereby contributing to economic development and social stability.

The GIS and LIS provided comprehensive health care benefits. Beneficiaries received free outpatient and inpatient services. Dependents of the LIS beneficiaries were reimbursed 50% for their health and prescription drug expenditures, and there was no financial limitation set for what services they could utilize. Beneficiaries had every right to seek health care from the highest quality service available regardless of expense.

Health insurance coverage for employees in small collectively owned enterprises was similar to those of peasants. Each collective unit ran its own insurance programs. Their employees were usually covered but not necessarily their dependents. Often the employees had to pay for their medical expenses first and to obtain reimbursement later (Henderson and Cohen, 1984:94; New, 1986).

4 Both used to cover 100% of treatment and prescription drug expenses. They are often called “Free Medical Care”.

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ii. Health care Delivery System

Four main principles shaped China’s health care delivery: 1) medicine must serve the people; 2) priority should be given to prevention; 3) health education must be built on mass campaigns; and 4) The Chinese traditional medicine and the Western medicine should be integrated. (Rosenthal, 1987).

Under these four principles, China developed a three-tiered organization for the delivery of health care. In urban areas they are the street (sub-district), district and municipal level hospitals, and in rural areas they consist of village stations, township health centers, and county hospitals. With the creation of the “barefoot doctor” in 1965, Mao Zedong attempted to accelerate this process of synthesis while establishing a powerful model of egalitarian health care delivery system (Rosenthal, 1987).

The three-tier hospitals have similar functions but were different in scale and “target” groups. In Shanghai’s case, the municipal level hospitals were treating the employees of state-owned enterprises, institutions, municipal level government bodies, retirees, disabled veterans, and university teachers, staff and students. The district hospitals were treating employees of large and medium-sized collective owned enterprises, the district and street level government bodies, institutions under the supervision of district government, retirees, and middle and primary school teachers and staff. The street level hospitals were treating employees of small collective owned enterprises, service stations, etc. In addition, most large work units had their own hospitals, and medium and small firms/institutions had their own clinics or health care stations.

Each work-unit issued an insurance card to its employees. The insurance card was usually good at one hospital for free service and free prescription drugs. All hospital emergency rooms were open to everyone on a fee-for-service basis. In addition to three tiered hospitals, there were also neighbourhood health stations under each neighbourhood committee where trained health workers were responsible for the community’s health environment, health propaganda, in-station service and home care5, etc.

5 If the patient is entitled with GIS or LIS, the payment could be 100% reimbursed at his/her work-unit. Most of the stations are no longer exist after reform.
This *three-tiered system* was designed to promote the efficient allocation of health care resources between primary and tertiary care facilities. This system provided a framework for efficient patient referral for care in the most appropriate setting for several decades. Changes since the economic reform of the 1980s, however, have brought new challenges to this system.

**III. Reforms in China’s Health Care System**

Since the early 1980s, China has been reforming its economic and administrative systems. This has changed China’s socioeconomic scenario dramatically, and heavily affected China’s health system. Private initiatives and market forces have largely supplanted government planning, and the sources of health financing changed a great deal between 1978 and 1993. The Government’s share of total national expenditure on health (exclusive of GIS spending) fell from 28 percent to 14 percent and the allocation by rural cooperative medical schemes fell from 20 percent to 2 percent (Bloom and Gu, 1997). At the same time, several aspects of the original GIS and LIS schemes contributed to China's recent, rapid health care cost inflation and inefficient resource allocation.

Development and reform of the health care delivery system is intimately associated with that of the health protection system. But the tardiness of developing a comprehensive health protection system has led to a whole series of difficulties in the health care delivery markets. The tardiness contributed to inefficiency and an excessively rapid increase in health expenditures.

**i. Health care system reform policy**

In the 1980s, the Chinese government espoused health care principles that have been implemented in the past three decades. The seven principles for Health development are (MHO, 1986)⁶:

- To consolidate and improve both urban and rural primary health care services.
- To put into effect the principle of “prevention first” and reinforce disease prevention and control.
- To develop and promote traditional Chinese medicine and integrate it with Western medicine.
- To set up and develop maternal and child health institutions and enhance family planning technical guidance.
- To advance medical education and accelerate personnel training.

⁶ World Health Organization: Country Information Profile on China, Manila, 1986
To intensify and facilitate bio-medical research.
To improve health management by training management personnel and upgrading managerial skills.

In order to tackle the new challenges, the Ministry of Health developed a set of health reform measures for national implementation, which were approved by the Chinese State Council in 1985. The key objectives of these measures were:
To decentralize management responsibilities and regional development.
To expand existing facilities while introducing a range of financial incentives to medical staff for improving productivity.
To encourage the development of private practitioners and family patient beds (i.e. beds in domestic settings where patients are treated by health professionals).
To have city hospitals supporting rural and smaller hospitals through staff exchanges.
To form a health legislation system.
To reform the existing health insurance system.

The 1985 reform also included three major changes to the nation’s health care system: First, the government limited public funds available for health care, covering only basic personnel wages and new capital investments, which were about 25-30% of hospital expenditures, thereby allowing the private market to play a role in the health sector\(^7\) (Hsiao, 1995). Second, the government gave hospitals and health centers a large degree of financial independence. Bonus payments had to be funded from the hospital's earned profits. Since the government usually set drug prices at a level lower than its cost, hospitals could use the sale of drugs to generate profits\(^8\) (Bloom and Gu, 1997; Hsiao, 1995). Third, the government allowed private ownership of health facilities and private clinical practices. Private investment in new hospitals was promoted by allowing the private facilities to charge much higher fees than allowed for public hospitals (Hsiao, 1995).

In urban areas, the GIS and LIS had been effective in ensuring equal access to health services, but the two schemes had weaknesses that were common in government-owned insurance programs. The main weakness was inefficiency in health resource allocation and in health care provision. Another major problem was lacking of risk pooling across enterprises or across local governments,

\(^7\) There was no private health service allowed before reform.
\(^8\) In China, hospitals all have build-in pharmacies to deliver prescription drugs.
since each organization under the original GLS and LIS systems were self-insured (Grogan, 1995; Liu and Wang, 1991; Hsiao, 1995; Ho, 1995). Therefore, if an enterprise was running a deficit, it may not be able to reimburse its employee beneficiaries for their medical expenditures. On the other hand, fulfilling the GIS and LIS commitments to enrollees often imposes a heavy burden on enterprises, and hampers their ability to seriously compete in the market.

The Chinese policymakers realized that unless these problems were properly addressed, excessive health care cost escalation would continue to outstrip China's ability to pay, jeopardizing the improvement of urban residents' health status and social stability. As a result, beginning in the 1980s, China implemented a series of reforms in the urban employee health insurance system. These reforms have gone through two major stages: the first was from the early 1980s to 1991 and the second began in 1992.


During the first stage of health system reform (1980-1991), the primary objective was cost containment. Major reform measures included introduction of cost sharing both on the demand-side and supply-side. Before 1985, reforms mostly targeted the demand side (like the introduction of co-payments to make consumers more cost-consciousness when accessing medical services). From 1985 to 1991, the focus turned to the control of providers, especially economic incentives to hospitals.

The experiments with supply-side cost sharing reforms included pre-payment to hospitals according to the number of beneficiaries in their areas, and specifying a fixed fee for services. Since hospitals are allowed to retain their residual revenues when the costs of health care were less than the specified amount, the payment reform encouraged hospitals to increase their efficiency. Such pre-payments also shifted the financial risk to the provider's side by making the hospitals bear the financial burden if there is any shortage between the prepaid amount and the actual costs of the health care they provided.

Another supply-side reform measure was to define a limited list of pharmaceuticals for which GIS beneficiaries would be reimbursed. In addition to these experiments with demand-and supply-side cost sharing, efforts were made to improve the management of the GIS and LIS. Some areas also established district or industry level risk pooling funds for catastrophic medical expenditures, which strengthened the ability of individual enterprises to bear the risks associated with health care for their
beneficiaries.

These measures played a role in mitigating China's rapid health care cost escalation and relieved some of the financial pressures on enterprises. They also eliminated the inequity of health care expenses between enterprises or government work-units.

However, many problems were left unsolved. As a limited sectoral reform, these measures still lack support from other socioeconomic policies, especially in the health sector price sphere.

Prices in the health care system were designed to allow average or poor Chinese to access basic health care, and forced the providers to deliver basic services for prices below actual cost. When the government withdrew support to health providers, as a survival strategy, the providers increased revenues through drug charges and the usage of high technology for various tests/treatments, which are the two areas where fees were allowed to exceed the marginal costs. This pricing structure contributed to the rapidly increasing prevalence of high-tech medical equipment, and over relying on drug prescriptions for hospital revenues. The early stage of health sector reform neither tackled this issue nor other fundamental weakness that existed in financing, payment and management within the GIS and LIS.

iii. Reform on Health Insurance System (1992 –)

The Shanghai Insurance Company, a for-profit institution, started China’s first Medical Insurance in 1982. It covered workers in rural collective industries in the suburbs of Shanghai. The annual premium was 3.6 Yuan and the benefit was 70% reimbursement of medical expenses (Peng and Gao, 1988; Liu and Wang, 1991). Other medical insurance schemes followed such as: Children Immunization Insurance (CII), Mother-Infant Medical Insurance (MIMI) and Medical Operation Insurance (MOI). It was estimated that over 50% of children aged 0-7 in China are covered by CII (Liu and Wang, 1991).

Since 1992, the focus of health sector reform has shifted to more fundamental problems, like increasing the level of "socialization" or risk pooling with the original goal of cost containment. This major shift took place alongside some other significant reforms in the social protection system. A new social safety net was seen as the key to the further success of economic reforms, the state-owned enterprise reforms in particular. Prior to 1992, the State Council implemented health protection system reforms in four medium-sized cities, but the implementation was rather slow. At the same
time the problem of inefficiency and inequity became inevitable. In 1992, Shenzhen in Guangdong Province became the first city to implement citywide health insurance reforms that eventually paved the way for a new phase of pilot city reforms.

In early 1994, Jiujiang in Jiangxi Province and Zhenjiang in Jiangsu Province were selected as pilot reform cites and began to draft health care reform blueprints. Since January 1, 1995, Jiujiang and Zhenjiang formally began their reforms using a combination of individual savings accounts and social risk-pooling funds to finance medical expenditures. These reforms tackled the issue of inadequate risk-pooling by shifting the enterprise based insurance into citywide risk-pooling for catastrophic medical expenses. Before an individual can access the social risk-pooling fund, however, one must first pay "deductibles" from a first tier of individual medical savings accounts and a second tier of direct deductible (equal to 5% of one’s annual income). The individual savings accounts and the deduction of 5% of annual income were aimed at raising individual cost consciousness when accessing health care. The social risk-pooling component of the new system draws on the strengths of social insurance to spread the risk of catastrophic medical expenses. This model combines individual responsibility with social protection through citywide risk pooling for both the GIS and LIS beneficiaries.

These reforms have had some successes in slowing down health care cost escalation and in expanding coverage to those who were previously uninsured or underinsured. Employees who were nominally insured under the LIS or GIS but whose work-units were unable to reimburse their medical expenditures due to financial constraints, now have equal access to medical savings accounts and the social risk-pooling fund. Public school teachers and employees of deficit-running enterprises particularly benefited from the reforms.

iv. Reform of the employee health protection system (1996 -)

In early 1996, the State Commission for Economic Restructuring, the Ministry of Finance, the Ministry of Labor, and the Ministry of Health jointly drafted a document entitled "Opinions on Expanding the Number of Pilot Cities for Reform of the Employee Health Protection System". This document was approved and issued by the State Council. The policy decision was to expand and adapt the reforms to over 50 other cities in 27 provinces and administrative regions. The expansion cities started in the initial phases of implementing their own reform plans and to build directly upon the individual savings account social risk pooling fund model.
Although the document called for the 50 other cities to follow the model of Jiujiang Zhenjiang, it also encouraged the exploration of other possible methods to solve problems in their own context, such as finding appropriate payment mechanisms, coordinating health finance reforms with health provision reforms, and expanding insurance coverage to the uninsured.

v. Emerging health care insurance system

Some local governments in the special economic zones had discussed mandating joint ventures and private companies to provide health benefits to their employees. Shanghai implemented a pilot program requiring collectives to allocate 3% of total wages to health benefits for catastrophic and emergency care. Although it is lower than the requirement to state owned enterprise, which is 5.5% (Grogan, 1995), it is of some help to these employees.

There were two kinds of “self-management” or “relegated management” of health care funds that have evolved at the work-unit level or at the hospital level. A combination of both was also conceivable. It decentralized the management/decision making level from health administration branches of the government to consumers (workers) or providers (hospitals).

A successful “self-management” plan was one where the work-unit had an in-house clinic, (which was not new to most units) thereby, allowing the medical staff of the unit to be fully aware of the unit’s financial situation when they prescribe treatment for their patients. A “relegated management” plan would have a hospital in charge of the medical funds for a work-unit and work under a contract whereby the hospital holds responsibility for a part of any deficit that occurs (e.g. the Shanghai Collective Management Bureau implemented a “relegated management” system in 1990. The 32 enterprises under the bureau provided a defined amount of medical care funds to Beizhan Hospital, while the Hospital was to be fully responsible for their employees’ health care). The Luwan District in Shanghai started delegating hospitals to manage the GIS funds in 1988 and its per capita GIS expenditures dropped from over 30% in 1987 to 9.88% in 1990 (Huang, 1988; Ho, 1995).

IV. Shortcomings of the employment based health care insurance schemes (GIS and LIS)

The shortcomings GIS and LIS were largely caused by the urban economic reform, which almost fundamentally changed urban China’s social economic landscape.
i. Uninsured population

It was estimated that 37% of 1.25 billion Chinese are now living in China’s 641 cities. The occupation based health care insurance system excluded a large percentage of these urban populations.

In 1993, the GIS and LIS respectively covered approximately 9% and 40% of the urban, or 2.5% and 11.7% of the total population (National Health Survey 1993, Ministry of Health, China; Song, 1991; Hsiao, 1995). However, more than half of China’s urban residents are not covered by any health insurance.

1) The Employment related uninsured population:

In China, a person’s employment determines whether he/she will receive access to health care coverage and the extent of health care benefits. Membership in a public work-unit not only gave an individual membership but access to different resources and rewards. In many instances, families also belonged to work-units (Albrecht and Tang, 1990). Most work-units were responsible for providing many aspects of employee benefits, included accommodation, food, health care, childcare and retirement support. They also provided leisure activities like sight-seeing travels, sports and social recreation activities. Most work-units have their own clinic or health staff to promote the unit’s health, including health education. (Gan et al, 1995, Dong, 1996; Grogan, 1995).

However, the urban unemployed⁹, self-employed and those working in informal sectors are largely left out of the health care insurance system. At the same time, non-profit and loss-making firms’ employees are also facing the same problem. By the year 1990, most enterprises found they had to use their profit to fund the shortfall in their health insurance premium. When some enterprises earned no profit, the reimbursement of their employees’ health expenses became problematic, since there is no third party insurer to insure employees. (Hsiao, 1995)

2) Un-entitled Rural-urban migrants

There are a large number of rural migrants living in China’s cities now. The country’s urban population doubled from 1978 to 1988. Since the economic reforms, the government has relaxed its

⁹ According to a UN report in November 1999, 16 million are unemployed in China.
migration control policy, allowing rural residents to work in urban areas. Some estimates suggest that this mobile population has reached 70 million. “Temporary migrants” may register their presence in the community, but they are not entitled to state benefits that permanent residents enjoy, like health care. (Chen, 1991; Tang and Jenkins, 1990; Yang and Goldstein, 1990; Goldstein et al, 1991; Grogan, 1995; Dong, 1996; Hsiao, 1995, Grogan, 1995) Zhang Huizhong, director of pediatrics at A Shanghai Ninth People’s Hospital official said in an interview that “Our biggest headache is the migrants…even if they’re sick they don’t come to see a doctor” (Weil, 1996).

ii. Health care expenses escalation

The excessively rapid increase in medical expenditures under the GIS and LIS was partly a result of the lack of demand-side cost-consciousness. At the same time, public hospitals have a tendency to over-provide services for their own gain, which also contributes to cost escalation. Except for employees in large enterprises who received their health care from their work-unit hospitals and/or clinics, both GIS and LIS beneficiaries were seeking medical services from public hospitals. Old industrial work-units had been unable to finance the health care costs of their employees, dependents of their employees and retirees (Hsiao, 1995).

In China’s biggest city, Shanghai, the health expenditure under state insurance for the last few years was about 25 percent higher than the average annual level before the reform (Li, 1989). The Shanghai Price Bureau examined 4,000 items of hospital charges. Only 2,080 of them were confirmed as valid and 27 items were considered illegal. Of the 256 newly established health service institutions, only 107 were viewed as technically qualified (Fei, 1988).

A World Bank (1989) study of China’s health sector demonstrated that the greatest increase in spending during the 1980s was for hospital-based care. Increased demand for such expensive health care may either create new or augment existing inequities in access to services (Henderson et al, 1994).

A survey done by the Ministry of Health shows that drug prices increased at an annual rate of 14.9 % from 1979 to 1989; the annual increase in herbal drugs was 9.5% from 1978 to 1989. Prices for office visits, surgical operations and hospital daily rates were set much below actual costs, while prices for drugs and new high-tech and therapeutic treatments were set higher than cost, which was to allow for a profit margin (Hsiao, 1995). At the same time, health care reform has resulted in substantial increases in the private sector’s share of total health spending (Janovsky, K. 1996:27).
The GIS and LIS costs have increased dramatically since the economic reform. The reasons for the increases other than what had been stated above are:
The number of beneficiaries has increased.
People are living longer, leading to an increase in chronic disease.
Input prices and health service prices are increasing.

In an effort of contain these costs, the co-payment policy was introduced in the early 1980s\(^\text{10}\) and implemented in most cities after the mid 1980s. However, the health care costs continued to escalate especially after 1985 (Liu and Hsiao, 1995).

There is a close linkage among financing, price and organization of health care. Uncoordinated policies could exacerbate inequity and inefficiency in health care. Economic incentives greatly influenced the behaviour of hospitals and physicians regarding what drugs and medical modalities are used. Prices have to be rationalized and modern management of hospitals and health centers have to be instituted to produce better quality health services and improve efficiency (Hsiao, 1995).

Some believe that when the cost of medical care escalates, the need for risk-pooling and a larger degree of health care socialization will be greater (Ho, 1995). It is very true. And health care has become everyone’s concern now.

\textit{iii. Inequity in Health care access}

China achieved a very wide distribution of clinics and other services at the local level, but there is a trend of declining accessibility and unequal access to health care since reform. Those with the lowest education, income, and occupational prestige became significantly less likely to have coverage (Henderson \textit{et al}, 1994, Hsiao, 1995).

The economic incentives in China have led to: a) increasing inequities in health care; b) the emergence of “fee for service”, and a change from “serve for people” to “serve for profit”; and c) an even larger social inequality gap. There is a danger of going back to the old days when health care

\(^{10}\) It means patient has to pay a certain percentage of prescription drug cost, according to different health insurance schemes to which one is entitled. 10\% is a common practice for GIS patients.
was only for a privileged few and many were neglected (New, 1986). Indeed, since the reform, a firm’s financial success and profitability directly affected its employees’ health care welfare. This factor also led to an unequal access to types of health benefits among firms and between geographic areas under both the GIS and LIS (Grogan, 1995). The problem is lacking of a legal safeguards for health protection.

At the same time, there is growing documentation of a hidden, backdoor approach to goods and services in China. Social connections and norms of reciprocity influence the type and amount of care one receives (Albrecht and Tang, 1990). Those who have money or power could go through a “back door” to access first-class wards or scarce drugs, and they have the privilege of undergoing expensive examinations and treatments. Qiu believed that, “The founder of the public medical care system would find it surprising that the system has led to inequitable micro-allocation in health service” (1989).

iv. Weak infrastructure vs. increasing demand

Weak infrastructures for preventive and primary health care in China are evident. Moreover, there is an increasing burden of chronic diseases. In China, about 23.7% of urban residents have one or more types of chronic disease, and 105 per thousand persons fall ill in every two weeks (Huang, 1994:212). Meanwhile, the aging population in China’s urban areas is increasing rapidly. There are over 130 million people aged 65 and over in China. These aged people are most likely to have chronic diseases and have the highest need for easy access to health care. It is especially crucial after 20 years of the implementation of the “one child policy,” which has resulted in the smaller family size and many elderly people are living alone. When families are no longer able to carry the burden of elderly care, it is society’s turn to take the responsibility.

However, there are not even enough beds in hospitals. “Family patient-beds” is an alternative way to solve the problem (Qian, 1992), but the distances between patients’ homes and hospitals bring great inconvenience and difficulties to doctors’ patient-visits, which making lack of efficiency another major concern.

During the entire process of economic reform, China's central government has encouraged local experimentation and development of successful models that could later be adopted on a nationwide scale. In the health sector, as mentioned before, pilot cities have been the focus of urban health reforms since 1992.
V. Recent reform in the Chinese health care system

The most recent health care system reform in China started with the issuing of the Decision on Health Care Reform and Development by the Chinese Central Committee and the State Council in 1997. Through August 2000, the State Council issued a set of documents to elaborate detailed policies on urban health care reform. The main goals of the recent health care system changes in China are: 1) To establish a cost-sharing system, in order to control the growth of health care expenditure and ensure urban workers' basic health care; 2) To promote competition in the health care sectors, allowing patients to choose hospitals and doctors, and to improve service quality and efficiency; and 3) To break a regional and industrial monopoly in pharmacy research, production, selling and consumption, and promote better management in order to assure drug quality and to reduce costs (Hu, 2000).

The major change in recent reform is the changing of the health care financing. The newly issued Urban Employees' Basic Health Care Insurance Schemes clearly states that the government and the firms are no longer responsible for most of the health care costs as before. Since the implementation of this new cost-sharing medical insurance scheme in 2001, most people in the Chinese cities have to pay their share of health care expenses. At the same time, hospitals are no longer non-profit institutions. The market has started to play its role.

VI. Pros and cons of the recent health policy changes: a Shanghai experience

The most recent health policy changes have both positive and negative impacts on urban health care. The positive changes include the establishment of a basic social security system, which set a bridge for eventually independent the medical insurance from place of employment. The most negative changes include reduced health care coverage and social exclusion.

i. Main strength of the new health policy

The major achievement of this recent change in health care is separated medical insurance from one's place of employment, which helped employees and retirees of those not profitable firms to get medical care coverage without any delay. It is particularly beneficial to those retirees. In Shanghai's case, there are over 1.8 million retirees (Hu, 2000). Although almost all of them enjoyed medical insurance before, either with the GIS or LIS, some of them faced difficulty in reimbursement of their
medical care expenses from their previous employers. The newly issued "social insurance card" (at present, it is only used as a medical insurance card for the purpose of health care access) relieves them from the concern of their previous employer’s ability to pay their medical fees claims.

At the same time, the ongoing health resource restructuring benefits the whole society. More rationalized health resource allocation brings efficiency to medical services. It is especially good that almost all those enterprises-based health resources are now encouraged to open to the public, which resulting in the improvement of neighborhood residents' access. Meanwhile, patients are given more freedom to choose hospitals and doctors. It promotes competition amongst medical care providers, thus, quality of service is improving in almost all health institutions.

**ii. Main limitations of the new health policy**

The main limitations of the new health care policy are: 1). It didn't reduce inequality in health care access among urban residents; 2). It left social-economical vulnerable groups out of medical coverage; and 3). It brought the financial burden to most urban Chinese in health care, since most people have to pay their share of medical costs and the burden is not evenly distributed.

In Shanghai, the new medical insurance schemes only apply to urban employees. In fact, they only apply to those who are employed in or retired from the public sectors. As Bloom points out, formal employment has been a means for identifying those liable to pay health insurance and claim entitlements (Bloom, 2001). It left out the non-public sector employees and the urban unemployed from same health care coverage. Rural migrant workers are also not covered, since they don't have Shanghai permanent residence status, and more likely to be hired in informal sectors.

So far, the financing reform in Shanghai’s health care system has been mainly targeting at limit demand side’s expenditures. With effective cost-sharing, this new scheme forcefully reduced "unnecessary care". Under-privileged groups in urban China tend to share a higher burden of disease.

1). Exclusion in medical coverage

a. Urban unemployed and employees in informal economy:

There are around fifteen million unemployed in China. Those unemployed as well as people who are working in informal economy are asked to pay health care insurance and unemployment
insurance fees each month. By doing so, they would be entitled to certain medical insurance and share 30% of total medical costs they incur\(^{11}\) Being unemployed or working in informal sectors, these people's incomes are limited. It is clearly a burden for them to pay health care insurance fees each month. Many of them simply do not have any spare money to pay the fees. Thus, they have no health insurance.

There are over 10 thousand informal working units, with more than 130 thousand employees in Shanghai. The growing number of unemployed pushes people into the informal labor market to get jobs. Since there are no proper statistics, the actual numbers that work in the informal economy could be much higher (Ren, forthcoming). Those people are not well protected by any government policy.

b. rural migrants:

There are over 100 million people, mostly peasants, who have moved into large urban centres in recent years (Wang et al, 2001). These “temporary migrants” may register their presence in the community, but they are not entitled to the state benefits that permanent residents enjoy, like health care. (Chen, 1991; Tang and Jenkins, 1990; Yang and Goldstein, 1990; Goldstein et al, 1991; Grogan, 1995; Hsiao, 1995). Just like the situation of international immigrants, these migrants are experiencing all of the disadvantages in their new settlement. They usually became manual laborers in informal sectors with no job security and without any work-related benefit, (i.e. sick leave, unemployment insurance and health insurance). A study on female migrants in Shanghai shows that some women chose to deliver their babies outside of hospitals to save money (Wang et al., 2001).

China joined the WTO recently. A great number of rural surplus laborers are expected to move to the cities, especially when large amount of agricultural products enters the Chinese market from the US. According to a recent study, about 10 million agricultural workers would have to be transferred into urban sectors before 2010\(^{12}\).

c. Urban poor

There were 175 thousand people in Shanghai living under the poverty level and receiving social financial assistance in September 2000. According to a recent survey of 1400 poor households, the reasons for living in poverty were 1) unemployment, 60.3%; 2) disease, 52.9 (a typical sick and poor


\(^{12}\) Liaoning Daily November 1, 2001.
interplay). Since those who are unemployed have to pay their own health care expenses, it makes their daily life more difficult. The survey shows there are only 2.3% of those households covered by health insurance. The people that live in poverty and have no Shanghai permanent resident status would not entitle to any financial assistance or health care coverage (Liang et al, forthcoming). What they could do is to ask their relatives' help (83.5%). Some of them simply do not seek medical care when ill due to low affordability.

Since the government’s policy determined to assist those who are extremely poor, the government would share 25% of their total medical expenses, while the patients themselves pay 75% out of pocket. Obviously, it doesn't help the poor people much, since they can not afford to pay the cost anyway (Liang et al, forthcoming). Among those with perceived illness, "financial problems" are an important reason for not seeking care when needed. Many households fall into poverty through out-of-pocket payments and the tendency for this is greater among those who don't have medical insurance. It shows clearly that the burden of illness is not equally distributed amongst different groups of people in Shanghai.

These financial problems are partly caused by health financing strategies that require patients to make financial contributions, as well as by the lack of adequate insurance available to the population.

2). Limitation in coverage

Shanghai, as China's industrial and commercial center, has the best health resources when compared with most of other regions in the country. Its number of medical professionals, available beds, and other health related indexes reached the level of other urban centers in the developed world (Ding, 2000). At present, the Shanghai municipal government committed 19% of total employee wages to finance health care. However, the health outcome is not great.

The new medical insurance programme covers about 6.6 million employees and retirees in the city. Under the new system, the medical insurance funds are made up from payments by employers of an amount equal to 10 percent of total employees' annual salaries, and 2 percent of each employee’s annual salaries paid by them through payroll deduction (Hu, 2000).

There are two accounts of "Medical cost-sharing" in Shanghai:
1. Unified Planning Account: paying the insured's health care expenses on inpatient (including Emergency Room stay) and outpatient severe illness. The payment range is between 1400 Yuan
to 56,000 Yuan.

2. Medical Savings Account: imbedded in the individual Medical Insurance Card, usable values differ according to an individuals' age (old, mid-aged and young), and employment status (employed or retired). Overall, older and retired people receive the highest percentage of coverage.

Under the new medical insurance scheme, a typical middle aged person (employed in a public sector) has over 300 Yuan a year for health care deposited in his/her "insurance card". Once s/he has used this money, s/he has to pay 1400 Yuan on his/her own for further medical care. When the expenditure exceeds the amount, s/he would pay a 30% share of the health service costs.

The new health policy has burdened too many people with medical costs. Even commercial insurance companies are not willing to share the risk. As Ms. Liu of the American International Assurance Co., Ltd. (Shanghai Branch) said, "So far, our company's health insurance programs have not been all open here in Shanghai. Our concern is that we may not be able to pay the claims. This is because the new health insurance almost equals to no insurance. Therefore, the pressure will be on our commercial insurance." And Pingan Insurance Company's Director Mr. Zhou’s words echoes Ms. Liu’s: "the new health care insurance for many is just like having no medical benefit at all. They are not covered much by the public fund and mostly they have to rely on their own ability to pay. If our company to insure those people, we would not be able to run profitably”.

When people's medical benefit is not available, their financial burden of chronic diseases increases. In China, about 23.7% of urban residents have one or more than one type of chronic disease, and 105 per thousand persons fall ill every two weeks (Huang, 1994:212). Meanwhile, the aging population in China’s urban areas is increasing rapidly. In Shanghai, 2.3 million or 18% of the total Shanghai population are now aged 60 and over. Amongst them, 80% have chronic disease (Wei, 1999).

3). Increased medical expenditure with reduced service

The health reform was aimed at reducing health care expenditure by reducing unnecessary care but in fact it may well have reduced necessary care. Meanwhile, the medical care cost continues to go up.

For example, from March 1, 2001 to the end of August 2001, the first 6 months of the
implementation of the new health insurance policy in Shanghai, the hospital outpatient rate reduced sharply, but the expenditure increased\textsuperscript{13}. The reduction of "unnecessary care" is almost certain. However, the incensement in health expenditure implies that the hospitals are very likely to impose high cost drugs and hi-tech tests on their patients. Today, only high-ranking officials and the revolutionary veterans enjoy the full medical care coverage. Retirees are much less reluctant to use medical service since they only need to pay a minor cost. Knowing the medical insurance policy, hospitals would have more to offer to those revolutionary veterans and high ranking officials (i.e. longer stays in the hospitals and various tests), regardless of necessity.

This shows that this new system's theoretical framework is effective only in limiting demand side's consumption and does not have any incentive/measure to limit supply side's spending behaviour. Therefore, patients are in a disadvantaged position.

V. Conclusion:

China used to be a country with a relatively good health care system, but the economic reform unfolded its weakness and the system needs to be reshaped within the new socio-economic circumstances. The series of health care system reform in China have achieved certain goals, but there are much more need to be done. For example, the Chinese government should not only support work-related health insurance but also to protect the interests of uninsured population (Bloom, 2001).

At present, the main challenges to the Chinese health care system are that there are a huge number of urban residents who belong to the most vulnerable groups of urban societies in China, who have no or not sufficient medical coverage. These people include urban unemployed, informal sector employees and rural – urban migrants, etc. Most of them are experiencing difficulties in accessing health care.

The most recent health care reform in China implemented a cost sharing health insurance system to its urban residents. It is rather an innovative change considering many Chinese had never paid anything for their health care before. Policy makers seemed to believe that introducing a market operation system to health care sector would promote efficiency and reduce expenditure. However, market does not have much sense of people’s welfare. Therefore, as a social good redistributive

\textsuperscript{13} M. Xie (September 2001): 30\% in outpatient reduction; 10\% increase in health expenditure.
policy, health care insurance schemes need to be very sensitive to urban poor and other vulnerable social groups’ needs. Health care certainly should not be seen as just another business, and the Chinese people's health and well being are just too important to leave to the market alone.

Shanghai’s experience indicates that a simple designed cost sharing health care insurance scheme has negative impacts on equity and access, because health status and health needs would tend to vary inversely with income. Cost sharing limits access, especially to those who are most subject to the consequences of ill health and those in low-income groups. If the current Chinese Urban Employees’ Basic Health Care Insurance Schemes is to continue, the measurements that ensure maximum coverage of all social-economic groups need to be developed. Unless the level of the cost sharing varied according to income, or if low-income groups were free from any charge.
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