ABSTRACT

China achieved very wide coverage of health care service at the local level since 1950s. In urban areas, the employment based health care insurance schemes (GIS and LIS) worked hand in hand with the government’s full employment policy, which guaranteed almost every urban resident’s basic care. However, since the economic reform in the early 1980s, China’s health care system has met great challenges. Some came from labour system reform; other challenges came from the introduction of the market force to the health care sector.

The Chinese government’s new policy on the Urban Employees’ Basic Health Care Insurance is to introduce a cost-sharing plan in urban China (State Council, 1998). Like other major social policy changes, this new health policy also has great impact on the Chinese people’s lives. Affordability has been the major concern amongst urban residents. Shanghai implemented the cost sharing health care policy in the spring of 2001. It maybe too early to tell the pros and cons of the new policy, but evidence show that the employment based health insurance scheme excluded those who are in high risk and in most need.

The author argues that the cost-sharing health care system would limit some people’s access, especially those who are most vulnerable to the consequences of ill health and those in low-income groups, unless the deductible varies based on income and to exempt low-income groups from paying premium and deductible.
INTRODUCTION

The Chinese government designed a healthcare insurance system that was intertwined with the labour system as part of its social security system in urban areas. Since the 1950s, in order to provide the Chinese people maximum health care with limited available resources. Anyone with a job in the public sector was entitled to free or minor cost health care. The government’s full employment policy guaranteed almost every urban resident’s basic care.

The urban Chinese healthcare network was composed of the well established Government Insurance Scheme (GIS, gongfei yiliao), the Labor Insurance Scheme (LIS, laobao) and the collective medical care schemes. These arrangements ensured the success of Mao’s “prevention first” health policy. Chinese peoples’ health has been improving since 1949, the birth of the People’s Republic. It is commonly acknowledged 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 economic reform in the early 1980s, China’s healthcare system has met great challenges. Some came from labour system reform, because the health care system has been tightly attached to economic sectors. Other challenges came from the introduction of the market to the health care system.

China’s transition from state-led to market-led economy brought inequality to the egalitarian society. The emergence of unequal access to the health care system enforced social inequality. An urban survey conducted by the Chinese Statistical Bureau at the end of 2000 shows that health care is now the most pressing issue in urban China. Eighty-seven percent people said that they were concerned about the health care reform more than anything. It was the very first time that any issue became more important than employment to the Chinese people since urban reform started nearly two decades ago.
The Chinese government’s new policy on the Urban Employees’ Basic Health Care Insurance is to introduce a cost-sharing plan in urban China (State Council, 1998). Like other social policy changes, this new health policy also greatly impacted on Chinese people’s lives. Affordability has been the major concern amongst urban residents. By the end of 2001, 76.3 million people in China have joined the new plan. Since it is a very recent policy change, the pros and cons of the new health care insurance is still under debate. This paper tries to illustrate the implementation of the cost-sharing health care policy in one of the Chinese cities – Shanghai and the main implications.

Shanghai put the employees’ cost-sharing health care insurance schemes into practice in the spring of 2001. 6.66 million Shanghai employees and retirees are entitled to the new health care insurance (Shanghai Statistics Bureau, 2001), whilst those with the lowest education, income, and occupational prestige are mostly neglected (Henderson et al, 1994; Hsiao, 1995; New, 1986), namely, unemployed, employees working in informal work units and migrants.

II. Health Care system in urban China and its recent reform

II-i. GIS, LIS and the effects of the health care delivery network

The health care system for China's urban employees was established in the early 1950s. The two primary components of health insurance in urban China were: 1) the Government Insurance Scheme (GIS), which covered government employees, retirees, disabled veterans, and university teachers, staff and students; 2) The Labor Insurance Scheme (LIS) which covered state enterprise employees, retirees and their dependents (i.e., immediate family members who were not covered by GIS or LIS). Both health insurance schemes were financed by government budgets. 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 were providing LIS on a voluntary basis. Yearly, each enterprise 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 the early 1980s, 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 benefits that did not constrain beneficiaries in their consumption of medical services. Beneficiaries received free outpatient and inpatient services. Dependents of LIS beneficiaries were reimbursed 50 per cent 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 healthcare 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 necessary their dependents. Often the employees pay for their medical expenses first and to obtain reimbursement later (Henderson and Cohen, 1984:94; New, 1986).

With a set of systematically planned and strongly enforced organizational principles, the Chinese government was able to use all its possible resources, effectively provided healthcare with limited resources. It ensured maximum participation of the Chinese people in the delivery and easy access to health care (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, affordable health care services contributed to this achievement (Yang et al, 1991). An interesting comparison was reported in the New York Times in 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.”

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

Under these four principles, China developed a three-tiered health care delivery network. In urban areas, there are the street (sub-district), district and municipal level hospitals. The three-tier hospitals have similar functions but were different in scale and “target” groups. In Shanghai’s case, the municipal level hospitals cared for the employees and the retirees of state-owned enterprises, institutions, municipal level government bodies, and disabled veterans. They also cared for university staff and students. The district hospitals cared for employees and retirees of large and the medium-sized collective owned enterprises. The district and street level government bodies, institutions under the district government, and middle to primary school staff were also cared for by these district hospitals. The street level hospitals cared for employees and retirees of the small collective owned enterprises, service stations, etc. In addition to the three-tiered hospitals, there were also neighbourhood health stations under each neighbourhood committee staffed by trained health workers. These workers were responsible for the community’s health environment, health propaganda, in-station service and home care, etc. Most large enterprises had their own hospitals. Medium and small firms/institutions had their own clinics or health care stations.

Each work-unit issued health insurance cards to its employees. The insurance card was usually good at a designated hospital for free service and free prescription drugs. All hospital emergency rooms were open to everyone on fee-for-service base. The service costs usually were reimbursed in patients’ work unit afterwards.

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1 New York Times, 14 April 1991 P. 1
This three-tiered health care delivery system in urban areas was designed to promote the efficient allocation of health care resources between primary and tertiary care facilities. It provided an efficient framework to refer patients for care in the most appropriate setting for some decades. Changes since the economic reform of the 1980s, however, have brought new challenges to this system.

**II-ii. Economic reform and the challenges to the health care system**

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

In urban China, GIS and LIS had been effective in ensuring relative 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 healthcare provisions. Another major problem was lack of risk pooling across enterprises or across local governments. Each organization under the original GLS and LIS systems was self-insured (Grogan, 1995; Liu and Wang, 1991; Hsiao, 1995; Ho, 1995). Therefore, if an enterprise was running a deficit, it would not be able to reimburse its beneficiaries’ 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 compete in the market.
Meanwhile, many urban residents lost their entitlement to GIS or LIS, especially LIS. It was mainly due to the change of the labour system, because the GIS and LIS only covered those who were employed in the formal public sector, while many people started to work in various newly emerged informal economies, and the large scale lay-off from state owned enterprises. Table 1 shows that in 1998, only 38.92 percent urban population was covered by the GIS and LIS. Although the emergent commercial insurance plans filled some gap, it only provides options for those who could afford to buy their health insurance plans.

Table 1: Urban Chinese Health Care Coverage (1998)

<table>
<thead>
<tr>
<th>Forms of Health Insurance</th>
<th>Urban total* %</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIS</td>
<td>16.01</td>
</tr>
<tr>
<td>LIS</td>
<td>22.91</td>
</tr>
<tr>
<td>Commercial insurance</td>
<td>3.27</td>
</tr>
<tr>
<td>Half coverage</td>
<td>5.78</td>
</tr>
<tr>
<td>Health plan</td>
<td>1.42</td>
</tr>
<tr>
<td>Other</td>
<td>6.48</td>
</tr>
<tr>
<td>No coverage</td>
<td>44.13</td>
</tr>
</tbody>
</table>

* Migrants are not included  
Source: Ministry of Health, China: 2000 Chinese Health Statistical Digest

The most recent health care system reform in China started with issuing the Decision on Health Care Reform and Development by the Chinese Central Committee and State Council in 1997. Through August 2000, the State Council issued a set of documents to elaborate detailed new health care policies, with the Decision on Establish the Urban Employees’ Basic Health Care Insurance System (December 1998) at its core. The main goals of recent health care system changes in China are: 1) To establish a cost-sharing system, in order to control the 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 to improve service quality and efficiency; and 3) To break a regional and industrial monopoly in pharmacy research, production, selling and consumption, and ensure better management in order to ensure drug quality and to reduce costs (Hu, 2000).
The major change in recent reform is the changes in health care financing. The government and firms are no longer responsible for most of the health care costs as before. Most people in Chinese cities have to pay their share of health care expenses. At the same time, hospitals are no longer non-profit institutions. The market started to play its role in the health care sector.

Chinese policymakers realized that unless these problems were properly addressed, excessive healthcare cost escalation would continue to outstrip the Chinese people's ability to pay. This would jeopardize the improvement of urban residential health status and social stability. Furthermore, there is a close link between the health care system and overall economic development. For example, it is not possible for the reform of state-owned enterprises to be successful without taking the health care and other social welfare burden off the enterprises.

The central government’s new policy documents on urban health care system reform provided principals for local levels (provincial and municipalities) to design their own policy measures and to accomplish their local health policy implementation. Shanghai was one of the pioneer cities to implement the new policy.

III. The implementation of new health policy in Shanghai

As China's industrial and commercial center, Shanghai’s GDP was over 4500 US dollars per capita in 2001, which is the highest amongst Chinese cities. The Shanghai municipal government spends 19 per cent of its total employee wage bill to finance the city’s health care to its population of 16.74 million. By the year of 2000, its annual natural population growth rate was -2.27 percent; infant mortality rate was 5.53 per thousand; and one to four years’ mortality rate was 0.45 per thousand. There were 3813 hospitals and clinics in Shanghai and available beds for every thousand local residents were 5.37. The average life expectancy at birth reached 78.46 years (Shanghai Health Bureau, 2000; Shanghai Statistics Bureau, 2001). These health indexes show that Shanghai has reached the
similar level to the major urban centers in developed nations. A well established health care system would be able to sustain and even improve Shanghai’s accomplishment on health thus far, while a less sensitive health policy would impact on the city’s health negatively.

Shanghai government has been tackling the big problem of escalating health expenditures’ escalation, like governments elsewhere. Table 2 shows the rapid increase of the government’s spending on health and the Government Insurance Schemes funding.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total*</th>
<th>Health</th>
<th>GIS</th>
<th>Hcare**</th>
<th>Year</th>
<th>Total*</th>
<th>Health</th>
<th>GIS</th>
<th>Hcare**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>3.43</td>
<td>25%</td>
<td>5%</td>
<td>30%</td>
<td>1992</td>
<td>27.63</td>
<td>19%</td>
<td>8%</td>
<td>27%</td>
</tr>
<tr>
<td>1980</td>
<td>4.77</td>
<td>20%</td>
<td>4%</td>
<td>24%</td>
<td>1993</td>
<td>37.56</td>
<td>17%</td>
<td>11%</td>
<td>28%</td>
</tr>
<tr>
<td>1985</td>
<td>11.14</td>
<td>21%</td>
<td>4%</td>
<td>25%</td>
<td>1994</td>
<td>53.46</td>
<td>15%</td>
<td>10%</td>
<td>25%</td>
</tr>
<tr>
<td>1986</td>
<td>13.23</td>
<td>22%</td>
<td>4%</td>
<td>26%</td>
<td>1995</td>
<td>70.97</td>
<td>14%</td>
<td>10%</td>
<td>24%</td>
</tr>
<tr>
<td>1987</td>
<td>13.92</td>
<td>20%</td>
<td>5%</td>
<td>25%</td>
<td>1996</td>
<td>87.44</td>
<td>13%</td>
<td>11%</td>
<td>24%</td>
</tr>
<tr>
<td>1988</td>
<td>15.98</td>
<td>19%</td>
<td>6%</td>
<td>25%</td>
<td>1997</td>
<td>105.4</td>
<td>14%</td>
<td>11%</td>
<td>25%</td>
</tr>
<tr>
<td>1989</td>
<td>20.05</td>
<td>20%</td>
<td>6%</td>
<td>26%</td>
<td>1998</td>
<td>117.48</td>
<td>11%</td>
<td>12%</td>
<td>23%</td>
</tr>
<tr>
<td>1990</td>
<td>21.81</td>
<td>21%</td>
<td>7%</td>
<td>28%</td>
<td>1999</td>
<td>121.25</td>
<td>11%</td>
<td>13%</td>
<td>24%</td>
</tr>
<tr>
<td>1991</td>
<td>23.55</td>
<td>18%</td>
<td>7%</td>
<td>25%</td>
<td>2000</td>
<td>133.93</td>
<td>10%</td>
<td>13%</td>
<td>23%</td>
</tr>
</tbody>
</table>

* Total fiscal spending in the given year, unit: 100 Million Yuan
** Total health share in the fiscal year spending (Health spending plus spending on Government Insurance Scheme).
Source: Shanghai Statistics Bureau, 2001, Shanghai Statistical Yearbook 2001

Once the central government called for a reform of the public health financing and initiated a cost-sharing health insurance program for urban employees, a cost sharing health insurance scheme for employees was also designed in Shanghai. The actual implementation of the new health insurance scheme started in the spring of 2001.

**III-i. Cost sharing health insurance schemes**

Shanghai’s cost-sharing system combines two funds: the Unified Plan and the Medical Saving Account. The Unified plan is designed to pay insured’s health care expenses on inpatient, emergency room stay, and severe illness treatment from 1400 Yuan to 56,000
Yuan. The Medical Savings Account is imbedded in the individual Health Insurance Card. The usable values differ according to an individual's age (i.e. old, mid-aged and young), personal income and employment status (i.e. employed or retired). Amongst insured, older and retired people receive the highest percentage of coverage.

Under the new system, the medical insurance funds are made up of payments by employers of an amount equal to 12 percent of employees' annual salaries, and 2 percent of employees' annual salaries paid through payroll deduction (Hu, 2000). The formation of the health care insurance fund is:

\[
\text{Work Unit 12\% + Individual 2\%} \rightarrow \text{Health Care Insurance Fund} \rightarrow 1) \text{ Individual MSA; 2). Unified Plan; 3) Local Additional Fund}
\]

Each individual employee is given a Medical Saving Account. A certain amount of money is deposited in each account-holder's health care account (according to their annual wage). Table 3 shows the formation of employee’s Medical Saving Account.

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent of LYSAW*</th>
<th>Percent of LYPW**</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 and over</td>
<td>4.5</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Retirees 74 and under</td>
<td>4</td>
<td>Not applicable</td>
</tr>
<tr>
<td>45 to Retirement</td>
<td>1.5</td>
<td>2%</td>
</tr>
<tr>
<td>35 to 44</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Under 34</td>
<td>0.5</td>
<td>2%</td>
</tr>
</tbody>
</table>

* LYSAW: Last years Shanghai average annual wage (it is 14,000 Yuan now). Employer pay.
** LYPW: Last year’s personal wage. Employee pay.

The payment methods for inpatient and outpatient services are shown in the tables 4 and 5.

In order for the new health insurance schemes’ beneficiaries fully digest the policy, especially the complicated ways of calculation, most work units in Shanghai distributed detailed booklets to each of their employees; and the hospitals and pharmacies in
Shanghai not only provided booklets but also set “health care insurance information desks” to help their patients. The complexity of the new schemes is mainly due to the age groups’ differentiation in coverage rates. The following matrix shows the main factors of the Medical Savings Account in Shanghai.

**Table 4: Employees inpatient cost-sharing method**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Initial out of pocket payment (Yuan)</th>
<th>Ceiling** (Yuan)</th>
<th>Patient share of inpatient &amp; catastrophic disease care cost</th>
<th>Over 56000 Yuan out of pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent LYSAW*</td>
<td>Current rate (Yuan)</td>
<td>Percent</td>
<td></td>
</tr>
<tr>
<td>Retirees***</td>
<td>5%</td>
<td>700</td>
<td>56000</td>
<td>8%</td>
</tr>
<tr>
<td>Other age groups</td>
<td>10%</td>
<td>1400</td>
<td>56000</td>
<td>15%</td>
</tr>
</tbody>
</table>

* Last year’s Shanghai average annual wage.
** The ceiling equals to four times of last year’s Shanghai average salary.
***Retired veterans are not included.

**Table 5: Employees’ Outpatient/Emergency Room Visit Cost-sharing Method**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Medical Savings Account (Yuan/Year)</th>
<th>Before sharing cost, out of pocket (Yuan)</th>
<th>Patient share of the medical care cost (in primary, secondary and tertiary hospitals)</th>
<th>Employed %</th>
<th>Retired %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirees*</td>
<td>560/630</td>
<td>280</td>
<td>(2%)**</td>
<td>-</td>
<td>10/15/20</td>
</tr>
<tr>
<td>45 and over</td>
<td>About 490</td>
<td>1400</td>
<td>(10%)**</td>
<td>30</td>
<td>15/20/25</td>
</tr>
<tr>
<td>34-44</td>
<td>About 420</td>
<td>1400</td>
<td>(10%)**</td>
<td>40</td>
<td>30/35/40</td>
</tr>
<tr>
<td>Under 34</td>
<td>About 350</td>
<td>1400</td>
<td>(10%)**</td>
<td>50</td>
<td>45/50/55</td>
</tr>
<tr>
<td>New Employee</td>
<td>About 350</td>
<td>1400</td>
<td>(10%)**</td>
<td>100</td>
<td>45/50/55</td>
</tr>
</tbody>
</table>

* Retired veterans are not included.
** % of last year’s Shanghai average salary. It is 14,000 Yuan at present.

New Employee refers to those who start work in 2001.

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**Matrix 1: Medical Savings Account in Shanghai**

<table>
<thead>
<tr>
<th>Item</th>
<th>Practical Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective of the scheme</td>
<td>Increase risk pooling and cost containment</td>
</tr>
<tr>
<td>Covered population</td>
<td>Formal, regulated sector* employees and retirees</td>
</tr>
<tr>
<td>Enrolment principle</td>
<td>Compulsory</td>
</tr>
<tr>
<td>Holder of the MSA fund</td>
<td>Health Insurance Bureau</td>
</tr>
<tr>
<td>MSA Fund Contributor</td>
<td>Employer and employee</td>
</tr>
<tr>
<td>MSA Fund Contributions</td>
<td>Fixed proportion of wages</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>MSAs Spending</td>
<td>For enrollee’s healthcare only</td>
</tr>
</tbody>
</table>
| Healthcare financing tiers | 1) MSAs  
                               2) Out of pocket deductibles  
                               3) Unified Plan (risk pooling) |

* The work units that contribute to the health care insurance fund.

**III-ii. Inclusion and exclusion of the new medical insurance**

In Shanghai, the new medical insurance schemes only apply to urban employees. In fact, it only applies to those who are formally employed in the formal sector – mostly large and medium sized public work units and the regulated other ownership units. Since the policy states that only the employees of the work units that joined the Shanghai government’s health care “Unified Plan” are automatically entitled to the new insurance. Therefore, this so called employees’ health insurance does not simultaneously include all employees in the city. In most of the cases, work units in formal economy would join the “Unified Plan”, but not necessarily those of informal sector units. Thus, it naturally left out the informal sector employees and the unemployed from the same entitlement as formal sector employees. It is true that formal employment has been a principle for claiming entitlements to various social benefits, including public health care insurance (Bloom, 2001).

Also excluded by the public health insurance schemes are rural migrant workers, since they do not have Shanghai permanent resident status. Migrants are most likely to be working in the informal economy as well.

Like some other social policies, the new health policy is biased towards retired revolutionary veterans, as well as retired and on-the-post high ranking officials (bureau chief level and up). The new health care policy does not apply to these groups. All of them will continue to enjoy the full coverage of their health care expenses by the government. At present, these are the most privileged social groups in health care.
III-iii. The main achievements of the new health care policy

The implementation of the Shanghai Employees’ Basic Health Care Insurance Measures separated the medical insurance from the place of employment, thus enabling employees and retirees of those not so successful firms to get medical care benefit without any delay. It is particularly beneficial to those retirees. Since China has had a full employment policy for over three decades, most elderly persons in Shanghai are retired from public sectors, and therefore, they are mostly entitled to the Employees’ Basic Health Care Insurance. In Shanghai’s case, there are 1.8 million retirees (Hu, 2000). Although most of them enjoyed medical insurance (LIS or GIS) before, some of them faced difficulties in obtaining reimbursement of their medical expenses when their former work units did not making profits. The newly issued Social Security Card (at present, it is still limited to the purpose of health care access) relieves them from the concern about their previous employer’s ability to pay. This practice can be seen as part of the foundation of a basic social security system.

At the same time, the ongoing health resource restructuring and reallocation benefits the whole society. More rationalized health resource allocation brings efficiency and improved medical services. It is especially good that most of the enterprise-based health resources are now open to the society. Meanwhile, the new health care policy’s implementation rings the bell for cost-awareness to most of the patients when seeking care, which significantly reduced unnecessary medical spending. The health insurance enrollees are now given more freedom to choose hospitals and doctors. Therefore, the new health policy effectively promotes competition amongst medical care providers.

IV. The New Health Policy Meets New Challenges

The newly implemented health policy in China brought revolutionary changes to the health care system. A cost-sharing health care insurance schemes is now replaced the over thirty year’s of free health care access; like to consume household goods, a patient’s

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2 The insured’s choice of three hospitals to be cared for.
decision on whether to seek health care service is now depend on his/her household’s ability to pay. The emergence of health care “market” in China makes medical care a scarce consumption to many.

There are two layers of inequalities in health care access that are visible: one is entitled or not to the public health care insurance; the other is within the entitled, there are different rates of coverage amongst different age groups.

IV-i. Different ages, different coverage rates; different wages, different burden

Age is the only variable that differentiates coverage rates amongst employees in the new health care insurance schemes (see tables 4, 5 and 6). The older one’s age, the greater a person’s health care coverage rate. The new health insurance policy is clearly biased towards the retirees and senior employees. The breaking down of age groups to differentiate the coverage rates is very much in line with the Chinese tradition of protecting the well being of elderly. However, it not only added complexity to the new scheme, but also age discrimination. Although older people in general may have more health care needs than the younger ones, not all younger persons are healthy. Middle aged and young employees with chronicle diseases are under heavy financial pressure; especially those belong to the working poor – low income group.

What is more problematic is that the deductable is not based on the employee’s personal income, but the whole city’s average salary (see tables 4, 5 and 6). In a city where the wages gaps are great, this policy is clearly not fair to low income groups. The proportion of household income goes to health care to the low income groups is undoubtedly much greater than those in the higher income groups. Consequently, the new health care policy, as a redistributive policy, failed to distribute the health burden evenly amongst different social economic groups.

In recent years, Shanghai people’s personal share of the health care cost increased dramatically. In 1990, Shanghai household per capita annual expenditure on health care
was 11.40 Yuan; in 1995, it increased to 112.82 Yuan; it reached 346.93 Yuan in 1999. The newly implemented cost-sharing health insurance scheme would definitely be a heavier financial burden to those middle and low income households. The growing income gap between the rich and poor in Shanghai also determined that the health financial burden is not evenly distributed. Table 6 shows the great difference in earning power amongst Shanghai residents.

Table 6: Shanghai per capita annual income in 1999 (Yuan)

<table>
<thead>
<tr>
<th>Actual income per capita</th>
<th>Average: 10988.90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest income</td>
<td>5681.37</td>
</tr>
<tr>
<td>Medium income</td>
<td>9577.54</td>
</tr>
<tr>
<td>Highest income</td>
<td>24158.63</td>
</tr>
</tbody>
</table>

Source: *Shanghai Statistical Yearbook, 2000*

Figure 1: Luwan District Household Expenditure (1998)

3 All expenditures are in current prices. 1 Yuan = 0.12 US Dollar
A survey conducted by the Ministry of Health (China) shows the per capita annual income and the structure of expenditure in a district of Shanghai in 1998. These households average annual income was 7829 Yuan. The structure of their average expenditure is as following: Food: 64.04%; Clothing and household goods: 9.29%; Housing and utility: 11.35%; Education and entertainment: 9.15%; Health care: 6.09%; and Other: 0.08%. It is evident that the main proportions of these ordinary households’ incomes are for basic needs. It is almost certain that poor households would have to spend even higher proportion of their incomes for food. Any other spending is likely to compete with their basic food consumption. The new health policy undoubtedly will increase households’ spending on health. Therefore, it is not too difficult for us to imagine which part of the household expenditure will likely be compromised.

The new health policy is likely to burden many with medical costs. Even the 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 has not been all open. Our concern is that we may not able to pay the adjustment. Because now the new health insurance almost equals to no insurance, if we provide our insurance plans, the pressure will be on our company." Ping-An Insurance Company's Director Mr. Zhou said, "To many, the new health care insurance is just like having no medical coverage 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 provided health insurance to these people, we would not be able to run profitably”.

IV-ii. Different place of employment, different “hukou” status, different entitlements

According to the most recent Shanghai statistics, there are over 7.45 million people working in various sectors, and around 2 million retirees. However, amongst 9.45 million employees and retirees, only 6.66 million people are entitled to the Employees’ Basic Health Care Insurance Schemes. Although Shanghai municipal government has been forcefully pressuring the joint ventures, foreign invested firms and private firms, etc. to join the new health care insurance system, many informal sector economic units are still
hesitant to join the city’s health care “Unified Plan”. Therefore, it left their employees vulnerable in health care access, since their entitlement to the city’s public health insurance depend on whether their employers’ join the city’s “Unified Plan” or not. Also vulnerable are those unemployed and rural migrants in Shanghai.

If the un-entitled Shanghai residents (unemployed and people working in the informal sector) are willing to pay the health care and unemployment insurance premiums (around 260 Yuan/month), they would be entitled to certain medical benefits (after three months of the fees payment). Being unemployed or working in informal sector, these people's incomes are quite limited (informally employed workers are mostly belong to the working poor who earn minimum-wage). Therefore, some, or most of them simply can not afford to pay the premiums and thus, they are not insured.

At present, there are over 10 thousand informal economic units with over 164 thousand employees in Shanghai. Since there are no proper statistics, the actual number of people that working in the informal economy could be much higher (Ren, forthcoming). These people are not well protected by any government policy. A recent survey shows that, amongst reemployed women in Shanghai, only 45.1 per cent of them responded that their employers pay for their insurance fees. This means that the over a half of reemployed women do not have health insurance. It also indicates many reemployed women are informally employed or working in informal sector (small scale businesses).

A private company owner Mr. Lin seems to be reluctant to join the cost sharing health insurance plan for his employees’ health benefits. “I have over twenty employees in my company. The lowest monthly salary in my company is 600 Yuan. So far, my company hasn't joined any health insurance plan. I will think about joining only when I am forced to.”

Rural migrants are experiencing all the disadvantages in their new settlement location. “Temporary migrants” may register their presence in the community, but they are not entitled to the state benefits that permanent residents enjoy, like healthcare (Chen, 1991;
Yang and Goldstein, 1990; Goldstein et al, 1991; Grogan, 1995; Hsiao, 1995). Not only the local employment policy is biased against them, the Shanghai health care policy also ruled out providing health benefits to those do not have Shanghai resident status (*Hukou*). A study on female migrants in Shanghai shows that some of them chose to deliver their babies outside of hospitals to save money (Wang et al, 2001).

A well established urban health care system should take these groups’ health needs into consideration.

*IV-iii. Poor households’ burden of disease*

Shanghai Civil Affairs Bureau provided 175 thousand people, living under poverty, with living allowance in September 2000. A recent survey on 1400 poor households’ health situation shows that the major cause of poverty was unemployment (60.3%). The survey also shows that only 2.3% of those families were covered by some form of health insurance. Meanwhile, these households’ average income was 645.63 Yuan/month. When they had to seek medical care, they could only ask their relatives for financial assistance (83.5%). Some of them simply did not seek medical care when ill due to low affordability. Even though, the average health care debt in these families had reached 6574 Yuan (Liang et al, forthcoming), which is over ten months total household income for them.

The Shanghai government did oversee the poor households’ needs in health care. There is a policy set to assist those who are extremely poor. That is, the government would share 25% of the total medical expenses, while the patients themselves pay out of pocket 75% (Liang et al, forthcoming). However, it doesn't help the poor people much, since they can't afford to pay the cost anyway. Many households fall into poverty through out-of-pocket medical expenses. It is especially true among those who do not have medical insurance, and at high risk of getting ill. Table 8 shows Shanghai poor households’ health care needs and their utilization of care.
Table 8: Shanghai Poor Households’ Health Needs/Care Utilization (2000)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced illness in past two weeks</td>
<td>60.3</td>
</tr>
<tr>
<td>Major illness in the past year</td>
<td>20.6</td>
</tr>
<tr>
<td>(In which 65.6% families paid health service totally “out of pocket”)</td>
<td></td>
</tr>
<tr>
<td>Did not seek care when ill</td>
<td>18.5</td>
</tr>
<tr>
<td>Got drugs from any source to self-treat when ill</td>
<td>31.3</td>
</tr>
</tbody>
</table>

Source: Liang et al:  

The table shows that those households living under poverty have great health care needs, but a large proportion of their members do not seek care when needed.

Retiree Ms. Sun is concerning her brother’s well-being: “My brother is 51 years old and has chronic disease. Since his work unit is a small scale and a non-profitable one, his monthly income is only around 600 Yuan. His hospital visit and prescription drugs’ expenses are quite high. The new health insurance schemes made his life difficult, especially the self-payment 1400 Yuan to him is a big headache. It is more than his two months’ total income for him. I think this is not fair. In most of the cases, he asks his wife to use her health insurance card to get medicine he needs from the hospitals. As for diagnoses and tests, he has to go by himself. He is now too shy to use other people’s insurance card to pay hospital visits, but when it is absolutely necessary, he will.”

Ms. Sun’s brother’s case is not an isolated one. Many in low income and middle income groups are finding their way out once the new health policy has been implemented. Since hospital and clinic professionals are sympathetic about local people’s financial burdens on health care, patients’ using their relatives or friends’ health insurance cards for care are not likely to be rejected. However, the government is making new measures to prevent this sort of rule violation. One of which is for the hospital E-network to share their patients medical service seeking information.

IV-iv. Tackling the new issues
The Shanghai General Trade Union started building a safety-net for their members right after the new health policy was initiated. So far, their main accomplishments include: 1) The opening of Gonghui Hospital, which is serving with reduced service rates to all; 2) The establishment of the collective health insurance plan (critical illness insurance); And 3) it distributed fifteen hundred “assist-poor health care cards” donated by fifteen large hospitals to the most needed persons, etc. These special programs have been initiated and received positive responses. The Trade Union’s programs provided Shanghai employees – the trade union members in its umbrella branches – with alternative health insurance plans with minor costs. However, just like one of the Union’s officers said, “A safety net is supposed to help a minority group but the new health care policy left too many people in need of help”. Further more, since the programs the Shanghai General Trade Union initiated are all employment related (only the traditional formal sectors’ work units have trade union branches), those who are left out by the government’s health insurance schemes are also very likely to be excluded from these alternative plans.

V. Basic care and the cost effectiveness

A district level hospital in Shanghai recorded its outpatient service before and after the new policy came into effect: from January 1st to March 18th, the average outpatient per day was 1154.37; from March 19th to June 30th, the number reduced to 425.73 per day. The net reduction was 171.15 percent. At the same time, this hospital’s emergency room visits rate increased 20 percent. Another hospital in Pudong found it sharply reduced outpatient visits right after the new policy was implemented. The average daily outpatient numbers were: during December 2000, it was 7300; in February 2001, it was 10086; and it dropped to 2500 in late March 2001.

The new health policy’s theoretical framework is essentially designed to limit demand side consumption. It has successfully reduced "unnecessary care". However, it also set barriers for some necessary care. There is almost none incentives have developed to limit supply side spending. In fact, the health expenditures show no sign of going down.
Meanwhile, patients are now in a vulnerable position, especially when they have to share imposed high health care costs with their limited incomes. The unusually increased rate for emergency room visit may explain that some people did not seek care until it became absolutely necessary. When the financial means becomes crucial in health care, underprivileged groups tend to be at higher risk as far as their health is concerned.

It will be more cost-effective when the health care delivery is designed to meet the needs of its targeted population. The aging population in Shanghai is increasing rapidly. There are 2.3 million or 18 per cent of the total Shanghai population aged 60 and over. Amongst them, 80% have chronic disease (Wei, 1999). This is especially crucial after 20 years of implementation of the “one child policy”, since family size is smaller (2.7 persons per household), and many elderly people are living alone. Demographic changes over the years demand a great number of low cost nursing homes instead of admitting elderly people with chronicle disease to hospitals. This change will not only bring down the city’s health care expenditure considerably, but also make daily life more comfortable for these elderly people. In addition, it would also make family visits easier, more flexible and accessible.

When asked about the effectiveness of the new health policy, doctor Gong at a Shanghai district hospital has this to say: “It seems the new health insurance policy is not a success. Those middle aged people are not well insured, but they have lots of health problems. Our doctors' income is okay but I feel patients' burden is quite heavy. I found the out of pocket amount of 1400 Yuan\(^4\) [deductible] and the 30 per cent share after that is really too much for many people to bear. Retirees' situations are much better since they have fewer shares in self-payment. Those retired revolutionary veterans and the high ranking officials are the best protected, however, they are the minorities of the whole population.”

China has recently joined the WTO. This new commitment to a global economy will dramatically affect China’s internal social-economic situation in five to ten years. What

\(^4\) It’s about one and a half of an ordinary worker’s monthly salary, and more than two months salary for those receiving in low wages.
relevant to health policy is urban residents’ characteristics and their need for care. If the policy is to be effective, strategies for over come the current limitation and exclusion of coverage need to be developed.

Challenges to the Chinese health care system are far from over. These challenges require the government to design a health system that addresses the social reality. Namely, first, more rapid industrial restructuring will result in closing down loss-making firms. 2900 state-owned enterprises are expected to declare bankruptcy in the next few years. Thus, many more urban workers will lose their jobs. Second, China’s WTO accession will bring about a great number of rural migrants to the urban centres. A report from the Chinese Ministry of Agriculture notes that surplus rural labour in China has reached 100 million, and nearly 20 percent of Chinese farmers are jobless. Once the large quantity of agriculture products are imported to China, many peasants will have to leave their land to work in other sectors. Therefore, the trend of rural urban migration will continue. Third, more people will find jobs in various non-traditional sectors, to be employed in informal economy or to become self-employed.

VI. Ideal Model and Practical Solutions

There is no ideal health model for all societies, but good health system serves the nation’s populations’ needs well. Borrowing another nation’s model needs to take social reality into consideration. Each nation in the world has its unique health system that meets its own population’s health needs; each nation has its own characteristics in social, economic, political, cultural and common believes need to be integrated into their health system too. Good health models in the world tend to be developed gradually with the growing national health needs.

Bloom (2001) argues that it is important to focus on practical options in healthcare finance instead of debating about what is the ideal health model. Realising inequality exists in society, he suggests that governments should operate within this social segmentation, to balance the needs and demands of different social groups and find strategies to meet these needs and demands. Governments committed to equity could
collect revenue on the basis of ability to pay and disburse it on the basis of need. Although their capacity in resource redistribution through a tax system may be limited, governments could use their power to influence the stakeholders’ behaviour in the health sector. Through structuring appropriate rules and incentives, government can achieve risk and harm reduction, reduce unacceptably inequitable outcomes and improve users’ ability to select providers and overall access.

There is no quick way to solve the healthcare financing issue for people in Shanghai, but there is a way to slowly move towards an “ideal” situation, and Shanghai’s financial advantage will be able to facilitate a much better health system. A system that honours the existing entitlement rights as well as creating a new claim rule that appropriate to the social reality. Measures need to be developed to protect the indigent, and to draw more social resources to support those in need.

My policy recommendations are:

1. To identify different social groups and their health needs (employment status, resident registration status, sector of employment, age groups, etc.). Special attention should be paid to the high risk population. Shanghai policy makers need to learn from Germany and Singapore – to provide sufficient health care assistance to vulnerable groups.

2. According to the nature of the population, to design different schemes for different social groups. E.g., to have elderly people and children (up to certain age) enjoy special health programmes, and to provide special schemes for special groups at high risk of ill health.

3. To define “basic care” carefully: on the one hand, to eliminate privileged groups’ over use of health resources by removing their free care entitlement; on the other hand, to provide marginalized groups with necessary care. Assuring basic care for all is crucial for improving the health status of the population.
4. To design a health insurance scheme that could help people to find jobs in all sectors and do not have to consider employer's medical benefit while making a decision on job opportunities.

VII. Conclusion

Many nations in the world are now trying to find ways to reduce health care costs while ensuring their populations’ basic care. It is not an easy task. In order to solve the problem of health expenditures exceeding revenue, co-payments or cost-sharing in medical care have also been suggested in other nations. Employing the cost sharing health insurance schemes is effective in awakening people’s cost awareness when seeking care. However, Shanghai’s experience shows that it would almost surely have a negative impact on equity in access, because health status and health needs tend to vary inversely with income. It would limit some people’s access, especially those who are most vulnerable to the consequences of ill health and those in low-income groups, unless the cost-sharing level varies based on income, or if low-income people had no obligation to pay any share. The employment of the Medical Savings Account also lack of risk pooling. Since people’s health needs are different, some people can simply leave their health fund untouched (since it is a personal account) while others are struggling to find a means to seek care or even to save their lives.

Inequality in health care access is evident in Shanghai. The most visible inequality is the policy’s exclusion. Also, the low-income groups are spending bigger percentage of their incomes on health care. They are also more likely to be left out from public health insurance plans. It is urgent for the Chinese government to not only support work-related health insurance, but to protect the interests of the uninsured as well. If the current Urban Employees’ Basic Health Care Insurance is to continue, the measurements that ensure maximum coverage of all social-economic groups need to be developed. It is a great challenge, as well as an urgent need for both the Chinese government and the Chinese
people to find a better healthcare system that can provide everyone in society equal access, easy access, and better service.

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