

**HEALTH POLICY AND FINANCING IN CHINA:
AN UPDATE FOR AUSAID
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ABSTRACT

The health policy and financing framework in China has long made a clear distinction between urban and rural areas. A review of the health sector in China in the late 1990s demonstrates that inequities between rural and urban areas persist and have been exacerbated by recent reforms. In urban China major recent developments include changes in insurance, hospital privatisation, drug policy reform and the emergence of community health services. Changes to the health insurance system have involved attempts to find alternatives to the earlier schemes which provided almost universal coverage for workers and their families, the establishment of a health insurance department, and the problems associated with disadvantaged and vulnerable groups not being covered by insurance. The classification of hospitals into for-profit and not-for-profit organisations has resulted in the increasing privatisation of hospitals and particular departments within public hospitals and a growth in pricing differentials between hospitals. The establishment and promotion of community health services by government has been undertaken in an effort to increase the general population's ability to access health care. In the rural area developments remain focused on attempts to re-establish cooperative medical systems (CMS). These undertakings have had limited success and raise concerns about the schemes equity and ongoing sustainability. Experiments with Medical Financial Assistance point to possible models for health security, but intersectoral acceptance is a barrier for policy adoption. The newly released Rural Health Policy provides firmer guidance on ownership and workforce reforms, along with expectations for government financing, but falls short of concrete commitments on demand-side financing. Western Regional Development policies may bring social and economic benefits to the poor hinterland provinces, although the health sector has yet to be recognised as a priority area.

1: Introduction

This paper has been completed at the request of AusAID. Its purpose is to provide a briefing on developments in health policy and health financing in China since the AusAID China Health Sector Strategy was completed in mid-1999.

The most distinctive developments in urban China include: health insurance systems, classification of hospitals into for-profit and not-for-profit, and the establishment of community health services. These developments sit within the broader framework of health sector reform decisions of 2000. Rural developments remain focused on cooperative medical systems (CMS), and related to it, medical financial assistance (MFA). These developments are evolving within a new policy framework related to Western Regional Development, and the Rural Health Policy issued in mid-2001.

The paper will briefly review the situation in China in the late 1990s, to set the context for current developments. The paper will move on to separate reviews of the developments in urban and rural areas, as the China policy framework makes clear distinctions between the two. The paper will conclude with discussion about other reforms, emerging health problems, and issues for the future.

2: Review of developments to the late 1990s

The AusAID China Health Sector Strategy provided an overview of the problems and issues in the health care system by the late 1990s. Essentially, declining public support for health programs and reduced community financing of health services has been the major unintended consequences of the economic reforms since the 1980s. Between 1986 and 1993 the estimated share of government spending on health declined from 36 percent to 16 percent. In 1995 this represented about 3.8 percent of GDP, which is low in comparison with other countries (WHO 1999).

The combined impact of early policies of fiscal decentralisation and corporatisation has been profound. Corporatisation equated with each organisation being responsible for its survival, rather than depend on government subsidy. The economic incentive for state-owned enterprises to be competitive, when transferred into the health sector, meant health care institutions had to increase the volume of profitable services in order to meet the wages bill, rather than focus solely on the clinical needs of the patients. In the face of prices being regulated centrally and made artificially low, by the Pricing Bureau, health care institutions resorted to over-servicing.

Similarly, the intention to devolve health administration in the 1980s to various levels of government was a policy designed to achieve greater contribution from the responsible level of government. The consequence has been the accentuation of inequities between rural and urban areas, with resources increasing in urban centres and declining in rural communities, as the figures in Table 1 indicate:

Table 1: Government Spending in Urban and Rural Areas (in millions yuan)

	1978	1993
Hospital operating expenses	1794	4183
Subsidies to rural CMS	89	27

Source: Liu, Hsiao and Eggleston 1999

From 1990 to 1998, the share of personal spending as a proportion of total health expenditure increased from 37 percent to 58 percent, according to the China Health Economics Institute. The health care burden on individuals and households is not equitably distributed. Increasing numbers of the rural poor have become impoverished through costs incurred by serious illness. The perverse incentives (to over-service) in the health system have produced services of questionable quality, particularly where workforce capacity is limited. At the same time, competition in the medical marketplace has increased the concentration (and wastage) of resources in the urban tertiary sector.

By 1993, the urban-rural differences were already significant:

- Average per capita health spending (public and private) was 110 Renminbi (RMB) per annum, but the average for rural areas was 60 RMB per capita compared to 235 RMB per capita for urban areas;
- The proportion of health expenditure from public funds is much less in rural areas than in urban areas. Per capita health expenditure in the officially designated poverty counties (28 percent of all counties in China) is less than half the national average, but 80 percent of this expenditure (twice the national average) is out-of-pocket.
- The number of villages with health stations had reduced from 71 percent (in 1979) to 55 percent, at the same time the number of tertiary hospitals in urban areas had grown from 9478 (in 1980) to 14771 in 1995 (Liu, Hsiao and Eggleston 1999).

Health expenditure data also illustrate the regional differences within China. Despite increases in all regions, the already significant gap between them persists.

Table 2: Per Capita Health Expenditures (in yuan) in Different Economic Regions

Year	1995	1996	1997
Three Big Municipalities	686.31	812.3	996.02
Rich Regions	267.35	332.57	368.74
Medium Regions	154.14	190.05	210.52
Poor Regions	116.98	141.60	155.84

The rural-urban differential is further exacerbated by the nature of the health workforce, with inadequate levels of training among rural healthcare staff, and an overemphasis on specialisation in the urban centres. The number of senior level health professionals, working generally in urban areas, increased by 234 percent in the decade from 1980 and a further 142 percent from 1990 to 1995 (Liu *et al* 1999). With the relaxation of allocation of jobs by the state and as incomes come to rely on institution-generated revenues, more experienced and better trained staff have sought to work in county or urban hospitals. In more affluent areas there has been growth in private sector health care which offers competitive prices and amenable services (Bloom and Gu 1997).

Although urban residents have fared relatively better, the proportion of their out-of-pocket payments have increased significantly, with changes in the financing arrangements for the Government Insurance Scheme (GIS) and the Labor Insurance Scheme (LIS). Data from national household health surveys in 1993 and 1998 indicate that health insurance in urban areas declined, during that period, from 54 percent to 39 percent (Gao and Tang 2000). According to World Bank estimates in 1981, 29 percent of China's population were uninsured. This figure had increased to 79 percent by 1993 due largely to an increase in rural uninsured (quoted in Liu *et al* 1999). The general trend in total health expenditure is one of declining input by government and rapidly increasing input by individuals/household and social enterprises, as seen in Appendix A.

The structural constraints and the long-standing problems in the health system can be summarised as:

- Fiscal decentralisation and the absence of inter-governmental financial transfers (other than for particular national programs);
- Corporatisation of health service providers and the consequent adoption of a user pays system;
- Continuing government control on prices and labour markets, both contributing to accentuated gaps in health care access and quality between urban and rural areas;
- Perverse incentives for health service providers leading to poor quality (including overuse, under-use, and misuse) and low efficiency;
- Absence of a health security system leading to illness-induced poverty;
- “Incomplete” transition from planned to socialist market economy, with the absence of governance and regulatory arrangements suitable to the new conditions and a lack of policy clarity about the role that government should play in the health sector.

Throughout the 1990s, there were a number of efforts to develop new models and policies, in order to resuscitate the health system. Urban health insurance models were trialed in Jiujiang and Zhenjiang. Many rural places attempted to re-establish CMS on different models of financing and management. Regional health planning projects were supported through World Bank loans in Jinhua, Jiujiang, and Baoji, while other cities initiated their own efforts. There were other programmatic efforts aimed at improving specific aspects of service delivery including, *inter alia*, NCD prevention and control, a National Tuberculosis Program, Three-item Construction (for rural facilities re-development), and hospital accreditation.

The targets identified in the Ninth Five-Year Plan for China (1996-2000) are indicative of the issues in the health system at that time:

- Continue to strengthen rural health services;
- Strengthen disease control and MCH work;
- Reform medical insurance system for urban employees;
- Promote the progress of health science and technology; and
- Strengthen health inspection and law enforcement.

In 1996 a National Health Conference was convened by the State Council to discuss the emerging crisis in the health sector. The resulting policy document gave priority to the problems of rural areas and addressed both supply and demand-side issues. It advocated measures to improve service effectiveness and efficiency. It also encouraged the re-establishment of the cooperative medical system (CMS), based on voluntary contributions by households with additional financial assistance from local government and village collective funds. It called on local governments to incorporate health into anti-poverty programs, and on higher levels of government to provide financial support for health services in poor localities.

To address the emerging problems of unbalanced resource allocation in urban areas, the policy document identified the need to strengthen community health services, as a form of comprehensive primary health care, and to limit the role of hospitals to the diagnosis and treatment of acute, serious and difficult diseases. It also recognised the need to strengthen health facility management. It proposed that local governments establish new mechanisms of health financing, combining individual accounts with risk-pooling.

The new policy also called on provincial governments to develop regional health plans, improve supervision and regulation of health service providers, modify prices to reduce existing incentives towards costly forms of care, and ensure that public health measures and preventative programs were more effective.

This National Health Conference represented a watershed in the history of Chinese health policy development. Its decisions, and subsequent State Council circulars and guidelines (such as that on Cooperative Medical Service, issued in May 1997), signalled a concerted effort to redress the problems the health system experienced as a result of the application of market-based reforms. Notably, there was a commitment that all levels of government needed to increase their investment in the health sector at a rate commensurate with the local rate of economic growth.

Since the 1996 policy was released, there has been a gradual process of discussion and implementation, cascading down the various levels of government. The extent of implementation has been variable, with poorer areas experiencing greater difficulties for reasons of finances and management capacity. The implementation process has not been aided by a prolonged process in restructuring and downsizing of government agencies that began in 1999. The MOH lost 40 percent of its staff. That process is still working its way down through city and county levels.

3: Urban health policy and financing

3.1: Health Insurance Systems

Beginning in the mid-1950s, the government developed the Government Insurance Schemes (GIS) and Labour Insurance Schemes (LIS) which covered the medical expenses of government and labour workers and their families. Medical services were almost universally accessible to people living in the cities. In the early 1980s, when economic reform was initiated in urban

areas, SOEs began to be operated on a profit-making basis. This had consequences for the GIS and LIS. SOEs that failed to make a profit did not have the funds to pay premiums to cover their workers. The number of workers covered by these schemes declined sharply and this issue has resulted in the government agenda on social security system reform.

The government is committed to social security reform that is consistent with the broader socialist market reform. The basic distinction from the past structure is the development of a health insurance scheme that does not rely on the financial status of individual SOEs. While there are different insurance models available internationally, China has chosen to pilot a model that it anticipates will realise its key objective - that health is the joint responsibility of the individual, collective and state.

In 1994, the State Council decided to pilot Social Pooling Accounts (SPA) and Individual Savings Accounts (ISA) reform in the cities of Jiujiang and Zhenjiang. The aim was to replace the existing GIS and LIS health care insurance schemes across urban areas, in order to reduce escalating medical cost. The SPA/ISA health care system is the Chinese version of the Medical Savings Accounts health care system in Singapore. However, the Chinese system differs from the Singaporean system in the following ways:

- a) Unlike the Singaporean system that has a Central Provident Fund (CPF) (a central fund cumulated through general taxation revenue), the Chinese SPA/ISA is financed by individuals and their employer, and managed by individual jurisdictions.
- b) There is no managerial system developed to handle the financial flow between the institutions, and this has not been computerised yet. The movement of funds between patients, hospitals, employers and the insurance department is still unclear.
- c) On the supply side, there are no strictly-followed medical diagnosis and treatment protocols. This has severely limited the insurance department's ability to review the rationale behind diagnosis and treatment. As a result, the payment by the insurance departments to the hospital is rather discretionary.

The GIS and LIS were managed through the MOH. With the SPA/ISA pilot the two cities have created another administration body, the Health Insurance Department (HID), which was coordinated by MOH and MOLSS (Ministry of Labor and Social Security). In 1999, when nationwide SPA and ISA were being introduced, the State Council decided to make the MOLSS responsible for managing the Health Insurance Departments (HID). Thus, for the first time, China had separated health provision from health financing. Such separation is an important step in the development of the healthcare marketplace, consistent with overall economic reforms. The hospitals are now becoming more autonomous and will have to survive in a more competitive environment. Initially, hospitals are aiming to provide more services to secure their revenue. Eventually, hospitals will need to establish their reputations and attract patients using their name for quality services and low prices.

The HIDs were established at different levels of jurisdiction (such as county, prefecture and province), following the Decision Paper on Setting Up Urban Employees Basic Medical Insurance System, issued by the State Council in 1998. The administrative framework for insurance administration simply replicates the general approach to decentralisation of public administration. The HIDs are responsible for managing all aspects of the medical insurance reform including policy setting and routine operations.

One of the main functions of the HID is to review the qualifications of the health providers under the insurance scheme. Under the old system, GIS and LIS would only contract one health provider to deliver health services to the insured. This led to provider monopoly and

inefficiency. Under the new system, the HID would review the medical provider qualifications, and issue certifications where appropriate. Usually, at county seat, there are at least three to five hospital facilities, namely a general hospital, MCH hospital, Traditional Chinese Medicine hospital, and some specialised hospitals or clinics. It is the policy intention that such arrangements could stimulate competition among the providers and avoid the adverse impact of marketisation of the health care system. However, there is variability at each level in the way the policy has been implemented. In the absence of enough providers to compete, the policy would fail in its objectives. In addition, there are examples of hospitals hiring transport to bring patients from other counties into their facilities. This increases their service volume while jeopardising hospitals in neighbouring counties.

These new structures, similar to the preferred provider arrangements in other countries, are intended to lead to competition based on quality and price, rather than the expansionist approach adopted by hospitals in the past decade. As these policies have only recently been implemented, the exact impact has yet to be assessed. Initial observations are positive, as there are signs of price reductions of both services and drugs (although, in the case of pharmaceuticals there are other policy factors at play).

The payment systems for the new medical insurance schemes still require development. There are many variations across the regions which can be grouped into two broad categories: a) the patient pays the total bill in cash to the hospitals, then the patients present the receipts to the HID, and receive reimbursement for the benefits that are to be covered by the insurance; and b) the patients pay only the co-payment part to the hospital and then the hospitals will present the total bill to the HID and HID will reimburse hospitals the part (benefits) to be covered by the insurance. Usually, method a) is used where a computer system is not in place; and method b) is used where a computer system is in place. Such payment systems generally applied to the SPA, and to the in-patient expenses. For the individual ISA, quite often, a card system is applied, which is to cover the expenses for the outpatient visits. The outpatient card system is almost the same as a credit card, it only differs in that it is a prepaid (through payroll arrangement) and a dedicated account solely used for health purpose. There is no integrated computer system linking the hospitals and HID, and there is no unified payment system across the regions. Many localities are developing their own computer software and it will be some time before a standardised payment system evolves.

The ISA and SPA medical insurance schemes cover employees in the formal sector, leaving laid-off or retrenched workers without cover (although the exact number and proportion of the population in this category has not been estimated, due to the policy being progressively implemented). In addition, new immigrants from rural areas are not covered by the ISA/SPA. These two groups are poor and the most vulnerable to illness in the urban area, yet they have the least protection. The government response to this issue is limited. Many cities have established Re-employment Centres for the unemployed. Registering with the centres entitles people to certain benefits. However, even with such arrangements the costs associated with ISA/SPA deductibles, co-payments and ceilings still present a significant barrier. Teh-Wei Hu (1999) concludes that even with health insurance coverage, their benefits are so low that their situation is quite similar to those not covered by the insurance schemes. Rural immigrants are in the poorest position as they are fee-paying patients. The social protection system does not include this segment of the population. Although most immigrants are of working-age, they are usually accompanied by their families. This presents many unmet health needs, and often leads to considerable financial hardship.

3.2: Hospital reforms

On the supply side, with the decentralisation of fiscal responsibilities to the localities, public hospital budgets could not be fully met by the government's financial allocation. Ad hoc policies had been promulgated in meeting the hospital budget shortage. Such policies have encouraged the hospitals towards the privatising process and revenue earning activities. In 2000, a new policy on hospital classification has been issued. It is intended that hospitals be divided into two broad categories: for-profit hospitals and not-for-profit hospitals. The two categories would come under different taxation arrangements. Prices of hospital services have also been divided into state controlled prices in not-for-profit hospitals and market-driven prices in for-profit hospitals. Although such reform is still in the early stages of implementation, it is noted that many small-scale private hospitals have a fee schedule that is lower than public hospitals. This reflects the market at work, ie lower price but higher volume services. The ease of access and convenience of service provision have made the private sector more competitive than the public sector. This has gone some way to alleviating the inequity issue.

However, recent, informal discussion with government officials also suggest that significantly more hospitals have opted for the not-for-profit status, reflecting the use for such labelling as marketing tool. Whereas the government had seen the hospital classification policy has defining taxation and regulatory regimes, reflecting the relationship that government should have with health providers, the hospitals have played on the community's anxiety about their health being the basis of profit and use the not-for-profitable as a competitive tool.

With the implementation of regional health planning policy since 1997, and the rational distribution of health resources initiated recently in urban areas, key informants report that some of the urban hospitals are in the process of amalgamation or forming group hospitals. This horizontal integration process is concerned with increasing market share. At the same time, there is also a process of vertical integration. In the attempt to gain advantage in the competitive market and be complementary in service provision, these grouped hospitals have expanded their services even into community services such as family sick beds. The amalgamation of hospitals is also intended to absorb the previous secondary hospitals so that eventually, in the urban areas, there will be only two levels of service, hospital services and community services.

One consequence of this classification is the further privatisation of hospitals. In the big cities, not-for-profit public hospitals are still the dominant form of hospital ownership. In the small to medium sized cities, share-holding hospitals and group hospitals, which are of a private nature, are increasing. Despite government claims that hospital services will not be privatised, in reality, the privatisation of hospital services is increasing. Co-location of private services in public premises and the privatisation of certain departments in the public hospitals are frequently observed phenomena.

3.3: Development of community health services

With hospital services becoming increasingly sophisticated, expensive and difficult to access without insurance coverage, the government has recently moved to promote community health services. The purpose of such an initiative is to reduce the government's financial constraints and improve equity by increasing the access of the general population to health services.

This is a sound policy, but community confidence needs to be built. There is still a lack of qualified doctors practising at the community level and the community clinics are still in the process of development. One negative aspect of community health services is that people generally regard community services as inferior and, as a result, under-qualified doctors have

been diverted to practise at community level. Such an arrangement is detrimental to the healthy development of community services.

Another major problem is the community health services' ability to generate revenue and to retain qualified doctors. At this time, most of the community services are run by the public sector, the staff are poorly equipped and inadequately trained (Dong 2001). There are a growing number of private practitioners, who are recently retired from public posts, who have experience and good clinical reputations. They are a source of competition for the newly developed community health services. Increasing competition between public and private practices may result in operational and financial difficulties for public community services. The government could change its policy and allow the private sector to run community services. Alternatively, it could provide more financial support for community services development. Otherwise, contrary to its original policy design, the public sector may eventually be forced out of the market by the private sector. Such a scenario could result in a waste of government investment in community health services; eventually the public services would take up those impoverished populations as their target population. There are reports of private community services on a pilot basis, but there is no policy direction towards it.

There is evidence from current research (Chaojie Liu, PhD-in-progress at La Trobe University) that there is a further gap between policy intent and policy implementation. Although community health services had been seen as a universal service that would provide a gatekeeping and preventive function for the health system, it appears that few consumers view them as quality health care. They report self-management for common illness and seeking care at the hospital for more significant medical needs. As a consequence, the attendees at community health services are largely aged and unemployed people.

3.4: Pharmaceutical reforms

Pharmaceuticals have long been the most problematic issue in China in that its role is to help hospitals and the pharmaceutical industry to earn the money from the people. Chinese health policy has allowed hospitals to earn a 15 to 25 percent mark-up on drug sales to compensate for their budgetary shortfall. This has encouraged doctors to over-prescribe unnecessary drugs to the patients. This has contributed to the urban medical cost escalation of about 12 percent a year.

Given the widespread complaints about doctor's over-prescription, the pharmaceutical policy reform paper issued in 2000 has requested all hospitals to separate prescribing from dispensing and to have a separate accounting system in place separating the revenues from expenses. The taxation policy has also been issued this year requesting hospitals to differentiate their sources of revenue. Pharmaceutical reforms have been implemented over the past year and there are very few results. In big cities, such as Beijing, the initial results are the obvious separation of accounting. But, given that pharmaceutical incomes are an important source of revenue for hospitals, the financial department has still returned the major part of pharmaceutical income to hospitals for their operations. The real impact of such policy will not be seen until it has been implemented across a wide geographical area. The pharmaceutical reforms, if successful, may be a critical factor in ensuring the health system is focused on the health needs of the patients.

4: Rural health policy and financing

4.1: The situation in rural areas

Despite the high-level direction from the State Council in 1996 and the efforts of many in the health sector across China, the rural health situation in 2001 continues to lag behind the urban areas, just as the provinces in the hinterland lag behind the coastal areas.

Based on the UNDP Health Risk Index (UNDP 1999), the data for 1999 shows the worst-ranked provinces overall are mostly in central and western China:

1. Tibet (.75)
2. Ningxia (.56)
3. Guizhou (.52)
4. Henan (.47)
5. Gansu/Yunnan (.42)
6. Zhejiang (.37)
7. Guangxi (.35)
8. Shanxi (.34)
9. Jiangxi/Shaanxi/Qinghai (.33)
10. Sichuan (.31)

When examined in relation to selected categories of risk, the rankings again reflect similar geographical distribution:

Table 3: Environmental Risk Factors by Geographical Region

INDOOR AIR POLLUTION (index)	POPULATION EXPOSED TO UNSAFE WATER	POPULATION WITH POOR NUTRITION	POPULATION WITHOUT HEALTH UNITS
Tibet (1.00)	Tibet (81.50%)	Ningxia (12.56%)	Tibet (38.89%)
Guizhou (0.77)	Henan (54.81%)	Yunnan (7.97%)	Zhejiang (25.55%)
Qinghai (0.69)	Yunnan (33.91%)	Tibet (6.28%)	Guizhou (17.18%)
Tianjin (0.65)	Ningxia (30.60%)	Henan/Guizhou (6.17%)	Hainan (13.46%)
Beijing (0.54)	Guizhou (29.91%)	Qinghai (5.84%)	Sichuan (11.51%)
Gansu/Ningxia (0.43)	Gansu (29.90%)	Gansu (5.69%)	Shaanxi (10.02%)
Shanxi (0.36)	Guangxi (29.76%)	Jiangxi (5.21%)	Xinjiang (8.69%)
Heilongjiang (0.32)	Zhejiang (29.56%)	Guangxi (4.97%)	Hubei (8.26%)
Shandong (0.27)	Shaanxi (25.28%)	Hainan/Jilin (4.69%)	Shanxi (6.95%)

Health care expenditure data in 1998 for three poor provinces can be contrasted with three coastal provinces to illustrate the disparities in resources available. Appendix 2 shows the differences in public, social, and private expenditure as well as the differences between urban and rural.

Reasons for not seeking care also differ across regions. The economic barriers are notable, and differences can be seen even between rich and poor rural areas, as data in Table 4 below indicate.

Table 4: Reasons for Not Seeking Care

Reasons For Not Seeking Outpatient Care	Rich Rural Areas	Poor Rural Areas
Don't feel sufficiently ill	41%	34%
Economic difficulties	30%	39%

Other	29%	27%
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Economic barriers may be even greater than the data in the table above suggests. A National Health Services Survey reported that 58percent of rural patients who declined to be hospitalised, following medical advice that they should be, cited their inability to pay as their reason for refusing hospital treatment. In urban areas the figure is 39 percent (Liu *et al* 1999).

Data from the 1999 Annual Health Statistic Report provide comparisons between three poor provinces and three coastal provinces. Data in Table 5 illustrate the extent of differences in health services utilisation at different levels in the rural areas.

Table 5: Health Service Utilisation in Rural Areas

	National Total	Guizhou	Chongqin	Gansu	Shandong	Jiangsu	Guangdong
Utilisation Rate of Beds (%)							
County Hospitals or above	73.02	67.46	63.51	60.78	82.26	84.97	78.08
Township Health Centres	32.8	34.98	36.69	25.11	26.37	35.90	34.98
Average Daily Outpatients per Hospital							
County Hospitals or above	271	125	269	208	307	500	509
Township Health Centres	59	31	56	39	81	107	211
Annual Number of Outpatients Treated per Doctor							
County Hospitals or above	1159.9	882.3	1202.1	1028.2	1024.3	1358.3	1951.4
Township Health Centres	1000.9	496.3	1592.0	810.1	1136.1	2112.1	3441.0

4.2: Cooperative Medical Systems

There have been numerous experiments with the re-establishment of CMS. These attempts have occurred in both rich and poor rural areas. The models have varied in terms of:

- Premium and reimbursement levels (low versus high)
- Benefit coverage (in-patient versus outpatient)
- Level of management (village versus township)

Where CMS exist, experiences suggest they can make a difference in health services utilisation. Price signals are important and higher rates of reimbursement can bring about dramatic increases, as seen in DFID pilot counties in the World Bank Health VIII Project. Those who have suffered catastrophic events, particularly major injuries, report particularly strong support for CMS. Linking CMS to essential drug lists can also bring about positive changes in

prescribing behaviour, as demonstrated in operations research studies conducted under the World Bank Health IV Project.

An evaluation of a CMS re-establishment project found that, after a two-year trial, outcomes were mixed. The evaluation measured the results of a pilot project, begun in early 1994, in 14 counties of seven provinces. A primary focus of the evaluation was the effectiveness of health insurance protection – that is the degree to which the CMS was effective in reducing the risk of families having to pay burdensome health care bills. The evaluation found that the burden of health care costs on families had been modestly reduced. The study's authors believe that the pilot provides reasons to be optimistic for the future, it indicates systematic thinking about CMS at a national level and, in other counties, it has been influential in generating a desire to re-establish the system (Carrin, Ron, Yang *et al* 1999). An evaluation of a scheme initiated in Hechi Prefecture, Guangxi Province also reported mixed results. Despite some benefits, the authors expressed concern about the sustainability of the scheme and about its effectiveness in reducing the burden on poorer households. In addition, they argued that “the establishment of a CMS can do little to overcome basic deficiencies in service provision (Yu, Lucas, Gu and Shu 1998)

The overall experience suggests that it is easier to establish CMS in rich rural areas, compared with poor ones (Bloom and Gu 1997). More recent reports, however, point to difficulties in sustaining the schemes even in rich areas. There are a number of apparent difficulties in implementing CMS. The households' capacity to pay is an obvious problem in rural areas. Contradictory government policies represent an additional barrier. Despite support from MOH and the State Council, there are other Government decrees about limiting fees and charges collected from farmers. Given CMS participation is voluntary, collection of premiums can be seen as an impost from Government. The voluntary nature of contributions also limits the schemes redistributive ability, that is from the healthy to the sick and from the rich to the poor (Bloom and Tang 1999). More important, however, is the issue of trust and governance. Experience from a number of locations suggests that farmers are sceptical about the funds being managed by the Township Health Centre. They are concerned the funds will be used to support health and other officials, rather than be returned to farmers in the form of services. Although democratic supervision has been required by Government policy and implemented in a range of forms, there remain concerns that such mechanisms are not yet operating effectively or with an appropriate degree of transparency. In addition to farmers concerns, there is evidence that workers in rural areas believe farmers' contributions to CMS are inadequate given their relative income (Carrin, Ron, Yang *et al* 1999).

Research and anecdotes from those involved in developing CMS suggest that the major factors contributing to success or failure of CMS to date are: financial resources available to peasant household, government financial and policy support for the schemes, community trust about the management of the funds, beneficiary knowledge and understanding about service coverage, and community experience in receiving benefit.

The outcome of the Mid-term Review of Health VIII would suggest that changes can be expected in both CMS services and financial management in the near future, in order to encourage greater participation. Key amongst the strategies are:

- Benefits to cover catastrophic events.
- Financial management to move towards individual/family/household accounts. Under these scenarios, CMS would then look more like urban ISA and appropriately start to blur the urban-rural divide.

Policy-makers are also beginning to move away from the notion of one-size fits all for CMS. Key informants are making references to “three worlds, three worlds” to suggest that rich areas, middle-income areas, and poor areas may require very different solutions.

4.3: Medical Financial Assistance

CMS is intended to be a universal, albeit voluntary, scheme. A supplementary, or alternative, approach that has also been trialed is the Medical Financial Assistance scheme. This began with World Bank Health VI, in the form of a fund to cover antenatal and postnatal care for poor mothers. In World Bank Health VIII, this approach has been instituted in 71 poor counties, with the intention of covering basic health services for the poorest five percent of the households (on a means-tested basis and with a health care card).

The experiences so far suggest that MFA can have a significant impact on access to health care, provided the farmers know about it and the reimbursement level is sufficiently high. The slow rate of expenditure has been due to conservative management practices, that is, managers being concerned about running out of funds.

Despite the early success, there are major questions about its future by virtue of lack of clear policy direction on rural safety net development. In principle, the Ministry of Labor and Social Security should be concerned with safety net issues. They are, however, solely focused on urban areas. The Ministry of Civil Affairs attends to the needs of the destitute, including those falling into poverty because of ill-health and natural disasters. They have now successfully implemented a lottery scheme that raises funds for their work. Unfortunately, they have yet to see the development of an MFA-style scheme as coming within their brief. Only Qinghai province has agreed to expand the MFA to all counties, based on funds from Civil Affairs.

4.4: Service delivery system

The supply side of rural health remains equally problematic. Despite policy direction to re-establish and strengthen the functioning of the three-tier network, institutions at the same level (for example county hospital versus MCH) and at different levels (for example county and township) all compete for patients. There appears to be a growth in the private sector (for both traditional medicine as well as western medicine), although empirical information is limited. At the same time, public health institutions remain weak, as the combined result of the need to recover costs and the lack of public demand for preventive and inspectorial services (Liu, Hsiao and Eggleston 1999, Bloom and Gu 1997).

A review of the outcomes associated with devolving health services in the rural county of Donglan found that a combination of factors resulted in deterioration in the performance of health centres. These factors included:

- Severe financial constraints – the ratio of government funds to health centre revenue was reduced and health centres earned an increasing amount directly from patients;
- Shortages of personnel with medical and managerial skills;
- Inappropriate skill mixes within facilities caused by an inability to transfer staff; and
- Inappropriate employment practices where people were hired as a result of their association with local power holders, rather than their skills and experience (Tang and Bloom 2000).

Devolution has resulted in a change of role for rural health managers at the system level. Where they were once required simply to implement a central plan they must now operate as planners and regulators, a role which requires training and resources. For those at the institutional level, their imperatives are to become business managers.

Through projects such as World Bank Health VIII, there are some instances of “integrated management systems” in place. The models range from group purchasing of pharmaceuticals, to group administration of township and village health clinics, to each tier providing clinical training and supervision to the next level. The consistent barrier to improved operation is reported to be the financial imperatives and incentives that operate at the level of each institution.

4.5: Policy debates and developments

More recently, debates have emerged about the future ownership arrangements for rural health institutions. These have arisen, in part, from urban health policy supports new forms of ownership, and from local governments in rural areas that are no longer interested in supporting health services. These developments remain controversial. In Haicheng, Liaoning, the local government privatised the township health centres and is reporting vastly improved health services, as measured by utilisation and profit (Shi and Li 2000). Other places in China are watching with interest and scepticism.

There are also emerging debates about the future of community health financing in rural areas. Non-health sector economists have argued that CMS was suited to a planned and underdeveloped economy and provided only basic, mediocre-quality care. With the transformation of the rural economy, the old system is no longer sustainable, nor appropriate for meeting the health needs (Shi and Li 2000). A number of health economists and government officials are starting to suggest that household medical savings accounts, parallel to urban health insurance arrangements, should be tried, given the lack of progress on CMS. Others believe that improved governance arrangements, coupled with stronger government support, would make CMS viable and sustainable. This could be achieved through an increase in direct government payments to CMS, although this would do little to overcome management problems. Alternatively, government could increase funding to facilities in poor areas to enable basic services to be provided free of charge, however it might be difficult to ensure that the funds were spent on services (Bloom and Tang 1999).

In 2000, Li Lanqing, Vice Premier in charge of the health sector, called for a new rural health policy. This was released in May 2001 by the State Council. In contrast to the 1996 State Council policy document, this one gives more specific instruction to a range of policy debates:

- County government is to take the main responsibility for the rural health system, that is to make the three-tier network work;
- Ownership of rural health services should be primarily public, although different forms can be developed;
- Government should be setting aside specific funds to support public health and rural basic health services (that is township and below);
- Health workers should be moved onto contract employment systems; township health centres should be hired and fired on the basis of performance; urban medical personnel are to serve minimum periods in rural areas before they are eligible for promotion; and
- Essential drug lists to be introduced and strict control to be put into place for supply and distribution of pharmaceuticals.

The only area of policy, which remained at a high level of generality, was in relation to health security. The document supported the continued development of a diversity of models. At one level, this could be interpreted as giving permission for experimentation where CMS have not worked. At another level, it can be seen as lack of support for safety net arrangements for health.

Early evidence about implementation of the new policy suggests that the needed personnel reforms may meet some difficulties. With the authority of higher levels of government limited by lack of financial transfers to lower levels, provincial-level informants are reporting resistance from the county level to take direct responsibility for township health services, particularly to be shedding staff who have been employed/placed for their familial connections rather than their technical skills. Some suggest that the personnel reform is possible only when reforms on ownership and property rights are effected, ie government ceases to be the owner and employer.

The broader policy environment also continues to bring challenges for the health sector. The policy to convert fees to taxes is most troubling for those who are committed to the renewal of CMS. Local governments have always raised revenues through collection of fees and charges on a range of locally determined activities. The new policy direction to implement a unified tax system, and remove ad hoc fees and charges, provides an improved framework for public administration at the local level. However, collecting for CMS premiums is not included in the scheme, so this policy appears to add a further challenge to the local capacity to collect household contributions for CMS.

The new Government priority of Western Regional Development also appears to represent mixed signals. On one hand, a concerted effort to develop the economy and the urban and transportation infrastructure of poor provinces is likely to close some of the gaps with the coastal areas. On the other hand, the health sector has yet to be nominated as one of the priorities for investment (while the education sector was designated the last of ten priorities).

The MOH issued guidance in August 2001 on health work within the context of Western Regional Development policy. The key measures stated include:

- Special funding measures – through specific national program funds (for example endemic diseases and TB), directing funds from donor agencies, decreased counterpart funding requirements;
- Nominated public health priorities – infectious diseases, endemic diseases, HIV/AIDS, rural public health facilities and blood banks, strengthened inspection/supervision;
- Linking health with economic and infrastructure project – ensure health impact is anticipated and preventive efforts built in; and
- Education and training – pairing coastal institutions with ones in Western provinces, recruit and retain highly trained people from outside of Region, satellite education networks.

Many of these capture ongoing initiatives and current priorities, rather than represent significant and new approaches. Nonetheless, such an explicit policy statement may help lay the groundwork for further discussion with Government about the positioning of the health sector in the context of Western Regional Development.

It has been argued that the uneven, and in places underdeveloped, regulatory system in the health sector results in local administrative priorities taking precedence over national health policy objectives (Bloom and Gu 1997)

5: Other reforms and emerging issues

The policy priorities for the MOH, in the Tenth Five-Year Plan (2001-2005) are:

- Rural health reforms – basic health services and CMS development;
- Health sector reform, including regional health planning, hospital management reforms, sale and management of pharmaceuticals, and community health services development;
- Reform of health inspection; and

- New and re-emerging diseases, including HIV/STD, NCD and TB.

The broad priorities in a five-year plan do not reflect acutely the day-to-day preoccupation for health administrators. The reform program adopted in 2000 gives a better feel for the key issues being worked on – and these tend to be the systemic or structurally oriented issues in the health sector, rather than targeted to health issues: (MOH, 2000)

- Set up Urban Health Insurance System - an integrated urban health insurance scheme to replace the previous GIS and LIS, with emphasis on individual contributions, known as Medical Savings Accounts model;
- Separating Prescription from Dispensing - to separate the billing accounts of doctor's services from drugs income, as a measure to control over-prescription of drugs by the doctors in the hospitals;
- Differentiating Regulations on Urban Hospitals - to differentiate hospitals into for-profit-hospital and non-for-profit hospital, and thus to use different regulatory instruments to regulate the hospital services and financing;
- Drug Price Reform - to deregulate drug price controls for those for-profit hospitals, and regulate not-for-profit-hospitals through tax policies;
- Health Services Price Reform - to deregulate the service price controls for those for-profit hospitals, and regulate not-for-profit-hospitals through tax policies;
- Regional Health Development Program - to strengthen the government's planning role under market conditions in ensuring rational resource distribution in a given population region;
- Urban Community Services Development - to transform primary and secondary hospitals into community health services in an effort to control medical cost escalation and to provide accessible and essential services in the community setting;
- Health Inspection System Reform - intended to change the health departments' managerial functions from "owning" the public health facilities to "regulating" and inspecting health services, with emphasis on the role of regulator; and
- Personnel Reform – to change the public personnel management system from life-long employment to contracts, with an emphasis on performance and competence instead of seniority within the institutions.

Many of these reforms imply the continued domination of hospital and urban health issues in the Government's attention and efforts. Current debates on regional health planning policy, according to key informants, revolve around how to bring military and enterprise hospital into the planning brief and whether private sector services should be included in planning considerations. Clearly, China is still grappling with the meaning of "transition to a market economy" in the health sector.

A number of other changes are, however, occurring without fanfare and may have a significant impact on the health sector. In the recent round of agency restructure and personnel shifts at the provincial level, many new heads of provincial health bureaux come from non-medical backgrounds. Some have estimated this to be as high as one-third of the new leadership. Such shifts have the potential of either bringing health sector development closer to government's agenda (of complete transition to the socialist market economy) or having leaders who are more effective advocates within the framework of broader government policy imperatives.

The concern for preserving social stability is also likely to have subtle but importance influence on health sector priorities. For some years, there has been increased reporting of public discontent about the quality and prices of urban health care. These have more recently shifted toward consumer complaint about fraudulent pharmaceuticals and defective therapeutic products, pointing to the need for better regulation of the medical marketplace (Dong, Bogg, Rehnberg and Diwan 1999, Qi Bao 2000). Within the last year or so, popular unrest has been reported about

tainted blood supply. It is, therefore, within this context of social stability that public health issues will emerge and receive attention.

Whether the reform of the Epidemic Prevention Stations – to develop separate inspectorial arrangements and centres for disease control – will result in improved public health infrastructure and capacity will depend, in part, on whether adequate financing and accountability systems are in place. There will be the need for a clear legislative framework for operational activities and a shift away from user pays toward full public funding for salaries and operating costs.

What is notable about the current policy developments in China is the simultaneous implementation of reforms across the whole of the health system. Workforce capacity – to deliver clinical and public health services appropriate to current professional standards and community expectations – will be a key factor for success. Equally, the capacity of the managers in the health system – for institutions at each level and for administration of the system – will be another key factor. In that sense, another issue to be confronted is the shift of responsibility for educational institutions from the health sector to the Ministry of Education. Instead of a system that the Ministry of Health had control, the future shape of the health workforce will be determined by educational institutions and another ministry. Thus, how the health ministry moves to a regulator, leader, persuader/advocate, and coordinator role remains its most significant challenge.

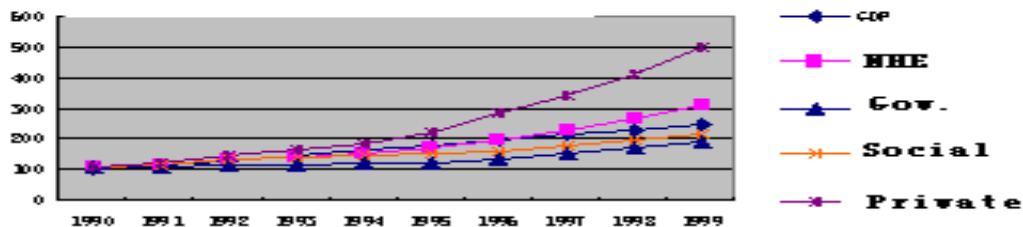
ACRONYMS

CMS:	Cooperative Medical Systems
CPF:	Central Provident Fund
DFID:	Department for International Development (UK)
GIS:	Government Insurance Schemes
HID:	Health Insurance Department
ISA:	Individual Savings Accounts
LIS:	Labour Insurance Schemes
MCH:	Maternal and Child Health
MFA:	Medical Financial Assistance
MOH:	Ministry of Health
MOLSS:	Ministry of Labor and Social Security
RMB:	Renminbi
SPA:	Social Pooling Accounts
UNDP:	United Nations Development Program

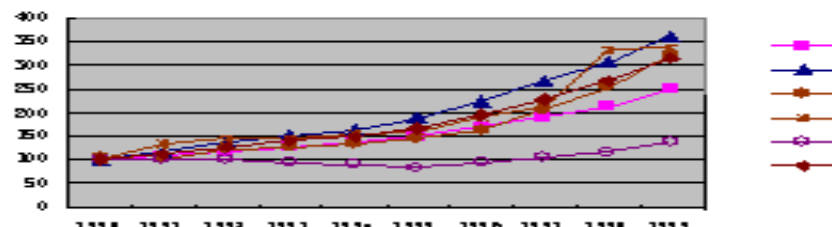
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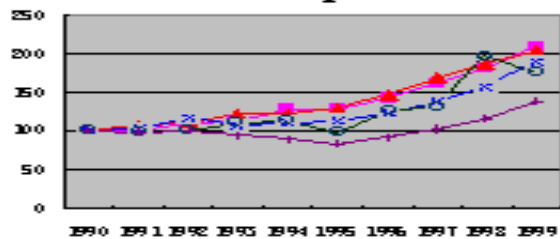
the Growth rate of GDP and HHE and Gov., Social, and Private Health Expenditure



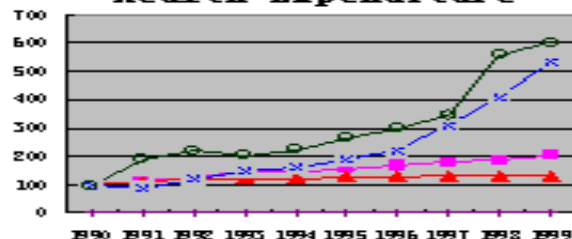
the Growth rate in different Function



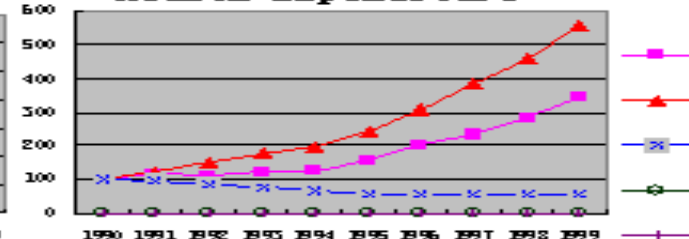
the Growth rate of Government Health Expenditure



the Growth rate of Social Health Expenditure



the Growth rate of Private Health Expenditure



Financing Channels and Levels

	National Total			Guizhou			Chongqing			Gansu			Shandong			Jiangsu			Guangdong		
Year	97	98	99	97	98	99	97	98	99	97	98	99	97	98	99	97	98	99	97	98	99
GDP 100 million Yuan	74462.6	78345.1	81910	790.3	843.5	907.3	1350.1	1429.3	1479.7	781.3	714.2	932.0	6650.0	7162.2	7662.3	6685.6	7200.8	77007	7316	7937	8460
Total Health Expenditure 100 million Yuan	3384.87	3776.51	4178.6	31.1	32.1	34.2	51.1	56.8	63.4	32.9	39.6	40.3	194.6	220.3	254.1	195.8	198.5	226.2	326	331	357
% to GDP	4.55	4.82	5.1	3.9	3.8	3.8	3.8	4.0	4.3	4.2	5.6	4.3	2.9	3.1	3.3	2.9	2.8	2.9	4	4	4
Per Capital Health Expenditure (yuan)	273.8	302.58	331.88	86.3	87.7	92.1	167.9	185.5	206.2	135.5	161.6	163.0	220.2	248.3	286.0	273.9	276.4	313.6	457	465	490
Governmental Health Expenditure	522.08	587.23	640.96				7.0	7.6	8.6	7.2	8.0	8.4	39.8	47.7	55.6	41.5	36.5	38.7	32	33	39
Social Health Expenditure	937.73	1005.97	1064.6				20.0	20.6	21.1	11.3	11.0	11.7	68.9	75.4	84.2	85.0	93.5	99.7	45	49	60
Individual Health Expenditure	1925.06	2183.31	2473.1				24.1	28.6	33.7	14.4	20.7	20.3	85.9	97.2	114.3	69.3	68.5	87.8	150	143	167
Urban Residents	789.04	976.52	1144.5	125.4	145.4	153.3	11.2	13.1	17.1	6.7	11.9	10.4	40.6	43.2	58.6	26.8	22.8	35.9	70	66	81
Rural Residents	1136.02	1206.78	1328.5	24.8	26.7	23.6	12.9	15.5	16.6	7.7	8.8	9.9	45.3	54.0	55.7	42.5	45.7	51.9	82	76	86
Governmental Expenditure				111.8	133.1	170.7	101.0	125.8	150.2	104.3	125.3	147.8	407.8	487.8	550.0	364.4	424.9	484.7	683	826	966

