



Taking Stock: An Essential First Step

For many decades Chinese health achievements were the envy of the world. More recently, however, national and international media have called attention to shortcomings in the health system in China: poor infrastructure, rising health care costs, widespread lack of access to essential health services on the part of the poor, etc. Whatever the merits of these anecdotal accounts, there is now a broad consensus that reforms are needed. There is, however, less agreement about what set of reforms are appropriate, and about what the health system of the future should look like.

At this important crossroads, the Government of China (GOC) has asked the World Bank (WB) to undertake a comprehensive sector study on China's rural health system.¹ This study—undertaken in collaboration with the Ministry of Health (MOH) and other government agencies, as well as selected international partners—is intended to contribute to the Government's efforts to formulate a coherent reform path for the future. It will do so by learning lessons from past experiences in China, as well as from policies and reforms implemented in other countries.

As a first step in preparing the study, a workshop was arranged by the MOH and WB in Beijing on July 1-2, 2004.



Mr. Adam Wagstaff, Lead Economist at the World Bank, in the first of two scene-setting presentations.

¹ The study is referred to as the *China Rural Health AAA (Analytical and Advisory Activities)*. This note was prepared by the World Bank AAA study team following the workshop. For further information on the study and related activities, contact L. Richard Meyers (lmeyers@worldbank.org).

The primary purpose of the workshop was to take stock of current knowledge about the Chinese health sector. The workshop was organized around five themes: (a) government health spending and resource allocation; (b) health service delivery; (c) public health; (d) rural insurance and financing; and (e) urban insurance and financing.²

For each theme, a multinational team, comprising both Chinese scholars and international experts, had been asked to critically examine available material on China's health sector, and make recommendations about areas that need further research and analysis. In addition to these five critical reviews, the MOH also presented findings from the 1998 and 2003 National Health Surveys (NHS), focusing specifically on the five themes of workshop. This note summarizes eight presentations made during the two days of the workshop, as well as the discussions that followed each session.³

The Challenges: An Overview

China's current health challenges can usefully be understood in relation to the role that the government plays in the health sector. This was the perspective offered by Mr. Adam Wagstaff, Lead Economist at the WB, in the first of two scene-setting presentations.

Mr. Wagstaff outlined the three classic market failures that provide a rationale for government intervention in the health sector: asymmetric information in insurance markets; asymmetric information in health care markets; and externalities and public goods (see Table 1). In addition to market failures, equity concerns provide a fourth reason why many governments intervene: most societies consider access to basic health care a right or entitlement, and are unwilling to accept large disparities in health outcomes.

² A sixth theme safety nets and social protection in the health sector will be covered separately.

³ The workshop was opened with remarks from Dr. Wang Longde, Vice Minister of the Chinese MOH, David Dollar, Country Director of the WB Beijing Office, and L. Richard Meyers, Task Manager and Lead Operations Officer, WB.

Mr. Wagstaff proceeded to show how, in each of these four areas, inadequate or inappropriate government intervention in China has resulted in some disturbing, albeit familiar, trends in the health sector: stubbornly low rural health insurance coverage, high and rising out-of-pocket medical expenses, over-provision of drugs and health services, under-provision of core public health services, and unequal access to health care.

The Government of China is firmly committed to addressing these problems in the medium and long terms. In doing so, it is clear that there are limits to what can be achieved through the market. Thus, this first presentation put two central questions on the table for the rest of the workshop: what is the appropriate role of the government in the health sector?, and how can it perform this role more effectively?

The second presentation by Prof. Rao Keqin, Director, Center for Health Statistics and Information, MOH, brought home more fully the nature and scope of challenges in the sector. Mr. Rao presented findings from the 2003 NHS, and

contrasted the current situation with results from earlier surveys in 1993 and 1998.

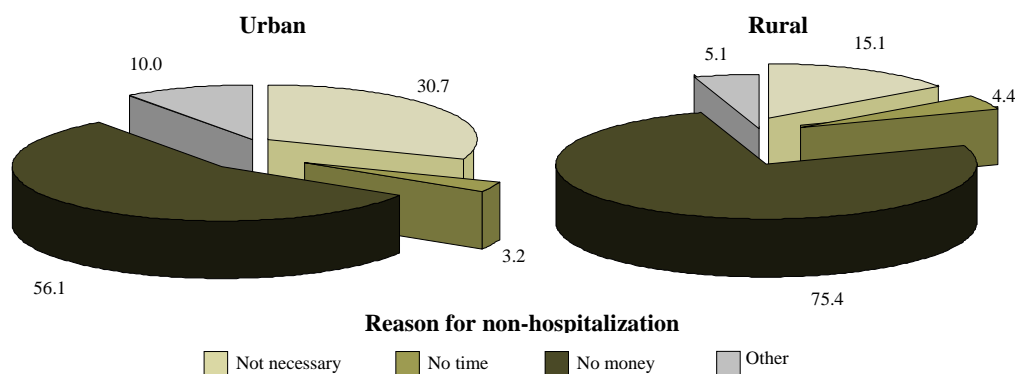
Although the surveys provided some good news—for example, the rate of insurance coverage increased in rural areas from 12.7 to 21.0 percent between 1998 and 2003—the results from the 2003 survey are mostly sobering. Medical expenditures have continued to increase (average annual growth rates between 1998-2003 reached nearly 14 percent); utilization of health services (outpatient visits and hospitalization) has declined in both urban and rural areas; financial constraint is the most frequently mentioned reason for not using outpatient service; and lack of money is also a key factor in constraining the utilization of inpatient services (Figure 1).

The presentation also included evidence from the MOH database on health institutions, which confirmed that low levels of productivity continue to be a problem in China: the number of outpatients per year declined from 504 per health professional in 1997 to 461 in 2002.

Table 1: Rationales for government intervention and how they play out in China

	The issue	How it plays out in China
Uncertainty, insurance & asymmetric information in insurance markets	Voluntary insurance suffers from selection problems, threatening sustainability—compulsion often considered necessary.	Compulsory social insurance for some workers in urban areas. Rural insurance left to local communities; low coverage since early 1980s; high exposure to risk of out-of-pocket expenses.
Asymmetric information in health care markets	Providers may exploit informational advantage to generate demand, especially if paid by fee-for-service (FFS). Regulation needed—of price & quality.	Increased reliance on FFS plus piecemeal price regulation creates negative incentives: unnecessary care; over-billing; increases in price per contact. Also quality concerns.
Externalities & public goods	Free market results in too little immunization, etc. Reduce price paid by consumer, but not fee received by provider. Also need surveillance, monitoring, etc.	Limited subsidies for public health, with public health institutions (PHIs) encouraged to generate fee income. Neglect of public health in pursuit of other revenue-generating activities?
Equity	Poverty deters use or drives households into poverty. Subsidies necessary for out-of-pocket payments & insurance costs.	Programs aimed at poor very limited. Insurance coverage low among poor. Out-of-pocket payments a cause of poverty.

Figure 1: Many who need care are not hospitalized because it is too expensive (%)



Source: 2003 National Health Survey

Ms. Hou Yan, Deputy Director General, Department of Social Development, National Development and Reform Commission (NDRC), and discussant of Mr. Rao's presentation, welcomed the hard evidence the NHS provides.

She noted that the findings are consistent with what she sees as part of her daily work. She also pointed to some important questions raised by the survey. Why do we see these negative trends despite all the efforts that are made to strengthen the health system? Do we have any evidence of successful experiences? Are the NHS data adequate to tell us about the impact of new policy initiatives? It is possible that the government efforts that Ms. Hou referred to have yet to bear fruit, and that 2003 survey results are a reflection of past rather than current policies. Her call for more and better evidence on the impact of policies was a theme that was to recur throughout the workshop.

**Public Expenditure for Health:
Value for Money?**

In the first of the five thematic presentations, Christine Wong, Professor at Washington State University, presented her team's findings on public expenditure and resource allocation in the health sector.⁴ Government expenditure on health as a share of GDP is low in China relative to many other countries. While this points to a possible case for increasing spending over the medium and long term, there are other features of health financing in China that are in even more urgent need of attention.

⁴ Other team members included Zhao Yuxing of the China National Health Economics Institute and Peter Smith of York University.

First, government expenditures on health are dwarfed by rapidly growing private expenditures, which now comprise nearly 60 percent of total health expenditures. This trend is worrying from both an equity and efficiency perspective.

Second, a high level of decentralization of health expenditures, combined with limited equalizing transfers, result in a highly inequitable allocation of public resources. Indeed, contrary to the situation in some countries, public spending in China is, at least in some areas, *inversely* related to needs (Table 2).

Table 2: Health spending is lower where needs are higher in China

	Under-75 mortality rate (% of national)	Public spending per capita (% of national)
Manchester	135.4	133.1
West Surrey	79.5	81.7
ENGLAND	100.0	100.0
Gansu	100.6	87.2
Fujian	86.9	111.0
CHINA	100.0	100.0

Third, the way in which the central and local governments currently spend money on health is not efficient. This can be seen in inadequate financing of core public health functions, which, in combination with financial incentives for providers to raise revenues through chargeable services, is resulting in a lack of attention to public health functions. But it can also be seen in the approach to provider payment. At the moment, providers are subsidized through a mix

of demand and supply-side subsidies. Although new insurance initiatives are shifting some of public spending to the demand side to make provider payment contingent on patient choices, norm and negotiation-based subsidies to providers persist.

The team noted the GOC faces a unique opportunity to reform the level and modalities of public expenditure on health: there has been a shift in policy priorities towards balanced development and the rural sector; SARS and other factors have resulted in a growing awareness and acceptance of the need for health sector reform; recent increases in government revenues as a share of GDP have created fiscal space to increase spending; and ongoing Public Service Unit (PSU) reforms create opportunities to improve the efficiency of public spending.

In summary, increased public spending on health is likely to be required in the medium to long terms, but measures must also be taken to ensure that money is spent more effectively.

Ms. Sun Zhijun, Deputy Director General, Department of Social Protection, Ministry of Finance (MOF), concurred with the team's conclusions. She agreed that China needs to increase public spending on health, that geographical disparities must be reduced, and that more strategic provider payment is essential for improving efficiency.

According to Ms. Sun, there is a strong government commitment for this to happen, and reforms are already under way. Nonetheless, successful reforms depend on clarity about the roles and responsibilities of different levels of government in the health sector, and this is an area that remains unclear.

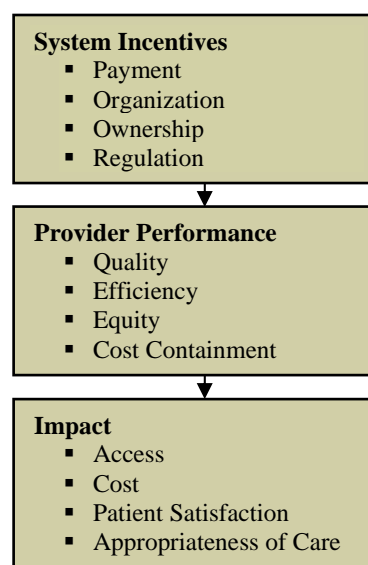
In the general discussion that followed, most contributors voiced agreement with both the presentation and Ms. Sun's comments, but some also questioned the proposed shift towards demand-side subsidies. They pointed out that the abandonment of direct supply-side financing would have far-reaching implications—e.g. relating to job security for staff—that would need to be thought through, and that effective demand-side subsidies depended on strong government capacity in areas such active purchasing, contract design and management, etc., where current expertise is scarce.

Service Delivery: Incentives Matter

In the second critical review⁵, Karen Eggleston, Professor at Tufts University, presented her team's review of the literature on service delivery in China.

The premise of the presentation was that incentives matter, and that many of the service delivery problems observed in China today—low quality and patient satisfaction, high costs and low productivity, and inequitable access to care—can be understood with reference to the incentives that providers face. These incentives are shaped by key health system characteristics, including provider payment methods, organizational features of providers, ownership, and regulation (Figure 2).

Figure 2: Analytical framework



The team presented striking evidence of health system incentives at work, in particular in relation to provider payment. Innovative reforms to replace fee-for-service with prospective payment, combined with careful data collection, has generated valuable evidence that payment reforms can contribute to cost control. But Prof. Eggleston also pointed out the Chinese evidence-base is limited in many areas, such as regulation of drug and service prices, hospital organization and management, provider competition, privatization and other ownership reforms.

⁵ Other team members included Meng Qingyue of Shandong Medical University and Li Ling of Peking University.

Despite a scarcity of evidence, the team argued that theory and international evidence suggest that more active purchasing by both government and health insurance agencies can improve provider performance, and that a “level playing field” for the public and private sectors will not only promote value-for-money in the purchasing of health care, but also avoid excessive segmentation in the health care market.

Similarly, Prof. Eggleston made a case for improved regulation, including in the areas of pharmaceuticals and service pricing. Most importantly, however, the review pointed out that there are no “silver bullets” in the area of service delivery reform, and that the impact of reform depends on context and implementation. It is therefore important that reforms be accompanied by careful impact evaluation and efforts to understand why a particular reform initiative can be successful in some contexts and not in others.

The discussant, Mr. Fei Zhaohui, Deputy Director, Division II, International Department, MOF, appreciated the structured approach to looking at service delivery and echoed the calls for reforms. He expressed particular concern about persistent growth in drug expenditures. “Radical reforms to cut the links between drug selling and hospital incomes are necessary,” said Mr. Fei. Even though the problems arise from institutional and organizational factors, rather than the motivation and integrity of health professionals, health professionals are increasingly looked upon as “wolves in white” rather than “angels in white”. This is undermining the respect and morale of the profession, he suggested.

Mr. Fei also noted that the current system is associated with strong vested interests, so any reform is likely to be controversial. Other contributors from the floor agreed that reforms are necessary, but raised questions about what expenditure increases should be considered “reasonable”.

A local health official from Shandong province noted the dual roles of MOH being both owner and regulator of hospitals is inappropriate, and called for international evidence on hospital ownership reforms. He also mentioned that reforms to separate drug prescription and sale is ongoing in Shandong. However, given the importance of drug revenues for hospitals, these reform initiatives have raised difficult questions

about how the resultant financing gaps can be filled.

Public Health: Old and New Challenges

The third critical review was concerned with public health.⁶ Professor Hu Shanlian, Fudan University, began the team’s presentation by noting the considerable achievements in public health in China over the last five decades.

Core public health functions are related to market failures, in particular externalities and public goods, which result in inadequate incentives for individuals to invest in certain activities. A classic example concerns communicable diseases. The prevention and control of diseases such as smallpox, polio, schistosomiasis, and TB have broad benefits. Yet, individuals tend primarily to take into account private costs and benefits when making decisions. To overcome this problem, the Chinese government has in the past intervened effectively to make sure that adequate resources are provided to address these market failures.

Notwithstanding past successes, Prof. Hu suggested that many challenges remain: new infectious diseases are emerging (e.g. SARS, HIV/AIDS) and some old problems are re-emerging with new force (e.g. STIs, schistosomiasis); non-communicable diseases and injuries account for a growing proportion of the burden of disease and require targeted public action; and MCH and TB comprise an unfinished agenda. Currently, the health system is not addressing these challenges as effectively as it could. The team questioned whether adequate resources are channeled to core public health functions.

More importantly, perhaps, the past has seen an inappropriate reliance on user fees for some services, and provider subsidies have not been used strategically to promote efficiency and to ensure that public health agencies and providers focus on the right set of activities. These arrangements have both discouraged use of public health services (e.g. immunizations), and distorted the incentives of providers.

⁶ Other team members included Wang Hong of Yale University and Mariam Claeson of the World Bank.

The team also pointed at other weaknesses in the public health system: unclear overlapping mandates of CDCs at different levels, and between the CDC and other agencies; lack of clear guidelines and enforcement of public health regulation; and weaknesses in surveillance systems, relating both to data reliability, transparency, and information disclosure.

The Government has made a commitment to increase public support to public health. The overall conclusion of the critical review, however, was to emphasize the need to look beyond the level of financial support to ensure that public health functions are performed effectively and efficiently.

Mr. Liu Yunguo, Deputy Director General, Foreign Loan Office, MOH and the discussant for the session, agreed with the team’s inter-sectoral approach, and with the view that too much money is being spent on treatment of disease rather than prevention and control. Mr. Liu was pleased to see that the government is now putting new money into the public health area. These initiatives highlight the need to establish clear objectives and targets on what would be achieved with this new money so that the impact on health system performance can be properly assessed.

Other comments from the floor also concurred with the presentation, and reiterated the call for reform of the arrangements for financing public health services.

**Health Insurance:
Which Way Forward?**

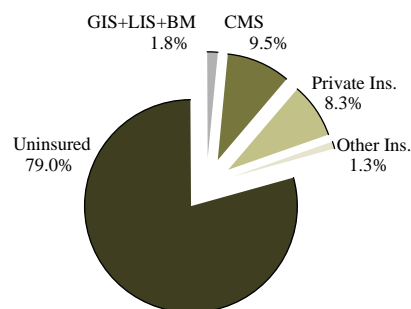
The main part of the workshop ended with two presentations on health insurance in China.

In the first presentation, Brian Nolan, researcher from the Economic and Social Research Institute in Ireland, discussed his team’s review of health insurance arrangements in rural areas.⁷ Ongoing reforms—in particular the introduction of the new, government-supported Cooperative Medical Scheme (CMS)—take place against a background of very low coverage since the old CMS schemes collapsed in the early 1980s (Figure 3). The new scheme is premised on voluntary participation,

⁷ Other team members included Mao Zhengzhong of China West Medical University and Liu Yuanli of Harvard University.

county-level risk pooling, a focus on catastrophic costs, and financing through contributions both from individuals and different levels of government.

Figure 3: Health insurance coverage in rural China is low



Source: 2003 NHS

While recognizing the innovative nature of the scheme, the team pointed out that voluntary schemes are invariably unsustainable due to adverse selection (“better” risks opt out). Indeed, in the international context, the historical evolution has been to schemes that are mandatory and fully integrated with urban schemes.

The team also pointed at other problematic features of the CMS scheme. The focus on catastrophic costs may reduce the perceived benefits of participation. Even for catastrophic costs, co-payments remain high, limiting the usefulness of the scheme for poor households who in many cases remain unable to pay for health care.

Although it is widely acknowledged that administrative capacity and accountability are important constraints in implementing the new CMS, Mr. Nolan suggested that current policy debates have not fully explored all options for addressing these problems. In particular, he emphasized the need for facilitating learning and sharing of experiences across counties, and for exploring administrative and other links between rural and urban insurance schemes.

Mr. Han Jun, Director General, Department for Rural Development, Development Research Center (DRC), the State Council, commended the review for raising important issues, and pointed out that many of the problems documented by the review are consistent with findings from WHO and DFID case studies. He also noted that

government subsidies to the new CMS are quite low, in particular relative to urban health spending, and not very well targeted to the poorest counties and individuals.

Other contributors from the floor also commented on the public expenditure implications of the new scheme, wondering whether the new commitments by government are really affordable.

In the second health insurance presentation, Gordon Liu, Professor at University of North Carolina at Chapel Hill, went on to present the critical review on health insurance in urban areas⁸, where far-reaching reforms have also been introduced during the last decade. Prof. Liu discussed the different models that have been used for the new Basic Medical Insurance (BMI) scheme.

While there has been a lot of variation in both design and implementation across different cities, a number of fundamental issues arise in all schemes: How can coverage of the schemes be expanded? What can be done to promote cost control and financial sustainability? What are the equity implications of the new schemes—both in terms of utilization and financing?

In an overview of international experience, the team noted that most countries achieve universal coverage through a combination of tax and social insurance financing. This has often been a gradual process, whereby dependents, self-employed, and rural residents are folded into the overall scheme. In general, international experience clearly points to the merit of systems that include the poor in the general scheme rather than setting up parallel arrangements.

Looking ahead, the new BMI provides a good base for building a coherent and comprehensive insurance scheme in China. Yet, as reform progresses, solid evidence on the impact of the new scheme will be needed. Indeed, there are currently many gaps in knowledge, concerning the merits of the medical savings accounts approach to health insurance, provider payment methods, the appropriate role of private insurance, etc. In this respect, lessons from urban areas can be of direct relevance for the design and implementation of rural insurance schemes.

⁸ Other team members included Wen Chen of Fudan University and Brian Nolan of Economic and Social Research Institute, Ireland.

But improved sharing of experience can also usefully pave the way for more integration between urban and rural schemes in the longer term.

Mr. Wang Hufeng, Director, Comprehensive Division, Department of Medical Insurance, Ministry of Labor and Social Security (MOLSS), was the discussant for the critical review on urban health insurance. Mr. Wang noted that many local governments were undertaking research on the new schemes, but concurred with the team's call for more careful data collection and detailed analysis. He also agreed that urban and rural schemes needed to be studied together—both because lessons may be learnt across schemes, and because decisions on policy reforms in one area will undoubtedly have an impact on the other.

Summing Up

Over two days, the workshop covered a broad range of issues. There were many areas of consensus, but some points also led to heated debates and disagreements.



Closing remarks by Vice Minister Wang Longde, MOH

Prior to the closing remarks of Vice Minister Wang Longde, Mr. Wagstaff summarized the conclusions from the workshop by pointing to both areas of agreement and issues that remain under discussion (Table 3).

Mr. Wagstaff also emphasized the need to look beyond the individual themes, and to explore the connections between different policy agendas: the synergies between rural and urban health insurance programs; the connections between different levels of government; the links between public expenditure issues and service delivery; the connections between health insurance and safety nets; and the connections between public

health infrastructure and the delivery of personal health services.

During the workshop many contributors called for more and better evidence on the impact of health sector policies.

The conclusions from the workshop provide a solid foundation for developing further analytical

work and detailed reform proposals—both as part of the AAA process and more broadly.

But while good evidence is essential for designing good policies, Mr. Wagstaff remarked that successful and sustainable reform also needs to take into account the interests of different stakeholders, as well as the inherent constraints in transitioning from one set of institutional arrangements to another.

Table 3: Some conclusions

Public Expenditure	Service Delivery
<p>Agreement</p> <ul style="list-style-type: none"> • Higher government spending is warranted; already increasing; rural areas being favored • Inefficiency: subsidies not linked to performance <p>Under discussion</p> <ul style="list-style-type: none"> • Reforms necessary to increase spending efficiency? • Role of supply-side subsidies? Link those left to performance? • Need for further equalizing transfers? • Projections and prioritization of government expenditure? • What increases in spending are reasonable and affordable? 	<p>Agreement</p> <ul style="list-style-type: none"> • Problems of cost escalation & inefficiency acknowledged • Also problems with unnecessary care and over-prescription of drugs <p>Under discussion</p> <ul style="list-style-type: none"> • What is the appropriate role for government and private sector in service delivery? • What are requisite institutional underpinnings for good performance? • Specific issue: how to reduce perverse incentives for providers?
Health Insurance	Public Health
<p>Agreement</p> <ul style="list-style-type: none"> • Health care increasingly unaffordable and access inequitable • Low coverage of health insurance still a big challenge • Remaining design issues in health insurance <p>Under discussion</p> <ul style="list-style-type: none"> • Links between urban and rural scheme: Cross-learning on management and provider payment? Unified management? Eventual integration? • What is best way of linking CMS and MA? • What is appropriate coverage mix of low-cost and catastrophic illness? • Appropriate level of financing to CMS? Urban/rural equity? Targeting of public subsidies? Affordability by different levels of government? • How can insurance promote better performance by providers? 	<p>Agreement</p> <ul style="list-style-type: none"> • Government has a fundamental role in public health and there is a commitment to increase public spending in this area • Working “upstream” important to reducing health costs <p>Under discussion</p> <ul style="list-style-type: none"> • What are key public health functions for government? What is appropriate level of financing? With limited resources, how should government (central and local) prioritize between different public health activities • Is key problem inadequate financing for public health or low efficiency in spending? • How should public health services and activities be paid for to promote efficiency in delivery? • How will we know whether recent increases in public health spending have achieved impact?