



Improving China's Rural Health System

The historic achievements of China's health system are well known. Yet during the 1990s, it became increasingly clear that it faced—and, despite recent reforms, continues to face—major challenges. Barely one fifth of the population is covered by health insurance. With the cost of a hospital stay amounting to half of average annual income, and rising by over ten percent per year, falling sick means either financial calamity or going without needed health care. People with insurance face problems too. Relying heavily on patient payments for their income, hospitals and doctors oversupply drugs and high-tech care on which government-set prices exceed cost. Arguably, government spends too much on programs benefiting the better off (such as support to city hospitals and urban health insurance schemes), and too little on public health and other programs directed at 'market failures'. At the turn of the Millennium, the issue was no longer *whether* China's health sector needed reforming, but rather *how* it should be reformed.

Recognizing this, the government recently took several important steps forward. It is expanding its new urban health insurance scheme (Basic Medical Insurance or BMI), and is creating a new cooperative medical scheme (NCMS) for rural areas, the aim being—with the help of government subsidies—to cover the entire rural population by 2008. A safety net scheme, known as Medical Assistance (MA), is being developed to assist the poorest 5 percent of the population with health expenses. These reforms in health financing have the merit of building on existing institutions, rather than starting with a brand new model of health financing. But they are at an early stage, and it is clear already that there are obstacles on the road ahead. In contrast to health insurance, no nationwide reform of health service delivery has been proposed thus far, although local 'supply-side' reforms have occurred. This unfinished agenda has stimulated a lively but inconclusive debate over the proper roles of government and the market in the delivery of health care.

How can China revitalize its rural health sector and replicate its impressive past record? This article looks at various options for improving China's health system—the financing of health care, as well as its delivery, and the role of government in the system. The aim is not to sketch out a blueprint for the system, but rather to highlight the issues at stake, present options, and offer some thoughts on the merits of each.

Transitioning to universal and comprehensive health insurance

The new cooperative medical scheme is starting small—arguably too small. The proposed level of funding for the scheme, 30 or so RMB per person, compares to an average (total) health spending in rural areas of around 274 RMB. To prevent itself going bankrupt, NCMS could either offer comprehensive coverage with large out-of-pocket payments from patients. Or it could limit the types of care it covers, and get people to pay in full for 'uncovered' services.

Both approaches leave households exposed to considerable financial risk. And the second may lead to providers to create demand for uncovered services, which could bring in more profits. Encouraging private insurance for uncovered services and getting private providers to deliver them could make this outcome even more likely. It would also likely result in large inequalities between those able to afford private insurance and the rest of the population, leaving the latter unprotected against the financial risks associated with illness.

Perhaps a better approach would be to dramatically scale up contributions to the new cooperative medical scheme from households and (especially) government to a level that approaches current per capita average rural health spending. This would allow the scheme to cover *both* basic health care *and* some high-cost inpatient risks. A balance could thus be struck between the goals of cost-effectiveness and reducing households' exposure to financial risk. This would increase government health spending, of course. Assuming that the NCMS covers 70 percent of the rural population, the current 20 RMB subsidy will increase Government Operating Expenses on Public Health by 14 percent. A 60 RMB subsidy would entail a 43 percent increase.

Is the new cooperative medical scheme sustainable on current plans? There is a case for making membership compulsory, at least once the benefits of the scheme have had time to become apparent. Otherwise, especially if government subsidies remain as low as they are, there is the risk that healthier people will not join the scheme. There is also a case for reconsidering the use of medical savings accounts in both rural and urban health insurance. They are supposed to discourage frivolous use of health services, but in practice have relatively small effects and leave patients exposed to considerable financial risk, because of the tight limits on the expenses that insurers will cover. Patients also find them too complicated to understand and track.

A "solidarity fund" to make the financing of health insurance fairer?

Especially if the resources going into NCMS are to be dramatically increased, the issue of equity will become increasingly important to address in health finance in China. Even today it is an issue—many poor local governments find even a 10-20 RMB contribution to NCMS a burden.

Making local government contributions fairer, by linking them to local income levels, is highly desirable. It could be achieved through a *health insurance solidarity fund*, which would raise revenues from different sources, and make the necessary payments to local insurance schemes to allow them to provide coverage to their members.

Central government—which currently pays just 10 RMB for each NCMS living in central and western provinces, but which in future is likely to contribute a larger share of NCMS finance—would be one contributor. But local governments would also contribute, with poorer governments contributing less per NCMS member than richer governments. Household contributions would also go into the fund. Counties would receive payments

from the fund according to the number of people in the scheme in the county. These ‘capitation’ payments need not necessarily be the same for every county. For example, richer counties might initially receive somewhat more generous capitation payments. Over time, the gap could gradually be closed as the benefit packages of poor and better-off counties converge. Other capitation differences might be more permanent. For example, counties where the cost of delivering health care is high could receive more generous capitation payments, as could counties facing particularly difficult health challenges (a lot of elderly or sick people, high mortality rates, specific local health problems such as a high prevalence of communicable diseases, etc.).

The effect of the solidarity fund would be to redistribute some NCMS funds from richer to poorer counties, and to enable better targeting of central government resources to poor provinces and counties. But its appeal goes beyond its ability to redistribute resources within NCMS—it could also help address disparities between urban and rural areas. Currently, the annual revenues of BMI are approximately 900 RMB per beneficiary, allowing a considerably more generous benefit package than in the rural scheme, whose funds are limited to 30 RMB or so per member. This imbalance between the schemes could be mitigated by mandating that a share of all BMI revenues be allocated to the NCMS solidarity fund. This would allow for more generous NCMS benefits, while limiting the need for extra government spending. For example, if 10 percent of urban insurance revenues were used to assist with rural health expenses, Government Operating Expenses on Public Health would need to rise by 12 percentage points less than if no BMI revenues were used.

As China’s urban population and urban health insurance membership grow, BMI solidarity payments will go even further in reducing pressure on government health spending. Pressure would be reduced still further if the 10 percent solidarity payment from urban to rural insurance were gradually increased to 15 percent or 20 percent, perhaps with the aim eventually of harmonizing the benefit packages of the urban and rural insurance.

Fairness in the health insurance system is not only about government financing—it is also about household payments. At the moment, in the NCMS, in contrast to the BMI, there is hardly any link between a household’s income and its NCMS contribution (10 RMB per person) and the amount it pays out of pocket for treatment. The only link is through the Medical Assistance scheme, which gives the poorest 5 percent of households help with their NCMS contribution and sometimes their co-payments as well. Both could be linked more closely to income. A useful start might be to expand Medical Assistance beyond the current target population (the 5 percent very poor in each county) to include all so-called ‘low-income rural dwellers’ (the 9 percent or so of the rural population living below 869 RMB in 2002 prices).

Improving service delivery and safeguarding patient interests

Two lessons emerge from the locally-inspired health service provider reforms to date, both consistent with evidence from abroad, and both important for the ongoing debate on supply-side reform. First, who owns and controls a facility (government or the private sector) matters relatively little for costs and other key outcomes—certainly less than people often think. This suggests that much of the current preoccupation with the issue of whether facilities should be privatized or put back under government control may be misplaced.

The second lesson is that how a health facility is paid as well as the amount it is paid *does* matter, irrespective of who owns it. Under the predominant system of fee-for-service (FFS), the fees for different services influence the volumes of care that get delivered. And costs can be reduced by moving from fee for service to a prospective payment system, such as diagnostic-related groups (DRGs) in which hospitals receive a fixed payment per patient depending only on the patient's diagnosis. This second lesson suggests that the current preoccupation over the issue of whether hospitals should be allowed to retain surpluses may also be misplaced. The point is that prospective payments cannot work if surpluses are clawed back and deficits are automatically covered.

China's recent lessons in this area suggest, then, that it is better to shift the focus away from the issues of ownership and surpluses towards reforming the way hospitals and health providers are paid—moving away from fee-for-service towards prospective payments.

This transition—like the transition to universal health insurance coverage—will obviously take time. In the meantime, there is a case for overhauling China's health-care price schedule, with the aim of aligning prices with costs, and hence reducing the existing incentives to over-prescribe and provide unnecessary medical care. To protect the poor, the government might want to keep the price paid by uninsured patients for 'basic' services unchanged, but use existing subsidies to cover the losses that providers incur on these services.

In the medium-term, introducing prospective payments throughout the system will help dramatically. Some form of prospective payment system for hospitals—at least for inpatient care—is worth exploring, building on China's apparently successful experiences to date. A similar system for ambulatory care also seems worth exploring. And for village doctors, it is worth considering payment by capitation, i.e. paying a fixed amount per person on the doctor's list, coupled with payments by government for specific items of preventive health care.

As the rural and urban health insurance coverage expands, NCMS and BMI will increasingly be the agencies paying health providers and implementing prospective payment methods. They will, in effect, be '*purchasing*' health care on behalf of their members—China's citizens. As agents for large groups of citizens, health insurers will be able to hold hospitals and other providers accountable—for appropriateness of care,

quality and cost—far more effectively than individual patients, whose limited knowledge of medical matters makes them ineffective consumers in the health care ‘market’.

Health insurers will take time to develop the ability to perform key purchasing functions, including deciding on a benefits package, certifying providers on the basis of their quality, accessibility, and other criteria, setting up a payment mechanism, and so on. To reduce duplication and encourage economies of scale, joint management of the two programs makes sense. The benefit packages could be kept distinct until the time the government is ready to harmonize them.

Government as steward or supervisor of the health system

As the health system evolves, the government’s role will increasingly become one of steward or supervisor, rather than one of provider and financier. It will play a key role in promoting equity—setting up and running any solidarity fund, and making health insurance and co-payments affordable for poor households. It will also have a key role to play in putting in place and enforcing regulations designed to avoid ‘market failures’.

One key area of market failure is public health. Many countries deliver some core public health functions of a ‘public-good’ variety—population-based activities such as surveillance—through a publicly-owned and publicly-financed public health agency. This agency should probably be a *national* agency, with local offices firmly under national control. The public health agency need not deliver all public health activities: the delivery of ‘personal’ public health activities, such as immunization and screening, can be left to hospitals, township health centers, etc. But there is a very strong case for the government to pay for these public activities, lest there be too little investment in them. Payments to providers of public health services should be linked to activities undertaken—hospitals should get paid according to the number of children they actually immunize.

Another key area of public involvement is helping to prevent patients from being exploited by health providers where the ‘purchaser’ is absent, i.e. on the procedures and drugs that are not covered by health insurance. Over-the-counter drugs are a good example. There is a case for the government mandating the separation of prescribing and dispensing drugs—requiring pharmacies to be financially independent of hospitals. Other solutions for reducing over-prescription of drugs include drug lists and including drugs in prospective payment allowances. And it is not a panacea—compensatory payments to those who lose out can be as large as the cost savings from lower drug spending, and enforcement is not easy. But it may be better than doing nothing. The government may want to consider tighter control of capital spending by health facilities—the diffusion of new medical technology in China is fast by international standards, and is undoubtedly one of the main causes of the rapid rise in costs in China’s hospital sector. Having health insurers acting as purchasers will help slow down technology diffusion and rising costs. But it may not be enough, not least because insurers will be concerned with technology diffusion only insofar as it impacts on the costs of the services that they cover. Finally, as

steward, the government will also need to supervise the health insurers, as well as the health providers.

The challenges of stewardship in the health sector are large. One key issue facing China's authorities as it goes forward is who in government should be responsible for what. As in many countries, responsibility for health is scattered horizontally across many ministries and agencies. In addition, and in contrast to many countries, responsibilities are also scattered vertically across many levels of government. Now might be a good time to reevaluate the allocation of these duties with the various stewardship functions in mind.

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