

Social Health Insurance in China:

An Example of Nascent Social Security in China

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Under Article 45 of the *Constitution of the People's Republic of China*, "Citizens have the right to material assistance from the State and society when they are old, ill, or disabled. The State develops the social insurance, social relief, and medical and health services required to enable citizens to enjoy this right."¹ Therefore, the constitution legally requires the state to provide social health insurance. It is in this spirit that the State has attempted to revitalise the medical insurance systems in China. Social health insurance within China is undergoing massive reforms. Current policy-making and development of social health insurance is in the joint hands of the Ministry of Health and the Ministry of Labor and Social Security, with significant local flexibility.² Medical Insurance has been developed into two structures, one for urban employees and one for rural citizens with the HRS structure as the administrative tool. Yet the question remains whether these new systems can accomplish the ambitious Constitutional goals it set forth decades ago, and if it can do so equally and effectively.

Urban Health Insurance

In December of 1998 the *Decision of the State Council on Establishing the Urban Employees' Basic Medical Insurance System* was issued. This decision marked the beginning of a new attempt at developing social health care in urban China since the old system massively deteriorated after the introduction of market reforms in the early 1980s.³ The old insurance system offered those covered free healthcare in government run facilities. It had two-tiers, one which covered State Owned Enterprise employees and one for military personnel, academics, social workers and the disabled. In contrast, the newly introduced urban system has one tier in which participation is planned to be mandatory to all employees in both public and private companies, with the exception of the self-employed. However, instead of being free to those covered, the new system employs a cost-sharing structure in which the government, employers and employees share the costs of healthcare. The employer contribution is 6 per cent of total wages and the employee contribution is 2 per cent of their wage/salary, although local flexibility

¹ *Constitution of the People's Republic of China*. As amended on March 14th 2004. Available online at <http://english.peopledaily.com.cn/constitution/constitution.html>.

² Guo, Baogang. *Transforming China's Urban Health-Care System*. Asian Survey © 2003 University of California Press.

³ Guo

allows for some sway in contributions. Local governments are then responsible for the management of two funds, a general medical trust fund, used mostly to pay for in-hospital services, and individual employee accounts. All of employee contributions and 30 per cent of employer contributions are put into the individual funds while the remaining 70 per cent of the employer contributions is collected into the general fund.

These funds are for use by those covered, but this group leaves out non-employed urban residents, with a few exceptions, who must rely on commercial health insurance or individually pay all medical costs. Unlike the old system which would subsidize healthcare costs of the dependents of workers who are covered by medical insurance by 50 per cent, the new system does not cover dependents at all.⁴ However, the new system does cover retired and laid-off workers. Laid-off workers have both their employee and employer contributions paid by re-employment centers at a level of 60 per cent of the preceding year's local workers' average wage, to be allocated following the same scheme as employed workers.⁵ Retirees are covered by the system at no cost to them, but the legislation does not say who bears their medical costs nor who contributes to their individual accounts, saying only that "the proportion of the amount of money charged into individual accounts of retirees and the medical expenses borne by individuals will be given appropriate preferential consideration,"⁶ which most likely leaves the issue flexible for local authorities to decide. Otherwise, non-employed residents do not have any social health insurance coverage.

The new system separates government-run hospitals from health insurance, instead allowing local governments the ability to negotiate with any health-care providers (including private) over terms, coverage, and reimbursement of services, although the vast majority (88 per cent) of hospitals remain not-for-profit.⁷

⁴ Duckett, Jane. *Political Interests and the Implementation of China's Urban Health Insurance Reform*. Social Policy and Administration: Vol. 35, No. 3, July 2001.

⁵ *The Decision of the State Council on Setting up Basic Medical Insurance System for Staff Members and Workers in Cities and Towns*. State Council: December 14, 1998.

⁶ *The Decision of the State Council on Setting up Basic Medical Insurance System for Staff Members and Workers in Cities and Towns*

⁷ Guo

Since social health insurance no longer includes government healthcare institutions, a new form of distributing funds was also introduced. Under the national plan distribution is largely handled by the locality, but some national guidelines were created as cost-cutting measures. These included: a ceiling on expenditures from the general fund of four times the local average yearly wage;⁸ a requirement for localities to create co-payment system that dictates minimum out-of-pocket payments; and a formulary of permitted prescription drugs (usually 5-10 per cent of cost).⁹ The law also requires local governments to divide permitted drugs into classes which are then reimbursed at different levels. For instance, Hunan Province formed a structure which has 25 per cent of drugs in a “Class A” and 75 per cent of drugs into a “Class B”, which are 70 per cent and 63 per cent paid for by social health insurance respectively of total drug costs paid by insurance funds.¹⁰

Rural Health Insurance

In February of 2003, the State Council issued the *Decision to Establish a New Rural Co-operative Health Care System* to re-establish health insurance for the rural population, which by 2000 had decayed to the point where over 87 per cent of sick people in rural areas paid their own medical expenses in full, and 25 per cent had to borrow in order to cover the costs.¹¹ In the past, the rural healthcare system in China has actually seen great success, raising the average life expectancy from 40 years in 1965 to 69 years in 1982.¹² This was thanks to establishment of “barefoot doctors” in rural regions, who were community members receiving basic training from the government who could administer primary basic care for free to the community. Secondary care, pharmaceutical drugs, and inpatient care had a coinsurance cost, but nowhere near the price these services became through the market reforms.¹³ The situation became grave after market-reforms as the old socialist cooperative health care system was not reformed and its funds fell to 15 per

⁸ *The Decision of the State Council on Setting up Basic Medical Insurance System for Staff Members and Workers in Cities and Towns*

⁹ Duckett

¹⁰ Guo

¹¹ WHO. *Social Health Insurance: Selected Case Studies from Asia and the Pacific*. SEARO Regional Publication No.42 © World Health Organization 2005.

¹² Brant, Simone, Michael Garris, Edward Okeke, Josh Rosenfeld. *Access to Care in Rural China: A Policy Discussion*. University of Michigan: April, 2006.

¹³ Brant

cent of operating costs, forcing hospitals and doctors alike to fend for themselves in a privatized environment. To meet operating costs and even turn a profit hospitals turned to selling expensive treatments that were largely unnecessary. Over-treatment is estimated to have reached over 60 per cent of medical costs and 75 per cent of drug prescriptions were thought to be unnecessary, meaning patients were paying inflated amounts for even basic problems that used to be free to treat.¹⁴ However, the severe acute respiratory syndrome (SARS) epidemic in 2003 really brought to light the shortcomings of the rural healthcare system.

The decision to reform the rural cooperative healthcare system came in the wake of the severe acute respiratory syndrome (SARS) epidemic in 2003.¹⁵ The 2003 decision reformed the communal system by emphasizing subsidies from multiple levels of administration, including township, county, principal, and central, which together originally supplied 20 RMB per participating citizen per year, but now contribute 40 RMB.¹⁶ Under the reformed plan, each participant pays only 10 RMB (\$1.35 US) per year and is then eligible to receive partial coverage of any medical expenses, which ranges up to 65 per cent of total medical expenses up to 30,000 RMB.¹⁷ The amount reimbursed ranges widely by province, and poorer western provinces are only required to fund as low as 10 per cent of medical costs, but participants are expected to contribute the same amount.¹⁸ However, unlike the mandatory urban basic medical insurance, the new rural cooperative healthcare system is voluntary in pilot areas, although some have reported instances where the system has been effectively made mandatory by deducting contributions for other funds, such as farm subsidies.¹⁹

Recent Developments

In July of 2007 the State Council issues *Guiding Opinions of the State Council about the Pilot Urban Resident Basic Medical Insurance* which essentially addresses the future of the urban medical insurance and hints at bringing rural and urban systems closer

¹⁴ Brant

¹⁵ *2.7 Bln RMB Proposed for Rural Health Care*. Xinhua: August 17, 2007

¹⁶ *Healthcare Scheme Spreading in Pilot Areas*. Xinhua: November 13, 2007.

¹⁷ *2.7 Bln RMB Proposed for Rural Health Care*.

¹⁸ *2.7 Bln RMB Proposed for Rural Health Care*.

¹⁹ *Missing the barefoot doctors*. Economist: Vol. 385, Issue 8550, 10/13/2007.

together.²⁰ The goal of the legislation is to create a healthcare system able to cover everyone, and focuses on one of the major groups yet to be given access to medical insurance, non-employed urban residents.²¹ Pilot cities are to be selected to implement the program and test results similar to the initial trials of the current Basic Medical Insurance system. During the 17th National Congress of the Communist Party of China Vice-Minister of Health Gao Qiang said at a joint news briefing that "All people in urban and rural areas will enjoy basic medical care and health services by 2020," which indicates that the newly designed system should be out of the pilot stage and widely operational by that time. Other details have yet to be revealed, but Gao Qiang claimed the state would undertake "coordinated and parallel" reform of the medical services, insurance and supplies systems.²²

Problems

Despite some legislation on medical insurance reform in China, major challenges remain in developing a successful social health insurance system. Attention to health insurance issues in China was aroused by a WHO report in 2000 that ranked China's health system at 144th among 191 WHO member states. The bad score was primarily due to the system's lack of equality and lack of government funding, illustrated in its rank of 188th out of the 191 WHO member states in "Fairness in financial contribution."²³

The inequality in the system is largely attributable to a larger proportion of healthcare costs falling on individuals due both to increasing costs of healthcare and degradation of former government run healthcare systems since market oriented reforms have been introduced into health services,. In fact, under the new urban health insurance plan individual cost of healthcare for urban employees has risen 25 per cent.²⁴ Meanwhile, the proportion of total medical expenditure paid by the government has decreased from 36%

²⁰ *Guiding Opinions of the State Council about the Pilot Urban Resident Basic Medical Insurance*. State Council: 07-10-2007.

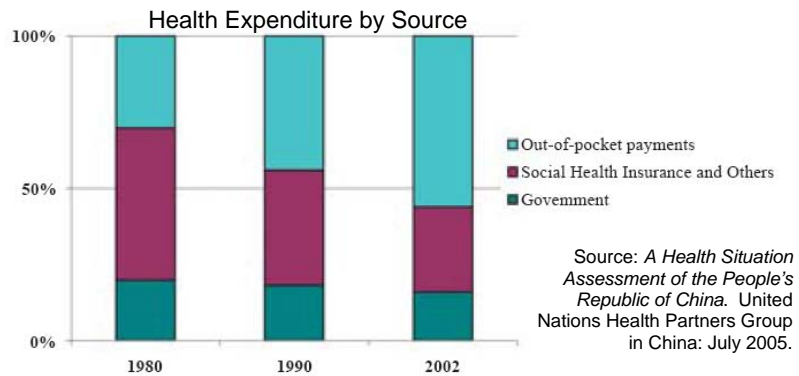
²¹ *Guiding Opinions of the State Council about the Pilot Urban Resident Basic Medical Insurance*.

²² 'Basic healthcare for all by 2020'. China Daily: October 19, 2007.

²³ WHO. *The World Health Report 2000–Health Systems: Improving Performance*. Geneva, Switzerland: World Health Organization; 2000:152-155.

²⁴ Guo

in 1980 to only 17% in 2004, making households' share increase from 21.6% to 53.6%.²⁵ Another study (illustrated to the right) saw medical care insurance plans' portion of total expenditures



drop from 47 per cent in 1980 to only 27 per cent in 2002, making individuals pay for an enormous 67 per cent of expenditures.²⁶ Overall, health expenses paid by individuals have increased by 110 times from 1980 to 2002²⁷ compared to a wage increase of about 16 times over the same period,²⁸ which poses a clear challenge to implementing a successful health insurance scheme.

A second issue contributing to health care inequality in China is the split between the rural and urban systems. While reforms have been helping to cover more and more people in all areas of China, rural areas maintain higher proportions of uncovered people than urban areas, having 79 per cent of people with no medical care coverage in 2003 compared to 45 per cent in urban areas.²⁹ In 2000, after the urban reforms had begun, rural healthcare was in an exceedingly bad state. For rural families, out-of-pocket payments for health care became *the* major cause of poverty, and over 60 per cent of patients were not able to afford to remain in the hospital to complete treatment.³⁰ 800 million citizens (~62% of total pop.) live in rural areas with only around 500,000 medical personnel to provide health services to them and 80 per cent of medical institutions located in urban regions.³¹ Even in areas that the Ministry of Health classifies as the most advanced and rich rural areas, there are only 1.3 doctors per 1,000 people, compared

²⁵ Houli Wang, MD; Tengda Xu, MD; Jin Xu, MD. *Factors Contributing to High Costs and Inequality in China's Health Care System*. JAMA. 2007;298:1928-1930.

²⁶ *A Health Situation Assessment of the People's Republic of China*. United Nations Health Partners Group in China: July 2005.

²⁷ Zhao, Zhongwei. *Income Inequality, Unequal Health Care Access, and Mortality in China*. Population and Development Review 32 (3): SEP 2006.

²⁸ China Statistics 2005 on www.allcountries.org (Based on figures supplied by the National Bureau Of Statistics of the The Peoples Republic Of China)

²⁹ Zhao

³⁰ WHO (2005).

³¹ Houli Wang

to almost 6 per 1,000 people in large cities. In China's least developed and poor rural areas, there are only 0.6 doctors per 1,000 people. Meanwhile disease is especially bad in rural regions, for instance the TB prevalence in the richest rural regions is 81.1 per 100,000 people compared to 223.2 per 100,000 people in the poorest rural region and 37.3 in large cities.³² This indicates rural regions have not only significantly lower quality healthcare than urban regions, but also have higher rates of infectious disease and hence a more severe health problem.

Another major issue challenging China's progress in creating a successful health insurance system is lack of supervision over the health care sector. One example of health care industry abuse is misuse of hospital run pharmacies in which doctors prescribed unnecessary drugs and treatments to patients to boost profits.³³ This problem is due to bribes to doctors and hospitals by medical producers, but also the intrinsic conflict of interest when hospitals profit from sales of treatments.³⁴ However, separating hospitals from their pharmacies is a tricky feat since over 80 per cent of hospital revenue comes from sales of pharmaceuticals.³⁵ Even remaining state-run hospitals are underfunded and expected to make up for the difference with drug sales.³⁶ Despite the difficulty, the central government is encouraging development of retail pharmacies to counter over-prescription of drugs for profit, with some success since 2003 in certain areas. For instance, Shenzhen is increased its percentage of retail pharmaceutical sales to 40 per cent, twice the national average, although this is still below the US national average of 60 per cent.³⁷ Yet, even so there is still limited legislation to regulate pharmacies' and physicians' performance, and abuses recur.

Corruption also rears its head at the government level. In one case, a lack of regional oversight became apparent after a scandal in which the Xichuan government stole over 700,000 RMB by inflating the number of farmers receiving checkups in the province.³⁸

³² Zhao

³³ Guo

³⁴ Duckett

³⁵ *Investing in China's Pharmaceutical Industry*. Price Waterhouse Coopers: March 2006.

³⁶ Guo

³⁷ *Investing in China's Pharmaceutical Industry*

³⁸ *Healthcare Scheme Spreading in Pilot Areas*

While this amount has recovered and the officials punished, the lesson is clear that insurance funds must have oversight to prevent fraud. Another case in Jiuxian, a township in Shaanxi Province, “voluntary” contributions toward the new pilot rural cooperative healthcare system from farmers were forcefully deducted from subsidies due to them, effectively making the system required, but in the end they received neither the subsidies nor the enrolment booklet required for the insurance scheme.³⁹ This left Yang Xiumei, a local of Jiuxian who paid her insurance contributions in this way, lying on her hospital bed devoid of any financial assistance thanks to the lack of proper local implementation of the national law.⁴⁰

However, even if Yang Xiumei had received her insurance coverage, she would still have been under an enormous financial burden that she could not have easily managed, indicating another problem with the modern medical insurance schemes: overly demanding insurance premiums, specifically for the rural system. The following excerpt from *The Economist* tells of Yang’s predicament:

What if Ms Yang had received her booklet? Her insurance would not kick in until she had spent 100 RMB, the equivalent of nearly 11 days' income for the average Luochuan rural resident. Beyond that she would then be able to claim 60% of her expenses, but these could amount to several hundred more RMB even for a relatively minor complaint. The Jiuxian hospital, with its three doctors, can perform only the simplest operations and provide only basic care. Anything more serious requires a trip to the Luochuan county seat, 20km (12 miles) away. For insured Jiuxian residents who used county-level facilities, average out-of-pocket expenditure in June was 1,219 RMB, or four months' income.

Therefore, the new system does not solve the financial troubles of its participants, and yet opens them up to the corrupt activities that have robbed the inhabitants of Jiuxian of their farm subsidies and not given them any insurance coverage, a stark contrast to the old “barefoot doctors” system that would have given people like Ms Yang free medical care with no contributions nor premiums.

³⁹ *Missing the barefoot doctors*

⁴⁰ *Missing the barefoot doctors*

While government spending on the national social health insurance system has slipped, the government has scandalously maintained very high spending on its own officials. This has led to the current alarming situation where 80 per cent of the government's healthcare budget is used to provide healthcare coverage to China's 8.5 million government officials, who account for less than 1 per cent of the population.⁴¹ Healthcare for officials is one of the only unreformed programs, meaning it remains free or low cost and has no individual account or contribution system and is almost completely government subsidized. Ironically, those who champion cost-reducing medical insurance reform for the rest of the nation are still covered under this older and more comprehensive social healthcare insurance.⁴²

Social Health Insurance for Migrant Workers

Despite development of systems for both urban and rural health insurance, one major group of workers is still falling through the cracks of the new systems: migrant workers. This group, around 120 million people up to 200 million, are largely unable to receive medical insurance since they are not registered as urban employees.⁴³ Migrant workers account for 50 per cent of workers infected with occupational disease,⁴⁴ and outside of work they tend to live in cramped living conditions with other poor or migrant workers, increasing the risk of disease.⁴⁵ During pilot testing of the basic medical insurance for urban workers some migrant workers who established contracts of longer than one year with state enterprises received coverage, but the national scheme has no such policy.⁴⁶ Theoretically migrant workers could be included in the national scheme because the national scheme is employment-based and employers are required to include all employees,⁴⁷ but in practice it has become more of a voluntary matter for companies. Since there are premiums to be paid employers widely choose against including

⁴¹ Jiangong, Zhou. *Red Hue to China's Health Care*. Asia Times: Aug. 23rd, 2007.

⁴² Duckett

⁴³ *China's Migrant Workers to Get Basic Job Healthcare*. Xinhua News Agency: 4/24/2006.

⁴⁴ Wei, Yan. *Rural-Urban Migrant Workers in China: the Vulnerable Group in Cities*. Accessed 11/27/07: http://www.irmgard-coninx-stiftung.de/fileadmin/user_upload/pdf/roundtable07/Wei.pdf.

⁴⁵ LEAD: *Rights group calls Chinese migrant workers 'urban underclass'*. Asian Economic News: March 5, 2007.

⁴⁶ Duckett

⁴⁷ *China's medical insurance to cover all urban residents by 2010*. Xinhua: August 15, 2007.

migrants.⁴⁸ Therefore, estimates now show that only about 10% of migrant workers are covered,⁴⁹ which must even be taken with a grain of salt considering the wide range of migrant worker population estimates.

Migrant workers' lack of insurance is a serious human rights issue, but it is also a serious threat of health epidemic. Established diseases such as tuberculosis (TB) are now covered by a system of epidemic prevention that includes migrants. For instance, now TB testing and treatment is conducted for free for everyone under a growing fund for obliteration of the disease.⁵⁰ However, TB is China's top epidemic killer with over 130,000 people dying from the disease annually, and has been around for the past century,⁵¹ but other diseases may spread through migrant workers untreated and even lead to the beginning of new epidemics, highlighting the importance of a means of providing healthcare for migrant workers.

In 2006 the central government announced it would try to do something to address the situation for migrant workers and indicated it would soon begin testing a program in 20 counties across 10 provinces to provide a form of occupational injury and disease insurance for the very vulnerable group.⁵² The difficulty to address the issue stems from the problem of classifying migrant workers within the Household Registration System (HRS) that registers families as rural or urban.⁵³ With this in mind, the Central Government has so far this only been announced this pilot project as an extension of occupational health and safety programs in the workplace, which has many flaws itself, and yet would only cover work related injuries and illnesses. Hence, even if implemented nationally, this program provides no form of social health insurance that covers non-occupational illness. While this would be a step forward, it ignores the need of health insurance for migrant workers for illnesses unrelated to work.

⁴⁸ Li, Juliette, Stephen Frost. *Towards better primary health care in China*. CSR Asia Weekly: Vol. 1, Week 40, 05/10/05. Accessed 12/18/07 at <http://www.csr-asia.com/>.

⁴⁹ Wei

⁵⁰ *China Steps Up Efforts to Fight Tuberculosis*. China Daily: March 21, 2007.

⁵¹ *China Steps Up Efforts to Fight Tuberculosis*

⁵² *China's Migrant Workers to Get Basic Job Healthcare*.

⁵³ Wei

For the 90 per cent of migrants who do not have health insurance, the healthcare alternative to expensive hospitals and doctors are illegal clinics that have emerged in urban areas across China. In Shenzhen's Baoan district there are more than 6,000 illegal clinics alone, compared to only around 100 legal clinics.⁵⁴ These clinics offer the services of a normal clinic, but at a reduced cost, but also with reduced quality of healthcare. For instance, in Shanghai pregnant migrant women can choose to give birth in a real hospital for about 2,500 RMB or they can go to an unlicensed hospital and pay between 100 and 500 RMB, depending on the gender of the baby.⁵⁵ Subsequently, while 40 per cent of all childbirths in Shanghai are by migrant women, 23 out of 29 cases of death during delivery were migrant women.⁵⁶

While there have been no medical insurance schemes for migrant workers on a national scale, some localities have chosen to face the problem. Shenzhen is a city of 8.64 million migrant workers (as of 2005), making up 83.5 per cent of the total population, and as such cannot ignore the problem of uninsured migrant workers, so it has begun its own pilot program, the Shenzhen Labour Cooperative Medical Insurance (SLCMI).⁵⁷ This scheme began in March 2005 to cover only migrant workers, the first of its kind in the nation, and has been hailed by the Shenzhen government, among others, as a success.⁵⁸ Under this scheme employers pay 8 RMB per worker per month and each worker pays 4 RMB per month. This 12 RMB per month revenue is then divided between several funds: 6 RMB goes toward outpatient medical costs, 5 RMB to inpatient costs, and 1 RMB to emergencies.⁵⁹ The coverage is mainly based on community health care centers rather than hospitals, which means it focuses on outpatient costs rather than inpatient. Hence SLCMI covers up to 90 RMB of outpatient medical center visit costs⁶⁰ and 60 to 80 per cent of drug costs for Class B or Class A drugs respectfully, as they are defined under the national system.⁶¹ However, it also covers 60 per cent of inpatient out-of-pocket

⁵⁴ Li (2005)

⁵⁵ *Beijing, Shanghai Improve Migrant Workers' Medical Conditions*. Shanghai Star: August 23, 2004.

⁵⁶ *Beijing, Shanghai Improve Migrant Workers' Medical Conditions*

⁵⁷ Li (2005)

⁵⁸ Yunxing, Zhang. *Shenzhen Co-op Medical Scheme Proves Successful*. China.org.cn: February 10, 2006.

⁵⁹ Yunxing

⁶⁰ Li (2005)

⁶¹ Yunxing

hospitalization costs (up from 33 per cent at the start).⁶² The ceiling for the annual reduction of inpatient cost is 60,000 RMB.⁶³ This program originally offered only manufacturing industry, but now has been expanded beyond. However, despite the progress in Shenzhen there are still major issues with this insurance. For one, it still only covers about 3 million migrant workers, accounting for less than half of the migrant population, and since this program is cheaper than other forms of medical insurance it is not hard to imagine all the migrants that were covered by the national plan are now covered by the SLCMI plan.⁶⁴ Even so, the success of this program should be noted, especially by the central government which has as of yet has done little to ensure the constitutional right of migrant workers to adequate social healthcare.

Conclusions

Despite having made these efforts in recent years, China still faces huge challenges to developing an effective national health insurance system which prevent it from accomplishing the goals set forth in the nation's constitution. However, it is uplifting to see that the government does not consider its work on health insurance reform complete, as illustrated through the 2007 developments in the State Council and in the National People's Congress. This gives hope that development of one universal social health insurance scheme which can help all citizens afford decent healthcare can emerge in the foreseeable future. However, the progress on health care can be seen as an extension of the Deng Xiaoping concept of Gradualist change, which indicates that the development of social insurance will be too slow to help many who are now being squeezed into poverty by out of control healthcare costs and ineffective cooperative hospitals. Even more disheartening is the continued lack of national health insurance for migrant workers, although there is hope that lessons from Shenzhen will encourage legislators to fight for such coverage. In the end, much must to be done, but this decade's attention to social health insurance has given hope to China's otherwise decimated social health insurance system.

⁶² Li (2005)

⁶³ Yunxing

⁶⁴ Yunxing

Links to Pertinent Legislation

Decision of the State Council on Establishing the Urban Employees' Basic Medical Insurance System

(Decision of the State Council on Setting up Basic Medical Insurance System for Staff Members and Workers in Cities and Towns)

http://www.chinalaw.gov.cn/jsp/jalor_en/disptext.jsp?recno=3&&ttlrec=8

Guiding Opinions of the State Council about the Pilot Urban Resident Basic Medical Insurance

<http://www.lawinfochina.com/law/display.asp?db=1&id=6326&keyword=Medical%20Insurance>