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Chinese Health Care System Reform at a Crossroads

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Chinese health care reform is at a major crossroads. China has been giving top priority to economic growth and largely ignoring social insurance, which has resulted in inadequate health insurance. As a consequence, the cost burden on people for health care has sharply increased, as has excessive commercialism on the part of medical institutions. Radical countermeasures by the government are imperative. It is reported that China is studying cases in other countries in order to formulate important policies, which will determine its future health care system. Japan's experience in health care system reform may furnish China with some ideas.

The Insurance System, Drug Prices and Many Other Problems

The present health care system in China is saddled with a multitude of problems. The most serious problem is a surge in health care costs. During the 10 years from 1995, the disposable income of urban dwellers increased 2.4-fold and net income of rural residents more or less doubled, while per capita health care cost for outpatients at general hospitals increased 3.2-fold. This can be attributed to 1) inadequate health insurance, which covered, as of 2003, only 44.8 percent of the urban population and 79.1 percent of the rural population (the Ministry of Public Health) and 2) the spreading of rampant commercialism among medical institutions, which misunderstood and abused the "transition to a market economy."

This situation is due to a number of factors. First, the government does not put enough money into the health care field. The ratio of government outlay to national health care expenditure stood at 36.2 percent in 1980. This figure declined gradually to a low of 15-17 percent in and after 2000. Personal outlays, which accounted for 21.2 percent in 1980, increased to more than 50 percent in 2000 and later. Second, health care resources are unevenly distributed. The number of general hospitals nationwide has increased steadily since 1980, but 80 percent of these hospitals are concentrated in urban areas. In contrast, the number of small public health clinics in rural areas has been declining year by year. Third, government supervision has weakened. Since the 1980s, the government has promoted a self-support accounting system for medical institutions to reduce the financial burden on the state. This has resulted in the spreading of rampant commercialism among medical institutions.

The common backdrop of all these problems is the severe state of public finance. Since the 1980s, local governments have assumed responsibility for their finance due to the

introduction of partial decentralization of government finance. As a result, the capacity to run the health care and public health business has declined in financially-weak regions. The tax reform, which went into effect in 1994, has strengthened the finance of the central government, but a system to transfer power over finance to local governments has not been firmly established.

The largest cause of the surge in the health care cost burden is underdevelopment of the health insurance system. The problem with the urban health insurance system is that it restricts those entitled to coverage. Although workers at state-owned enterprises are basically covered by health insurance, workers at rapidly increasing private enterprises and foreign-capital companies, “peasant-factory workers” from rural areas, and the jobless, including those who have lost jobs due to business restructuring, are not covered.

The rural cooperative health-care system is also fraught with problems. The government launched a new type of rural cooperative health-care system in 2003, which, it claims, covered 47.8 percent of all provinces (cities and districts) across the country by the end of March 2006. However, since the average annual premium of an individual is a mere 5 yuan (1 yuan = approximately 15 yen) and public assistance is also small at only 50 yuan, the system’s capacity to provide security is extremely limited. In addition, as participation in the system is optional, it is impossible to collect premiums from the peasants who are in the poorest stratum of society.

Drug price problems are also complex and serious. Since 1980, as one of the measures to alleviate the shortage of its outlay in the health care and public health field, the government has allowed medical institutions to put surcharges of 15 percent or more on drug prices. This has been a major cause of the surge in health care cost.

Japanese Experience is Instructive

What, then, will be the future direction of the health care reform in China? So far, a consensus has been reached on, among others, the following: i) Priority will be placed on measures against common, rather than serious, illnesses, in order to spread health care more widely; ii) in the long term, a universal health insurance (which covers every Chinese) will be aimed at; and iii) government leadership will be enhanced and supplementary roles assumed by the private sector. It is expected that a comprehensive health care reform plan will be presented before the 17th Party Congress to be held in the autumn of 2007. However, a great deal of debate and trial and error will continue over the specifics.

As it is reported that China is studying the health care systems in advanced, industrialized countries, here are some Japanese experiences that may prove instructive. With regard to universal health insurance, Japan enacted the National Health Insurance Act in 1938. Under this Act, the government provided financial assistance for building the foundation for regional insurance systems with cities, towns and villages serving as units, and the agrarian population began to join the system. The actual underpinnings to the system were provided by community-based cooperatives, which municipalities (cities,

towns and villages) had gradually begun to establish from the latter half of the 1920s. Local governments collected premiums through the cooperatives and paid the money to medical institutions. As China is contemplating the creation of rural cooperatives, if these cooperatives are to play the same role as the Japanese cooperatives played, a similar outcome can be expected.

Moreover, the facts that the Japanese system was established during a period of economic recovery and that government spending played an important role are significant. They suggest that, since China has realized rapid economic growth and its public finance has improved, this is a good opportunity to take the first step in the development of an insurance system.

Furthermore, Japan's government-led "government-managed health insurance system" for employees of small and medium enterprises could serve as a model. The establishment of a government-managed health insurance for small and medium enterprises, which found it difficult to establish their own health insurance associations, had a decisive impact on the development of the health insurance system in Japan.

In coping with a graying population, Japan's experience suggests that a health insurance system for the elderly should be established first, followed by old age insurance (pensions). This is because families can provide livelihood, but not health care, to the elderly. Japan's nursing care insurance system can also serve as a reference. In Japan, due to a lack of welfare facilities, "socially-induced hospitalization" of the elderly, who are too frail to be cared for at home, has become endemic and has been pushing medical expenditure up. In order to prevent such a situation, "it is important in the care of the elderly to plan from the beginning either a transition 'from health care to welfare' or an improvement of welfare services in terms of both quality and cost efficiency." [Yoshinori Hiroi, Kokusai Kyoryoku Kenkyu, (Japan International Cooperation Agency), Vol. 20, No. 1, 2004].

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