Healthcare-financing Reforms in Transitional Society: A Shanghai Experience

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ABSTRACT

Since the 1950s, China has had a very wide coverage of healthcare service at the local level. In urban areas, the employment-based healthcare-insurance schemes (Government Insurance Scheme and Labour Insurance Scheme) worked hand in hand with the full employment policy of the Government, which guaranteed basic care for almost every urban resident. However, since the economic reforms of the early 1980s, China's healthcare system has met great challenges. Some came from the reform of the labour system, and other challenges came from the introduction of market forces in the healthcare sector. The new policy of the Chinese Government on the Urban Employees' Basic Health Care Insurance is to introduce a cost-sharing plan in urban China. Like other major social policy changes, this new health policy also has a great impact on the lives of the Chinese people. Affordability has been the major concern among urban residents. Shanghai implemented the cost-sharing healthcare policy in the spring of 2001. It may be too early to assess the pros and cons of the new policy, but evidence shows that the employment-based health-insurance scheme excludes those at high risk and in most need. It is argued that the cost-sharing healthcare system will limit access by some people, especially those who are most vulnerable to the consequences of ill health and those in low-income groups, unless the deductibles vary according to income and unless low-income groups are exempt from paying premiums and deductibles.

Key words: Healthcare; Health expenditure; Healthcare costs; Inequalities; Health equity; Health insurance; Shanghai; China

INTRODUCTION

The Chinese Government designed a healthcare-insurance system that was intertwined with the labour system as part of its social security system in urban areas since the 1950s, so as to provide the urban Chinese people maximum healthcare with limited available resources. Everyone with a job in the public sector was entitled to free or minimal cost healthcare. The full employment policy of the Government guaranteed almost every basic care for the urban resident.

The urban Chinese healthcare network consisted of the well-established Government Insurance Scheme (GIS, gongfei yiliao), the Labour Insurance Scheme (LIS, laobao), and the collective medical care schemes. These arrangements ensured the success of Mao's 'prevention first' health policy. The health of the Chinese people has been improving since 1949, the year of birth of the People's Republic. It is commonly acknowledged that health issues have been priorities of the Chinese Government, especially during Mao's era (1-3). However, since the economic reforms in the early 1980s, the healthcare system of China has met great challenges. Some came from the reform of the labour system, because the healthcare system has been tightly attached to the economic sector. Other challenges came from the introduction of market forces in the healthcare system.

The transition of China from a state-led to a market-led economy has brought inequality to an egalitarian society. The emergence of unequal access to the healthcare system has enforced social inequality. An urban survey conducted by the Chinese Statistical Bureau at the end of 2000 showed that healthcare is now the most pressing issue in urban China. Eighty-seven percent...
of the people stated that they were concerned about healthcare reforms more than anything else (4). It was the first time that any issue became more important than employment to the Chinese people since urban reform started nearly two decades ago.

The new policy of the Chinese Government on the Urban Employees' Basic Health Care Insurance is to introduce a cost-sharing plan in urban China (5). Like other social policy changes, this new health policy also has a great impact on the lives of the Chinese people. Affordability has been the major concern among urban residents. By the end of 2001, 76.3 million people had joined the new plan. Since it is a very recent policy change, the pros and cons of the new healthcare insurance are still under debate. This paper illustrates the implementation and the main implications of the cost-sharing healthcare policy in Shanghai.

Shanghai implemented the cost-sharing healthcare-insurance schemes for employees in the spring of 2001. In total, 6.66 million Shanghai employees and retirees were enrolled to the new healthcare insurance (6), while those with the lowest education, income, and occupational prestige (3,7,8), namely the unemployed employees working in informal work units and migrants, are mostly neglected.

HEALTHCARE SYSTEM IN URBAN CHINA AND ITS RECENT REFORM

GIS, LIS, and effects of the healthcare delivery network

The healthcare system for urban employees in China was established in the early 1950s. The two primary components of health insurance in urban China were: (i) the Government Insurance Scheme (GIS), which covered government employees, retirees, disabled veterans, and university teachers, staff, and students, and (ii) the Labour Insurance Scheme (LIS), which covered state enterprise employees, and retirees and their dependants (i.e. immediate family members who were not covered by GIS or LIS). Both the schemes were financed by both local and central governments. Enterprises owned and managed by central or provincial governments with more than 100 employees were required to participate in LIS. Smaller state enterprises and industries owned by district or street (county or town) governments provided LIS on a voluntary basis. Yearly, each enterprise sets aside a certain percentage of total wages as a welfare fund to finance health expenditure incurred by LIS beneficiaries of that work unit. From 1950 to the early 1980s, GIS and LIS played an important role in providing the urban population of China with health protection, thereby contributing to economic development and social stability.

GIS and LIS provided comprehensive benefits that did not put constraints on beneficiaries in using medical services. Beneficiaries received free outpatient and inpatient services. Dependents of LIS beneficiaries were reimbursed 50% of their health expenditure and the cost of prescribed drugs, and there was no financial limitation set for what services they could use. Beneficiaries had every right to seek healthcare from the highest quality service available regardless of expenses.

Health-insurance coverage for employees in small collectively-owned enterprises was similar to that for peasants. Each collective unit ran its own insurance programme. Employees were usually covered but not necessarily their dependants. Often the employees paid for their medical expenses first and were reimbursed later (3,9).

With a set of systematically-planned and strongly-enforced organizational principles, the Chinese Government was able to provide healthcare effectively with limited resources. It ensured maximum participation of the people in the delivery and easy access to healthcare (1-3). The health status of the people rose dramatically during Mao's era. An ideology of equity for all citizens, and the near-universal availability of adequate food, education, housing, jobs, and accessible, affordable healthcare services contributed to this achievement (10). In its 14 April 1991 issue, the New York Times reported the following interesting comparison:

"In Shanghai, 10.9 infants out of 1,000 die before their first birthday, while in New York City infant mortality is 13.3 per 1,000 live births. And life expectancy at birth in Shanghai is now 75.5 years, compared to a life expectancy in New York City of about 73 years for whites and 70 years for nonwhites as of 1980, the last year for which data are available."

Four main principles shaped China's healthcare delivery: (1) medicine must serve the people; (2) high priority should be given to prevention; (3) health education must be built on mass campaigns; and (4) Chinese traditional medicine and western medicine should be integrated (11).
Under these four principles, China developed a tiered healthcare-delivery network. In urban areas, there were the street (sub-district), district and municipal-level hospitals. The three levels had similar functions but were different in scale and 'target' groups. In the case of Shanghai, the municipal-level hospitals cared for the employees and retirees of state-owned enterprises, institutions, municipal-level government bodies, and disabled veterans. They also cared for university staff and students. The district hospitals cared for the employees and retirees of large and medium-sized collectively-owned enterprises. District and street-level government bodies, institutions under the district government, and middle-to-primary school staff were also cared for by these district hospitals. The street-level hospitals cared for the employees and retirees of small collectively-owned enterprises, service stations, etc. In addition to these hospitals, there were also neighbourhood health stations under each neighbourhood committee staffed by trained health workers. These workers were responsible for the health environment of the community, health propaganda, in-station service, home-care, etc. Most large enterprises had their own hospitals. Medium- and small-sized firms and institutions had their own clinics or healthcare stations.

Each work unit issued health-insurance cards to its employees. The insurance card was usually valid for free service and free-prescription drugs at a designated hospital. All hospital emergency rooms have been always open to everyone on a fee-for-service basis. The service costs were usually reimbursed later by the patient's work unit.

The three-tiered healthcare-delivery system in urban areas was designed to promote the efficient allocation of healthcare resources between primary and tertiary care facilities. For decades it provided an efficient framework for referring patients for care in the most appropriate setting. Changes since the economic reforms of the 1980s, however, brought new challenges to the system.

**Economic reforms and challenges to the healthcare system**

Since the early 1980s, China has been reforming its economic and administrative systems. This has dramatically changed the country’s socioeconomic scenario. It has also heavily affected the healthcare system. Private initiatives and market forces have largely supplanted government planning, and the sources of health financing changed a great deal between 1978 and 1993. Over the years, the Government’s share of total national expenditure on health (exclusive of spending on Government Insurance Schemes) fell continuously (from 28% to 14%), and the allocation by rural cooperative medical schemes fell from 20% to 2% (12). Meanwhile, several aspects of the original GIS and LIS schemes contributed to rapid inflation in healthcare costs and inefficient allocation of resources.

In urban China, GIS and LIS had been effective in ensuring relatively equal access to health services, but the two schemes had weaknesses that were common in government-owned insurance programmes. The main weakness was inefficiency in the allocation of health resources and in the provision of healthcare. Another major problem was the lack of risk pooling across enterprises or across local governments. Each organization under the original GLS and LIS was self-insured (8,13-15). Therefore, if an enterprise was running at a deficit, it would not be able to reimburse medical expenses to its beneficiaries. Furthermore, fulfilling the GIS and LIS commitments to enrollees often imposed a heavy burden on enterprises and hampered their ability to compete in the market.

Meanwhile, many urban residents lost their entitlement to GIS or LIS, especially LIS. This was mainly due to changes in the labour system. Because GIS and LIS only covered those who were employed in the formal public sector, but many people began working in the various newly-emerging informal economies, and there were large-scale lay-offs from state-owned enterprises. Table 1 shows that, in 1998, 38.92% of the urban population was covered by GIS and LIS. Although the emergent commercial insurance plans filled part of the gap, this was only an option for those who could afford to buy their own health-insurance plan.

<table>
<thead>
<tr>
<th>Table 1. Coverage of urban Chinese healthcare (1998)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forms of health insurance</td>
</tr>
<tr>
<td>Government Insurance Scheme</td>
</tr>
<tr>
<td>Labour Insurance Scheme</td>
</tr>
<tr>
<td>Commercial insurance</td>
</tr>
<tr>
<td>Half coverage</td>
</tr>
<tr>
<td>Health plan</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>No coverage</td>
</tr>
</tbody>
</table>

* Migrants are not included

Source: Chinese health statistical digest (16)
The most recent reform in China's healthcare system started with the Decision on Health Care Reform and Development issued by the Chinese Central Committee and State Council in 1997. Through August 2000, the State Council issued a set of documents elaborating new healthcare policies, with the Decision to Establish the Urban Employees' Basic Health Care Insurance System (December 1998) at its core (5). The main goals of the recent changes to the healthcare system are to: (a) establish a cost-sharing system to control healthcare expenditure and ensure the basic healthcare of urban workers; (b) promote competition in the healthcare sector, allowing patients to choose hospitals and doctors so as to improve quality of service and efficiency; and (c) break regional and industrial monopolies in pharmaceutical research, production, sales, and consumption, and promote better management to ensure better quality control of drugs and to reduce costs (17).

The major change in the recent reforms concerns healthcare financing. The Government and firms are no longer responsible for most healthcare costs. Most people in cities have to pay their share of healthcare expenses. At the same time, hospitals are no longer non-profit institutions. The market has started to play a role in the healthcare sector.

Chinese policy-makers realized that unless these problems were properly addressed, excessive escalation of healthcare costs would outstrip the people's ability to pay. This would jeopardize the improvement in urban residential health status and social stability. Furthermore, there is a close link between the healthcare system and overall economic development. For example, it is not possible for the reform of state-owned enterprises to be successful without freeing them from the burden of healthcare and other social-welfare costs.

The new policy documents of the central government on urban healthcare system reform lay down the principles for local government (provincial and municipalities) to design their own policy measures and to accomplish the implementation of their own local health policy. Shanghai was one of the pioneer cities to implement this new policy.

IMPLEMENTATION OF NEW HEALTH POLICIES IN SHANGHAI

As the industrial and commercial centre of China, the gross domestic product (GDP) of Shanghai was over 4,500 US dollars per capita in 2001, which is the highest among Chinese cities. The Shanghai municipal government spends 19% of its total employee wage bill on financing the city's healthcare for its population of 16.74 million. By 2000, its annual population growth rate was -2.27%, infant mortality rate was 5.53 per 1,000, and rate of mortality of children aged 1-4 year(s) was 0.45 per 1,000. There were 3,813 hospitals and clinics in Shanghai, and the number of available beds for every 1,000 local residents was 5.37. The average life expectancy at birth reached 78.46 years (6,18). These health indexes show that Shanghai has reached a similar level to the major urban centres in developed nations. A well-established healthcare system would be able to sustain and even improve on the accomplishments of Shanghai, while a less-sensitive health policy would impact negatively on the health of Shanghai's population.

Like governments elsewhere, the Shanghai Government has been tackling the big problem of escalating health expenditure. Table 2 shows the rapid increase in the spending of the Government on health and the funding of the GIS.

Once the central government had called for a reform of public-health financing and had initiated a cost-sharing health-insurance programme for urban employees, a cost-sharing health-insurance scheme for employees was also designed in Shanghai. The actual implementation of the new health-insurance scheme started in the spring of 2001.

Cost-sharing health-insurance schemes

The cost-sharing system of Shanghai combines two funds: Unified Plan and Medical Savings Account. The Unified Plan is designed to pay the healthcare expenses of the insured for inpatient costs, emergency room stay, and the treatment of catastrophic illness from 1,400 to 56,000 Yuan. The Medical Savings Account is imbedded in the individual's Health Insurance Card. The level of cover varies according to the age of the individual (i.e. old, middle-aged, and young), personal income, and employment status (i.e. employed or retired). Older and retired people receive the highest percentage of coverage.

Under the new system, the medical insurance funds are made up of payments by employers of an amount equal to 12% of the annual salaries of employees, plus 2% of each employee's annual salary paid through payroll deduction (19). The make up of the healthcare-insurance fund is: Work Unit 12% + Individual contribution 2% = Health Care Insurance Fund = (i) Individual MSA;
Healthcare-financing reforms in transitional society

(ii) Unified Plan; and (iii) Local Additional Fund

Individual MSA + Unified Plan → Basic Health Care Insurance Fund.

Table 2. Shanghai fiscal spending on health, 1978-2000

<table>
<thead>
<tr>
<th>Year</th>
<th>Total*</th>
<th>Health (%)</th>
<th>GIS (%)</th>
<th>Hcare** (%)</th>
<th>Year</th>
<th>Total*</th>
<th>Health (%)</th>
<th>GIS (%)</th>
<th>Hcare** (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>3.43</td>
<td>25</td>
<td>5</td>
<td>30</td>
<td>1992</td>
<td>27.63</td>
<td>19</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>1980</td>
<td>4.77</td>
<td>20</td>
<td>4</td>
<td>24</td>
<td>1993</td>
<td>37.56</td>
<td>17</td>
<td>11</td>
<td>28</td>
</tr>
<tr>
<td>1986</td>
<td>13.23</td>
<td>22</td>
<td>4</td>
<td>26</td>
<td>1995</td>
<td>70.97</td>
<td>14</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>1988</td>
<td>15.98</td>
<td>19</td>
<td>6</td>
<td>25</td>
<td>1997</td>
<td>105.4</td>
<td>14</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>1989</td>
<td>20.05</td>
<td>20</td>
<td>6</td>
<td>26</td>
<td>1998</td>
<td>117.48</td>
<td>11</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>1990</td>
<td>21.81</td>
<td>21</td>
<td>7</td>
<td>25</td>
<td>1999</td>
<td>121.25</td>
<td>11</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>1991</td>
<td>23.55</td>
<td>18</td>
<td>7</td>
<td>25</td>
<td>2000</td>
<td>133.93</td>
<td>10</td>
<td>13</td>
<td>23</td>
</tr>
</tbody>
</table>

* Total fiscal spending in the given year, unit: 100 million Yuan
**Total health share in the fiscal year spending (health spending plus spending on GIS)
GIS=Government Insurance Scheme
Hcare=Healthcare

Source: Shanghai statistical yearbook 2001 (6)

(ii) Unified Plan; and (iii) Local Additional Fund

Each individual employee is given a Medical Savings Account. A certain amount of money is deposited in each account-holder's healthcare account (according to their annual wage). Table 3 shows the make up of the employee's Medical Saving Account.

Table 3. Employee's Medical Savings Account

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>% of LYSAW*</th>
<th>% of LYPW**</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 and over</td>
<td>4.5</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Retirees 74 and under</td>
<td>4</td>
<td>Not applicable</td>
</tr>
<tr>
<td>45 to retirement</td>
<td>1.5</td>
<td>2</td>
</tr>
<tr>
<td>35 to 44</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Under 34</td>
<td>0.5</td>
<td>2</td>
</tr>
</tbody>
</table>

* LYSAW: Last years' Shanghai average annual wage (at present 14,000 Yuan). Employer pays
**LYPW: Last year's personal wage. Employee pays

The payment methods for inpatient and outpatient services are shown in Tables 4 and 5.

In order for the beneficiaries of the new health-insurance schemes to fully digest the policy, especially the complicated methods of calculation, most work units in Shanghai distributed detailed booklets to each employee, and the hospitals and pharmacies in Shanghai not only provided booklets but also set up 'healthcare-insurance information desks' to help their patients. The complexity of the new schemes is mainly due to the differentiation between age groups in the rates of coverage. The Matrix shows the main factors of the Medical Savings Account in Shanghai.

Inclusions and exclusions in the new medical insurance scheme

In Shanghai, the new medical insurance scheme only applies to urban employees. In fact, it only applies to those who are formally employed in the formal sector—mostly large and medium-sized public work units and the other regulated ownership units. The policy states that only those employees of the work units who join the healthcare 'Unified Plan' of the Shanghai government are automatically entitled to the new insurance. Therefore, this so-called employees' health insurance does not include all employees in the city. In most cases, work units in formal economy would join the 'Unified Plan', but not necessarily those in the informal sector. Thus, informal sector employees and the unemployed are deprived of the same entitlement as formal sector employees. It is true that formal employment has been following a principle of claiming entitlements to various social benefits, including public healthcare insurance (20).

Matrix. Medical Savings Account in Shanghai

<table>
<thead>
<tr>
<th>Item</th>
<th>Practical reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective of the scheme</td>
<td>Increase risk pooling and cost containment</td>
</tr>
<tr>
<td>Population covered</td>
<td>Formal, regulated sector employees and retirees</td>
</tr>
<tr>
<td>Principle of enrollment</td>
<td>Compulsory</td>
</tr>
<tr>
<td>Holder of the MSA fund</td>
<td>Health Insurance Bureau</td>
</tr>
<tr>
<td>MSA Fund contributor</td>
<td>Employer and employee</td>
</tr>
<tr>
<td>MSA Fund contributions</td>
<td>Fixed proportion of wages</td>
</tr>
<tr>
<td>MSA's spending</td>
<td>For enrollee's healthcare only</td>
</tr>
<tr>
<td>Healthcare-financing tiers</td>
<td>Medical Savings Accounts</td>
</tr>
<tr>
<td>Out-of-pocket deductibles</td>
<td>Unified plan (risk pooling)</td>
</tr>
</tbody>
</table>

Also excluded from the public health-insurance schemes are rural migrant workers, since they do not have...
Table 4. Employees' inpatient cost-sharing method

<table>
<thead>
<tr>
<th>Age group</th>
<th>Initial out-of-pocket payment (Yuan)</th>
<th>Ceiling** (Yuan)</th>
<th>Patient's share of inpatient and catastrophic disease care cost (%)</th>
<th>Over 56,000 Yuan out-of-pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirees*</td>
<td>5</td>
<td>700</td>
<td>56,000</td>
<td>8</td>
</tr>
<tr>
<td>Other age groups</td>
<td>10</td>
<td>1,400</td>
<td>56,000</td>
<td>15</td>
</tr>
</tbody>
</table>

* Last year's Shanghai average annual wage
** The ceiling equals to four times of last year's Shanghai average salary
† Retired veterans are not included

Table 5. Employees' outpatient/emergency room visit cost-sharing method

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Medical Savings Account (Yuan/year)</th>
<th>Before sharing cost, out-of-pocket (Yuan)</th>
<th>Patient's share of medical care cost (in primary, secondary, and tertiary hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirees*</td>
<td>560/630</td>
<td>280 (2%)</td>
<td>-</td>
</tr>
<tr>
<td>45 and over</td>
<td>About 490</td>
<td>1,400 (10%)</td>
<td>30</td>
</tr>
<tr>
<td>34-44</td>
<td>About 420</td>
<td>1,400 (10%)</td>
<td>40</td>
</tr>
<tr>
<td>Under 34</td>
<td>About 350</td>
<td>1,400 (10%)</td>
<td>50</td>
</tr>
<tr>
<td>New employee†</td>
<td>About 350</td>
<td>1,400 (10%)</td>
<td>100</td>
</tr>
</tbody>
</table>

* Retired veterans are not included
** % of last year's Shanghai average salary. At present 14,000 Yuan
† New employee refers to those who started work in 2001

Shanghai permanent resident status. Migrants are also most likely to be working in the informal sector.

Like some other social policies, the new health policy is biased towards retired revolutionary veterans, and retired and working high-ranking officials (bureau chief level and up). The new healthcare policy does not apply to these groups. All of them will continue to enjoy full coverage of their healthcare expenses by the Government. At present, these are the most privileged social groups in healthcare.

Main achievements of the new healthcare policy

The implementation of the Shanghai Employees’ Basic Health Care Insurance Measures separated medical insurance from the place of employment, thus enabling employees and retirees of those not so successful firms to obtain medical care benefits without delay. It is particularly beneficial to retirees. Since China has had a full-employment policy for over three decades, most elderly persons in Shanghai are retired from public sectors and, therefore, they are mostly entitled to the Employees’ Basic Health Care Insurance. In Shanghai, there are 2.2 million retirees (6). Although most of them enjoyed medical insurance (LIS or GIS) before, some of them had difficulties in obtaining reimbursement of their medical expenses when their former work units were not profitable. The newly-issued Social Security Card (at present, its use is still limited to healthcare access) relieves them from worries about their previous employer's ability to pay. This practice can be seen as part of the foundation of a basic social security system.

At the same time, the ongoing restructuring and reallocation of health resources benefits the whole of society. More rationalized allocation of health resources brings efficiency and improved medical services. It is especially good that most enterprise-based health resources are now open to society. Meanwhile, implementation of the new healthcare policy rings the bell for cost-awareness to most patients when seeking care, which significantly reduces unnecessary medical spending. Health-insurance enrollees are now given more freedom to choose hospitals and doctors (the insured has a choice of three hospitals to be used). Therefore, the new health policy effectively promotes competition among providers of medical care.

NEW HEALTH POLICY MEETS NEW CHALLENGES

The newly-implemented health policy has brought about revolutionary changes to the healthcare system. A cost-sharing healthcare-insurance scheme has now replaced the free healthcare system that was in place for over 30 years. Now a patient's decision on whether or not to seek
A survey conducted by the Chinese Ministry of Health recorded the per-capita annual income and the structure of expenditure in a district of Shanghai in 1998 (Fig. 1). The average annual income of these households was 7,829 Yuan. The structure of their average expenditure was as follows: food: 64.04%; clothing and household goods: 9.29%; housing and utility: 11.35%; education and entertainment: 9.15%; healthcare: 6.09%; and other: 0.08%. Clearly, the major proportion of an ordinary household's income is spent on basic needs. It is almost certain that poor households would have to spend an even higher proportion of their income on food. Any other expenditure is likely to compete with their consumption of basic food. The new health policy undoubtedly will increase household spending on health. Therefore, it is not too difficult for us to imagine which part of the household expenditure will likely be compromised.

The new health policy is likely to burden many with medical costs. Even commercial insurance companies are not willing to share the risk. Ms Liu of the American International Assurance Co., Ltd. (Shanghai Branch) said,
“So far, our company’s health insurance has not been all open. Our concern is that we may not be able to pay the adjustment. Because now the new health insurance almost equals to no insurance, if we provide our insurance plans, the pressure will be on our company.”

The Director of Ping-An Insurance Company Mr. Zhou said,

"To many, the new healthcare insurance is just like having no medical coverage at all. They are not covered much by the public fund and mostly they have to rely on their own ability to pay. If our company provided health insurance to these people, we would not be able to run profitably.”

Different place of employment, different 'hukou' status, different entitlements

According to the most recent Shanghai statistics, over 7.45 million people work in various sectors, and there are over 2 million retirees. However, of the 9.45 million employees and retirees, only 6.66 million are entitled to the Employees' Basic Health Care Insurance Scheme. Although the Shanghai municipal government has been forcefully pressuring the joint venture companies, foreign investment firms, private firms, etc. to join the new healthcare-insurance system, many informal sector units are still hesitant to join the city's healthcare 'Unified Plan'. Therefore, they leave their employees vulnerable, since their entitlement to the city's public-health insurance depends on whether or not their employers join the city's 'Unified Plan'. Also vulnerable are the unemployed and rural migrants in Shanghai.

If the non-entitled Shanghai residents (unemployed and employees in the informal sector) are willing to pay the healthcare and unemployment-insurance premiums (around 260 Yuan per month), they would be entitled to certain medical benefits (after three months of payment of fees). Being unemployed or working in the informal sector, these people have limited income (informally employed workers mostly belong to the working poor who earn the minimum wage). Therefore, some, or most of them, simply cannot afford to pay the premiums, and thus, they are not insured.

At present, there are 259,245 privately-owned firms (146,863 public-owned firms) in Shanghai (22). According to the Shanghai 5th Census (November 2000), 26% and 4.2% of Shanghai employees are working in state-owned and collective work units respectively (23). In a recent survey, 45.1% of re-employed women in Shanghai responded that their employers pay for their insurance fees. This means that over a half of re-employed women do not have health-insurance entitlement. It also indicates that many re-employed women are informally employed or working in the informal sector (small-scale businesses). At present, employees in the informal sector are not well-protected.

A private company owner, Mr. Lin, seems to be reluctant to join the cost-sharing health-insurance plan for health benefits for his employees. According to him,

"I have over twenty employees in my company. The lowest monthly salary in my company is 600 Yuan. So far, my company hasn't joined any health-insurance plan. I will think about joining only when I am forced to.”

Rural migrants experience many disadvantages in their new settlement location. ‘Temporary migrants’ may register their presence in the community, but they are not entitled to the state benefits, such as healthcare, that are enjoyed by permanent residents (8,13,24-26). Not only the local employment policy is biased against them, the Shanghai healthcare policy also rules out providing health benefits to those who do not have Shanghai resident status (Hukou).

A well-established urban healthcare system should take the health needs of these groups into consideration.

Poor households' burden of disease

In September 2000, the Shanghai Civil Affairs Bureau provided 175,000 people, living under poverty, with a living allowance. A recent survey of the health situation of 1,400 poor households showed that the major cause of poverty was unemployment (60.3%) (27). The survey also showed that only 2.3% of those families were covered by some form of health insurance. The average monthly income of these households was 645.63 Yuan. When they had to seek medical care, they could only ask their relatives for financial assistance (83.5%). Some of them simply did not seek medical care when ill because they could not afford it. The average healthcare debt in these families was 6,574 Yuan (28), which is over 10 months' total household income for them.

The Shanghai government oversees the needs of poor households in healthcare. There is a policy to assist those who are extremely poor. That is, the government covers 25% of the total medical expenses, while the patients
 themselves pay 75% from their pockets (26). However, this does not really help the poor people, since they cannot pay the cost anyway. Many households fall into poverty through out-of-pocket medical expenses. This is especially true among those who do not have medical insurance and are at a high risk of falling ill. Table 7 shows the healthcare needs of Shanghai’s poor households and their care-seeking behaviour.

Table 7. Healthcare needs of Shanghai’s poor households (2000) (26)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced illness in past two weeks</td>
<td>60.3</td>
</tr>
<tr>
<td>Major illness in the past year (in which 65.6% families paid health service totally ‘out of pocket’)</td>
<td>20.6</td>
</tr>
<tr>
<td>Did not seek care when ill</td>
<td>18.5</td>
</tr>
<tr>
<td>Got drugs from any source to self-treat when ill</td>
<td>31.3</td>
</tr>
</tbody>
</table>

Table 7 shows that those households living under poverty have great healthcare needs, but a large proportion of their members do not seek care when it is needed.

Retiree Ms Sun expressed concern about the well-being of her brother by saying:

"My brother is 51 years old and has a chronic disease. Since his work unit is small scale and non-profitable, his monthly income is only around 600 Yuan. Expenses for his hospital visits and prescribed drugs are quite high. The new health-insurance scheme has made his life difficult, especially the self-payment of 1,400 Yuan is a big headache. It is more than two months' total income for him. I think this is not fair. In most cases, he asks his wife to use her health-insurance card to get medicines he needs from the hospital. As for diagnoses and tests, he has to go by himself. He is now too shy to use the insurance cards of other people to pay for hospital visits, but when it is absolutely necessary, he will."

Ms Sun's brother's case is not an isolated one. Many in low- and middle-income groups are in a similar position, now that the new health policy has been implemented.

Tackling the new issues

The Shanghai Federation of Trade Unions started building a safety-net for their members soon after the new health policy was implemented. So far, their main accomplishments include: (i) opening of Gonghui Hospital, which is providing health services at reduced rates to all; (ii) establishment of the collective health-insurance plan (critical illness insurance); and (iii) distribution of 1,500 'assist-poor healthcare cards' donated by 15 large hospitals to the most needy persons. These special programmes have received positive responses because these programmes provide trade union members with alternative health-insurance plans at minor costs. However, one of the Union's officers said:

"A safety-net is supposed to help a minority group but the new healthcare policy left too many people in need of help."

Furthermore, since the programmes initiated by the Shanghai Federation of Trade Unions are all employment-related (only the work units of traditional formal sectors have trade union branches), those who are left out by the health-insurance schemes of the Government are also very likely to be excluded from these alternative plans.

BASIC CARE AND COST-EFFECTIVENESS

A district-level hospital in Shanghai recorded its outpatient service before and after the new policy came into effect. From 1 January to 18 March, the average number of outpatient visits per day was 1154.37; from 19 March to 30 June, the number decreased to 425.73 per day. The net reduction was 171.15%. At the same time, the rate of emergency room visits to this hospital increased by 20%. In another hospital in Pudong, the number of outpatient visits reduced sharply immediately after the new policy was implemented. The average daily outpatient numbers were: 7,300 in December 2000 and 10,086 in February 2001, but dropped to 2,500 in late March 2001.

The theoretical framework of the new health policy is essentially designed to limit demand-side consumption. It has successfully reduced 'unnecessary care'. However, it has also set barriers for some necessary care. Since there is no incentive developed to limit supply-side spending, patients are vulnerable to imposed high cost tests and prescription-drugs. In fact, health expenditure shows no sign of decreasing. Meanwhile, patients are now in a disadvantaged position, especially when they have to share high healthcare costs with their limited
incomes. The unusual increase in emergency room visits may mean that some people did not seek care until it became absolutely necessary. When the financial means becomes crucial in healthcare, under-privileged groups tend to be at a higher risk as far as their health is concerned.

It is more cost-effective when healthcare delivery is designed to meet the needs of its target population. The aging population in Shanghai is increasing rapidly. 2.3 million, or 18% of the total Shanghai population, are aged 60 years and over. Of them, 80% have chronic diseases (27). This is especially crucial after 20 years of implementation of the 'one child policy' since family size is smaller (2.7 persons per household), and many elderly people are living alone. Demographic changes over the years demand more low-cost nursing homes instead of admitting elderly people with chronic disease to hospitals. This change will not only considerably reduce the city's healthcare expenditure but also make daily life more comfortable for these elderly people. In addition, it would also make family visits easier, more flexible, and accessible.

When asked about the effectiveness of the new health policy, Dr. Gong at a Shanghai district hospital stated:

"It seems that the new health-insurance policy is not a success. Middle-aged people are not well-insured, but they have lots of health problems. The income of our doctors is okay but I feel that the burden for patients is quite heavy. I find the out-of-pocket expenses of 1,400 Yuan (About one and a half times are monthly salary of an ordinary worker, and more than two months salary for those who receive low wages) [deductible] and the 30% share after that is really too much for many people to bear. Conditions of retirees are much better since they have fewer shares in self-payment. Those retired revolutionary veterans and high-ranking officials are the best protected, but they are a minority of the whole population."

Challenges to the Chinese healthcare system are far from over. These challenges require the Government to design a health system that addresses the social reality. Namely, first, more rapid industrial restructuring will result in closing down loss-making firms. 2,900 state-owned enterprises are expected to declare bankruptcy over the next few years. Thus, many more urban workers will lose their jobs. Second, China's WTO accession will bring about a great number of rural labourers to the urban centres. A report of the Chinese Ministry of Agriculture notes that the number of surplus rural labourers in China has reached 100 million, and nearly 20% of Chinese farmers are jobless. Once large quantities of agricultural products are imported in China, many peasants will be compelled to leave the land to work in other sectors. Therefore, the trend of rural-urban migration will continue. Third, more people will find jobs in various non-traditional sectors to be employed in the informal sector, or to become self-employed.

IDEAL MODEL AND PRACTICAL SOLUTIONS

There is no ideal health model for all societies, but a good health system serves the needs of the nation's population. Borrowing the model of another nation must take social reality into consideration. Each nation in the world has a unique health system that meets the health needs of its own population; each nation has its own social, economic, political and cultural characteristics, and common beliefs that need to be integrated into the health system too. Good health models in the world tend to be developed gradually with the growing national health needs.

Bloom argues that it is important to focus on practical options in healthcare finance instead of debating about what the ideal health model is (20). Realizing that inequality exists in society, he suggests that governments should operate within this social segmentation to balance the needs and demands of different social groups and find strategies to meet these needs and demands. Governments committed to equity could collect revenue on the basis of ability to pay and disburse it on the basis of need. Although their capacity to redistribute resources through a tax system may be limited, governments could use their power to influence the behaviour of stakeholders in the health sector. Through structuring appropriate rules and incentives, governments can achieve risk and harm reduction, reduce unacceptably inequitable outcomes, and improve the ability of users to select providers and overall access.
There is no quick way to solve the healthcare-financing issue for the people of Shanghai, but there is a way to move slowly towards an 'ideal' situation, and the financial advantage of Shanghai will be able to facilitate a much better health system—a system that not only honours existing entitlement rights of those belonging to the healthcare-insurance scheme but also develop a new claim rule for currently-excluded population, especially vulnerable social groups. Special measures need to be created to protect the very poor and to draw more social resources to support those in need.

My policy recommendations are:

1. To identify different social groups and their health needs (employment status, resident registration status, sector of employment, age groups, etc.). Special attention should be paid to high-risk populations. The policy-makers need to learn from other nations (i.e. Germany and Singapore) on how to provide sufficient healthcare assistance to vulnerable groups. To design a new insurance scheme that deductible varies according to income and exempt low-income groups from paying premiums and deductibles.

2. According to the nature of the population, to design different schemes for different social groups, e.g. to have elderly people and children (up to a certain age) enjoy special health programmes, and to provide special schemes for special groups at a high risk of ill health.

3. To define 'basic care' carefully: on the one hand, to eliminate privileged groups' over-use of health resources by removing their free care entitlement; on the other hand, to provide marginalized groups with necessary care. Assuring basic care for all is crucial for improving the health status of the population.

4. To design a health-insurance scheme that can help people find jobs in all sectors without concerning medical benefits provided by employers.

CONCLUSION

Many nations in the world are now trying to find ways to reduce healthcare costs while ensuring basic care for their populations. This is not an easy task. To solve the problem of health expenditure exceeding revenue, co-payments or cost-sharing in medical care have also been suggested in other nations. Employming the cost-sharing health-insurance schemes is effective in awakening cost awareness of people when seeking care. However, experience in Shanghai shows that it would almost surely have a negative impact on equity in access because health status and health needs tend to vary inversely with income. It would limit access for some people, especially those who are most vulnerable to the consequences of ill health and those in low-income groups, unless the cost-sharing level varies according to income, or if low-income people had no obligation to pay any share. The employment of the Medical Savings Account also lacks risk pooling. Since the health needs of the population are different, some people can simply leave their health fund untouched (since it is a personal account), while others are struggling to find a means to seek care or even to save their lives.

Inequality in healthcare access is evident in Shanghai. The most visible inequality is the new healthcare-financing system that ignores healthcare needs of some social groups and that excludes most of them from entitling any healthcare benefit. Also, the Medical Savings Account scheme made low-income groups spending higher percentage of their income on healthcare. It is urgent for the Chinese Government not only to support work-related health insurance, but to protect the interests of the uninsured as well. If the current Urban Employees' Basic Health Care Insurance is to continue, the measures that ensure maximum coverage for marginalized socioeconomic groups need to be developed. The recent outbreak of severe acute respiratory syndrome presented a special warning. It was a crisis, but it is also an opportunity for the Chinese to assess the shortcomings of the existing healthcare system and develop strategies to improve the system. It is a great challenge, and there is an urgent need for both Chinese Government and Chinese people to find a better healthcare system that can provide everyone in society equal access, easy access, and better service. Once a better healthcare system is established, China will win back its old glory in healthcare.

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