Health Policy Reform in China

Jiwei Qian
Ake Blomqvist

Available at: https://works.bepress.com/jiwei-qian/14/
Chapter 1

HEALTH POLICY IN CHINA:
INTRODUCTION AND
BACKGROUND

1. Introduction

Government policy toward the health care system has played an important part in the process of modernizing China’s economy and society that began with the founding of the People’s Republic in 1949. At the end of its first three decades, the government could point to its health policy as a comparative success, with some justification. Although the attempt to manage the economy at large through comprehensive central planning ultimately proved unsuccessful and was substantially abandoned around 1980, the health care system that was organized during the period of the centrally planned economy represented a vast improvement in comparison with what had gone before it.¹

By the 1980s, the system of health care funding in China was such that almost everyone had access to at least a basic standard of care, at little or no out-of-pocket cost. In the countryside, most of the population belonged to an agricultural commune, and every member of a commune had access to basic primary care as well as (on referral) hospital care, at low out-of-pocket charges. In urban areas, workers and their dependents, as well as retirees, also had access to subsidized care through their employer (the government or a state-owned enterprise

As in rural areas, user charges were strictly controlled at low levels, and most of the funding of health service providers came either from the employers or as direct state subsidies; hospitals were owned either by the state or by large SOEs. In rural areas, primary-care providers were paid by the commune, and hospitals were funded by a mix of state and local subsidies and fee payments from the Cooperative Medical Schemes to which commune members belonged.

One important consequence of the strengthening of the health care system during this period was a great improvement in the standards of public health. Not surprisingly, great emphasis was put on improving population health through measures such as control of infectious disease via improved sanitation, vaccination campaigns, and so on. These developments were accompanied by dramatic improvements in the basic indicators of population health. For example, between the first half of the 1950s and the mid-1980s, average life expectancy at birth in China rose from around 40 years to 65 years. History offers few examples of such a large population undergoing as rapid and sustained a decrease in mortality as China did during that period. While other factors, such as improved food security after the famine during the Great Leap Forward, also were part of the reason for this transformation, it can nevertheless be taken as evidence that the health care system that had been established by the 1980s functioned remarkably well, producing population health indicators that were very good for a country at the low level of per capita income that China then had. As Figure 1 shows, life expectancy in China in recent decades has consistently been much higher than in India, and relatively close to that in Europe even though China’s per capita income is still much lower than the European average.

In the three decades since the early 1980s, the most dramatic development in China has of course been the remarkable success of the new approach to economic management that was started under Deng Xiaoping after Mao’s death. But China’s health care system has also continued to undergo dramatic changes, along with society

---

2Again, see Banister (1987).
3A comprehensive recent discussion is in Vogel (2011).
as the economy has grown and more resources have become available, the standards of medical care provided in some large hospitals in large Chinese cities are now similar to those in the world’s high-income countries. Although the economy has been growing rapidly, health expenditures have grown even faster: between 1980 and 2010, the fraction of China’s GDP that was devoted to health care grew from about 3.2% to over 5% (Figure 2).

But while the resources spent on health care have been rising rapidly and the standards of care may have been rising on average, as more modern and advanced drugs and treatment methods have come into use, they have not done so for all population groups. For a large proportion of China’s citizens, access to medical care may currently be worse than it was several decades ago. At the same time, those people who are able to get medical care when they are seriously ill now often have to pay large amounts out of their own pocket, and the fear of large medical bills is one reason often cited in the press for the Chinese population’s extraordinarily high savings rates. Generally speaking, dissatisfaction with the health care system in China today...
Fig. 2. China’s GDP 1990–2012 (RMB Billions in 2005 prices), and the share of health expenditure in GDP.

Source: China Statistical Yearbook, various years.

ranks much more highly among citizens’ concerns than it did three decades ago. In part, this of course reflects the remarkable success that China has had in raising the general standard of living of the population and lifting large numbers of people out of poverty. But while the economic policies that have been pursued to accomplish this have been enormously successful in most sectors, there are many who believe that in health care, they have made the system worse, not better, in important respects.4

4A substantial English-language literature now exists on the recent history of China’s health care system and health policy. A detailed account from the late 1990s is Economist Intelligence Unit (1998). A very readable short summary of debates about Chinese health reform in the 1990s and early 2000s is Blumenthal and Hsiao (2005). A very detailed and careful set of Chinese-language papers on recent history and policy proposals is Ge et al. (2007). Blomqvist and Qian (2008) assess the reform proposals in an international comparative perspective, and in the year 2009, both Health Economics and China Economic Review published special issues about the reform process. Qian and Blomqvist (forthcoming) review recent developments of health reform in China since 2009. Duckett (2010) also reviews the history of health policy and how it has been affected by politics. Many papers and reports focusing on more specialized topics have also been published. For rural health care, an exceptionally detailed early account is in
2. The Health Care System Since the 1980s: Decentralization, Deregulation, and Reduced Subsidies

As China began moving away from the earlier centrally planned system of economic management toward a market-based one in the 1980s, three kinds of measures were implemented that deeply affected the population’s access to health care. First, the commune model of organizing agricultural production was replaced by the “Household Responsibility System” under which land is allocated to individual families, and production and marketing decisions are decentralized to the family level. Second, many SOEs were privatized, reorganized, or even closed down. Third, responsibility for tax collection and funding of many kinds of government activity was to a large extent decentralized from the state to local levels of government. These developments were to have profound effects, directly and indirectly, on the health care system.

2.1. Reduced subsidies and higher patient charges

As part of the fiscal decentralization process, state subsidies to hospitals were greatly reduced. While this was partially offset by increased subsidies from local governments, most hospitals nevertheless saw a large net decline in the government funding they received (especially in poorer regions where local government revenue was limited). To compensate, they were encouraged to find ways of generating more revenue from sources such as patient fees or markups on the drugs they provided.

Asian Development Bank (2002); more recently the World Bank has reviewed the rural system’s progress in Wagstaff et al. (2009). Liu (2002) has a good early description of the background and design of the basic urban plans that cover employees; additional detail is in Liu, Nolan, and Wen (2004). For an account of public perceptions regarding these plans, see Wong, Tang, and Lo (2007).

[5] Here and in the rest of the book, we follow the convention of using “state” to refer to the central government, while “local government” refers to the provincial and lower levels.
While the state continued to maintain control over the fees charged for common (“basic”) services and standard drugs, hospitals had more freedom in setting their own charges for various kinds of non-basic procedures (often those involving diagnosis or treatment with advanced equipment) and newer drugs. With reduced government subsidies and increased hospital autonomy, it became common for hospitals to compensate their doctors through a system of bonuses that were tied to hospitals’ net revenue, which in turn depended partly on the amounts of money they were able to generate from patient charges and markups on the drugs they prescribed and sold. Indirectly, therefore, many doctors had an incentive to treat, and collect revenue from, a large number of patients, and to take into account the impact on the hospitals’ revenue when making choices with respect to how to treat a patient with a given medical condition.

This shift in incentives on physicians may be part of the reason for the increase in the acquisition and high utilization of certain types of advanced medical equipment for which hospitals could charge high patient fees, and for the increasing rate of prescriptions of new drugs on which hospitals could charge high markups. These new patterns of medical care and drug prescriptions partly explain the very large increases that took place in the average cost per treatment or hospitalization episode during the late 1980s and 1990s.6

2.2. Collapse of the rural Cooperative Medical Schemes

At the same time that new treatment and prescription patterns raised the cost of each illness episode, there was an increase in the share of health care costs that individuals had to pay out-of-pocket. Prior to the 1980s, the fees charged by township and county hospitals for treating patients from rural areas were to a large extent paid for collectively, either by

---

6Data from *Chinese Health Statistical Yearbook* (various years) show that the average medical expense per in-patient episode rose from about 1,700 to 3,100 Yuan between 1995 and 2000, and to as much as 4,700 Yuan in 2006. (There was little or no general price inflation over this period.) In 2011, the average medical expense per in-patient episode rose to 6,600 Yuan.
the commune-sponsored Cooperative Medical Scheme to which all commune members belonged, or (for those with low income) from the village’s collective welfare fund. Moreover, communes arranged and paid for most of the local primary care and pharmaceuticals that residents utilized. Since almost the entire rural population belonged to a local commune, this system came close to providing universal coverage, albeit for a relatively low level of care.

In the early 1980s, however, the system of communes was disbanded as agricultural production was reorganized on the basis of the “Household Responsibility System”. While local government took over some of the functions that the communes had had, the state tried to maintain a low level of taxation on farmers and placed restrictions on local officials’ taxation powers. An important decision was to interpret compulsory membership fees in a Cooperative Medical Scheme (CMS) as a tax, so that these schemes could only continue if farmers were willing to enroll on a voluntary basis. In most cases they were not, and most CMS plans collapsed. At the low point in the 1990s, only some 6.6% of the rural population belonged to a CMS; the remaining 87.3% were completely uninsured and had to pay the full cost of any medical care and drugs out of their own pocket (see Table 1).7

Table 1. Extent of health insurance coverage (percent of the respective populations).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BHI</td>
<td>30.4</td>
<td>N/A</td>
<td>N/A</td>
<td>1.5</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>GIS/LIS</td>
<td>8.6</td>
<td>38.9</td>
<td>66.4</td>
<td>0.3</td>
<td>1.7</td>
<td>3.41</td>
</tr>
<tr>
<td>CMS</td>
<td>6.6</td>
<td>2.7</td>
<td>1.62</td>
<td>9.5</td>
<td>6.6</td>
<td>9.81</td>
</tr>
<tr>
<td>Other social insurance</td>
<td>2.2</td>
<td>10.9</td>
<td>4.44</td>
<td>1.2</td>
<td>3.0</td>
<td>2.34</td>
</tr>
<tr>
<td>Private insurance</td>
<td>5.6</td>
<td>3.3</td>
<td>0.25</td>
<td>8.3</td>
<td>1.4</td>
<td>0.33</td>
</tr>
<tr>
<td>No insurance</td>
<td>44.8</td>
<td>44.1</td>
<td>27.28</td>
<td>79.0</td>
<td>87.3</td>
<td>84.11</td>
</tr>
</tbody>
</table>


Note: BHI and GIS/LIS are insurance schemes that primarily cover urban workers.

7An extensive review of the situation in the rural-area health care sector is in Asian Development Bank (2002).
2.3. Reduced insurance coverage in urban areas

In the urban areas, too, the proportion of health care that patients had to pay out-of-pocket increased, as many workers and their dependents became uninsured. Under the earlier system, most urban residents were insured either under the Government Insurance Scheme (GIS) which covered government employees and their dependents, or under the Labor Insurance Scheme (LIS) which covered workers in SOEs and (with reduced benefits) their dependents. But through the 1990s, there was a substantial reduction in the proportion of residents covered by these plans. Part of the reason for this was the trend toward privatization and increased financial autonomy for State-Owned Enterprises (SOEs).  

SOEs scheduled for privatization resisted taking over the responsibility of paying for the health care of current and (especially) retired workers and their dependents, and loss-making SOEs that could no longer count on having their deficits covered by the state sometimes chose to reduce their expenditures by no longer paying for the health care of these groups; some loss-making SOEs were even closed. As a result, the percentage of urban residents with health insurance coverage declined rapidly through the 1980s and especially in the 1990s. By 1998, it was estimated that as many as 44% of urban residents were without health insurance (see the row labelled “No insurance” in Table 1). This statistic probably understates the problem, as it most likely is based on the number of registered urban residents. But after 1980, China also has seen an increasing inflow of migrant workers from the countryside to the cities. These workers typically were not covered by the LIS under which SOE employees were covered, and may not be completely accounted for in the population base used in the estimate of the uninsured share of the population.

2.4. Summary: A surging economy, worsening health care

The switch toward economic policies based on market mechanisms that began in the late 1970s was based on the expectation that in a modern
economy, voluntary transactions in competitive markets at prices freely agreed between buyers and sellers are likely to be more successful in raising productivity and incomes than a model of centrally planned allocation of economic resources. In accordance with this principle, the authority to decide what to produce and what inputs to purchase was decentralized to producing units such as families in the farm sector and individual enterprises of various sizes in other sectors. The incentives on producers to respond to market signals were enhanced by withdrawing subsidies from many loss-making enterprises, and by allowing those who were able to make a profit to keep much of it for re-investment in the firm or for increasing the pay and benefits of managers and employees.

In general, the policy was of course spectacularly successful, particularly in the agricultural sector and in manufacturing, whose production has increased by enough to not only satisfy the increased demand in the domestic market, but also to transform China into the world’s dominant manufacturing exporter. The rapid growth in productivity in these sectors has led to large increases in the real incomes for the majority of China’s citizens, especially in the large urban and coastal regions where the export-led economic expansion has had the greatest impact.9

But while the market-based approach has been successful in the economy at large, the evidence discussed earlier suggests that in health care, it has been much less so. While the total amounts that are spent on health care have increased faster than other spending, the access to health care for seriously ill people is no better than it was in an earlier era. Indeed, for the reasons discussed above, the incidence of untreated illness may be higher today than it was 30 years ago, as sick people forego treatment for fear that it will be very costly. Instances

9An often cited measure of the success of China’s economic policy since 1980 is the large number of people who have been raised out of poverty as a result of the country’s economic growth. For example, *The Economist*, June 1–7, 2013, quotes the astounding figure of 680 million for the reduction in the number of Chinese citizens whose income fell below a poverty line of $1.25 per day (in 2005 U.S. dollars, adjusted for purchasing power) over the period 1981–2010. Also see World Bank (2009).
of waste, in the form of treatment in cases where it is not needed but which is supplied because it raises providers’ income, are frequently cited. Expensive forms of medication are often chosen over cheaper ones because hospitals benefit from the higher markups that they can charge on them, or because doctors can charge a fee when drugs are given through injections rather than by mouth.

Thus, in contrast to the case in most other sectors, the shift to a more market-based incentive system in health care has not led to higher productivity, only to substantially higher costs and more waste of resources. While the increased spending on health care has raised the incomes of doctors and other health care workers, and of producers of other health sector inputs such as drugs or medical equipment, the lagging productivity and waste in the health care sector has implicitly acted as a drag on the real incomes of the population as a whole. Why is it that the model that has worked so well in most other sectors has not done so in health care?

3. Do Market Mechanisms Work in Health Care?

While the Western literature on economics in general tends to be sympathetic to a market-oriented approach as an instrument to determine the allocation of society’s resources, the literature on the economics of health care often is not. In particular, three interrelated ideas have been stressed in support of the view that markets typically will not perform well in the health care sector, so that there is a strong case for the government to intervene and actively manage both the financing and the production of health care.

The first is that some health services have the characteristics of public goods; an appropriate level of production of such goods will only occur if they are subsidized or provided by the government. The second is that the sick patients who appear on the demand side in the market for most health services cannot be looked at in the same way as the buyers who appear on the demand side in the market for other goods and services, even if attention is restricted to health services that are private goods. The third is that in a well-functioning health care system, consumers must not just have access to health services
when they are sick, but also to health insurance, because they may get sick in the future. A market-oriented health care system, therefore, must not only produce health services efficiently, but must also give consumers access to health insurance on reasonable terms. However, even the evidence from countries with active private insurance markets suggests that without extensive government regulation, these markets do not function well.\textsuperscript{10} We discuss these three ideas in more detail in the following.

3.1. Some health services are public goods

One clear reason why voluntary transactions in private markets will not ensure that sufficient resources are allocated to certain kinds of health services is that some of them have what economic theory refers to as spillover effects. Spillover effects exist for health services that yield benefits not just to the person who receives them, but to others in the community as well. The most important cases of this kind are treatment and prevention of contagious disease: If a person receives services that prevents or cures a contagious disease, these services benefit not just the person who receives them, but also other members of the community as the risk that they will contract the disease is reduced.\textsuperscript{11}

In a voluntary transaction where individual patients have to pay the full cost of these services in the market, their decision whether or not to get such services will typically depend on a comparison of the cost with the expected benefits to the buyers themselves; unless individuals are particularly civic-minded, they will not give sufficient weight to the benefits to others when they make these decisions. For goods and services with spillover effects — public goods, in the terminology of economic theory — government must take the initiative to subsidize them, or provide them to consumers for free, in order for enough of them to be produced.

\textsuperscript{10}These three ideas, especially the last two, are discussed extensively in three major surveys of health economics that currently exist: Culyer and Newhouse (2000), Glied and Smith (2011), and Pauly, McGuire, and Barros (2012).

\textsuperscript{11}Both Culyer and Newhouse (2000) and Glied and Smith (2011) have chapters on infectious disease.
In high-income countries, policies to ensure that health services with significant spillover effects are adequately supplied are typically enforced by public health departments at the local level, although they may work together with providers of regular health services, such as primary-care doctors or nurses. Examples of tasks for which public health departments are responsible include administration and supervision of immunization programs for children and adults, and programs to prevent and contain various types of epidemics such as different types of influenza or sexually transmitted diseases. Their responsibilities can also include enforcement of rules relating to environmental factors that indirectly influence population health, even though they do not involve health services, strictly defined. For example, they may be the agencies that ensure high standards of cleanliness of food handling in restaurants and stores, and the quality of the water that citizens use and the air they breathe. All of these activities are organized and paid for by the government, since they would not be undertaken on an adequate scale through voluntary market transactions.

But while the work of public health departments is a critical component of the system that promotes population health everywhere, in high-income countries the resources that they use are very small in comparison with the amounts spent on regular health services. By far, the largest amount of health sector resources is accounted for by the provision of health services (and drugs) to deal with illness that is not contagious. While such services and drugs can be very valuable to the patients who receive them, they do not have significant spillover effects that benefit the community at large. Thus, while there may be other reasons why markets may not work well in the health care system at large, as further discussed in the next subsections, most health services are not public goods in the sense that this term is used in economic analysis: because they do not have significant spillover benefits, they are private goods.

In the early stages of the economic reform era in the 1980s, China was still a low-income country, and the per capita spending on health care was quite low as well. At that time, the share of health care resources that were used to deal with contagious disease and public health services with public-goods characteristics was large
relative to the total: Spending on health services that were private goods and were directed at non-contagious disease was relatively limited. When the policy of reduced subsidies and greater reliance on revenues raised from sales in the market was extended to producers of health services such as urban and rural health clinics and hospitals, an unintended consequence was a reduction in some of the public health activities (such as immunization programs and control of various kinds of infectious disease) for which many of the providers had been responsible.\footnote{The other example in China is mental healthcare. See Qian (2012b).} As we will further discuss in later chapters, subsidies and other government policies to ensure that these functions are properly discharged should be an important element of future Chinese health policy, even if market transactions are allowed to play a greater role in the provision of private health services for which spillover effects to the community are less important than they are for services that are properly classified in the public health domain.

### 3.2. Patients as buyers of health services: Information asymmetry and competition

The ability of buyers to benefit from being able to obtain a good or service through a voluntary purchase in the marketplace is obviously better when they have good information in advance about the characteristics of what they are buying, and how it will benefit them once they have bought it. Even if one focuses on services that are private goods without significant spillover effects, it is clear that in markets for health services (and drugs), patients usually do not have very good information. Beyond knowing that they are sick, the average person cannot diagnose what his or her problem is, nor do patients have the training and expertise to tell what drugs or treatment methods are available to deal with their problems, or how likely it is that they will get well. The doctors who treat them (the sellers), in contrast, have much better information about these things than the buyers do, and may be tempted to use this information asymmetry to their advantage. The bargaining power of buyers of health services is also
inherently weakened by the fact that most diagnostic and treatment services must be provided with the patient being present, and that the nature of the complete treatment process cannot be negotiated in advance.

The information asymmetry and the personal nature of health services also reduce the effectiveness of competition between sellers as a way of strengthening the ability of patients to benefit from access to health services in the market. In markets where buyers know exactly what they want or need in advance, and where it is easy to specify the exact characteristics of the good or service that is being purchased, buyers can easily compare the offers of competing sellers and choose the offer that they know in advance is their best option. In the health services market, in contrast, getting offers from more than one provider is likely costly and cumbersome as it might require the patient to be seen personally by each potential provider, and in any case may not be worth it since the typical patient does not have the technical expertise to properly compare the quality of the service that different providers are likely to offer, or different approaches to dealing with their particular problems.

The idea that the information asymmetry between patients and providers and the special characteristics of health services put patients, as buyers of health services, in a particularly weak and vulnerable position in their relationship with the sellers of these services, has been a central one in much of the economic analysis of the health care sector. Predictions based on this analysis suggest that unless the market is regulated or controlled in some way, the weakness of competition among sellers is likely to result both in prices of health services that are high relative to the cost of producing them, and possibly in an oversupply of many kinds of health services. The latter effect is especially likely to occur if new producers (doctors and hospitals) are allowed to enter the market without restrictions, and if there is an insurance system that reduces the out-of-pocket costs that patients face when they utilize health services, as discussed below. The high cost of health care in the U.S., where relatively unregulated private markets play a larger role in the health care system than in any other high-income country, is often seen as evidence that supports these predictions.
3.3. **Risk pooling and private insurance markets**

A third reason why voluntary transactions in private markets may not perform well in regulating the use of economic resources in the health care sector is that a well-functioning health care system must not only supply health services at reasonable cost, but must also respond to citizens’ demand for risk pooling. This demand arises because the incidence of various health problems, and hence the need for possibly expensive health services, is both highly variable and unpredictable.

Many individuals are lucky in the sense that they go through life with only relatively minor and uncomplicated health problems that can be treated without using large amounts of health services. But a minority of individuals are less lucky and are afflicted by serious kinds of illness that require large amounts of ongoing treatment and medication in order for them to survive or to avoid severe pain and disability. For some, the demand for expensive health care will be concentrated toward the end of their lives if they suffer from painful and disabling conditions for a long time before they die.

The demand for risk-pooling arises because, on average, people in the community will be better off if at least part of the health care costs is paid for out of a common pool, rather than out-of-pocket by the individuals who are unlucky enough to experience serious ill-health, or their families. In retrospect, those who have contributed to the pool but have not had high health care costs are worse off than they would have been without pooling, but their losses are small in comparison with the gains to those who have had serious health problems and have been able to access health care that they otherwise would not have been able to afford, or that would have impoverished them and their families.

Risk-pooling arrangements, under which a substantial part of the cost of health care is paid for collectively, can be thought of as responding to a community’s desire for equity in the distribution of economic resources, since it implies a redistribution from those who are better off in the sense of not requiring costly health care, to those who are unlucky enough to do so. However, risk pooling can also be justified on efficiency grounds. If it is not known in advance who will have serious health problems and require expensive care, risk-averse
individuals will be willing to contribute to a risk-pooling arrangement that guarantees them access to health services and reduces the risk of financial disaster, even though they know that in retrospect they may not need this protection.

In a system where health services are heavily subsidized or directly supplied by the community, as in China before the 1980s, there is implicit risk pooling since individuals only pay a relatively small share of the cost of their health care out of their own pockets, with the rest being shared among all members of the community. When the degree of government subsidization is reduced, as it was through the 1980s and 1990s, the degree of risk pooling will also tend to be reduced, unless the reduction in implicit risk pooling through government is offset by an expansion in the amount of explicit risk pooling through the market for health insurance.

In theory, insurance-based risk pooling can be supplied in private competitive markets even if there is little or no government regulation or subsidy. Since risk-averse individuals are willing to pay for insurance if it is available in the market, private firms can make a profit by offering insurance contracts under which they agree to pay for all or part of the health care that plan members use, in exchange for premiums that they charge everyone who belongs to the plan. As in other markets, the cost to the consumers (in the form of the insurance premiums they must pay) will be influenced by the extent of competition among sellers (different insurance plans); if the market is sufficiently competitive, the premiums will be just high enough to pay for the cost of the care that plan members use, as well as the costs incurred in setting up and administering the plans.

However, as has been extensively discussed in the economics literature, private unregulated insurance markets generally, and in health insurance specifically, are unlikely to be very competitive. Moreover, administration and marketing costs can be quite high. Entry into the insurance market can also be costly and difficult, especially in a health care system that is in transition so that there is little statistical information that can be used to estimate the expected cost of the health care that plan members will be using under a new plan.
A particularly difficult problem in offering new plans in a market in which private insurance is not well-established is that of “adverse selection”. This term refers to the tendency for the demand for insurance to be especially strong among individuals who know themselves to be at high risk for future health problems that will require expensive services. But if most of those who sign up for private insurance plans are in this category, the plans will have to charge high premiums in order to cover their expected costs; these high premiums, in turn, will make the plans unattractive to average individuals, limiting the profitability of offering them in the market.\(^{13}\)

Given these problems, it is perhaps not surprising that the development of private health insurance in China was quite limited in the 1980s and 1990s, even though the extent of government risk pooling was dramatically reduced during those decades. As has been extensively documented, the result was that the policy of reduced subsidization of the production of health services and the increased role of charges on patients as a source of revenue for providers led to a dramatic increase in the population’s exposure to illness-related financial risk, and even precluded large population groups from access to urgently needed care. It was these developments, perhaps more than anything else, that led many observers to characterize the application of market-based principles to the health care sector as a failure. Moreover, as we will further discuss in Chapter 3, the question of how to strengthen the degree of risk pooling remains a central issue in the debate regarding China’s future health policy, with some favoring an expansion of the system of social health insurance as the best option, and others advocating a return to implicit risk pooling through increased direct government subsidies to providers of primary care and hospital care.

\(^{13}\)The classic statement of the adverse selection problem in insurance is in Rothschild and Stiglitz (1976). There is ample evidence that it is especially likely to be present in health insurance markets in particular, and that attempts by private insurers to guard against it through “risk selection” are a major reason why private insurance markets tend to be both inefficient and inequitable.
4. Conclusion and the Way Forward

Given the developments in China’s health care system in the 1980s and 1990s, it is not surprising that health policy and health system reform have become increasingly important topics in the Chinese debate over economic and social policy in recent years. China’s experience has confirmed the prediction from the health economics literature that largely unregulated private markets will not perform well as an instrument for governing resource use in the health care sector. In retrospect, policymakers may wish that they had taken a somewhat more gradual approach in decentralizing the management of the health care sector and putting pressure on providers to raise more of their revenue from patients.

At the same time, one should not underestimate the difficulties and resistance the reformers faced in bringing about a dramatic restructuring of the economic system as a whole, and how, under the circumstances, they may have been reluctant to make exceptions to the general principle of dismantling the system of comprehensive central planning in any individual sector.14 The process of reform was highly controversial, and there were influential conservative forces both in the bureaucracy and in the academic world who believed that the reduced influence of the state in the economy went too far and should be at least partially reversed. In health care, the opposition to reform continues to be strong, in part because the current public dissatisfaction with the health care system can be unfavorably contrasted with the way it was managed in China in earlier decades, and also because those who favor a more interventionist role for the state can point to an extensive Western literature which elaborates on the likelihood of various forms of market failure in health care. Today, even those who are strong supporters of the policy of economic liberalization in general recognize that the state must at least take a more active regulatory role in the health sector.

14Interestingly, former Premier Zhu Rongji is reported to have said, some time after leaving office, that health policy was one area in which he felt somewhat dissatisfied with the outcome of the reform efforts.
But while there may now be widespread agreement that health care is a sector in which the tendencies toward various forms of market failure justify a more activist role for government than elsewhere, there is much less agreement on what form that role should take.

One major conclusion of the review of Chinese health policy since the late 1990s that we provide in this book is that its future directions are highly uncertain. The major policy initiatives that have been taken so far, seen as a whole, constitute somewhat of a stand-off between the forces on the new left who favor a return to a system of heavy direct subsidies and public management of health services providers, on one side, and liberals who believe that government intervention should focus on financing and regulatory measures, whilst allowing markets and competition to continue playing a major role in governing the production of health services and drugs, on the other.

4.1. The rest of the book

The rest of the book is organized as follows. In Chapter 2, we attempt to place our discussion of recent Chinese health policy in an international comparative framework, by reviewing developments that have led to health system reform becoming a major preoccupation of governments and the policy debate in most major countries in the world. As a background to our later recommendations for policy directions in China, we identify two countries in which there exist clear and consistent models that guide the ongoing reform process, namely the United Kingdom and Holland, and explain why elements of these models may be adapted and applied to a future Chinese system.

In Chapter 2, we also describe the health care systems in two other countries whose economies have been successful in the past, the U.S.A. and Japan, and explain why we believe the systems in those countries have fewer useful lessons for China than the U.K. and Holland, even though their economic performance in general has been very good. One conclusion we draw from considering the experience of health system reform in other countries is that it is a process that is very controversial everywhere, and which to a large extent is dominated
by the actions of politically powerful special interest groups. China is not likely to be an exception to this pattern, and effective reform can only be accomplished if the political leadership succeeds in containing and limiting the influence of these interest groups.

In the following four chapters we then go on to consider the major developments and initiatives that have featured in Chinese health policy since the late 1990s. Chapter 3 discusses the strengthening of the social insurance system that began in the late 1990s, while Chapters 4, 5, and 6 deal with the three additional pillars of health system reform that were cornerstones of the 2009 health policy announcement by the State Council: establishing a network of basic (primary) care clinics throughout China’s rural and urban areas, reforming the system whereby public hospitals are managed, and implementing a new national drug policy. In each case, we analyze the approach that China has attempted to use in the light of relevant principles from the Western literature on health economics and general economics, and draw on examples from other countries.

In Part III, we broaden the analysis somewhat and consider how health policy in China relates to two major trends that have become prominent in the more general debate about the future of China’s economy. The first is the gradual re-orientation of economic policy from an almost exclusive emphasis on the objective of economic growth, toward more focus on the target of universal economic security and a more equal distribution of real income. Although economic analysis of income distribution policy typically focuses either on measures that affect the labor market (from which most people derive most of their income), or on the incidence of a country’s tax-transfer system, we argue that in a middle-income country like China, policies to broaden the access to good health care potentially constitute one of the most effective instruments for raising the welfare of the poor, and hence contributes to increased equality in real income, broadly defined. We discuss these issues in Chapter 7.

---

15Another area of social policy that also can have a powerful effect on the distribution of real income is education.
The second major trend is that toward increased decentralization of responsibility for the expenditure side of China’s system of public finance, under which responsibility for the implementation of health policy in China now rests principally with governments at the local level. As we discuss in Chapter 8, while decentralized management of health policy has the desirable property of allowing the system to adapt to local conditions in a more flexible way, the incentives to which local officials and political decision-makers are subject may make it difficult to implement principles regarding health policy that have been formulated by the state. The fiscal pressures that local governments are subject to under China’s present system of central-local revenue sharing and expenditure responsibilities may reinforce this tendency, which must be taken into account if central initiatives to use the health care system as an indirect instrument for promoting a more equal distribution of real income are to be successful.

In the last two chapters, finally, we summarize what we see as the main future problems that China’s health policy makers must address. In Chapter 9, we consider how the current social insurance system can be strengthened and integrated with the initiatives to reform primary care, hospital management, and regulation of the pharmaceutical sector, to attain the goal of creating a system that provides universal insurance coverage and access to efficiently produced care of high quality. The basic model that we consider in this chapter is inspired by the U.K. example that we describe in Chapter 2, with appropriate modifications to the Chinese context. While markets and competition can play a significant role in promoting efficiency in the production of health services under this model, on the financing side it is dominated by the social insurance system, with only limited competition from private insurance.

In Chapter 10, we go further and consider an approach under which markets and competition play a significant role not just in the production of health services, but also on the insurance side. The scenario we consider in this chapter is inspired by the model that is serving as the guidepost for the reforms that have been underway for a number of years in Holland, as also discussed in Chapter 2. In Chapter 10, we also briefly discuss a policy issue that is of fundamental
importance no matter which model is used on the financing side, namely how to regulate and manage the training of doctors and other health personnel in such a way as to promote cost-effective patterns of high-quality care based on choosing from the most advanced technology available anywhere in the world.