The Path to Integrated Insurance System in China

Executive Summary

Universal medical insurance

Since the 2003 SARS outbreak, health care in China has become a leading national ncern. Often highlighted by the popular phrase, *kan-bing-nan, kan-bing-gui* (seeking care is difficult and expensive), health care costs can be devastating. Three health insurance schemes have been set up. First, the Urban Employee Basic Medical Insurance (UEBMI) was set up for the urban employed population in the early 1990s. Second, the New Rural Cooperative Medical Insurance Scheme (NCMS) was set up for rural residents in 2003. Third, the State Council initiated a pilot experiment of the Urban Resident Basic Medical Insurance (URBMI) in 79 cities in 2007, targeting urban residents without formal employment, especially the elderly and children.

These three medical insurance programs constitute the foundation for healthcare financing in China today. Together, they comprise a framework to achieve a fundamental goal of healthcare reform: a universal system of basic medical insurance that will cover and protect the entire population of China.

Comparing UEBMI and URBMI

During the 1980s, the Labor Medical Insurance (LMI) for many enterprises and the publicly funded Government Medical Insurance (GMI) for some agencies ran into serious financial trouble. They could no longer pay healthcare institutions for services rendered. Consequently, many individuals had to purchase medical services out of pocket, and they incurred substantial risk and financial hardship. With UEBMI, medical insurance agencies work directly with health providers to pay for services, thereby eliminating the risk of default. Thus, while UEBMI coverage and benefit levels may be lower than that of the previous government and labor schemes, direct group payments to providers and increased risk pooling provide greater financial security than the previous schemes, which were unable to protect employees of failing enterprises.

Compared with the old government and labor medical insurance schemes, UEBMI has improved equity and access to health resources. It covers a wider range of incomes, jobs, and health conditions. Under the old labor medical insurance schemes, each enterprise had its own insurance. Coverage and benefits depended on employees' status, with differences in employment leading to overall inequity in benefits. By contrast, under UEBMI all employment units in a region provide similar coverage.

There is significant inequity between UEBMI for the employed and URBMI for the unemployed. Many factors contribute to the disparities between the two programs. First, purchasing power is lower among URBMI enrollees, including children, students, seniors, and the unemployed. The lower level of financing translates into less coverage and benefits. Second, URBMI pilot projects adhere to the principle of modest startup to

ensure stable development. It is easy to expand services with steadily increasing financing. Third, government subsidies were also low at startup to limit financial risk. However, healthy development justifies and invites increased investment. The central government announced a doubling of its subsidies in 2008, and encouraged local governments to do the same. This should reduce the inequity in coverage and benefits between UEBMI and URBMI.

UEBMI and URBMI provide insurance coverage and health benefits to all urban residents, including migrant workers. With mandatory enrollment, adverse selection is not an issue. However, enforcing mandatory enrollment can be a problem, because individuals and enterprises must identify themselves for the system to work. Individuals and enterprises experiencing financial trouble are not likely to enroll voluntarily in medical insurance schemes, and it is difficult for the government to track them and force compliance. For this reason, some urban residents do not have medical insurance, and they will not use the basic health services that insurance schemes provide. Mandatory enrollment is preferable for safety nets. On the other hand, the substantial administrative costs of enforcement (as is the case with URBMI) and the substantial additional expenditures that would be needed for services (as in the case of NCMS) work in opposite directions. Temporarily at least, voluntary (rather than enforced mandatory) enrollment serves as a compromise. A different solution may be necessary over the longer term.

As UEBMI, URBMI, and NCMS are managed by separate ministries with different levels of premium payments and financing, their insurance coverage and health benefits lack portability. Provinces, regions, municipalities, and counties also maintain medical insurance systems that are not transferable to other areas. Individuals risk losing their insurance coverage and health benefits when their employment status and residency change. Further insurance reforms include regional-level integration of UEBMI, URBMI, and NCMS in order to establish transferability across systems and ensure individuals of continuous coverage and benefits.

Comparing China's medical insurance system with OECD countries

China's medical insurance system has three components—UEBMI, URBMI, and NCMS—as well as the Medical Assistance (MA) program, which provides supplemental safety-net support to the poor. Viewed as four elements in an overall "system," China is moving toward universal basic medical insurance in the manner of OECD countries such as Canada, Netherlands, Sweden, the Republic of Korea, Japan, and Singapore.

Among OECD countries (excluding the United States and Singapore), the general principle in financing is that people should contribute according to their means (what they can afford), but patients should receive services according to their needs (what is medically necessary). The goal is equal access to health care regardless of income, location, or age. To achieve this goal, the government pools risk and transfers wealth from rich to poor, through either tax-based financing or social health insurance (SHI).

In principle, a tax-based system should be the simplest way to reach these objectives, as the central government is responsible for the entire population. However, tax-based financing is usually associated with public ownership of hospitals and the inefficiencies of a budget-based delivery system. Tax-based financing is also less stable as it varies with changes in government policy and economic fluctuations. For middle-income countries, the mismatch between the goal of equal access for all and actual budgets typically results in scarce resources being concentrated in urban hospitals at the expense of rural areas.

The social health insurance (SHI) model originated in Germany, where it was based on the principle of solidarity and mutual assistance within each occupational group, enterprise, or geographic region. Each member contributed a set percentage of income regardless of income level or risk of illness. Dependents were covered by the plan of the head of household. Although benefits were essentially the same for all social insurance plans (referred to as sickness funds), there continue to be differences in premium levels among the plans. These differences have decreased since the government established a central pool into which a higher percentage of low-risk individuals contribute (primarily, the young), while plans enrolling a high percentage of high-risk individuals (older people) receive relatively more benefit. In Japan, these differences also decreased as the government provided subsidies from general revenues to plans that enroll low-income individuals. The hybrid system could serve as a model for middle-income countries to achieve universal coverage. Japan has established risk pooling and income transfers within each SHI plan as the first step. The second step is to gradually reduce differences in the benefit package and premium levels among SHI plans.

Private health insurance (PHI) can work in several ways. It can *substitute* (as in the United States, Germany, and The Netherlands), *complement* (as in Canada for drugs and dental care not covered), or *supplement* the public financing system (as in the UK and Australia). The conceptual merit of PHI is in the institutional structure of the private market, which should increase efficiency and relieve pressure on public budgets by focusing on the needy.

Globally, there are many approaches to pooling and integrating insurance funds. In Japan, a single pooling fund was created in 1983 to share costs equally among multiple insurers. A second model, used in Germany, adjusts payments to insurance pools retrospectively based on relative risks. A third model, used in Netherlands, adjusts premiums or payment rates. Income-related contributions are paid into a risk-equalization fund, which equals 50 percent of total insurance revenue. Premiums are based on community averages. A fourth model is to pool either at the national level (as in Sweden and the United Kingdom) or at regional or provincial levels (as in Canada and Kazakhstan). As decentralization has a long history in China, this might be an interim model.

There is no "right" or "best" arrangement for pooling funds, and the essential starting point for decision-makers is to understand existing arrangements. Both theory and evidence suggest that reforms should reduce fragmentation in pooling.

Practical approaches to accomplish this vary considerably among countries. One approach is to create a *virtual single pool* from multiple pools by establishing a redistribution fund with risk-adjusted allocations to various insurers. The experience of the Czech system is instructive. Czech reforms have redistributed the entire insurance pool (thereby maximizing the scope for risk protection), and simultaneously lowered the benefits from risk selection for competing insurers.

Longer-run, China might consider a unified single-pool system of funding a core package of services for all citizens. This model is currently found in the United Kingdom, Sweden, Norway, Canada, and Oman. This model lowers administrative overhead and provides increased leveraging for purchasing and commissioning of services.

A uniform payment system for all patients across insurers has many advantages. First, it increases billing efficiency. This is why the United States, with multiple payers, has higher costs than Canada, with a single payer. Second, uniform payments result in equal treatment of all patients, regardless of insurance plan, because providers are paid the same amounts for the same services. Third, as healthcare expenditures are equal to price multiplied by volume, containing price also contains expenditures. Fourth, as physicians and hospitals are sensitive to changes in payment methods, their behavior can be changed by revising fee schedule regulations. In contrast, with multiple payers, providers can maximize income by focusing on patients whose insurance plans cover the most services and have the least restrictive billing conditions. The generous standards for these patients becomes the industry standard and exerts pressure on the public payment system.

Policy implications for China's health system

China's medical insurance system is now a mixed system for the employed and unemployed (UEBMI and URBMI) as well as for the urban and rural populations (UEBMI, URBMI, and NRCMI). Employer/employee contributions, individual contributions, and government subsidies are the major sources of financing for these medical insurance systems, as in The Netherlands and Japan. Because the level of financing varies, health benefits also vary among UEBMI, URBMI and NCMS; while in Japan, health benefits are standardized with the help of government subsidies across the two health insurance systems. Standardized health benefits help improve equity in access to and use of health services.

With the recent healthcare reform, China is moving rapidly toward a universal insurance approach. This mission is tangible, achievable, and can be built upon the foundation of UEBMI, URBMI, NCMS, and the Medical Assistance program. Each program covers a specific group, and together they form the basis for a universal, albeit still-fragmented system. Segmenting healthcare financing by the socioeconomic and demographic characteristics of particular groups makes sense in the near term while a universal basic medical insurance system with more homogeneous coverage and benefits is developing.

Segmentation by income and social status ensures a certain degree of equity in access and use within each group (horizontal equity). The downside, however, is inequity *across*

income and social groups (vertical inequity). Segmentation also weakens the risk-pooling capacity of social insurance. The State Council now provides subsidies to URBMI and NCMS to resolve vertical inequity, but these subsidies provide only limited relief. Vertical equity can only be achieved by merging the separate components of the medical insurance system.

URBMI can provide useful links with the other three programs in the merging process. URBMI is in a position to play this role for several reasons: its level of financing and health benefits is in between UEBMI and the NCMS; the sharing of its administrative structure with UEBMI; the overlap in its target population with medical assistance; and numerous institutional characteristics it shares with the other three programs.

Options and recommendations for further reform

• ***Replace medical savings accounts (MSAs) with social pooling for outpatient services***.

Medical savings accounts should be gradually abolished. Existing individual accounts could be transferred to the pension fund. In their place, establish social risk pooling for outpatient services. Social pooling will enhance coverage and benefits to low-income groups and to the unemployed urban population covered by URBMI.

Create greater equity across funds. Costs and benefits vary greatly for different groups within UEBMI, URBMI, and NCMS. This cannot be fully rectified because incomes vary so greatly among groups. The short-term challenge is to focus on a basic package for low-income groups. It is not practical to immediately integrate UEBMI, URBMI, and NCMS (as well as MA). As a first step, differences in co-payments and benefits within UEBMI and within NCMS should be decreased. The national government could increase subsidies to NCMS so that the basic package could be available for the poorest municipalities. A second option for enhancing coverage and benefits for migrant workers is to combine the NCMS and URBMI subsidies. When migrant workers move to urban areas they could use government assistance for NCMS for premium payments that would enable them to join URBMI.

Restructure the benefits package. A step-wise process must be taken to achieve uniform basic benefits for all individuals and families. The cash limit on coverage in NCMS should be abolished as patients face financial impoverishment when medical costs exceed the cap. Co-insurance should be abolished for basic benefit services. If co-insurance must be levied, then patient payments should be used for that purpose only—not as an indemnity in which patients must first pay and then be reimbursed. The co-insurance rate for services and drugs outside the basic benefit package should be based on their proven efficacy. If services are provided outside the benefit package, reasons need to be provided in writing along with signed informed consent. Physicians who make misleading statements should face criminal prosecution.

Restructure URBMI. The URBMI must be restructured. Expanding the insured population will be difficult if enrollment is kept voluntary and coverage is limited to

inpatient care. All employers must contribute premiums based on the number of fulltime equivalent employees.

- ***Establish the family as the basic unit for medical insurance enrollment.*** Enrollment in URBMI is now individual. This follows the principle of a low-level startup where coverage is expected to extend to all urban residents. When coverage and enrollment reach a certain level, URBMI should be merged with UEBMI, so that the family is the enrollment unit, as it now is in NCMS. The natural cross-subsidy among family members with different incomes will reduce the costs of transferring funds between the two systems.

- ***Set pharmaceutical policies for insurers.*** Insurers should work with the government to establish a national council under the National Development and Reform Commission (NDRC) or another agency to select and periodically revise the list of essential and licensed drugs, their prices, and the conditions for prescribing. The national government must enforce Good Manufacturing Practices (GMP) to ensure quality, especially for essential drugs and generics. If the current GMP is too strict to be enforceable, it must be revised.

- ***Pooling across regional medical insurance fund.*** Thousands of medical insurance funds now operate independently in China. The lack of relationships among them is a major deficiency in the system. The solution is to create a provincial (and perhaps later, a national) pooling system of medical insurance funds. A medical insurance management center should be created for these provincial funds. All insurance funds should pay a fixed proportion of their funds to this provincial or national agent as a transitional fund. This would not only help adjust for financial risk but would also facilitate the portability of health benefits from one scheme to another.