IDS Working Paper 176

Financing health care in China's cities: balancing needs and entitlements during rapid change

Gerald Bloom, Yuelai Lu and Jiaying Chen

December 2002

INSTITUTE OF DEVELOPMENT STUDIES
Brighton, Sussex BN1 9RE
ENGLAND

ISBN 1 85864 478 X

Summary

China is undergoing a demographic and epidemiological transition, a transition to a market economy and a transition to an urban, industrial society. These simultaneous transitions are affecting urban health systems in a number of ways. Many state-owned enterprises and local governments find it hard to fund health care for their employees and pensioners. Urban residents are increasingly worried about the rising cost of medical care. Large scale rural-urban migration and the growing numbers of urban poor pose new health challenges. The paper describes the changing patterns of medical need and entitlement to health benefits. It discusses the need to reconcile the pressures to finance claims for benefits by retired workers and establish a new system of rules-based entitlements for younger urban dwellers. It presents a framework for analysing options for urban health reform and concludes that the outcome of present efforts to negotiate new rules of entitlement to urban health services will influence China's health system for a long time to come.

Acknowledgements

The authors would like to acknowledge helpful comments by Cai Renhua, Sarah Cook, Pei Xiaomei, Hilary Standing, Xiong Xianjun and participants at workshops on Social Policy in China at Shanghai in July 2000 and Oxford in October 2001. The preparation of this paper was jointly funded by an ESCOR grant to the IDS programme on Social Policy and grants by ESCOR and the European Union for a study of urban health reform in China. The opinions expressed are the sole responsibility of the authors.

Contents

Tables

Matrices

1 Introduction

China is simultaneously undergoing a demographic and epidemiological transition, a transition to a market economy and a transition to an urban, industrial society (Hussain 1999). It is also experiencing major changes in the pattern of social segmentation (Li Peilin 2002). This paper situates efforts to reform urban health systems in the context of these transitions.

There is growing concern about the rise of medical costs and its consequences (Hsiao 1995; Liu and Hsiao 1995; Hu and Gong 1999). During each year between 1991–6 *per capita* health expenditure in urban areas grew more rapidly than income (Zhao 1999). Gao *et al.* (2001) show that the average *per capita* income of urban households (corrected for inflation) rose by 6.5 per cent a year between 1992 and 1997, whilst the average cost of an outpatient visit and hospital admission rose by 10.2 per cent and 13.8 per cent, respectively. The rise in medical costs has contributed to a rapid growth in disbursements by health insurance schemes. This has created difficulties for employers. State owned units (enterprises and government agencies) spent 5.8 per cent of salary costs for health in 1980 and 9.1 per cent in 1996 (Xu 1998).

Two recent surveys show that the proportion of urban residents fully covered by government insurance or labour insurance decreased from 52 per cent to 39 per cent between 1992–7 (Gao *et al.* 2001). During the same period, the proportion reporting no health insurance rose from 28 per cent to 44 per cent. These percentages underestimate the proportion of city dwellers without health insurance, since the survey only covers registered urban residents. During the same period there was a growth in the proportion of urban residents who did not seek medical care when ill. In 1992 20 per cent of people referred to hospital declined admission and 40 per cent of them said it was due to cost; five years later 32 per cent declined admission and 65 per cent said it was due to cost.

Many state-owned enterprises and local governments find it hard to pay for their employees' and pensioners' health care. Urban residents are increasingly worried about the high cost of medical care. There is considerable pressure on government to address these problems. This paper suggests that present efforts to reform urban health finance can be understood as an effort to reconcile the interests of different stakeholders in newly agreed rules of entitlement to benefits. This is taking place in the context of economic reform and changes to the pattern of medical needs. Sections 2 and 3 discuss medical need and entitlement to health benefits, respectively. Section 4 discusses how policy-makers are dealing with the problem of financing claims for benefits by retired workers whilst establishing a new system of rules-based entitlements for younger urban dwellers. Section 5 discusses the implications of this analysis for urban health reform.

2 Changing medical needs

Williams (1991) defines medical need as the existence of ill-health for which an effective treatment is available. The amount of need is a measure of the physiological and psychological status of individuals, their expectations of what constitutes well-being, the availability of effective interventions and the social

arrangements that determine the roles of households and health providers in caring for the sick. According to this definition, need is determined by the burden of sickness and the social consensus about the kinds of support sick individuals require. This section discusses how changes in urban China are affecting the factors that determine need.

2.1 Demographic and epidemiological transition

The structure of China's population is changing rapidly due to reductions in mortality and birth rates. There are proportionately fewer children and more elderly. The share of the population over 65 years old doubled and the proportion over 75 years old increased from 0.8 per cent to 2.1 per cent between 1964 and 1997 (Table 2.1). 8.0 per cent of registered urban residents were over 65 years and 2.3 per cent were over 75 years in 1997.

Table 2.1 Population composition of China by age (%)

Age	All China			Cities only
	1964	1982	1997	1997
<45	82.3	80.2	75.0	70.7
45–65	14.1	14.9	18.2	21.4
65–74	2.7	3.5	4.8	5.7
75+	0.8	1.4	2.1	2.3
Total	100.0	100.1	100.1	

Source: China Statistical Yearbook (1998); China Health Statistical Abstract (1998).

The ageing of the population is expected to continue. The China Population Information and Research Centre projects that the percentage over 65 years will rise to 8 per cent by 2010, 11 per cent in 2020 and 20 per cent in 2040. Around 30 per cent of people over 65 were over 75 years, in 1990; this proportion is projected to rise to 35 per cent in 2010 and around 50 per cent in 2050 (Sun 1998).

The demographic transition has been accompanied by an epidemiological transition. Improvements in the standard of living and specific public health measures have contributed to a substantial fall in the incidence of infectious diseases in urban areas. The ageing of the population and high rates of risky behaviour, such as smoking, have led to increases in the prevalence of non-communicable diseases. Recent studies amongst the elderly identify a number of problems with chronic disease (Deng *et al.* 2000; Ou and Zhu 2000; Zhou and Wang 1998). They also report high levels of non-use of health services due to cost.

Data from advanced market economies suggest that average medical care costs rise rapidly with age (Barer *et al.* 1987). Those over 75 years old have a particularly great need for expensive health care. The aged account for a substantial share of medical care costs in urban China. A brief analysis of the disbursements of Shenyang's government insurance scheme by one of the authors indicated large differences in utilisation between age groups. Pensioners spent 2.3 times as much as current employees;

veterans of the liberation war (many over 75 years old) spent twice as much again[1]. Pressure on the medical system is likely to grow as the numbers of old-old increase.

The high cost of care for the elderly reflects their complicated health problems and the cost of effective interventions. It also reflects changes to family structures, which have made people less able and willing to care for very dependent people at home (Xiong 1999). The lack of affordable medical support for the aged puts a heavy burden on family caregivers, particularly women.

Demographic transition is affecting pensions and health services differently. The rise in the number of pensioners is well advanced. The ratio of pensioners to workers rose from 1:12.8 to 1:4.8 between 1980 and 1995 (West 1999). The cost of health care continues to increase beyond retirement age and the rise in cost of health insurance is likely to lag 10–15 years behind the rise in pensions.

2.2 Economic development and restructuring the labour market

China's cities have experienced rapid economic growth for more than two decades. This has increased the availability of effective interventions and altered the understanding amongst urban residents of what constitutes medical need. It has also led to an influx of migrants and the emergence of a more segmented social structure.

2.2.1 New interventions and changing expectations

Disposable income per urban resident more than trebled, in real terms, between 1978 and 1998 (China Statistical Yearbook 1999, table 10-2). Health expenditure grew even faster (Zhao 1999). Income inequalities grew during this period and the rises in disposable income and expenditure were even greater for members of the higher social strata. These changes were associated with a change in the kinds of health care people used.

Urban residents can afford increasingly sophisticated medical care. Their tastes have been strongly affected by changes in communications, which have increased their knowledge about lifestyles elsewhere. There has been a rise in marketing of medical products to health facilities and the general population. These factors have combined to alter the expectations of providers and users of health services.

The locus of care has largely shifted from clinics and simple inpatient facilities, to outpatient departments and wards of sophisticated hospitals. The consumption of drugs, particularly expensive branded products, has grown rapidly. In 1993, 52 per cent of total health expenditure in China was on pharmaceuticals (World Bank 1997a). Expenditure on other inputs has also risen rapidly. The Ministry of Health (1998) recently reported that 50 per cent of 3640 county and higher level hospitals had a CT scanner. This reflects the proliferation of diagnostic and treatment technologies.

The shift towards a more expensive style of medical care reflects the availability of expensive, but effective, interventions and a growth in demand for them. It also reflects cost increases related to government policies. Government health budgets have risen less rapidly than salary costs. Despite this,

[1] These differences also reflect the high levels of benefits to which veterans of the liberation war are entitled.

some local governments have encouraged health facilities to employ more staff. Health facilities have had to generate revenue to meet the income expectations of their employees (Bloom *et al.* 2000). The government has controlled the price of a consultation with a health worker and a day in hospital, whilst allowing health facilities to earn a mark-up on drug sales and the use of sophisticated equipment. This has encouraged costly forms of practice (Wu 2002). During the early 1980s, when new patterns of service provision were being established, there were few pensioners over 75 years of age and enterprises could afford sophisticated hospital care. By the 1990s an expensive style of care had become the norm.

2.2.2 Changing patterns of social segmentation

Li Chunling (2002) claims that a complex pattern of social segmentation has emerged in the cities over the past decade or so. At the top are those with social influence and/or financial power. Then come a variety of categories of salaried workers, middle-managers and small business owners. At the bottom of the social scale are the urban poor and vulnerable. They include laid off workers, the unemployed and those who cannot work (Cook 2001). In addition, around 80 million rural people work in the cities (Wong 1999). These migrants are entitled to few of the benefits of registered urban residents.

There is some international evidence that health-related problems are linked to social segmentation (Wilkinson 1996). This is due to the direct effect of deprivation on health, higher levels of exposure to environmental and occupational hazards, the greater tendency of socially disadvantaged groups in some countries to engage in behaviour that is risky for health and unequal access to effective medical care. The experience of the former Soviet Union, where male mortality rose sharply during a period of economic crisis and social change, demonstrates that socio-economic factors can have a major impact on health (Shkolnikov *et al.* 2001).

There is some evidence that the growth in social segmentation has had an impact on health and the pattern of health care in urban China. Some members of the political elite, such as veterans of the revolutionary war are entitled to free health care. Hospitals have tended to provide them with an expensive style of sophisticated care, which has over time set a "gold standard", to which others have aspired. Some people now have enough money to pay for sophisticated treatment. But, recent surveys have found that most urban residents are concerned about the high cost of medical care.

There is little systematic information on the living conditions and health situation of the urban poor and vulnerable. There are indications that they have more health problems and less access to services than other city dwellers. Some studies link psychological problems to the experience of being laid off (Zhang *et al.* 1999; Chen and Guo 2000). Studies of rural urban migrants tend to focus on the incidence of infectious diseases. Chen (2000) associates the resurgence of tuberculosis and sexually transmitted diseases in the cities, with rapid urbanisation. Wang *et al.* (2000) report that 60 per cent of STD cases were associated with migrants in Xiaoshan City, Zhejiang.

Urban public health services and preventive programmes have not expanded to cope with this additional population. A recent study in Nantong reports that their share of the government health budget has fallen (Shu *et al.* 2001). Migrants do not have the same access to basic health services as registered

residents. For example, migrants to Shanghai and Chengdu use reproductive health services much less than permanent residents (Zhan *et al.* 2000; Tian *et al.* 1999).

3 Changing patterns of entitlement to social benefits

This section discusses how economic changes are affecting entitlements to social benefits. Entitlements are legitimate claims by individuals on the state or other institutions. A government's ability to honour entitlements is an important source of its legitimacy. Attempts to renegotiate entitlements involve political costs. China has assigned entitlements to social benefits mostly on the basis of a person's place of residence and the kind of work they do (Wong 1998; Solinger 1999; Bloom 2001).

One aspect of the transition to a market economy has been the transformation of entitlements from informal claims on employers and government into ownership of assets and rules-based rights to government assistance. Two examples are the sale of housing to employees at subsidised prices and the establishment of safety nets for people living below a defined poverty line. These changes are institutionalising new patterns of differential access to social benefits (Wang Y.P. 2001).

A paper by the Project on Social Development in China at the Chinese Academy of Social Sciences (CASS 1998) argues that China has reached the 'middle stage' of its reforms. It argues that 'difficult questions of patterns of interest' must be addressed and that successful reforms will depend on the management of the 'readjustment of basic interest relationships'. It stresses the need to ensure that all social groups benefit from development and identifies the following interests to be reconciled during the establishment of a new social security system over the next 10–15 years:

- the very high financial burden of social benefits on state-owned enterprises compared to other categories of enterprise;
- the difference in social benefits between urban and rural residents and the rapid growth of employment in enterprises outside the cities;
- the differences in earnings and access to benefits between well-developed and under-developed regions and the need for substantial investment to close the gap;
- the effort by governments of rich localities to limit the outflow of tax revenue and by national government to reduce inter-regional inequality.

Li Peilin (2002) argues that it is 'essential for future sustainable development in China to bring about a reasonable order of social stratification with the aid of the legal system'. He goes on to say that 'without a legal economy there will be no moral economy' (p 45). This appears to be an argument for the establishment of rules-based entitlements appropriate to new (socially legitimate) patterns of social stratification. The following sub-sections discuss the challenge of balancing the need to honour existing claims and the need to create new rules of entitlement appropriate to present and future social arrangements (Zhang 2002).

3.1 Balancing claims of rural and urban residents

The household registration system, which limits the movement of people, underpins a sharp divide between rural and urban residents (Cook and White 1998; Chan and Zhang 1999). Rural residents have been entitled to little more than access to the means of agricultural production. This translates into a right to a fair share of land in a locality. The government makes modest fiscal transfers to poor areas and organises national poverty reduction programmes. Local governments and collective bodies finance basic support for the poorest people. In contrast, urban residents have been entitled to a wide range of benefits in what Solinger (1999) calls 'the urban public goods regime'.

The clear demarcation between urban and rural entitlements has begun to erode. There is an increasing divergence between the number of registered urban residents and the total urban population. Hussain (1999) points out that 32.2 per cent of the population is classified as non-agricultural by household registration, but 53.4 per cent of the labour force actually works in services and industry. This is due to the rapid growth of township and village enterprises. Hussain estimates that 51 per cent of the population live in urban settlements, with high population density and a preponderant share of non-farming activities in the local economy. He points out that employees of enterprises in "rural" localities are mostly entitled to fewer social benefits than are urban residents.

Large numbers of rural-urban migrants work in a variety of settings (Solinger 1999). Some have become registered residents in the smaller centres, however most retain their rural registration. Chan and Zhang (1999) point out that the urban workforce is stratified into categories of registration such as fully registered, newly registered, temporary residents and unregistered peasants. These categories have quite different entitlements to benefits.

Urban registration is still associated with much higher levels of entitlement to benefits. For example, only a small proportion of Shanghai's migrants has health insurance (Wang and Zuo 1999). The labour market is much more complex than it was. There is no longer a simple identity between urban registration and non-agricultural employment. The challenge is to create a rules-based system of entitlements that reflects this complexity (CASS 1998).

3.2 Changing patterns of entitlement amongst urban residents

City dwellers were entitled to a job under the command economy (Leung 1995). In 1978, 78.3 per cent of the urban labour force worked for state owned enterprises or the government (Hussain 1999). Entitlements to most benefits are based on place of employment. The government and state owned enterprises provide comprehensive packages of benefits. Other employers provide less generous benefits. Local governments also finance benefits for specific social groups. Their health departments fund medical care for veterans of the liberation war and certain retired government officials. Departments of civil affairs provide a basic living allowance to people whose household income falls below a locally determined minimum living standard.

Urban residents have a strong sense of entitlement to social security and services. The report by the Chinese Academy of Social Sciences cited above highlights this: 'the elimination of workplace security in

cities means the elimination of employees rights and benefits. Widespread resistance to this measure is therefore a matter of course' (CASS 1998: 89). Croll (1999) and Howell (1997) cite recent outbreaks of civil disturbance and strikes in defence of jobs, pensions and health insurance as evidence of the strength of feeling on this issue. Government strategies for social sector reform have been strongly influenced by these attitudes.

The transition to a market economy has led to changes in the pattern of entitlements (Selden and Lou 1997). There has been a shift from permanent employment to fixed term contracts. Between 1986 and 1997 the proportion of employees of state enterprises on short-term contracts rose from 7 per cent to 51.6 per cent (Hussain 1999). Enterprises now have the right to lay off workers. Urban residents are no longer guaranteed a job. Government has acted to prevent large-scale unemployment (Wong 1999). It has encouraged people to retire; it has pressured government institutions, such as hospitals, to increase their workforce; it has subsidised loss-making enterprises and it has established a system of unemployment benefits.

A growing number of urban residents work for neither government, nor state-owned enterprises (Table 3.1). The different categories of enterprise vary considerably in the age and sex of their employees and the levels of pay and benefits they provide. Government institutions and state-owned enterprises tend to have older employees with well-established entitlements to benefits. Their new employees are more likely to be on short-term contracts, associated with fewer benefits. Some of these new employees may not have full urban registration.

Table 3.1 Number of employed persons by type of enterprises (million)

Year	Number of employees in different type of enterprises in urban areas							
	State owned	Collect-ive owned	Joint owned	Share holding	Foreign funded	Other types of owner-ship	Private	Individ-uals
1980	80.2	24.3	-	-		-	-	0.1
1985	89.9	33.2	0.4	-	0.1	-	-	4.5
1990	103.5	35.5	1.0	-	0.1	-	0.6	6.1
1995	112.6	31.5	0.5	3.2	5.1	0.1	4.9	15.6
1996	112.4	30.2	0.5	3.6	5.4	0.1	6.2	17.1

Source: China Statistical Year Book (1997).

Other categories of enterprise tend to be newer and to employ younger people. Successful companies pay high salaries but provide fewer long-term benefits. One of the authors visited a joint venture, which employed mostly young female migrants from surrounding counties. The company provided excellent maternity benefits but was not building a fund for future health care needs.

Older workers and those who have been in the same job for a long time are more likely to have health insurance. A survey of 22 cities in 1992 by Hu *et al.* (1999) found that older workers are more likely

to have health insurance than younger ones. A survey in Shanghai found that 47 per cent of those hired within the past ten years had health insurance, compared with 80 per cent of those hired before then (Wang and Zuo 1999).

State owned enterprises are finding it increasingly difficult to finance health insurance. Over a third of the workforce of some enterprises are retired. Their health benefits can be costly. Many state-owned enterprises are losing money and cannot afford their employees' medical benefits. Late payment or non-payment of medical costs is common.

The government is transferring the organisation of social security benefits from employers to newly created social security institutions. One of the government's challenges in formulating strategies for social security reform is to reconcile the interests of different age cohorts and categories of enterprise and people with varying registration status. Selden and Lou (1997) put this forward as an explanation of the difficulty it is having in establishing a uniform pension scheme. They suggest that compliance rates below 100 per cent reflect the unwillingness of new enterprises to contribute to a fund from which the main beneficiaries will be current pensioners.

Yu and Ren (1998) make a similar point about health insurance. They suggest that a company's decision to join a local scheme is influenced by the size of contributions, the age of their workforce and whether they own a health facility. A scheme in one middle-size city illustrates this. Profitable state-owned enterprises, with many pensioners, joined because they had to contribute less than they had been spending on health benefits. Joint ventures with a young workforce refused to join, as did loss-making state owned enterprises. The scheme was reformed to reduce contribution levels and strengthen the legal pressure on enterprises to join. The coverage increased, but it is too early to assess whether the scheme is sustainable.

4 Reconciling entitlements of different age cohorts

The government is managing two simultaneous processes in creating new social security arrangements. It is attempting to establish a system of rules-based entitlements, which people trust. It is also endeavouring to finance current entitlements. In doing so it has to balance claims by different age cohorts.

Policy debates mostly concern the broad shape of future social security arrangements. They tend to reflect the views of national ministries and heads of provincial governments (Liu and Bloom 2002). Implementation is strongly influenced by local government, social groups with political influence and enterprises. Young and old, men and women, and employees of different categories of enterprise have different interests. The following sub-sections discuss policy and implementation in turn. They focus on pensions, because a considerable amount of work has been done on this topic. However, similar issues arise with health insurance.

4.1 Policy vision: the shape of future arrangements

Discussions about pensions have focused on the arrangements to be established after a 10–15 year transition. China's future system has to balance social solidarity against the need to take differences in pay

into account (CASS 2000). The government advocates the establishment of a basic pension, funded by government and enterprises, individual pension accounts financed by individuals and employers and voluntary private top-up pensions.[2] The idea is to permit the size of pensions to vary with salaries whilst ensuring that the entire eligible population has a basic pension. It leaves unresolved issues regarding who is eligible for a basic pension and how it should be financed.

The great differences in average earnings between localities are a major barrier to the creation of a unified pension system. The provision of a uniform basic pension assumes a relatively integrated labour market. Otherwise residents of poor localities would receive a higher share of local salaries and residents of rich localities would receive a lower one. These differences would be heightened if coverage were extended to employees of rural-based enterprises and rural-urban migrants. This would leave residents of expensive cities relatively unprotected and either put a substantial financial burden on governments of poor localities or imply substantial resource transfers between localities.

The inclusion of peasants in the pension scheme would create greater difficulties since many rural households live on less that the basic pension. James (2001) points out that people living on very low incomes may prefer to spend money on present needs or invest it productively, rather than pay it into a pension fund. It may be more appropriate for government to protect the aged in rural areas with a publicly funded minimum pension or a targeted safety net for the aged poor.

The most difficult questions regarding the basic pension concern finance. Should each locality fund basic pensions for its own residents? Or should contributions be related to a local government's ability to pay? If local governments are fully responsible, they have to reconcile the need to finance pensions for city dwellers against calls on their resources to provide benefits to farmers. Richer governments could be required to subsidise pensions in poor areas. The advantage of this form of redistribution has to be weighed against its impact on the willingness of governments to transfer funds to poor rural counties. Discussions about the financial basis for pensions are closely linked to broader discussions about the reform of public finance.

4.2 Entitlements, assets and financing the transition to a sustainable system

China is reforming its social security system late in the demographic transition. It has to finance current claims for pensions whilst building up pension funds. It also has to address the problems of the majority of the elderly, who do not have pension entitlements.

Much Chinese and international thinking is based on the understanding that an individual's entitlement to a pension is an asset in the form of a claim on future revenue flows (World Bank 1997b). This view of pensions is articulated in the concept of the implicit pension debt, which calculates the present value of these future flows. Ma and Zhai (2001) cite several papers that estimate the implicit pension debt at between 50 and 80 percent of GDP. They estimate that the additional costs of transition to a funded system would be around one-third of GDP, because some pension commitments will be

[2] State Council Documents No 26 (1997) and No 42 (2000).

financed by contributions by a growing labour force. These estimates assume that existing entitlements will be fully honoured. They do not include the needs of the majority of the elderly, who do not have pension entitlements.

The government already subsidises pensions. The Ministry of Finance transferred rmb 17 billion to cover pension shortfalls in 1999 and rmb20 billion in 2000 (Ma and Zhai 2001). This was a major transfer of resources to urban residents. One possible explanation of government's unwillingness to translate pension entitlements into clear financial commitments is that it wants to leave open the possibility of renegotiating entitlements as the situation changes. For example, it is keeping the retirement age low to reduce open unemployment, but the long-term sustainability of funded pensions depends on raising the retirement age. Urban dwellers will ultimately have to come to terms with competition from rural-based enterprises, who will provide very modest pensions to their employees. Present entitlements to pensions are fuzzy and arrangements for financing them are *ad hoc*. This gives stakeholders time to adjust their expectations to changing economic realities.

The lack of clear rules has costs. It contributes to feelings of insecurity. This encourages stakeholders to seek ways to minimise short-term financial burdens. For example, municipalities with profitable firms and/or younger populations have resisted arrangements that would involve substantial transfers of resources to other localities (Wong 1999). New enterprises have attempted to avoid excessive liabilities for pensions and health insurance by keeping out of new schemes. Some enterprises may have been set up outside municipal boundaries for this reason.

Some *ad hoc* measures have had a deleterious effect on the establishment of a rules-based system. In theory, the creation of individual accounts provides a means to build up a funded pension scheme. In practice, schemes have used funds from individual accounts to finance existing pensions. Ma and Zhai (2001) estimate that they withdrew rmb 199 billion from individual accounts for this purpose in 2000. Little is known about how young workers view this use of their pension contributions. These examples illustrate the difficulties associated with managing simultaneously the establishment of a new social security system and the funding of existing claims to benefits. One requires transparency and the other requires opaqueness.

It may be helpful to separate the issues of financing existing entitlements and establishing actuarially sound social security institutions. There are several options for financing existing pensions (CASS 2000; Wang X 2001; Ma and Zhai 2001). Young workers and their employers could be asked to make higher contributions to social security schemes than would be required to build up their own entitlements, or they could be required to pay higher taxes. Local governments could issue bonds with promises to repay out of future taxes. Assets could be transferred to the social security fund in the form of ownership of a company, shares in a company or cash earned by selling a company. The latter options represent a translation of fuzzy pension entitlements into ownership of funded assets. They would institutionalise differences in entitlement between social groups. Government has to reconcile the interests of pensioners and of social groups that do not have work-related benefits in establishing levels of pensions to be funded this way.

Health insurance is more complex than pensions. The cost of pensions is directly related to the number of people above retirement age and the rules defining the size of payment. The cost of health benefits depends on the many factors that determine needs and expectations of services to address them. However, the same issues concerning the need simultaneously to finance existing claims and establish a rules-based insurance scheme apply.

5 Meeting needs and entitlements to health services

This section presents a framework for thinking about the reform of urban health services.

5.1 Health needs and entitlement groups

Matrix 5.1 maps entitlement groups based on employment, poverty/vulnerability and place of residence against three categories of medical need: treatment of chronic disease and major illnesses, prevention of non-communicable disease and prevention and treatment of infectious diseases including HIV/AIDS. The matrix points to some issues that policy-makers need to address. It does not include all medical needs.

A number of factors have led to a rapid rise in the cost of medical care for an ageing urban population. This rise is likely to continue as more people reach 75 years. A substantial proportion of the urban population has had the right to virtually free health care. An expensive, hospital-based style of medical care has been established as the norm. Older employees of government and state-owned enterprises believe they are entitled to this kind of care. There are strong pressures on employers and local governments to honour this entitlement.

The government and long-established state-owned enterprises have a disproportionate number of pensioners and bear a large share of the cost of health insurance. Some companies can no longer afford this benefit. Others are heavily disadvantaged in competition with newer firms. This has led to pressure to spread the burden more evenly. This involves the translation of fuzzy claims on enterprises into rules-based claims on an insurance scheme.

In creating health insurance schemes, the government has to reconcile the perspectives of insured people, who have a strong sense of entitlement to medical care, and younger workers, rural-urban migrants and workers outside the cities who have alternative claims on public resources. As with pensions, there is evidence that many newly established health insurance schemes have financed claims by drawing down individual savings accounts. Although these schemes are based on the Singapore model, they operate as pay-as-you-go health benefit schemes. There is little evidence that schemes have built up savings to fund future claims by young beneficiaries. The government needs to find new ways to induce young workers and their employers to finance benefits for the elderly.

Matrix 5.1 Health needs and entitlement groups

Categories of need			
Basis of Entitlement	**Chronic disease / major illness**	**New health problems/ rise in non-communicable diseases**	**Resurgence of infectious disease and spread of HIV**
a) Employment status {employee, family member of employee, unemployed, pensioner}	• insurance depends on kind of employer • fewer health benefits for family member of employed • fewer health benefits for employees of rural enterprises • most farmers are not insured	• Insurance covers IP care, some OP care but no prevention or community support • weaknesses of preventive programmes • diseases related to occupational hazards and pollution • diseases related to behaviour influenced by social factors (drug/alcohol abuse, smoking, diet)	• population movements between rural and urban areas • sex industry • public health systems lagging behind rapid urbanisation • possible need for AIDS-related services
b) Poor or vulnerable {poor, disabled}	• needs of disabled • illness and problems of access linked to poverty		
c) Registered residence {urban, rural, migrant}	• compulsory insurance linked to registration • lack of insurance for migrants		

The large flows of migrants into the cities and the emergence of vulnerable groups are another source of pressure on health services. These people have a number of health-related needs and most are not insured. Decision-makers have to balance claims by those with insurance against pressures to meet the needs of the uninsured.

5.2 Thinking about health reform

This section explores the implications of the web of entitlements and needs for health development strategies. Several Ministries share responsibility for the urban health system: Health – service delivery, Labour and Social Security – insurance, and Civil Affairs – the needs of the poor and vulnerable. This division reduces the risk that disproportionate weight will be given to the interests of service providers. It encourages integrated approaches to social security and poverty reduction. However, it fosters a split in policy discussions between demand and supply-side issues and between insurance-funded curative care and government-funded preventive health services. Matrix 5.2 identifies five objectives for reform that address the changing pattern of needs and entitlements. It maps these objectives against possible demand and supply-side initiatives.

a) Effective public health programmes

City governments have to ensure that their public health and preventive programmes are appropriate to a changing situation. Local governments will have to allocate sufficient funds to meet growing needs. City

Health Departments may need to respond to demographic and epidemiological changes by shifting their emphasis from maternal and child health and infectious disease to the needs of the elderly, migrants and poor and vulnerable groups and also to AIDS prevention. They also need to monitor for emergent problems with health and health-related behaviour of vulnerable groups.

b) Access to effective and affordable health services for the elderly

Many experimental health insurance schemes have experienced financial problems associated with the high cost of benefits for the elderly. Some have collapsed and others have remained solvent by raiding individual savings account. They all face rising costs as more beneficiaries reach 75 years of age.

It is difficult to convince young and healthy people to make substantial contributions to a scheme from which the major beneficiaries are the elderly, unless they are confident that they will eventually benefit, themselves. It is difficult to create this kind of confidence in a period of rapid change. Local governments may need to supplement insurance contributions with funding from tax revenue, borrowing and the transfer of assets (in cash or shares) to a health insurance fund.

International experience suggests that referral hospitals do not provide the most cost-effective health care for the elderly. The hospital insurance schemes encourage people to seek care from these facilities. A major effort is needed to identify an appropriate mix of community support, basic preventive and curative services, and care in hospitals and nursing homes. The government could encourage some cities to experiment with an integrated benefit for the elderly, rather than the present insurance provisions. The benefit would be financed in the same way as existing schemes. Employers would be able to purchase supplementary benefits for their retirees. The benefit fund would use alternative forms of payment for services, such as capitation payments adjusted for age, or contracting with specified facilities to provide services on demand. The purpose would be to test alternative approaches for addressing the needs of the elderly.

c) Health insurance phased in

The government has enunciated principles for health insurance reform, which combine a basic benefit for urban residents, contributory insurance and a voluntary private top up (State Council 1998 and 2000). Questions remain about the breadth of coverage and sources of finance. Present proposals suggest that all urban residents should be entitled to a basic benefit. Government will have to subsidise membership by low-income earners. Or, other beneficiaries will have to contribute an extra amount. There is a trade off between the size of the basic benefit package and the feasibility of extending coverage to all. The proposals are not clear about the degree to which contributory insurance schemes should cover family members. This is important, if significant numbers of working age people will not be employed.

Matrix 5.2 Agenda for urban health development and reform

Objectives for reform	Implications for demand side	Implications for supply side
a) Effective public health and preventive programmes	• Fund local government public health services adequately • Define the responsibilities of these services more clearly • Co-ordinate health activities funded from different sources with the ultimate aim of integration	• Reform public health services to address new needs • Monitor emerging needs linked to social change
b) Access to effective and affordable health services for the elderly	• Define basic health entitlement and redefine benefit packages to remove incentives for hospital-based care • Establish sources of finance (contributions, tax, transfer of assets) • Define relative responsibilities of local government and insurance funded services	• Restructure health system (facilities and service delivery) to give greater emphasis to primary care services • Strengthen facility management and improve efficiency • Introduce new payment mechanisms to reduce incentives for cost increases • Define roles of local government services in terms of prevention and community support systems
c) Health insurance scheme phased in	• Establish compulsory scheme and convince beneficiaries that it is sustainable • Define geographic base of scheme • Define family members to be covered in contributory schemes	
d) Health safety net for the poor and vulnerable	• Decide whether to include all urban residents in basic insurance • Define criteria for eligibility for government support • Growth of charitable foundations	• Strengthen programmes to meet needs of vulnerable groups • Make low cost services more available
e) Reduce urban-rural imbalances in public health	• Ensure adequate funding of urban local government health services • Fund basic rural public health • Begin discussions about insurance for migrants and rural workers	• Expanded public health system and preventive programmes in cities • Low cost services for migrants • Strengthened rural public health services

There are questions about the geographic basis for pooling. A scheme that covers all cities in a province would put a heavy strain on poorer localities unless there were fiscal transfers between cities. This would reduce inequalities between cities, but might increase rural-urban segmentation. The larger the commitments of city governments to finance benefits for urban dwellers, the greater the likelihood they will resist fiscal transfers to poor rural localities. This kind of trade-off becomes particularly important as coverage is extended to workers in rural-based enterprises and to rural-urban migrants. There are also questions about the kinds of health services to which the insured population should be entitled. This

involves the balance between ambulatory care, hospitals, prevention and community support. It also involves choices of cost-effective interventions.

The most important challenge is to convince young people that they will eventually benefit from newly established schemes. One reason for the introduction of individual accounts was that they provided assurance to account holders that they had a firm claim on these resources. The fact that insurance schemes have had to draw down the balances in these accounts means that they have to find an alternative strategy to win the trust of potential contributors.

d) Health safety net for the poor and vulnerable

There are only minimal arrangements to finance health care for the urban poor. Municipal Health Departments need to take the problems associated with poverty into account in planning their preventive programmes. They also need to devise strategies to make effective basic services available at an affordable cost where people live.

Local departments of civil affairs finance little more than *ad hoc* arrangements to write off bad debts of hospitals. There is a growing recognition that poor health and the high cost of medical care is an important factor leading to household impoverishment. This suggests the need for some form of safety net, which would involve co-operation between local departments of health and civil affairs. The design of a targeted health benefit will not be easy. Government will have to address issues such as the identification of beneficiaries, the definition of a package of appropriate health services and the design of payment mechanisms that encourage facilities to provide services of a reasonable quality and price. In establishing this kind of benefit policy-makers should be aware of the ultimate aim of providing universal coverage to urban residents. Nonetheless, measures will be needed to protect the poor and vulnerable during the period of transition.

The government has begun to encourage the establishment of charitable foundations to address the needs of the indigent. This development raises difficult questions about the relative responsibility of government and private charities in raising money from profitable enterprise and people with substantial incomes and in supporting those in need.

e) Urban-rural imbalances in public health reduced

The health of urban and rural populations is inter-linked. The reduction of structural barriers in the labour market will make it increasingly difficult to maintain large differences in entitlement to health insurance between urban and peri-urban residents. The high burden on urban enterprises of health insurance gives an advantage to those outside the city boundary. New enterprises may take this into account in deciding where to locate. This could ultimately erode urban social benefits. The many rural-urban migrants also push the social wage down. These pressures can be addressed by keeping the cost of urban health insurance down and by extending coverage to rural-based workers over time.

There is a constant threat that infectious diseases will spread to the cities. One way to address this problem is by ensuring that local public health services keep up with urbanisation. Another approach is to

improve rural public health. This is one reason for cities to agree to an increase in fiscal transfers to poor rural areas. Also migrant workers and their employers could be required to contribute to a health insurance fund. The contributions would accrue to individual medical accounts and/or be transferred to a health fund in the migrants' registered places of residence.

f) The need for regional plans

Regional health plans presently focus on rationalisation of infrastructure and human resources. The next step in the development of this approach would be to base plans on an analysis of the health needs of various social groups and of the present arrangements for meeting them. This would necessitate an integrated approach to issues of health finance and supply-side reform. All relevant departments (health, labour and social security, civil affairs and so forth) would have to collaborate in formulating these plans.

6 Conclusions

This period of rapid change has created a need for health reform and an opportunity for achieving it. It should be possible to win support for quite new arrangements amongst young workers. But, the entitlements of older workers will have to be re-negotiated. The outcome will reflect the influence of different stakeholders.

Policy-makers face the challenge of establishing a health insurance system appropriate to the emerging patterns of labour market segmentation. They need to avoid a race to the bottom in which the social benefits in rural areas become the norm for cities. This will ultimately require the establishment of compulsory basic health insurance schemes that can be extended to all employees. Measures are needed to protect governments of poor localities from an excessive burden in financing this benefit. Health insurance reforms will have to be linked to system-wide changes to government financial management.

Discussions about future insurance arrangements have been dominated by negotiations about how to finance existing medical benefits. Once explicit agreements are reached on this issue, it may become easier to agree on longer-term reforms of urban health finance.

International experience suggests that it is very difficult to change expectations of entitlement to care, once they have been created by a health insurance scheme. An inappropriate scheme can preserve unequal access to benefits and become an impediment to labour market development (Mackintosh 1997). The outcome of the present efforts to negotiate new rules of entitlement to urban health services will influence China's health system for a long time.

References

Barer, M., Evans, R., Hertzman, C. and Lomas, J., 1987, 'Ageing and health care utilization: new evidence on old fallacies', *Social Science and Medicine,* Vol 24 No 10: 851–62

Bloom, G., 2001 'Equity in health in unequal societies: meeting health needs in contexts of social change', *Health Policy,* Vol 57 No 3: 205–24

Bloom, G., Han, L. and Li, X., 2000, 'How health workers earn a living in China', *IDS Working Paper* 108, Brighton: Institute of Development Studies

Chan, Wingchan and Zhang Li, 1999, 'The Hukou System and rural-urban migration', *The China Quarterly,* Vol 160: 818–55

Chen, Q.Z. and Guo, W.B., 2000, 'A survey of psychological health of laid-off workers', *Journal of Psychological Health,* Vol 8 No 4: 465–8

Chen, X., 2000, 'Health problems and countermeasures during urbanisation', *Medicine and Society*, Vol 13 No 3: 1–3

China Health Statistical Abstract, 1998, Beijing: National Health Statistical Centre

China Statistical Yearbook, 1999, 1998, 1997, 1996, 1992, Beijing: China Statistical Publishing House

—— 1997, Beijing: China Statistical Publishing House

Chinese Academy of Social Sciences (CASS), Research Group on China's Social Security System, 2000, 'A study of China's social security system', *Social Sciences in China,* Vol 21 No 4: 50–9

—— Project Group on Social Development in China 1998, 'Institutional reforms and challenges at the middle stage of China's reform', *Social Sciences in China, English Language Edition,* Vol 19 No 2: 83–93

Cook, S., 2001, 'After the iron rice bowl: extending the safety net in China', *IDS Discussion Paper* 377, Brighton: Institute of Development Studies

Cook, S. and White, G., 1998, 'Changing pattern of poverty in China: issues for research and policy', *IDS Working Paper* 67, Brighton: Institute of Development Studies

Croll, E., 1999, 'Social welfare reforms: trends and tensions', *China Quarterly,* Vol 159: 684–99

Deng P., Mi, G.M., Wang Y.C., *et al.*, 2000, 'Study of health services demand of elderly people in an urban community', *Chinese General Practice,* Vol 3 No 5: 373–4

Gao, J., Tang, S., Tolhurst, R. and Rao, K., 2001, 'Changing access to health services in urban China: what implications for equity?', *Health Policy and Planning,* Vol 16 No 3: 302–12

Howell, J., 1997, 'The Chinese economic miracle and urban workers', *European Journal of Development Research,* Vol 9 No 2: 148–75

Hsiao, W.C., 1995, 'The Chinese health care system: lessons for other nations', *Social Science and Medicine*, Vol 41: 1047–55

Hu, X. and Gong, X., 1999, 'Appraise the increase in the cost of health care', *China Health Economics,* Vol 18 No 6: 9–12

Hu Tehwei, Ong, M., Lin, Zihua and Li, E., 1999, 'The effects of economic reform on health insurance and the financial burden for urban workers in China', *Health Economics* 8: 309–21

Hussain, A., 1999, 'Social welfare in China in the context of three transitions', unpublished paper, Asia Research Centre, London School of Economics

James, E., 2001, 'Old Age Security Programs', in N. Lustig (ed.), *Shielding the Poor: social protection in the developing world*, Washington, D.C.: Brookings Institution Press

Leung, J., 1995, 'The political economy of unemployment and unemployment insurance in the People's Republic of China', *International Social Work,* Vol 38 No 2: 139–49

Li, Chunling, 2002, 'The class structure of China's urban society during the transitional period', *Social Sciences in China,* Vol 23 No 1: 91–9

Li Peilin, 2002, 'Changes in social stratification in China since the reform', *Social Sciences in China,* Vol 23 No 1: 42–7

Liu, X.Z. and Hsiao, W.C., 1995, 'The cost escalation of social health insurance plans in China: its implications for public policy', *Social Science and Medicine* 41: 1095–101

Liu, Yunguo and Bloom, G., 2002, 'Designing a rural health reform project: the negotiation of change in China', *IDS Working Paper* 150, Brighton: Institute of Development Studies

Ma, J. and Zhai, F, 2001, 'Financing China's pension reform', presented to the Kennedy School, Harvard University, International Conference on China and the WTO: the Financial Challenge

Mackintosh, M., 1997, 'Managing public sector reform: the case of health care', *Development Policy and Practice Research Group Working Paper* 37, Milton Keynes: Open University

MoH, 1998, *Health Resources and Utilisation Since 1980s,* Beijing: Statistical and Information Centre, Ministry of Health

Ou, A.H. and Zhu, Y., 2000, 'Analysis of condition of elderly people and their health service utilisation in Guiyang City', *Chinese Primary Health Care,* Vol 14 No 3: 47–8

Selden, M. and Lou, L., 1997, 'The reform of social welfare in China', *World Development,* Vol 25 No 10: 1657–68

Shkolnikov, V., Field, M. and Andreev, E., 2001 'Russia: socioeconomic dimensions of the gender gap in mortality', in T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya and M. Winth (eds), *Challenging Inequities in Health*, Oxford: Oxford University Press

Shu, B. *et al.*, 2001, 'Health finance and expenditure in Nantong City', paper presented to the workshop on Urban Health Reform, Beijing, December

Solinger, D., 1999, *Contesting Citizenship in Urban China: peasant migrants, the state and the logic of the market,* Berkeley: University of California Press

State Council, 2000, *Guidelines for Urban Health and Medicine System Reform*, Beijing

—— 1998, *The Decision on Establishing Basic Health Insurance System for Urban Employees*, Beijing

Sun, F., 1998, 'Ageing of the population in China: trends and implications', *Asia–Pacific Population Journal,* Vol 13 No 4: 75–92

Tian, A.P., Lu, S.F. and Qu, L., 1999, 'The situation of reproductive health care need and provision for the floating population in Chengdu City', *Journal of Chinese Family Planning,* Vol 7 No 5: 211–3

Wang, F. and Zuo, X., 1999, 'Inside China's cities: institutional barriers and opportunities for urban migrants', *American Economic Review,* Vol 89 No 2: 276–80

Wang, X., 2001, 'China's pension system reform and capital market development,' presented to the Kennedy School, Harvard University, International Conference on China and the WTO: the Financial Challenge

Wang, Y.L., Ma, D.G. and Fang, J., 2000, 'The immunization issues caused by immigrating population and the corresponding solution strategy in Xiaoshan', *Chinese Rural Health Services Administration,* Vol 20 No 3: 41–2

Wang, Y.P., 2001, 'Prospects and problems of urban housing reform', presented to workshop on Social Policy Reform in Socialist Market China, Oxford, October

West, L., 1999, 'Pension reform in China: preparing for the future', *Journal of Development Studies,* Vol 35 No 3: 153–83

Wilkinson, R., 1996, *Unhealthy Societies*, London: Routledge

Williams, A., 1991, '"Need" – an Economic Exegesis', in A. Culyer (ed.), *The Economics of Health Volume I*, Aldershot: Elgar Reference Collection

Wong, Chack-kie, 1999, 'Reforming China's state socialist workfare system: a cautionary and incremental approach', *Issues and Studies,* Vol 35 No 5: 169–94

Wong, L., 1998, *Marginalization and Social Welfare in China*, Routledge: London

World Bank, 1997a, *China 2020 Issues and Options: Financing Health Care*, Washington, D.C.: World Bank

—— 1997b, *Pension Reform in China*, Washington, D.C.: World Bank

Wu Ming, 2002, 'Health expenditure control and its policies', unpublished report, Department of Health Policy and Management, School of Public Health, Peking University

Xiong, Y., 1999, 'Social policy for the elderly in the context of ageing in China: issues and challenges of social work education', *International Journal of Welfare for the Aged* 1: 107–22

Xu, F., 1998, 'Expenditure under labour insurance medical service scheme', *China Social Insurance* 10: 19–20

Yu, W. and Ren, M., 1998, 'The conflicts of social ideals and actual interests – the contradictions and problems existed in the reform of social medical insurance in the towns of China', *Chinese Health Economic*, Vol 17 No 9: 5–8

Zhan, S., Liu, X., Xie, L., Wangfen, Zhen, G., Shun, Z. and Yan, S., 2000, 'Maternal care for internal migrants in Shanghai', presented to the conference on Rural Health Reform and Development in China, Beijing, November 2000

Zhang Wanli, 2002, 'Twenty years of research on stratified social structure in contemporary China', *Social Sciences in China,* Vol 23 No 1: 48–58

Zhang, S., Cheng, C.Q., Liu, C. *et al.*, 1999, 'Negative psychological behaviour, its cause and possible responses', *International Journal of Chinese Psychological and Physiological Medicine,* Vol 1 No 4: 245

Zhao, Y., 1999, 'Estimation and analysis of the nation's total health spending in 1996', *Chinese Health Economics,* Vol 18 No 1: 29–31

Zhou, L.P. and Wang, R.Z., 1998, 'Analysis of health need and utilisation of elderly population in Hangzhou City', *Journal of Zhejiang Medical University*, Vol 27 No 2: 84–7