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# Universal Insurance Coverage ≠ Universal Health Coverage, but China is Getting Closer

## China's Vision of Universal Health Coverage

China's remarkable progress in building a comprehensive social health insurance (SHI) system has been swift and impressive. Starting from less than 30 percent coverage in 2003, after only 10 years, 98 percent of the population now have financial protection. Lauded as "unparalleled," this achievement is "exemplary for other nations that pursue universal health coverage." The national health care reform launched in 2009 clearly announced the central leadership's vision of building a universal health system in which every citizen has equal access to affordable and equitable care by 2020. Expanding the coverage of SHI schemes stands out as one of the five strategic objectives. An additional RMB850 billion (approximately US$125 billion) has been spent in the first phase of the reform from 2009 to 2011, with close to 50 percent dedicated to premium subsidies for urban and rural residents' programs.

Yet the way forward will be long and challenging. Notwithstanding the country's impressive accomplishments in expanding insurance coverage, a recent review of empirical evidence suggests that social insurance is not the silver bullet for China's health reform. While the major SHI schemes have covered the vast majority of citizens, financial protection remains shallow, in part due to limited benefits and rapid inflation of costs (He & Meng, 2015). High deductibles and copayments, low reimbursement rates, and unsupportive claim procedures have introduced major barriers. Moreover, China's decentralized and incremental approach to universal coverage has created a fragmented SHI system under which a series of structural deficiencies has caused not only additional barriers to access, but also detrimental impacts on efficiency and public satisfaction.

### The Existing Social Health Insurance System and its Deficiencies

The current SHI system consists of three schemes (see Table 1), namely the Urban Employee Basic Medical Insurance (UEI), the Urban Resident Basic Medical Insurance (URI), and the New Cooperative Medical Scheme (NCMS). Tailored to different segments of the society,

these three schemes together have covered close to 100 percent of the Chinese population. The fragmentation of the SHI system (Pooled at city and county levels respectively, there are close to 3,000 NCMS schemes and more than 300 UEI schemes and URI schemes), however, has created a plethora of problems undermining both equity and efficiency.

**Table 1 Profiles of major social health insurance schemes**

| | UEI | URI | NCMS |
|---|---|---|---|
| Eligible Population | Urban employed | Urban unemployed | Rural |
| Number of Enrollees | 283 million (2014) | 315 million (2014) | 802 million (2013) |
| Administration | Municipal human resources and social security bureaus | Municipal human resources and social security bureaus | County health bureaus |
| Funding | 2% of payroll income from employee;6% from employer | Government subsidy: 70%; individual contribution: 30% | Government subsidy: 80%; individual contribution: 20% |
| Per Capital Fund | US$424.7 | US$66.2 | US$61.2 |

Source: 2013 China Health Statistical Yearbook and 2014 China Human Resources and Social Security Statistical Yearbook.

First, contingent on local conditions and financing capacity, benefit packages vary considerably across regions and population groups, leading to structural inequity. Hundreds of millions of migrant workers in the cities have been excluded from financial protection. Second, the existence of multiple schemes, complicated by a low level of risk-pooling, has resulted in weak portability, especially between urban and rural systems. Third, the fragmented nature of the system, massive migration, and opportunistic behaviors of both individuals and local governments have led to many individuals enrolling in multiple schemes, giving rise to highly inefficient use of fiscal resources. Moral hazard and adverse selection are not properly curbed. All these systemic deficiencies are rooted in the fragmentation of the Chinese SHI system, which has not only created significant inequity in financing, access, and financial protection, but also yielded tremendous administrative costs.

**The Way Forward**

Recent years have heard increased calls for the consolidation of the fragmented SHI schemes into an equitable and efficient system, but progress was very slow until early 2016, when the State Council finally announced the long-awaited blueprint for consolidating the

NCMS and URI into the new Urban & Rural Resident Basic Medical Insurance Scheme (URRI). The policy document stipulates the coverage of both inpatient and outpatient services for urban and rural residents with equal benefits and announces a target reimbursement rate of up to 75 percent for inpatient costs. Marking an important stride towards universal health coverage, this policy paves the way for the ultimate consolidation of all SHI schemes in China.

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While the 2016 document does not indicate whether the URRI will be merged with the UEI in the foreseeable future, this integration is believed to be necessary (Meng et al., 2015). Yet the significant gap between the two schemes in terms of funding capacity and benefit package makes integration rather challenging. In principle, three alternative strategies are available as far as equal benefits for all are concerned. First, if a single-pool system—at least at the prefectural level—is to be established, closing the coverage gap between the UEI and URRI would require the government to source a gigantic amount of public funds to subsidize the premiums of the URRI's enrollees, a level far higher than its current financial injection to the NCMS and URI enrollees. Needless to say, this ultimate merger would have major advantages, including equal packages, more efficient risk pooling, greater financial protection, lower administrative costs, and stronger purchasing power of single insurers.

Second, it must be noted that while a single-pool system is generally preferred in order to minimize the level of fragmentation, a multiple-fund system can also realize universal coverage and equal entitlement if risk-equalization measures are properly adopted (Carrin and James, 2004). Typically, a risk-equalization fund, also referred to as a solidarity fund, can be created alongside a multiple-fund system to compensate insurers with the difference between a standard premium per enrollee and the full expected costs of care for that person, adjusted for age, gender, and chronic conditions (Söderlund & Khosa, 1997). By injecting subsidies into insurance funds for high-risk individuals—usually on an ex post basis, this arrangement can establish necessary connections across pools and help meet the objective of one benefit package for all the insured (Carrin & James, 2004). Chinese policymakers may also consider using tax revenue or earmarked premiums to establish a similar fund if the URRI and UEI are not to be merged in the near future.

The third alternative is to take a micro household approach by pooling together the URRI and UEI funds of family members and granting all members equal benefits regardless of differences in premium contribution. Without creating additional fiscal outlays, this method

could help achieve greater risk redistribution and cross-subsidization across insurance funds while continuing to allow the URRI and UEI to operate separately. Representing a convenient approach to universal equal benefits, this intermediary approach could also be considered by policymakers.

**Caveats**

Universal insurance coverage is not synonymous with universal health coverage. That said, the progress China made in the last decade and a half is still laudable. It is in fact the government's programmatic strategy to first achieve wide but shallow coverage before expanding benefits (Yu, 2015). Aside from the three alternative strategies proposed above, two caveats warrant policymakers' attentions.

First, reforming the SHI system requires not only political will, but also strong governance capacity, which unfortunately is not present. Entrusted to manage urban SHI funds, the social security bureaucracy, however, has failed to become an effective purchaser capable of containing cost inflation and guiding providers to pursue quality improvement through selective purchasing. Its primary bureaucratic concern has been to balance the books of the insurance funds and avoid financial risks (Hsiao, 2007). As such, while integration has tremendous theoretical potential, reform will fail if it is not matched by stronger analytical as well as regulatory capacities (Ramesh, Wu & He, 2013). The first task would be to consolidate the fragmented information system, or build up a new one to enable the new SHI agency, be it dominated by the social security bureaucracy or the health bureaucracy, to access and analyze the large data repositories without which the SHI system would not be able to exert its expanded purchasing power to negotiate better terms of service while curbing cost escalation.

**"The reform of public hospitals, the cornerstone of the Chinese health care delivery system, has unfortunately been rather slow, reflecting the government's inability to identify an overarching and viable roadmap"**

Second, it must be recognized that higher insurance coverage does not necessarily mean higher protection. Numerous pieces of evidence have shown that insurance may actually increase the risk of high and catastrophic spending. When compounded by low benefits and supplier-induced demand, insurance is often found to aggravate the out-of-pocket burden of consumers. This alerts policymakers to the necessity of reforming China's fragmented and inefficient health service delivery system, the ultimate driver of its double-digit cost explosion, which will bankrupt the financial system if it remains unchecked (Yip & Hsiao, 2008). The reform of public hospitals, the cornerstone of the Chinese health care delivery

system, has unfortunately been rather slow, reflecting the government's inability to identify an overarching and viable roadmap (He & Meng, 2015). Realigning the variety of perverse incentives embedded in the hospital system is a formidable mission due to the huge number of tangible and intangible interests involved. While a battery of new initiatives, such as clinical pathways, the separation of revenue and cost, and salary reform, have produced mixed results, provider payment reform appears to be promising (Yip & Hsiao, 2009). There is a growing consensus that reform of the delivery system ultimately hinges on reforming how providers are paid, moving away from fee-for-services towards more scientific methods including case-mix, capitation, global budget, and so on.

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**Notes**

1 The State Council's Opinions on the Integration of Urban and Rural Basic Health Insurance Schemes, January 3, 2016.

Website: http://ippreview.com/index.php/Home/Blog/single/id/42.html