China’s future healthcare system: what is the role for private production and financing?

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Abstract: In China, the private sector may make healthcare markets more competitive, thereby improving affordability, increasing the supply and quality of healthcare services and improving the accessibility to healthcare. It can also improve financial coverage via private health insurance, as a substitute or complement to government plans. However, strict regulation, insurance designation bias against private hospitals, insufficient risk-management capacity and crowding out by social health insurance have hampered private sector involvement in health services production and insurance. We argue that the best option at China’s current state of development may be a compromise model in which competing private providers are given an important role, but in which the government intervenes in such a way as to attain both a high degree of equity of access to healthcare, and to avoid the most significant forms of ‘market failure’ in an unregulated private system.

Keywords: health insurance; healthcare service provision; private sector; China.

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1 Introduction

In forecasting what China’s future healthcare system will look like, and in particular, what role will be played by private financing and production, one must first look back at its recent history. It is important to recognise that in the first three decades of the People’s Republic (roughly 1950 to 1980), the construction of a government-owned healthcare system in which the private sector had virtually no role, constituted one of the Communist regime’s major successes. Under this system, every Chinese citizen, whether in urban or rural areas, was guaranteed access to at least a basic level of healthcare, regardless of ability to pay. Although the level of care in most places was very basic indeed, healthcare resources were efficiently managed and population health improved dramatically, with average life expectancy at birth rising from about 40 years to 65 years between the mid-1950s and the mid-1980s (Qian and Blomqvist, 2014; Banister, 1987).

But while China’s publicly owned and managed healthcare system performed well in comparison with those in other countries at a comparable level of development at that time, central government planning as a general approach to managing the economy at large was no more successful in China than it had been in the Soviet Union or in Eastern European countries. Starting with Deng Xiaoping, Chinese leaders have moved toward more decentralised methods of economic management with a more prominent role for markets and private ownership and for international trade (Blumenthal and Hsiao, 2005). These policies, of course, were remarkably successful in generating a high rate of economic growth, to the point where China’s estimated per capita income now places it in the ranks of the world’s upper-middle income countries and where China, by some measures, now has the world’s largest economy (The Economist, 2014).

The changes in the way the economy was managed had profound effects in the healthcare sector. Most importantly, the earlier system of collective financing of most healthcare was eroded. Under that system, most primary care had been largely paid for by the communes to which almost all agricultural workers belonged, or, in urban areas, by the government-controlled and funded employers (work units) with whom urban workers were registered, and which often employed their own nurses and doctors to provide care for their employees. Hospital services (secondary and higher levels of care) were typically paid for through a combination of direct government subsidies and public insurance plans that covered both urban workers and rural farmers (Hsiao, 1995).

Following the economic reforms that began around 1980, the rural communes were dissolved and their health workers laid off, while fewer urban employers were willing to continue supplying in-house healthcare to their workers in an environment where they could no longer count on having any losses from operations covered by government. By the same token, most rural workers, and many in urban areas as well, lost the social insurance coverage that had previously paid a share of their hospital costs. At the same time, governments became more restrictive in the direct subsidies they granted to hospitals, requiring them to finance a larger share of their operations through charges to patients and markups on the drugs they sold. The net result of these changes was that
around the year 2000, as much as 60% of all healthcare costs in China was financed through out-of-pocket payments by patients [Qian and Blomqvist, (2014), p.97]. Not surprisingly, the fear that they would not be able to afford care if they became seriously ill, or the risk that major illness would send patients and their families into permanent poverty, became recurrent themes in surveys of what economic problems most concerned Chinese citizens at that time.

While private out-of-pocket payments had become the predominant source of healthcare financing in the early 2000s, there was less change in the private-sector role on the production side, as government-owned hospitals, and the drugs they supplied, continued to account for the largest share of total healthcare costs. However, although most beds continued to be in hospitals that were owned by government, many of them gradually came to be managed as if they had been private for-profit hospitals, as diminished reliance on government subsidies made them more and more dependent on the revenues that they could generate through patient charges and drug markups (Yip and Hsiao, 2014). The incentives on hospitals to generate more revenue in this way were often transmitted to the doctors who worked in them, by tying their compensation to the amount of revenue the hospital earned from the patients they treated. Indirectly, the role of the private sector also grew as hospitals earned a larger share of their revenue from procedures involving technology and devices supplied by foreign private firms, or from markups on drugs that the hospitals bought from the international pharmaceutical companies. This trend was reinforced by the fact that government controls on the fees and drug prices that hospitals were allowed to charge often did not extend to the newly developed drugs and technologies that the foreign firms were promoting.

2 China’s health policy since 2000

In response to the growing dissatisfaction with the problems in the healthcare system, debate about further reform began in earnest around the year 2000. But while there was agreement that changes had to be made in the way healthcare was financed and produced, opinions on what form these changes should take differed widely. In general, it was clear that as new and more advanced medical technologies and drugs were coming into widespread use, a financing model in which the main source of funding was patient out-of-pocket payments was no longer acceptable, meaning that the role of third-party payment had to be strengthened. There were sharp differences with respect to how this should be accomplished, however. On one side were those who favoured a return to a direct government funding approach under which the salaries and other operating costs of health services providers would be paid out of government revenue, with little or no revenue being derived from patient charges (Ge et al., 2007). On the other were those who advocated an insurance approach under which providers would continue to fund their operations mostly through charges collected from patients, but in which patients would belong to insurance plans that would reimburse them for part or all of these charges (Gu et al., 2006).

The differences between these two sides can be seen as part of a broader debate in China between conservative elements who believe that the relaxation of government controls over the economy has gone too far and should be slowed or reversed, and more liberal groups who favour more rapid deregulation and a continuation of policies to move
China toward a more market-based system, with a greater role for the private sector in both the financing and production of healthcare.

Under the reforms that took place during the first decennium of the 21st century, the strategy that was pursued was to continue limiting the direct government subsidies to hospitals and other providers, but to strengthen the protection of the population against the financial risk of expensive health services through a comprehensive set of social insurance plans that would reimburse citizens at least a share of their healthcare costs. The social health insurance system that was developed during that period has three types of plans for different population groups. The basic health insurance (BHI) plans cover urban formal-sector workers and are financed through pay-roll deductions. For rural residents there are new cooperative medical scheme (NCMS) plans that are voluntary and are funded through a combination of member premiums and government subsidies. People who live in cities but are not covered by a basic medical insurance plan, finally, can enrol in one of the urban residents basic medical insurance (URBMI) plans, also financed through a combination of member premiums and government subsidies [Qian and Blomqvist, (2014), Chapter 3]. Although membership in a social health insurance plan was compulsory only for urban formal-sector workers, the government subsidies for the voluntary NCMS and URBMI plan made them attractive, so most people enrolled in them. In total, as many as 95% of Chinese residents were covered by the system by 2011 [Qian and Blomqvist, (2014), p.93]. The impact of these initiatives on the health financing system was large, with the share of total healthcare costs that is financed through patient out-of-pocket payments falling from 60% in 2001 to around 34% by 2013 (Ministry of Health, various years).

Although expansion of the social health insurance system was the main focus of Chinese health policy during the first decade of the 21st century, the debate over the future role of government in health services production continued. Unusually, the government encouraged a relatively open debate about various options, and even asked for reports with recommendations from universities, international organisations, and even an international consulting firm [Kornreich et al., 2012; Qian and Blomqvist, (2014), p.99]. In an eagerly awaited announcement in 2009, the government confirmed that the social insurance system would remain the main element of China’s future health financing system. However, in response to the calls for at least a partial return to a more direct role for the public sector, it also announced plans for strengthening the primary-care sector through establishment of a network of ‘basic care clinics’ whose salaries and operating costs would be paid directly by government, and where every resident would be able to obtain basic care (and approved drugs) at low, controlled prices. Government funding of these clinics, and training of new primary-care doctors to work in them, have been important elements in the continued evolution of China’s healthcare system in the years since 2010.

3 The role of the private financing and production since 2000

Although there was little or no private-sector activity in the healthcare sector during the central planning era, the policy of allowing more freedom for private enterprises and market-based transactions has been extended to that sector as well. As a result, a growing share of health services production has been by private firms, and a portion of healthcare costs have been paid through private insurance plans. The role of the private sector was
part of the health policy debate from the late 1990s, and in the 2009 guidelines, the government explicitly noted that private-sector activity was to be encouraged, but with limitations: In reforming China’s healthcare system, the government was to ‘play the leading role’, while that of the private sector and the market mechanism would be ‘complementary’ [Qian and Blomqvist, (2014), p.100].

Various post-2009 central government documents relevant to health policy have contained further discussion of the private-sector role, generally with a positive tone. In the official documents from the third plenum of the 18th Party Congress released in November 2013, the entry of the private sector in the health-care services market was encouraged.\(^1\) In October 2014, the State Council announced a government action plan to promote private health insurance,\(^2\) and in January 2015, it endorsed a guideline for health resource planning for the period 2015–2020\(^3\) in which the establishment of private hospitals and hospitals with mixed ownership are encouraged. A policy guideline for regulating the practices of doctors was also released by the National Health and Family Planning Commission in January 2015, which recommended increased mobility of doctors so as to fill the shortage of medical practitioners in the private sector.\(^4\)

Available statistics confirm that the private sector has had a growing role in the system in recent years. Aggregate health expenditure in China has been rising very rapidly, reaching an estimated RMB 3,160 billion in 2013 (about 5.6% of China’s GDP), as have its main components, namely payments for care in hospitals and outpatient clinics, and for pharmaceuticals.

### 3.1 Health services production

As a result of both new construction and privatisation of existing ones, the number of private hospitals accounted for over 40% of total number of hospitals in China in 2013 (Table 1). Most of them are relatively small in size: in 2013, less than 100 private hospitals versus more than 2,200 public hospitals had more than 500 beds. Less than 40% of private hospitals have more than 50 beds while about 75% of public hospitals have more than 50 beds.

<table>
<thead>
<tr>
<th>Capacity</th>
<th>0–49</th>
<th>50–99</th>
<th>100–199</th>
<th>200–299</th>
<th>300–399</th>
<th>400–499</th>
<th>500–799</th>
<th>800 and above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>13,384</td>
<td>3,395</td>
<td>2,003</td>
<td>2,548</td>
<td>1,505</td>
<td>951</td>
<td>714</td>
<td>1,236</td>
</tr>
<tr>
<td>Private</td>
<td>9,786</td>
<td>5,941</td>
<td>2,475</td>
<td>940</td>
<td>219</td>
<td>81</td>
<td>38</td>
<td>65</td>
</tr>
</tbody>
</table>

*Source:* China Health and Family Planning Statistical Yearbook 2014

Outpatient hospital visits to private service providers grew from 66 million in 2005 to over 330 million in 2014, and the share of privately owned hospitals in total outpatient visits in hospitals surged from 4.8% in 2005 to 11.07% in 2014 (Figure 1).

Inpatient services provided by private hospitals also saw a phenomenal increase, from two million in 2005 to over 19 million in 2014, and the share of privately owned hospitals in total inpatient services in hospitals increased from 4% in 2005 to 12% in 2014 (Figure 2).
Figure 1  Outpatient visits to privately owned hospitals (see online version for colours)

Source: China Health Statistical Yearbooks, various years, and Statistical Communiqué on Health Care and Family Planning Development in China 2015

Figure 2  Inpatient visits to privately owned hospitals (see online version for colours)

Source: China Health Statistical Yearbooks, various years, and Statistical Communiqué on Health Care and Family Planning Development in China 2015
Although many of China’s private hospitals are relatively small, some of them are part of large firms that own more than one. Privatisation of public hospitals was involved in creating some of these firms. China Resource Healthcare Company (Huarun Yiliao) started to build up a hospital chain in 2011 by buying public hospitals from their local government owners. By the end of 2014, it had at least six hospitals and over 7,000 hospital beds in five provinces. Foshun Pharma (Fuxin Yiliao) has also attempted to establish a hospital chain; it now has over 2,000 beds. Some private hospitals are foreign-owned and there are special rules that favour hospitals with Hong Kong, Taiwan and Macau investors.

Private investment in Chinese hospitals has also come through the ‘mixed ownership’ model for public hospital reform. ‘Mixed ownership’ refers to investment in public enterprises, including public hospitals, by institutional investors from either the public or private sector. Such arrangements can be advantageous for both sectors given that public hospitals have an advantage in terms of human resources (i.e., more qualified doctors and nurses) while the private sector has larger financial capacity. Hospitals with mixed ownership may also be less subject to regulation in local health resource planning than purely private ones.

Some recent data on out-patient visits to primary-care clinics suggest that the private sector has a large share in that market as well: Of an estimated 4.3 billion visits to primary-care clinics in 2013, only about 40% were to government-owned clinics (Ministry of Health, various years). However, these data must be interpreted with caution, since some of the ‘non-government owned’ clinics that accounted for the remaining 60% may actually have been employer-managed clinics that are not classified as government-owned even if the firms that manage them are wholly or partially owned by government.

While the data show that there has been rapid growth in the amount of care supplied through private hospitals and clinics, there is little evidence regarding the reasons why this has occurred. It most likely reflects a combination of factors, including overcrowding and long wait times in the public sector, for example, in major urban hospitals. In some places, it may also reflect a lack of confidence in the quality of the care supplied in public hospitals and clinics, and a willingness of individuals with high income to pay more for services in foreign-owned institutions, or in clinics owned and operated by doctors with a well established reputation.

A large share of private-sector activity in China’s healthcare sector is accounted for by the pharmaceutical industry. Total sales revenue of the pharmaceutical industry has increased from RMB 249 billion in 2002 to over RMB 2,455 billion in 2014. The annual grow rate on average is over 20%. Pharmaceutical spending accounts for a much larger share in total healthcare costs in China than in other countries: in 2011, it amounted to as much of 43% of the total, much higher than the average of 16% in other OECD countries at that time (Yip and Hsiao, 2014). The rapid growth in drug sales revenue in recent years (Figure 3) suggests that its share has continued to be high.
Although the data are somewhat ambiguous, most of the pharmaceutical revenue goes to firms that should be classified as private. A recent report shows foreign-owned pharmaceutical companies accounting for some 25% of sales, and privately-owned domestic firms for a large share of the remainder\textsuperscript{10} (Ministry of Industry and Information Technology, 2013).

### 3.2 Healthcare financing

As noted earlier, the most dramatic development in China’s healthcare system since 2000 has been the decline in the share of total costs that is financed by patient out-of-pocket payments. Most of the decline has been due to the expansion in the social insurance programs, but over time, there has also been an increase in the share accounted for by private insurance. As Figure 4 shows, premium revenue of private health insurers grew fast in 2001-03, a time period when coverage by the new social insurance programs still remained relatively limited. The private share then stabilised or even declined after 2008 as the government programs expanded. However, private plan revenues have again grown quite rapidly in recent years. In 2014 it reached RMB158.7 billion, a leap of 41% from that in 2013.\textsuperscript{11} There are over 100 companies offering private health insurance and about 2,300 private insurance products are offered in the market.\textsuperscript{12}
**Figure 4** Premium revenue of private health insurance plans (see online version for colours)

**Figure 5** Health insurance reimbursement from different plans (RMB billion) (see online version for colours)

*Source:* China Insurance Regulatory Commission website

*Source:* China Health Statistical Yearbooks, various years, and Statistical Communiqué on Health Care and Family Planning Development in China 2015
Evidence on the profitability of private health insurance in China so far is mixed. In one source, over 40% of private health insurers are reported to have paid out more than 100% of their premium income as reimbursements to patients, with some even paying out more than 200% of their premium income (Yan et al., 2013). On the other hand, available data show that in the aggregate, annual reimbursements to patients from private health insurance have been substantially less than their total premium revenue. The total amount of reimbursement has been increasing, however, from RMB 21.7 billion in 2009 to over RMB 57 billion in 2014. The annual growth rate on average was over 20% between 2009 and 2014. However, the reimbursement from private health insurance corresponds to less than 10% of that from basic health insurance (BHI for urban employees) and less than 20% of NCMS reimbursement in rural areas (Figure 5).

As in other countries with social health insurance or direct government financing of healthcare, the relationship between private insurance and the government social insurance plans is a complex one.

For workers in the formal urban sector, enrolment in the local BHI plan is compulsory, so for this population group, private insurance does not compete directly with social insurance. However, many such workers have private insurance that serves as a supplement or complement to their BHI coverage (that is, their private insurance may pay part or all of the patient co-payments that are required under their local BHI plan, and extend that plan’s coverage beyond an upper limit on the benefits that it will pay). Private plans may also supplement the BHI plan (that is, cover all or part of the cost of drugs or services that are excluded from the list of eligible benefits in the BHI plan).

For population groups not eligible for the BHI plans (that is, people in rural areas or urban residents not in formal-sector employment), enrollment in the social insurance system (that is, in their local NCMS plan or URBMI plan) is voluntary, so they can opt to use private insurance as a substitute for social insurance coverage. However, enrollment in the social insurance plans is heavily subsidised, so for these population groups, too, the most sensible choice may be to enroll in the social insurance plan for which they are eligible, and then sign up for a private plan that complements and supplements the social insurance plan. Although detailed data on the relative prevalence of different private plans are not available, evidence from a recent national survey suggests that most of them serve as supplements and complements for persons who also are covered by social insurance. About 87% of enrollees in private health insurance plans were also covered by social health insurance in 2010, compared to only 18% in 2003 (Yan et al., 2013).

China’s central government has recognised that private insurers can play several useful roles that help strengthen the social insurance system. For example, when a government guideline on a ‘catastrophic medical insurance programme’ (Dabing Yibao) was released in August 2012,13 social insurers were advised to reinsure with private insurance companies and improve their enrollees’ coverage. In designing such arrangements, private insurers and social health insurers can play complementary parts. While social insurers have huge financial resources, with accumulated surpluses of BHI plans reaching over RMB810 billion in 2013 (Ministry of Health, various years), private insurers have the professional expertise to accurately estimate the financial risks associated with catastrophic health-care spending. In 2014, the ‘catastrophic medical insurance programme’ covered about 400 million people in 28 provinces.14

As another example, in a government guideline for private insurance released in October 2014,15 it is recommended that private insurers should have a role in helping administer the social insurance plans, drawing on their management expertise. Social
insurance plans can save money through methods such as negotiating contracts with health service providers which imply incentives on them to make cost-effective choices in prescribing drugs or selecting treatment methods for patients with different illness conditions. While some localities have started pilot reforms with payment methods intended to accomplish this, their social insurers typically do not have the capacity or the professional training to negotiate these kinds of purchasing contracts for health services from providers (Ramesh et al., 2013). Expertise supplied by private insurers may then be helpful.

4 China’s mixed public-private healthcare system in the future

Even if China’s economic growth rate is slowing down, the healthcare sector almost certainly will continue to grow at a relatively rapid rate, as the gains from the last several decades are consolidated and China’s social policy programs become more similar to those in advanced countries where healthcare spending takes up a larger share of GDP than in China today. Another factor that will contribute to this trend is the rapid aging of the population. Data from other countries show that on average, healthcare spending per person over 65 years of age may be four or five times as high as for those in younger age brackets (Casey et al., 2003), and the percentage of China’s population that is over 65 is increasing rapidly. In 1990, it was no more than 4.9%, but by 2011 the figure had already increased to 9.1%, and according to World Bank estimates it is predicted to be twice as high by 2030 (Qian and Blomqvist, 2015).

The data cited earlier show that the plans for allowing the private sector and the market mechanism to play a growing role in the sector are in fact being realised, but it is also clear that the social insurance plans will remain the backbone of China’s developing healthcare system. Thus there are still considerable uncertainties with respect to the evolving role of markets and private firms, and how they will integrate with the social insurance programs. This is true not only with respect to the future role of private insurance, but also for private service producers such as hospitals, primary care clinics, and physician practices, and for the private firms in the pharmaceutical sector. In the following paragraphs, we outline possible future scenarios in these respects.

4.1 Private provision of services and pharmaceuticals in the future

With stagnating direct government subsidies to hospitals in the 1990s and early 2000s, the privately funded hospital sector grew in response to rapidly rising demand as average incomes grew, and as patients increasingly turned to higher-level hospitals rather than rural or urban government clinics for their health problems. Since most of the revenue of private hospitals during that period came directly from patients, rather than from third-party insurers, hospitals could charge high fees and drug markups and in many cases be highly profitable: A well-known principle in health economics is that markets for health services in which individual patients are the buyers, will not be very competitive.

In the present system, the share of third-party financing through social and private health insurance has increased, and future expansion of private hospitals and clinics will increasingly depend on transactions with the social and private insurers. Under current
rules, there is nothing that prevents the managers of local social insurance plans from negotiating with private hospitals regarding the terms according to which they will provide services to the plan members. Their incentives to do so depend partly on the fact that the local governments that are responsible for managing the social insurance plans are also responsible for managing the local public hospitals, which may regard private hospitals as unwelcome competitors [Chen and Wang, (2013), Chapter 1]. With rapidly rising demand, however, high-level hospitals have not been worried about lack of patients and competition, so many local governments have welcomed the supply of services from private hospitals. Moreover, as discussed above, the role of private hospital investment has also expanded because many public hospitals (which also are managed by local governments) have converted to mixed public-private ownership. We think the most likely scenario is that these trends will continue, so more hospitals in the future will be at least partly owned by private investors.16

The future role of the private sector in health services provision will also be influenced by the development of the network of government-owned basic-care clinics that were part of the 2009 reform blueprint. Available data suggest that the number of these clinics, and the number of visits to them, have increased rapidly in recent years. Over time, a strengthened primary-care sector may slow the demand for hospital services to some extent; furthermore, competition between public and private hospitals is also influenced by the patterns of referrals to hospitals from primary-care providers, and doctors in government-owned clinics may be more likely to refer patients to public hospitals. But the data also suggest that the volume of visits to non-government owned clinics has grown rapidly as well. As before, competition between public and private providers in primary care will be heavily influenced by local regulations and the management of the local social insurance plans, and we believe the most likely scenario for this sector also is one where a considerable degree of public-private competition will be allowed in many places.

The pharmaceutical sector is already dominated by privately owned firms,17 and will continue to be so in the future. However, we think it likely that the sector will experience more regulation than in the past. Improving the quality of the drugs sold in the market remains an important policy objective, as the prevalence of counterfeit brand name drugs, or drugs that are mislabelled or produced with substandard ingredients, continue to be major concerns. We also believe that the rate of spending growth will moderate, as social and private insurance plans apply more pressure on providers to mostly limit their prescriptions to drugs that are on the list of essential medicines, rather than more expensive ones that are not.

4.2 Private insurance in the future

China has been extremely successful in raising average incomes and reducing the extent of absolute poverty in recent decades (World Bank, 2009). The benefits of this success, however, have not been evenly distributed, and income inequality in China is now quite high by international standards.18

For health policy, a high degree of income inequality poses a difficult dilemma. In China as elsewhere, there is support for the idea that seriously ill people should be guaranteed access to needed healthcare whether they are rich or poor. But if government were to take responsibility of paying for the same standard of care for everyone who needed it, that standard of care would be very basic at most. Even though growth has
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been rapid, China’s income still is that of a middle-income country with limited taxable capacity. Well-off people at the high end of the income distribution expect healthcare of a higher standard, similar to that in advanced countries. The dilemma, therefore is that in a country such as China, a purely public system cannot both meet the objectives of guaranteeing an equal access to care for everyone who needs it, whether they are rich or poor, and provide care of a standard that meets the expectation of those at the high end of the income scale. This is the basic reason why, for the foreseeable future, a substantial portion of healthcare costs in China will continue to be privately financed, and part of the demand for private health insurance will continue to come from well-off individuals who want to be able to afford care of a high standard.

A role for private insurance as a supplement or complement to the social insurance plans that today cover most Chinese residents is now also well established, as discussed above, and if anything, that role is likely to become stronger in the future. Strengthening of the expertise that is available for managing health insurance plans, public or private, is urgently needed in China, and it is also reasonable to expect continued growth of the model under which the administration of social insurance plans is partly subcontracted to private insurers.

In the present social insurance system, the level of benefits offered under the BHI scheme that covers urban formal-sector workers typically are much higher than those in rural NCMS plans or the URBMI plans that cover most other urban residents. This of course is not surprising, given that BHI plans have substantial revenues from compulsory worker payroll contributions, while the other plans’ revenues come from limited membership premiums and modest government subsidies. As part of the central government’s policy of reducing inequality, however, the subsidy levels to the latter plans have been increasing and most likely will continue to do so, as government seeks to reduce the differences in the care that is accessible to different income groups. As this happens and the resources of the NCMS and URBMI plans become larger, we expect that the role of private insurance in administering and supplementing these plans will become more extensive as well. We also think the government should consider the possibility of allowing private insurers to offer approved plans that compete with these social insurance plans, and allow people eligible for coverage under them to use the government subsidy toward the premium costs of such substitute private plans.

References


Ministry of Health (various years) *China Health Statistical Yearbooks*.


**Notes**


7 The willingness of many wealthy mainland residents to seek care in Hong Kong, Singapore, or even Australia and the USA, in spite of the high cost of doing so, is consistent with this view.

8 For example, many state owned enterprises have their own clinics. See http://www.gov.cn/zhengce/content/2015-06/15/content_9845.htm (accessed 28 January 2016).

9 For example, many state owned enterprises have their own clinics. See http://www.gov.cn/zhengce/content/2015-06/15/content_9845.htm (accessed 28 January 2016).

10 Shareholder-owned enterprises accounted for about 42% of total sales revenue in the pharmaceutical industry in 2012 while ‘other’ types of domestic enterprises (i.e., not state owned, collectively owned, foreign-owned or shareholder-owned) accounted for 28% (Ministry of Industry and Information Technology, 2013).


12 Ibid.
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16 As discussed in Qian and Blomqvist (2014, Chapter 10), local governments in China find themselves in a position similar to that which inspired the UK reforms involving the so-called ‘purchaser-provider split’, in which a clear separation was made between the local officials that were supposed to be purchasers of services on behalf of the public, and those who were responsible for managing health services providers.

17 Statistics for 2014 show that only 6 out of the top 20 pharmaceutical companies in that year were state owned/controlled companies, (21st Century Business Herald, 15 September 2015; http://m.21jingji.com/article/20150915/9d59a653e53cd811f0bae8ed552be9c.html (accessed 30 January 2016).


19 For example, the average reimbursement rate of inpatient services under BHI in 2013 was 81.9% while for URBMI, the rate was 66.7%. See China Youth Daily, 7 January 2016. http://www.chinanews.com/m/gn/2016/01-07/7705309.shtml (accessed on 30 January 2016).