



China's Healthcare Reform: What Does it Mean to the Insurance Industry?

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Background

The economic rise of China over the past three decades has been remarkable. The country's real GDP has grown at an average annual rate of 9.8 per cent between 1978 and 2008 (China Statistical Yearbook 2009). However, behind the stirring headlines of China's economic success are various lingering socio-demographic concerns. One of the foremost concerns on policy-makers' agendas is the provision of adequate healthcare to the 1.3 billion population. "*Kan bing nan, kan bing gui*", which means poor accessibility and unaffordable, has become a standard terminology for Chinese medical care. This is in stark contrast to the experience of many Chinese. Prior to the economic reform, health services were provided to virtually all urban and rural population free of charge (Wu, 1997). During the orthodox era of Communism, the country had been successful in the provision of preventive healthcare and promotion of community-based risk sharing. But the system was dismantled as the country attempted to switch to a market-oriented health care system.

In March 2009, the State Council issued a blueprint document entitled *The State Council's opinions on deepening the reform of pharmaceutical and medical system*. Commercially-run insurance is mentioned as part of the total reform package:

"(China) Should develop commercially-run health insurance proactively. (Actions include) Encourage insurance institutions to develop health insurance products in order to serve different needs; simplify claims procedures and make them convenience to the community for the benefits of diverse needs. Encourage enterprises' and households' enrollments on commercial plans and supplement schemes to address the demand exceeding the government basic plan. Promote governmental procurement of various health protection arrangements by entrusting qualified commercial insurers without compromising on the consideration of financial security and effective supervision." (Translated from Chinese by the author)

In summary, the reform strategy seems to offer room for insurers' continual involvements in the health financing. It is, therefore, instructive to understand the latest development of health insurance in China. While much has been talked about China's healthcare reform in the literature (the public health literature in particular), coverage on commercially-run medical insurance is relatively scant.

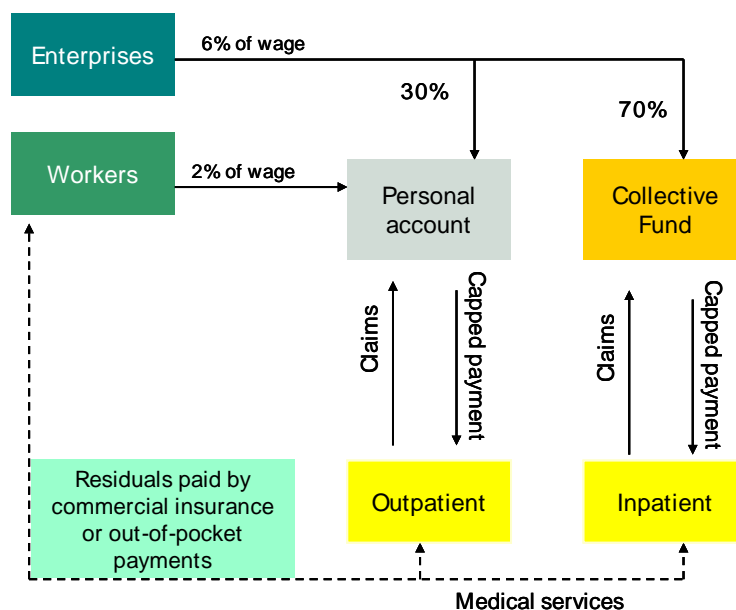
Health financing in China

In the old days, every citizen in the Communist country was either employed by State-owned enterprises or worked in government institutions. The transition to a market economy since early 1980s has eroded the protection enjoyed by most population segments. Privatisation and civil service reform have led to cessation of the provision of free healthcare through their old labour health insurance and government medical benefit previously entitled to many employees and their dependants. Meanwhile, the increasing withdrawal of government financial support to hospitals in the 1980s severely limited the ability to

perform supply-side control. This induced a strong economic motive for hospitals and healthcare professionals to maximise their revenue through a fee-for-service model (Ma *et al.*, 2008). Establishing a system to protect households against health financing risks is top in the government’s agenda.

Cognizant of the socio-political significance of this situation, the government began to reestablish the social security system towards the end of the last century. In 1998, China launched the Urban Employee Basic Medical Insurance. Local governments began to implement their local versions of the scheme in accordance to the framework devised by the Ministry of Human Resources and Social Security (formally known as Ministry of Labour and Social Security). Firms are required to contribute (about 6 per cent of wages, depending on location) to a Social Collective Fund while workers deposit (about 2 per cent of wages) to a personal account. All funds are administered locally by local finance bureaux.

Figure 1: Urban Employee Basic Medical Insurance



Sources: Government documents and author’s interviews

In light of the massive influx of mobile population into urban areas, in 2007 the government began to expand this scheme to cover all urban residents, regardless of their employment status. The State Council issued its *Opinions about the establishment of Urban Resident Basic Medical Insurance Pilot Scheme*. To induce the formation of risk pool, the Central Government planned to subsidise CNY40 for a person’s enrollment on a government-initiated scheme, matched by local government subsidy and personal contribution. Although participation in the scheme is supposed to be voluntary, the Central Government targets such schemes will cover all urban population by 2010.

With respect to the villages, the government encouraged the formation of a mutual scheme called the New Rural Medical Cooperative System in some cities in 2003. Similar to the Urban Basic Medical Insurance schemes, the Central and local treasuries each contributed CNY20 per head. Rural households enroll in the scheme on a voluntary basis (CNY10 per head). In 2010, the contribution by the Central and local governments will be CNY60 each, matched by the individual contribution of CNY30 per year. Marketed and managed by local medical cooperative offices, participating hospitals deliver services to members who in turn receive reimbursement. By the first quarter of 2009, the arrangement had covered 8.3 billions of persons in the rural area and is virtually universal coverage. In the second half of 2009, the maximum sums assured was about six times the average per capita earnings of the rural population.¹

¹ Ministry of Health Press release, 13 July 2009 (http://www.gov.cn/xwfb/2009-07/13/content_1363939.htm).

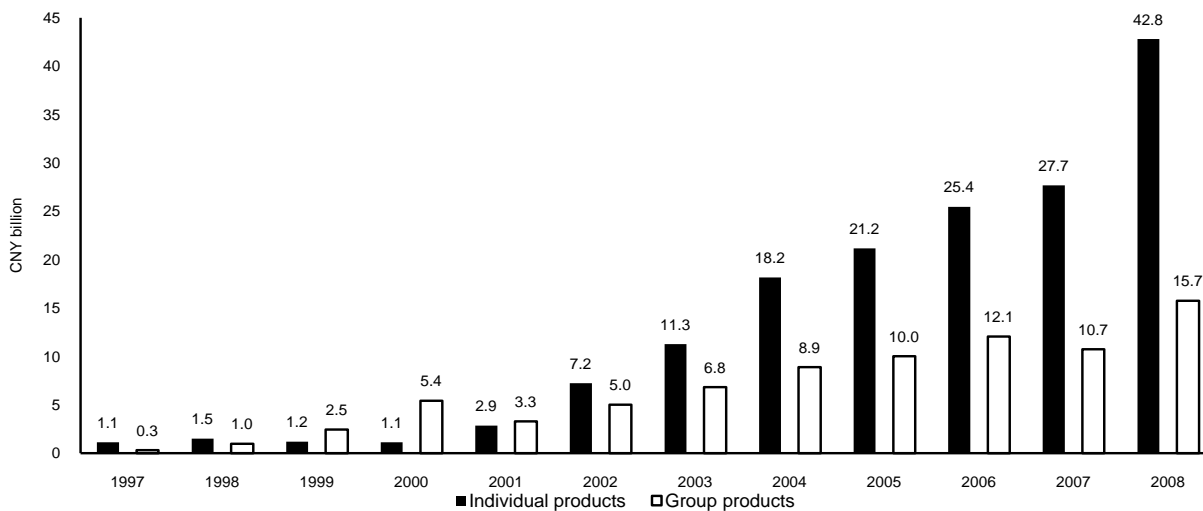
These rural and urban social schemes have become headline strategies for China to reestablish a nationwide medical insurance system. According to the State Council's blueprint released in 2009, it is expected that 90 per cent of the Chinese population will be covered by the three government-led schemes, namely, Urban Employee Basic Medical Insurance, Urban Resident Basic Medical Insurance, and New Rural Cooperative System, with an average subsidy of CNY120 per person annually. However, there is no specific target and action plans for the development of commercially-run health insurance in the next three years.

The market of medical insurance in China

Health insurance operated by commercial insurers has become an indispensable element in the healthcare system. According to the 2003 National Health Survey, about 6 per cent of the urban and 8 per cent of the rural population are covered by health insurance plans in various forms. Although the 2008 National Health Survey did not release the updated figures of this category, they are expected to be higher as commercial insurers have increased their involvement in various schemes initiated by local governments in the period between 2003 and 2008.

In fact, health insurance has emerged itself as a growth business in China's insurance market. Since 1997, total health premiums (including critical illness and medical reimbursement insurance) have increased at an average annual growth rate of 40 per cent and reached CNY58.5 billion in 2008 (Figure 2). There has been noticeable growth since 2001 (when China liberalised its insurance market upon accession to the World Trade Organization). However, the growth of group products, including the top-up medical schemes provided to enterprises and local governments, has been less striking relative to individual health products, as the latter has been mainly composed of long-term critical illness products.

Figure 2: Premium incomes of health products of Chinese insurers 1997-2008



Source: *Yearbook of China's Insurance*, various years.

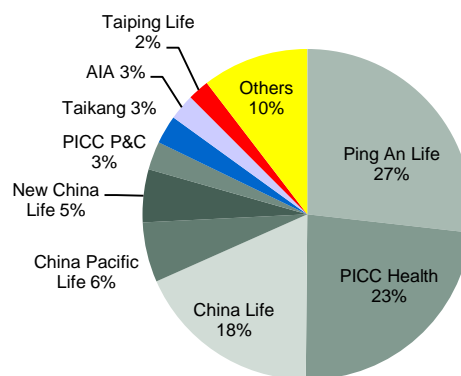
According to a special survey of seven largest life insurers (Swiss Re, 2007), more than 70 per cent of individual health insurance products were sold as riders to life insurance policies in 2005. In terms of premium revenues, 81 per cent of individual health business related to critical illness plans. Claims payment of these plans is triggered by diagnosis rather than medical expenditure. In China, many of these long-term critical illness plans were part of life insurance plans which allow early benefit payment (i.e. acceleration) of part or all of the death benefit. On the other hand, *medical insurance* was mainly offered as group plans which represented 90 per cent of the group health market. These policies were written on an institutional basis, covering employees in private and State-run enterprises. In some cases, commercial insurers also collaborated with local government to run Urban Enterprise Supplement Schemes.

Since the liberalisation of the insurance industry in the early 1990s, commercial insurers (mostly domestic) have launched more than 700 health insurance products to the market. Since the end of 2002,

non-life insurance companies have also been allowed to offer short-term health policies. Through the encouragement of China Insurance Regulatory Commission, specialised health insurers have been established (some of which are spin-offs from insurance conglomerates). As of 2009, there are four specialised health insurance companies in China.

In 2008, the health insurance market was dominated by a few life insurance companies. The top three insurance companies shared 68 per cent of the market in terms of premiums received (including both long-term and short-term products). For companies writing health business as part of life insurance portfolios, health premiums are closely associated with these life insurance portfolios. For example, companies that have a larger market share of the individual market are expected to have a higher proportion of premiums coming from their rider policies.

Figure 3: Market share of health insurance by premiums income 2008



Source: Yearbook of China Insurance 2009.

Opportunities from the public-private partnership

The national blueprint released in 2009 indicates the government intention to include the private sector in the reform. Insurance companies could be engaged to administer social insurance schemes, leveraging their professional expertise. In Shandong Province, a case-control study found that insurance companies had made a significant contribution in containing medical inflation (Meng *et al.*, 2004). Encouraging hospital competition for insurance contracts, and implementing a fixed-charge payment method and drug formularies system can assist in controlling medical charges imposed by the networked hospitals. Despite evidence showing that insurance companies could be effective vehicles to implementing social insurance schemes, at present involvement of commercial insurers in the social medical insurance system is still limited in scope and scale.

Notwithstanding the above, there were ample successful cases in which private sector players contributed to the early development of social health insurance. In Xiamen, Fujian Province, China Pacific Insurance Company (CPIC) has assisted the Labour & Social Security Office (LSSO) to develop a Major Medical Supplement Scheme for urban workers since 1998. Urban workers contribute CNY53 to purchase a cover that reimburses medical expenses exceeding CNY50,000 in any policy year period. In the early years, CPIC retained the risks but poor loss experience eventually convinced the company to operate as a pure third party administrator (TPA). In the latest arrangement, CPIC receives 3 per cent of total contributions if total claims of that year exceed contribution; and 9 per cent if the reverse holds. The performance-based scheme is designed to encourage better claim control of the TPA, although their ability to override clinician decisions is still very weak. Nonetheless, this case has become a benchmark through which local authorities make use of private sector players when the social scheme was at the embryonic stage.

Projects similar to the Xiamen’s case have been experimented in the rural areas. For example, in Xinxiang, China Life Insurance company assisted the government to manage the fund operation of its

New Rural Medical Cooperative scheme and received a management fee of 2 per cent of total premium contributions. Partly due to its corporate social responsibility, the State-owned insurer devoted its resources to train hospital staff in claim settlement and invests in a proprietary software that links to terminals in the hospitals.

The experiences of these piloted sites exhibit how governments have leveraged the comparative advantages of insurance companies in the overall health financing reform and assisted the development of social health insurance. Operating in a relatively competitive environment with the hope to benefit from cross-selling opportunities and branding, commercial insurers are supposed to be operating more efficiently than the public administration. By outsourcing the management of health funds and claim control/settlement to commercial insurers, government can focus on its core competencies as a regulator.

Conclusion

The 2009 blueprint outlined by the Central Government has already laid out a multi-faceted approach to health financing reform. It is expected to induce some potential opportunities for insurance companies should they want to be involved in the policy reform. At present, commercial insurers are supervised under the roof of CIRC. Social health insurance in the urban region is under the umbrella of the Ministry of Human Resources and Social Security. At the same time, the Ministry of Health is responsible for the promotion of New Rural Medical Cooperative schemes. Close coordination between different government agencies who are stakeholders in the Chinese healthcare system will be required. Consistent and well-coordinated government initiatives are critical to inducing engagement between commercial insurers and local authorities to tackle the health financing problem.

China, being the most populous nation in the world with such a low per capita income level at US\$2,000, has to deal with a whole range of healthcare issues including inequitable access, runaway expenditure and lack of risk protection. It is, therefore, paramount for the country to proceed its medical reform with great caution in order to avoid pitfalls of some other countries. China is one of many countries in the world encountering health financing challenges, and the successful implementation of a public-private partnership in China could become a useful reference for other countries.

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