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Working Paper 4
December 2009

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1. Introduction

In recent years, health system reform has emerged as a priority for economic policy in China. High out-of-pocket cost of medical care and drugs has become a serious concern for Chinese residents in both urban and rural areas, as hospitals have responded to reduced government subsidies by trying to increase their revenue from charges on patients or high markups on the drugs they sell. The problem has been exacerbated by the reduction in the resources provided by employers and local governments to support primary-care facilities (such as enterprise clinics in urban areas or village and township health centers in the countryside) in which a large amount of health care was provided at low cost in an earlier era.[1]

Government efforts to deal with the health sector's problems in the last decade or so have consisted principally in trying to reduce patient out-of-pocket costs by strengthening China's social insurance system. In major urban areas, the system is managed by city Social Insurance Bureaus which collect employer and client contributions under the various urban social insurance plans, reimburse patient for a share of eligible charges, and negotiate regarding the fees charged by local providers for medical services and drugs. In rural areas, social insurance principally takes the form of some form of a Cooperative Medical Scheme, which is managed at the county level by the county Health Bureau, with subsidies from government at the provincial and central level.

Although the percentage of the population covered by urban and rural insurance plans has increased rapidly, the insurance-based strategy for dealing with the health sector's problems has come under considerable criticism in recent years. In particular, critics have charged that some of the social insurance plans have only offered a limited degree of protection against the high cost of medical care because they only cover a restricted set of medical procedures and drugs, may require considerable consumer cost sharing even for the items that are eligible for coverage, and

[1] For a brief review of the history of China's health care system in the last several decades, see Blomqvist and Qian (2008).

in many cases have low upper limits on total annual reimbursements. Some have even gone so far as to characterize the insurance-based strategy as a failure, and have advocated an alternative approach under which there would be a return to a larger role for direct government subsidies to health care providers, accompanied by more stringent controls on what they could charge patients for medical care and drugs. Under one concrete proposal for a new strategy along those lines (henceforth referred to as the DRC proposal), a network of government-owned clinics would be established in rural and urban areas in which all Chinese citizens would be allowed to obtain needed basic care (and drugs) at low subsidized rates. This clinics would also be operated by government employees, and would be funded in such a way that they would not depend on patient charges or markups on drugs for paying their employees' salaries and other operating expenses. Defenders of the insurance-based strategy have characterized this proposal as a return to a centrally planned "command-and-control" model of health services funding and production.[2]

The wide difference between the social insurance and direct subsidy approaches can, to some extent, be interpreted as reflecting competing views and interests within China's government bureaucracy. The proponents of the DRC proposal include many officials in the Ministry of Health which would see its influence and budget expand if the proposal were adopted. Conversely, the defenders of the social insurance approach include many officials in the Ministry of Finance who favour financing of health services through charges on patients and insurers, rather than via government subsidies. They also include officials in the Ministry of Labor and Social Security which oversees the urban Social Insurance Bureaus. At the same time, the differences between the two approaches also reflects the more explicit debate that is now taking place in China between the New Left which argues against further strengthening of the role of privately owned firms and market competition in certain key areas, such as health care.

The purpose of the present paper is to show that much of the literature on health economics and on the international experience with different forms of health system organization can be interpreted as supporting the idea that reliance on an unregulated market mechanism for organizing the production and financing of health services is likely to result in major problems both with respect to efficiency and equity. However, reliance on a centralized "command-and-control" model managed by government has also been shown to entail problems in practice. For

[2] For the background to these proposals, see DRC (2005). Gu (2008) argues the case against the DRC proposals.

this reason I 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, both for the production of health services and in the provision of health insurance, but in which the government intervenes (through regulation and direct provision) in such a way as to attain both a high degree of equity of access to health care, and to avoid the most significant forms of "market failure" that would arise in an unregulated private system.[3]

The rest of the paper is organized as follows. In the following two sections, I briefly review the standard arguments why government intervention is needed to offset strong tendencies toward market failure in the markets for both health services and health insurance, and the main models of intervention that have been used in various countries. In the next three sections I turn to a discussion of a broader role for private health insurance in China. I first review the trend toward managed-care insurance in the U.S. and other countries, and then argue that managed-care plans might be able to compete effectively with government health insurance in China if rules were implemented that created a level playing field for such competition. The paper ends with a brief concluding section.

2. Traditional arguments for government intervention

The principal reasons why the health care sector can be expected to display a high degree of "market failure" in the absence of government intervention, are well known.[4] Some kinds of health services (those involving control of serious forms of contagious disease) have substantial external effects (external benefits), and it is a standard conclusion of micro-economics that such services will be undersupplied if there is no government intervention. However, control of contagious disease account for a relatively limited share of total health care costs in most countries; most health services are "private goods" in the sense that they don't have substantial external effects. A more important source of market failure is the information asymmetry between buyers and sellers of health services (providers have much more information than patients themselves about the potential health benefits of different drugs and interventions.

[3] Elsewhere (Blomqvist and Qian, forthcoming), I and my co-author have described in more detail a model of provider competition which includes a network of primary-care clinics as proposed in the DRC model, and financing is through a set of social insurance plans. In that paper, we pay less attention to the role of private insurrance, which is the focus in the present one.

[4] For recent reviews, see, for example, Blomqvist (2008), or Blomqvist (forthcoming).

Moreover, the nature of medicine also precludes the use of features such as warranties that are used to overcome the information asymmetry problem in some other markets where complex goods and services are sold. Finally, a substantial portion of medical care is provided to consumers in situations where they are worried or in pain, making it effectively impossible for them to compare offers from different providers, something that must be possible if competition is to be effective as an incentive for providers to keep prices low and provide only those services that truly will benefit consumers.[5] Alternatively, the fact that many health services are demanded only in states of the world in which the consumer is in some degree of distress means that it may be advantageous to contract in advance with providers regarding what care should be delivered, and on what terms. Such arrangements are sometimes referred to in economic theory as *state-contingent* contracts.

Because illness strikes randomly, there is, in any given population, large variability in the amounts that are spent on health care for different individuals. When people are risk-averse, there are then potential gains from risk-pooling arrangements under which some or all of the costs of care for those who fall ill is paid for by some type of insurance plan to which all individuals who are at risk have contributed in advance.[6] Health insurance plans can be interpreted as prepaid state-contingent contracts under which all individuals pay premiums that reflect the risk that they become ill, while the plan will pay benefits in some form to those who do. In most advanced countries, government provides some degree of implicit or explicit risk pooling, through compulsory social insurance plans, or through tax-financed subsidies for the provision of health care. Risk-pooling can also occur via private insurance, and it does so to a significant extent in many countries, the U.S. in particular. However, as has been extensively discussed in the literature, the operation of private health insurance markets is likely to be afflicted by certain major problems that will cause them to operate inefficiently in the absence of some form of government regulation. As in the case of health services, these problems can to a large extent be traced to incomplete and asymmetric information.

[5] "Supplier-induced demand" is a term that is often used in health economics to refer to services that patients utilize because it is in the interest of the doctor to supply them to patients who do not realize that they are of little or no benefit. For discussions, see any standard health economics text, or McGuire (2000).

[6] Even though those who pay premiums and do not fall ill are worse off as a result of insurance, the expected utility in the population at risk is higher when there is risk pooling.

The most familiar problems with certain types of private insurance are *moral hazard* and *adverse selection*. Moral hazard occurs when insurance coverage causes individuals to behave in ways which increase the probability or magnitude of the losses that their plans cover, in comparison to those for uninsured individuals, and exists because it is difficult and costly for insurers to formulate and enforce insurance contracts that rule out such behaviors. One form of moral hazard in health insurance relates to individual behavior that increases the probability that illness will occur (for example, smoking and failure to exercise); another more familiar one arises when the insurance contract stipulates that the plan will pay a share (perhaps 100%) of the cost of the individual's care, so that utilization of health services is effectively subsidized for insured individuals.[7] Adverse selection in private insurance markets arises when individuals have better information regarding their risk of illness than the insurer does, so that insurance plans with generous coverage tends to disproportionately attract relatively high-risk individuals and hence can become very expensive. (By assumption, insurers cannot charge higher premiums for those at high risk, since they do not know who they are.) Both moral hazard and adverse selection tend to produce equilibria in private insurance market in which risk-pooling is more expensive and less complete than it would be if the problems of incomplete and asymmetric information were less severe. Attempts by private insurance plans to counteract moral hazard and adverse selection problems also tend to make insurance contracts more complex, which in turn makes them more difficult for consumers to evaluate and compare. This means that the problem of information asymmetry between buyers and sellers is a significant one in the market for health insurance, as well as in the market for health services.

Moral hazard, adverse selection, and asymmetric information between buyers and sellers are factors that reduce the *efficiency* of private insurance markets. In addition, relying largely on private insurance to pool risk and finance health care would also be regarded by many people as incompatible with common concepts of *equity*. In particular, it may be considered inequitable that individuals who are at high risk of illness for reasons that are not their own fault (for example, because of a history of family illness) would have to pay higher insurance premiums than persons at lower risk. Health care financing through compulsory government program

[7] This form of moral hazard would not arise if insurance contracts specified state-contingent lump-sum payments rather than a subsidy for health services. However, such contracts would be expensive and difficult to enforce, though some versions of them exist (so-called “dread disease” insurance, for example).

through uniform premiums or through taxes can therefore be interpreted as being motivated not only by efficiency considerations (as it overcomes the adverse selection problem), but also by equity considerations (since it redistributes real income from those at low risk of illness to those at high risk).[8]

A possible objection against redistribution of real income through publicly funded health insurance is that it represents redistribution in kind, rather than in the form of cash. It therefore violates the principle that, when consumers' tastes differ, redistribution in cash generally is superior to redistribution in kind. While one may argue that this principle is of limited relevance in the context of health insurance since it would be administratively complicated to design a tax and transfer system that took into account different individual risks of illness, I will argue below that a model where citizens receive what essentially amounts to a risk-adjusted health insurance voucher (as in the system being implemented in the Netherlands since 2006) actually represents an attempt to do so.

3. Alternative models of government intervention

To overcome the efficiency and equity problems that would arise in an unregulated system of private provision of health services and health financing, governments in all advanced countries have intervened heavily in the health care system. Very different approaches have been used in different countries.[9] At one end of the spectrum are countries where government has essentially taken over the health care system, both in terms of financing and in terms of providing health care through government-owned hospitals and clinics, through personnel directly employed by government. Examples of countries usually classified in this category (sometimes referred to as the National Health Service, or the "public integrated", model) include the U.K. and Sweden.

While the public integrated model is the one that most closely resembles the way the health care system was organized in China and other socialist countries before the 1990s, it has suffered from the same shortcomings of planned centralized economic management as those plaguing the Chinese economy as a whole before 1978, and even countries like the U.K. and Sweden have constantly experimented with health system reforms aiming introducing more

[8] An early paper that discusses this idea is Blomqvist and Horn (1984).
[9] For a broad survey, see Gerdtham and Jönsson (2000).

decentralized and market-like approaches to managing the system. In a model that is now more common, government takes the responsibility for the task of *financing* most of health care through a uniform public insurance plan, but most health services are supplied by private providers. This is the model used in several continental European countries (including France and Germany), as well as in Canada and Japan; it is also the one used in the U.S. Medicare plan that covers all Americans who are older than 65 years.

Once again, there is a great deal of variety in the way the health care systems are organized even within this broad category. For example, the financing of the government insurance plan may be through taxation (as in Canada), or through compulsory social insurance contributions (France, Germany, Japan).[10] When the system is based on social insurance, there may be either a single fund or multiple funds which require different contribution rates. There may also be differences in the way providers are reimbursed. For example, in Germany and under the basic U.S. Medicare plan, hospitals are paid through a prospective system based on Diagnosis-Related Groups, while in Japan they are paid on the basis of fee for service ("itemized billing"). While some of these differences are important (for example, those relating to provider reimbursement), these systems nevertheless have certain common strengths and weaknesses that are relevant to the question what lessons they contain for health system reform in China.

First, the plans are *universal*: They cover everyone in the population, and the nature of coverage is the same for everyone.[11] Because everyone belongs to the same plan, there is no problem of adverse selection. Moreover, though individual contributions to the plans are generally not the same, the contributions are unrelated to individuals' risk of illness, so the systems are equitable in that sense.

Second, in all the cases mentioned above, insured consumers can choose to receive care from any provider in the system. Other things equal, consumers obviously see this as an advantage relative to other systems in which the choice of provider is restricted in some way (as in U.S. managed care plans, or under the old system in countries like Sweden where consumers

[10] In practice, social insurance systems use a mixture of social insurance contributions and government subsidies.
[11] The U.S. Medicare plan is not universal, of course, since it only covers a certain population group. Moreover, as discussed below, not all Medicare beneficiaries are covered by the same plan. Nevertheless, the plan is an example of public funding with private provision.

at one time were restricted to seeking care only from specific designated local clinics and hospitals).

While they do address the problem of adverse selection and generally are designed in an equitable manner, none of these plans provides effective solutions to the problems of moral hazard and information asymmetry. In France, Japan, and in the basic U.S. Medicare plan, the extent of ex post moral hazard is reduced by requirements that patients pay part of the cost of their health care (as the plans have deductibles and/or partial patient cost-sharing), but although this reduces the moral hazard problem it does so at the expense of providing a lower degree of risk pooling. As outpatient physicians in these plans are paid on the basis of fee for service, they have an incentive to increase their income by exploiting their information advantage and supply their patients with a high volume of services at high prices. The plans try to counteract this incentive by limiting the rates at which they reimburse patients for different services. In Canada and Japan, the plans directly control the fees that physicians can charge. While such controls can be successful in keeping fees and aggregate costs down, they also tend to cause the standard problems associated with excess demand in some areas (in Canada, waiting times for certain procedures have become long, and patients in many places have been unable to obtain primary care from a regular family doctor).

Finally, while private insurers pay for a substantial part of total health care costs in some of these countries, private insurance is not able to compete directly with the public plan since membership in the latter is compulsory. Thus when private insurance does play a significant role, it takes the form of either a supplement or a complement (in the OECD terminology) to the public plan. In France, for example, the most important function of private insurance is to pay for the patient charges that are required under the public plan (that is, to serve as a complement to the public plan), while in Canada private insurance only covers the cost of drugs and certain health services that the public plan does not (that is, private insurance is a supplement to the public plan).[12] However, because citizens cannot opt out of the public plan, they cannot use private insurance as a substitute for it. As will be further discussed below, under the U.S. Medicare plan, there *is* some degree of private-public competition, as a form of opting out of the

[12] The so-called Medigap plans in the U.S. has played both roles: They typically pay the user fees for which Medicare enrollees are responsible, and before 2008, the often covered drug costs (which before that year were not covered by the basic Medicare plan).

public plan is possible, and since 2007 Germany has moved toward a system there effectively is competition between public and private insurance.

The conceptual model of financing health care through a uniform universal public insurance plan, but relying on private producers for supplying health services to the population appears to have been the one underlying China's health system reform in recent years. At present, public-plan coverage is of course not yet universal, either in urban or rural areas, and different versions of publicly arranged health insurance cover different segments of the urban population. Moreover, most hospitals are still formally government-owned. Nevertheless, the stated objective is to achieve universal coverage, and over time, hospitals and other providers have become more autonomous and responsible for supporting themselves through the revenue they earn from fees and charges, rather than through government subsidies. That is, they have become more like private firms. Thus it seems reasonable to suggest that a health care system such as that in Canada, France, or Japan might implicitly have served as rough models toward which health sector policy makers were trying to move the Chinese one.

The examples of countries like Canada, France, and Japan demonstrate that it is possible to design versions of this model so as to meet high standards of equity, and to reach a reasonable degree of efficient performance. However, the experience of these countries also demonstrates that doing so is a task of great administrative complexity (for example, with respect to regulation of provider fees and other terms of practice), that the design and management of the system is likely to be highly controversial, and that it will involve dealing carefully with various interest groups (such as physician and hospital associations, or the pharmaceutical industry) that seek to influence the government agencies that are responsible for funding and regulation. Thus while management of a system of this kind may give rise to challenges that are somewhat different from those in one organized along the lines of a National Health Service model in which the government is also responsible for the *production* of health services, they can nevertheless be daunting. In a later section, I will argue that a system with a more significant role for private insurance may be somewhat less difficult to manage.

4. Digression: New forms of competition in health insurance markets

In the discussion above, it was noted that two of the major problems that have afflicted private markets for health services and health insurance were moral hazard and buyer-seller

information asymmetry; these problems are often cited as reasons for government intervention in the health sector. However, it is important to recognize that in countries where government intervention has been limited, private agents and the market mechanism have developed arrangements that have mitigated these problems to some extent. In particular, managed-care plans in the U.S. and elsewhere have entered into contracts with health services providers under which the providers agreed in advance on the terms according to which they would supply care to the plans' customers, and under which they were paid in such a way that they did not have an incentive to exploit their information advantage by supplying a high volume of services.[13] The incentives that these payment arrangements implied for providers (often referred to as *supply-side incentives*) constituted an alternative to charges paid by patients (demand-side incentives) as a means for controlling the insurers' costs. The plans also attempted to hold costs down by various restrictions on the way doctors were supposed to treat patients (for example, by requiring a second opinion before a patient was referred to hospital, or requiring doctors to prescribe generic version of drugs when they were available). As a consequence of both these restrictions and incentives, the plans could offer relatively complete protection against high out-of-pocket costs of care, while charging relatively low premiums. It is interesting to note that such insurance plans correspond more closely to the principle of prepaid state-contingent health services purchases than conventional plans that pay for a share of the costs of the care supplied to patients by providers compensated via the conventional fee for service method.

A critical feature of managed-care plans of this type, however, was that those covered by them were restricted to receiving their health services only from providers who appeared on the plans' list of eligible ("preferred") providers. Consumers (or their employers) agree to such restrictions because the plans that use them are able to offer insurance at relatively low premiums; providers agree to the plans' terms because unless they do, they cannot sell their services to the plans' clients.

The experience in the U.S. and some other countries thus suggests that in a system where private insurance plans are allowed to compete in the market place, many of them will be of the managed-care form, with restricted lists of providers paid via arrangements that involve supply-

[13] A good survey of managed-care plans is Glied (2000); the most recent edition of the popular textbook by Folland, Goodman, and Stano (2007) also contains a clear discussion.

side incentives. It is also important to note another feature of insurance market competition in the U.S. that may be important if China is to design a model with a significant role for private insurance: That the private insurance market is dominated by employment-related group insurance, not individual insurance. There are several reasons for this.

One explanation is specific to the U.S. in that it reflects a long-standing principle in U.S. tax law: That employer contributions toward payment of employees' health insurance premiums are regarded as a non-taxable fringe benefit. This rule makes it more attractive for employees to obtain health insurance coverage from their employers, rather than purchasing insurance individually, out of after-tax income. A second important reason why group insurance is more common than individual plans has to do with the fact that there is a high degree of information asymmetry between buyers and providers of health *insurance* (as well as health *services*). Overcoming this information asymmetry would require insurance buyers to acquire enough expertise to evaluate and compare different complex insurance plans, something that would be quite costly. Under group insurance, this information cost can be spread out over many people as employers evaluate plans on behalf of many employees. Finally, while group insurance may not entirely eliminate the problem of adverse selection, or insurance plans' incentive to engage in "risk selection" (sometimes referred to as "cream skimming"), it reduces the extent of these problems to some degree, by restricting employees to a single plan or a few similar plans.

In markets for employment-related insurance, therefore, private insurance has been able to do a reasonably effective job of pooling risk while avoiding some of the cost-increasing tendencies associated with moral hazard and information asymmetry, and it has also served to alleviate the problems of adverse selection and risk selection that arise when health insurance is marketed to individual consumers. However, employment-based group insurance is only available to persons who have regular employment, whereas for other population categories (the self-employed, retirees, and those outside the labour force for other reasons, including physical and mental disabilities), private insurance will not be available on reasonable terms. In the remainder of the paper, I therefore turn to the question: Is there a model in which state intervention focuses on ensuring that these groups are protected as well, while allowing private plans to compete in providing insurance for those groups for which it *does* constitute an effective alternative?

5. A government default plan with opting out

A possible answer to the question raised above is by implementing a system under which every citizen is automatically covered by some kind of government insurance plan, but in which individuals, or groups of individuals, are allowed to *opt out* of the government plan which covers them, and enroll in an approved alternative private plan instead. A key feature that must be present in order for such a system to work effectively is a clear set of rules under which the government would pay a subsidy to those who opted out; the subsidy would be paid to the alternative private plan that each opted-out individual had chosen instead. By definition, such a model would ensure that all members of the population had access to basic health insurance (through the default plan), but would allow innovative and efficient private plans to compete with the government plans,[14] if they could offer a more attractive package to some population groups.

The general model under which the government pays for all or part of its citizens' health insurance, but individuals can use the government subsidy to either enroll in a public plan, or to pay the premium for an approved private plan is not new, of course. A model of this kind was the basis for the proposed national health insurance system introduced by the Clinton administration in the U.S. in the early 1990s (elements of this plan survive in the Medicare Advantage plan that covers U.S. citizens aged 65 years or above). The health financing system being implemented in the Netherlands since 2006 also is based on this principle. In some respects, the models resembles the proposals for voucher systems that have be advocated by some economists for the education sector, among others, in some countries.[15]

In the resot of this section I turn to a sketch of a model in which China would implement a form of universal public health insurance coverage with provisions for opting out and competition among private insurers and public-sector plans.

[14] As discussed below, one may allow opting out from several kinds of government plans, for example, in a situation where different population groups are covered by different plans, as in China today.

[15] For a succinct description of the Dutch model, see van de Ven and Schut (2008). Alain Enthoven, the American health economist of Dutch ancestry whose writings have been very influential in promoting the model of "managed competition" that was the basis for both the Clinton plan and the current system being implemented in the Netherlands, has emphasized that the Clinton plan, for example, was much more complex than a simple voucher system. See Enthoven (1993).

At present, China's publicly organized health insurance system is not yet universal, though it covers a large proportion of both the urban and rural populations.[16] It has three main components: The Basic Health Insurance System for urban employees (henceforth BHIS), managed by Social Insurance Bureaus (SIBs) under the Ministry of Labor and Social Security in China's major cities; an Urban Residents' plan (henceforth UR) for urban residents not eligible for the BHIS, which is also managed by the SIBs; and, for rural residents, some form of Cooperative Medical Scheme (henceforth CMS), managed by each county's Health Bureau. The coverage of all these three schemes focuses on the cost of drugs and inpatient care for hospitalized patients, while payment for outpatient services is either out of pocket or from individual accounts established in conjunction with one of the plans.

In the following discussion, I will assume that a limited form of universal coverage will be created as the government moves ahead with the establishment of a network of rural and urban clinics where every Chinese citizen will be entitled to basic medical care at controlled, low fees, in accordance with the plans that have been announced. Though the details regarding exactly what type of care will be provided in these clinics are not yet available, I will assume that it will be what is usually described as primary medical care (and drugs) for outpatients, and that the clinics will have only basic equipment, perhaps along the lines of existing rural township health centres. I also assume that the cost of establishing, and subsequently operating, these clinics will be covered mostly from the budget of the Ministry of Health. In the following, I will interpret access to primary care at low subsidized fees as a limited form of a universal public health insurance plan (henceforth referred to as the Primary Care, or PC, plan) to which everyone belongs by default. In addition, the urban BHIS is compulsory, at least in principle, for employees. The UR and CMS plans, in contrast, are voluntary, and require payment of a premium in order for a person to be covered, but each enrollee is eligible for a fixed government premium subsidy.

Strictly speaking, the concept of opting out should perhaps only be applied to programs in which citizens are automatically enrolled, which would be true only for the future PC plan, and for the BHIS plan for urban employees (who would, in fact, be covered by both plans). For

[16] The following sections draw heavily on Blomqvist and Qian (2008) and Blomqvist and Qian (forthcoming), which contain additional references.

this latter group, allowing enrollees to opt out would open up the market for private employment-related group insurance, or, in the case of large employers, self-insurance. Administratively, an effective opting out system would require that those who did so would be excluded from receiving care in government PC clinics, something that would in turn require some kind of registration system for those who were eligible for such care. In order for there to be a reasonably level playing field in the competition among private and public plans, firms that opted out of both public plans would have to not only be exempted from the contribution they otherwise would have to make to the BHIS, but should also receive a subsidy equivalent to the expected cost that government PC clinics would have incurred for the opted-out employees. Establishing a set of rates that would represent actuarially fair subsidies of this kind, would be an important administrative task in designing a system that allowed for opting out in this sense.

Once such a set of subsidies had been established, it would also be possible to allow opting out for those covered only by the universal PC plan, or by a combination of that plan and either the UR or CMS plans. For the latter plans, the concept of opting out would not be relevant, since they are voluntary plans. However, the principle of a level playing field would require that the per capita government subsidy that is paid on behalf of those who enrol in these plans, would be paid as a premium subsidy to any approved private substitute plan that an opted-out person, or group of persons, had chosen.

It is, of course, difficult to predict to what extent a set of rules that *allowed* opting out and competition among public and private plans would indeed result in a significant role for the latter. Evidence from the U.S. and elsewhere might suggest that in urban areas, employment-based group insurance based on managed-care principles may be able to compete effectively with a public plan, provided the subsidies to private insurance are indeed effective in creating a level playing field. With the same proviso, it also seems reasonable to predict that private insurance could might be able to successfully compete with a combination of the future universal PC plan and the government-sponsored UR plan. Experience from many countries indicates that primary care can be competitively supplied in the private sector, and private managed-care plans could well be able to negotiate contracts that would join primary-care providers, hospitals, and drug suppliers into networks that would supply cost-effective packages of care at relatively low cost.

It is less clear to what extent provisions for opting out could result in effective private-public competition in rural areas. For geographic reasons, local county hospitals may have substantial local monopoly power for a broad range of services, reducing the ability of private insurance plans to make them agree to supply services at low cost. Similarly, fixed costs and economies of scale may reduce the ability of private primary care providers to compete with government clinics in supplying basic care in rural areas.

However, private insurance can play a role in rural health care in different ways. A recent article in China Daily (March 27, 2008) cited instances in which county governments had contracted with private insurers to manage local CMS plans. According to the article, private insurers "provided fund reimbursement, settlement and auditing for medical care schemes that covered 30.17 million rural Chinese" in 2007, in ways that helped in "preventing fraudulent operations and saving government costs". A broader role may be possible for private insurers in future years, for example, through involvement in negotiating new forms of contracts between CMS plans and local health services providers (hospitals and township health centers). By operating in many townships and regions, insurers can gather evidence on what kinds of arrangement are likely to work well, and hence facilitate the dissemination of best practices across counties and regions.

6. Administrative arrangements

In China's current system of governance, allocation of administrative and budgetary responsibilities across government departments can sometimes be important issues in debates about social policy. In health policy in recent years, anecdotal evidence from insiders has frequently suggested that somewhat different approaches to future health system reform have been favoured by the Ministry of Health (MOH), on the one hand, and the Ministries of Finance and Labor and Social Security (MLSS), on the other, as noted earlier. Roughly speaking, MOH officials tend to advocate a pullback from the strategy of relying on charges to patients as a principal means for financing health care, and a return to budgetary funding of most health care costs, with the funds being managed by the MOH. The Ministry of Finance and MLSS, in contrast, tend to support the approach under which health services providers are required to finance their activities by selling their services in the marketplace, but patients are protected against the high cost of health care through programs of social insurance.

The health system policies that have been pursued in the last several decades have reduced the share of health care resources that have flowed through the MOH, as they have focused on strengthening the social insurance programs (BHIS, UR, and CMS plans) that have been managed by urban Social Insurance Bureaus and county Health Bureaus. At the central level, these programs have principally been overseen by the MLSS. The recent decision to put more emphasis on primary care through establishing a network of basic-care clinics (that is, to implement what was referred to above as the PC plan) potentially means that a larger share of health care resources will be managed by the MOH which, under the current version of the plan, will be their owner. (The MOH has also been an active supporter of this plan.) In order for these clinics to work effectively with hospitals and other existing providers, it is obviously important to create an administrative framework in which the ministries can work well together. In particular, this is necessary in order for a system that allows opting out and public subsidization of private insurance, to work effectively.

Under the opting out scheme sketched in the previous section, government subsidies would be paid to consumers (or groups of consumers) who opted out of any of the existing or future plans, including the PC plan, and signed up for an approved private plan instead. It would seem to be a natural arrangement that the MLSS would oversee these arrangements (including setting criteria for approving private plans), on behalf of *all* social insurance programs, including the PC plan. As was also noted above, a system under which individuals were allowed to opt out from the PC plan would require a patient register in the government primary-care clinics so that opted-out persons could be excluded from receiving services in the clinics. With such a registration system, it could also be considered a natural arrangement to channel a portion of the clinics' regular funding through the MLSS in the form of per capita grants for persons on the clinics' lists. For persons who opted out, the grants would simply be redirected to the substitute private insurers that they had chosen instead.

7. Conclusion

The question of what should be the appropriate role of the market mechanism in health care is one of the most controversial ones in the social policy debate in many countries. China is no exception: The future course of health policy is hotly debated, both within the government bureaucracy and, somewhat unusually, in public as well. In this paper I briefly discuss the nature

of the market failures both in the market for health services and in that for health insurance, that give rise to the need for government intervention in the form either of regulation or direct provision. In recent years, the direction of health system reform in China seems to have been toward a model somewhat similar to those in countries like Canada, Japan, or France, where most health services are supplied by private, or at least autonomous, providers, while most health care financing is through government plans, with private insurance playing mostly a role as a complement or supplement to the public plans.

While the recent plans to devote substantial resources to establishing a network of government-owned basic care clinics are seen by some as a move back toward China's earlier system that was dominated by direct government service provision, it can also be interpreted as simply a strengthening of the primary care component of the health services production sector. The fact that the clinics are owned by the government need not be considered a particularly significant change in the nature of the health care system if they are managed with a high degree of independence and have to compete for patients or contracts with insurance plans for operating revenue.

In the second part of the paper, I turn to an analysis of the possibility that the future health care financing system in China could leave room for a broader role for private insurance plans, not only as a complements or supplements to the government plans, but also as a substitutes that would compete with them in the market for health insurance. I argue that private managed-care plans may well be able to offer cost-effective packages of care as substitutes for the BHIS or UR plans in the cities, and that private insurance may have a useful role within the rural CMS system as well. Actual and potential competition from private insurance might serves as an incentive for the managers of government plans to be efficient and client-friendly, as as a counterweight to the tendency for provider interests to unduly influence health policy. Although designing a system that allows private plans to compete fairly the public plans is not an easy task, models for doing so exist, and can be implemented in such a way as to reduce the efficiency and equity problems that arise in unregulated insurance markets. In the final section, I argue that managing such a system should most appropriately be the responsibility of the ministry overseeing the social insurance system, that is, the Ministry of Labor and Social Security.

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