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From plan to market in the health sector? China's experience

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ABSTRACT

Countries worldwide confront the challenge of defining and achieving appropriate roles for government and market forces in the health sector. China—as both a developing and a transitional economy—represents an important case. This paper uses an international comparative perspective to examine how the health of China's population and other aspects of health system performance changed during the reform era. We draw on standard public finance and health economics theory, as well as the more recent incomplete-contracting theory of property rights, to summarize the comparative advantages of government and market for financing and delivery of health services, particularly in developing and transitional economies. We then describe and analyze against this theoretical background the transformation of China's health sector and recent commitment of government funds to move toward universal coverage.

1. Introduction

Countries worldwide confront the challenge of defining and achieving appropriate roles for government and market forces in the health sector. Although extensive theoretical, empirical and policy-oriented scholarship analyzes this issue for established-market economies, much work remains to be done to understand the institutional challenges of developing countries and countries transitioning from centrally planned to market-based economies.

China – as both a developing and a transitional economy – represents an important case. China's economic reforms since 1978 spurred unprecedented economic growth and lifted millions out of poverty. To what extent these achievements can be sustained and deepened will not only impact the lives of one-fifth of mankind, but will also affect the global course of such health threats as tuberculosis and HIV/AIDS, as well as the world's ability to achieve the Millennium Development Goals.

How has the health of China's population, as well as the performance of its health system, changed during the reform era? International comparison provides a useful lens for evaluating China's experience. The World Health Organization (WHO) applied one such set of metrics to a cross-section of countries in the World Health Report 2000. In a ranking of health system performance, China ranked 144 out of 191 countries. Despite a relatively high ranking for level of population health (61), China's system was deemed to be weak in the distribution of health and responsiveness, as well as particularly unfair in distributing financial burdens of health coverage and illness expense. Although many might quibble with the WHO's

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performance metrics, few would disagree that China's health sector faces tremendous challenges, as the crisis of Severe Acute Respiratory Syndrome (SARS) in 2003 brought into the international spotlight.

More recently, China has announced ambitious reforms aiming to achieve basic universal coverage by about 2010. The government has committed major new funds to the health sector, and expanded social insurance programs to the formerly uninsured majority. The New Cooperative Medical Scheme (NCMS) offers subsidized basic insurance in rural areas, and insurance programs have been piloted for the urban residents not covered by the Basic Medical Insurance (BMI) for formal sector employees.[1]

Thus, 30 years into reform, as part of efforts to build a ''harmonious society'' and address the disparities across different segments of the population, China's leadership has launched major initiatives to correct perceived dysfunction in the health sector and meet the expectations of a population with ever-increasing per capita income. To understand the prospects for newly infused government funds to translate into effective health care service delivery and improvements in population health requires understanding the starting point: how China's health sector evolved over the first quarter century of reform.

This paper examines the factors underlying China's uneven health sector performance since 1980. The first section examines how several key health status indicators have changed over the past few decades, compared to other countries and relative to income per capita. China began the reform era as an international outlier, having achieving high population health status for its relatively low per capita income level. One might have hoped that China's above-average economic growth would have reinforced China's previously above-average health indicators. Instead, compared to unprecedented economic growth, health status measures have improved more slowly, or even stagnated at the aggregate level, with growing population disparities. By 2000, life expectancy, infant mortality and under-five mortality rates were all about average for countries of similar per capita income. Sections 2.1 and 2.2 consider several alternative explanations for this ''regression to the mean,'' including the stresses of systemic transformation, reverse causality from health to subsequent growth, and changes in health care financing and delivery.

Depending on which measures of health and health sector performance one chooses to analyze, China's performance in the health sector is neither significantly better nor spectacularly worse than its Asian neighbors. Some developing Asian countries, such as Indonesia, experienced more balanced improvements in health along with GDP, but with similar overall results.[2] India, with a population also over one billion, has had lower life expectancy and higher infant mortality since 1980, with only a modest reduction in the gap by 2005; both China and India have had high out-of-pocket spending and large disparities between the rich and poor in terms of disease and financing burdens (Yip & Mahal, 2008). In developing Asia, as elsewhere in the world, systems of health care financing and delivery are closely shaped by historical and cultural context; although China might benefit from specific elements of many systems and from the ''advantage of backwardness'' (Gerschenkron, 1962), no single health system model offers a panacea. For example, South Korea and Taiwan have established National Health Insurance (in 1989 and 1995, respectively), assuring their populations universal access to health care. Yet neither faces China's challenges in reaching a large rural population. China has borrowed from Singapore, implementing a system of individual Medical Savings Accounts combined with social risk-pooling funds. China has also built upon its own successful experience with subsidized rural community financing to extend NCMS to rural residents, and has largely followed a path similar to that of other transitional economies (in Eastern Europe and the Former Soviet Union) of adopting social insurance rather than a National Health Service model. Future reforms may feature a mixture of models designed to fit China's wide geographic and socioeconomic variations across provinces and rural versus urban areas.

In Section 2.3, we draw on standard public finance and health economics theory, as well as the more recent incomplete-contracting theory of property rights, to summarize the comparative advantages of government and market for financing and delivery of health services, particularly in developing and transitional economies. We describe and analyze the transformation of China's health sector and recent commitment of government funds against this theoretical background.

The first three sections feature positive economic analysis; the final section summarizes normative judgments and policy recommendations for China's health system reforms.

2. Performance of China's health system: an international comparison

To analyze how China's population health and health system have evolved during its transition from a centrally planned to a market-based economy, we examine how China's health system indicators have changed, compared to other countries and relative to income per capita. We use analogs of the famous ''Preston curve'' exploring the relationship between life expectancy and gross domestic product (Preston, 1975).[3] Figs. 1 through 5 present data on health, health care and economic

[1] For recent overviews of China's health sector reforms, see Ma, Lu, and Quan (2008); Eggleston (2008); Evans and Xu (2008); Yip and Mahal (2008); and Wagstaff and Lindelow (2008).

[2] For example, Indonesia and China both dramatically decreased under-five mortality rates from similarly high levels in the mid-1960s, but with divergent paths. Indonesia achieved steady falls in under-five mortality rates along with increases in per capita income. By contrast, China's under-five mortality rate fell rapidly during a period of meager economic growth to a level that was by 1980 comparable to that of Indonesia in 1995. However, China's under-five mortality rate has virtually stagnated since then, while per capita income has grown dramatically (Wagstaff, 2004).

[3] See Deaton (2004) for the millennium version.