

# Recent Health Care Financing Reform in China and Taiwan

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## Health Care Financing Reform in China

- Introduction
- Urban Health Financing Reform
- Rural Health Financing Reform
- Conclusions
- Future Challenges

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## Socio-Economic Background

	1980	1990	2000
GDP (billion RMB)	452	1855	8940
(Real Term, 1980)	452	916	2204
Population (million)	987	1143	1266
Urban (%)	19	26	36
Per Capita Income (RMB)			
Rural areas	191	686	2253
(Real Term, 1980)	191	339	555
Urban areas	439	1387	6280
(Real Term, 1980)	439	685	1548

Source: www.stats.gov.cn

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## National Health Expenditure

	1980	1990	2000
<b>National health expenditure (billion RMB)</b>	<b>13</b>	<b>74</b>	<b>476</b>
<b>( Real Term, 1980)</b>	<b>13</b>	<b>37</b>	<b>117</b>
<b>Government (%)</b>	<b>36</b>	<b>25</b>	<b>15</b>
<b>Social insurance (%)</b>	<b>40</b>	<b>38</b>	<b>25</b>
<b>Personal (%)</b>	<b>24</b>	<b>37</b>	<b>60</b>
<b>% of GDP</b>	<b>2.9</b>	<b>4.0</b>	<b>5.3</b>
<b>Per capita health expenditure (RMB)</b>	<b>13</b>	<b>65</b>	<b>376</b>
<b>( Real term, 1980)</b>	<b>13</b>	<b>32</b>	<b>93</b>

Source: Zhao Yuxin, China National Health Expenditure Report in 2000

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## Health Service Utilization in 1998

	Rural	Urban
Outpatient		
Two-week visiting rate (‰)	165	162
Per-visit-expenditure (RMB)	45	160
Inpatient		
Hospital admission rate (‰)	31	48
Per-admission-expenditure (RMB)	1532	4037
Annual medical expenditure per capita (RMB)	134	247

Source: National Health Survey Report in 1998, MOH, P.R.China, 1998 .

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## Reasons for not seeking outpatient care

	Urban	Rural
Don't feel sufficiently ill (%)	39	35
Economic difficulties (%)	32	36

Source: National Health Survey Report in 1998, MOH, P.R.China, 1998

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## Reasons for asking for discharge

	Urban	Rural
Difficult to recover (%)	13	7
Economic difficulties (%)	46	61

Source: National Health Survey Report in 1998, MOH, P.R.China, 1998

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## Uninsured Population

	1993	1998
Urban (%)	46	58
Rural (%)	87	90

Source: Dr. Rao Keqin, "Transitional Economy and Health Reform" (presentation) to Hospitals and Development under Market Principles in China (Dalian, Feb., 2003)

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## Urban Health Financing Reform in 1994

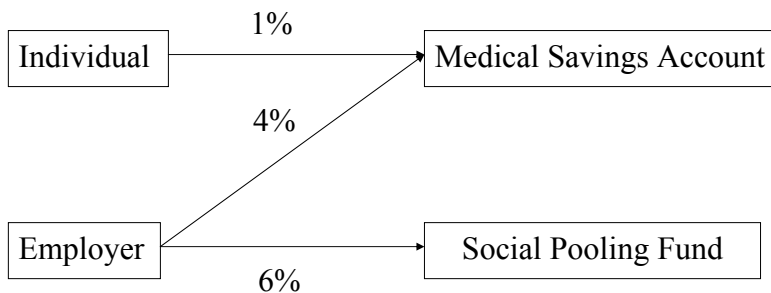
- Combine GIS and LIS into single system
- Individual Medical Savings Account (MSA)
- Pilot in two counties:

Zhenjiang, Jiangsu Province

Jiujiang, Jiangxi Province

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## MSA Pilot Financing Scheme



Source: [www.molss.gov.cn](http://www.molss.gov.cn) "Comments on Urban Medical Insurance reform Piloting"

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## MSA Pilot Payment Scheme

- MSA used for both outpatient and inpatient expenditure
- Deductible before drawing the social pooling fund: 5% of individual annual income
- Co-payment scheme under social pooling fund
  - < RMB 5,000: 10%
  - RMB 5,000-10,000: 8%
  - > RMB 10,000: 2%

Source: [www.molss.gov.cn](http://www.molss.gov.cn) "Comments on Urban Medical Insurance reform Piloting"

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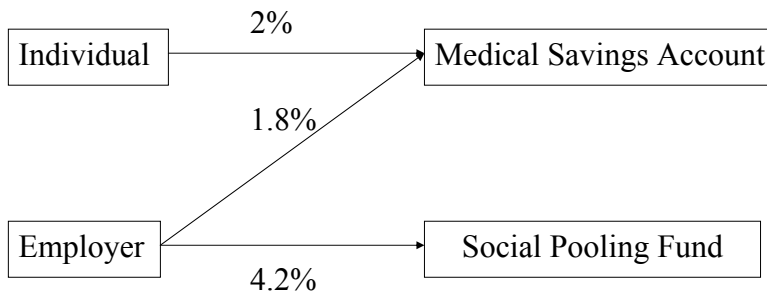
## Medical Insurance Reform in 1998

- Institutional reform: jurisdiction transferred from MOH to MOLSS
- Implement New MSA countrywide
  - MSA used for outpatient expenditure
  - Social pooling fund for hospitalization
  - Payment ceiling: 4 times annual income

Source: [www.molss.gov.cn](http://www.molss.gov.cn) "Decision on Urban Medical Insurance reform" in 1998

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## Medical Insurance Reform in 1998



Source: [www.molss.gov.cn](http://www.molss.gov.cn) "Decision on Urban Medical Insurance reform" in 1998

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## Issues of the New MSA

- Delay doctor visit to save money
- Hospitalization substitutes outpatient visits
- Large accumulation of social pooling fund
  - In 2003, revenue of RMB 86.5 billion and expenses of 63.6 billion.
  - Second round reimbursement

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## Urban Medical Insurance Coverage

	Population Coverage (million)
1998	51
1999	59
2000	43
2001	73
2002	94
2003	109

Source: Presentation made by Vice Minister of MOLSS, Dongjin Wang at China medical insurance conference on Feb 17, 2004

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## Urban Health Financing Reform

- Drug formulary in 2000
  - “clinically necessary, widely used, safe, and efficacious, and having price advantage of the same therapeutic class”
  - A category drug: National level (327 Western, 135 Traditional)
  - B category drug: Provincial level  
Up to 15% adjusted

Source: [www.molss.gov.cn](http://www.molss.gov.cn)

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## Urban Health Financing Reform

- Initiate provider cost control
  - Case payment
  - Global budget

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## Rural Health Insurance Coverage

	Population Covered (%)
1976	90 <sup>a</sup>
1981	62 <sup>b</sup>
1993	13 <sup>b</sup>
1998	10 <sup>c</sup>

a For villages covered by CMS. Source: Li, Weiping, Zhang, Licheng, Zhu, Peihui, "Options for Rural Health Security in China's New Policy Environment—Synthesis Report" 2002

b Source: World Bank 1984

c Source: National Health Survey Report in 1998, MOH, P.R.China, 1998

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## Community-Based Organized Financing Experiments in Rural areas

- Sichuan Rural Health Insurance Experiment (1989)
- IHPP and UNICEF: The Study of Thirty Poor Counties (1992)
- IHPP and IDRC: Finance of Health Service in Poor Rural China (1993)
- WB Funded Health IV Project (1993)
- WHO: Fourteen County Study of Community Financing (1994)
- IHPP and UNICEF: Chinese Rural Health System Research (1996)
- WB Funded Health VIII Project (1997)

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## Issues under CMS experiments

- Not enough financing
  - Limited financing ability of households
  - Limited subsidy from local government
  - The impact of fee-to-tax conversion reform
- Adverse selection in enrollment in the scheme
- Unattractive benefit package
- Poor quality of health service delivery system
- Failure to control cost under fee-for-service plan
- Lack of farmers' trust in fund management

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## **New Cooperative Medical System (NCMS)**

- Implemented by MOH (Ministry of Health)
- Multiple source financing: 10 Yuan from Central Government, 10 Yuan From Local Government and 10 Yuan From Households
- Mainly cover catastrophic disease
- Voluntary participation
- Piloting in each province
- It is expected to enroll all the rural people by 2010.
- Fund pooled and managed at county level

Source: [www.moh.gov.cn](http://www.moh.gov.cn) "Decision on Enforcing the Rural Health Care" in 2002 21

## **Medical Financial Assistance System (MFA)**

- Implemented by Ministry of Civil Affairs
- Targeted groups: low income families
- Fund sources: local government, central government and social donations.
- Combined when NCMS is available.
- 2-3 demonstration counties each province
- Fully established by 2005.

Source: "Suggestions on the Implementation of Medical Assistance in Rural China" in 2003

## Conclusion (I) Urban Reform

### Urban Health Financing Reform

- Expand risk pooling to expand coverage into urban area and employee dependents
- From demand side cost control to provider side cost control

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## Conclusion (II) Rural Reform

### Rural Health Financing Reform:

- Past experiments have found numerous challenges.
- Central government has taken leadership and provided subsidies to establish NCMS
- Supplement with low income medical insurance

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## Future Challenges

- China still has a large uninsured population (58% in urban and 90% in rural)
- Need to develop a systematic and integrated health care financing system
- Reimbursement still uses fee for service

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## Health Care Financing Reform in Taiwan

- Introduction
- A Decade of Achievement
- Challenges
- Ways Forward

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# Health Care Reform in Taiwan

## Time Schedule

- Planning Period 1989-1994
- Legislation 1994-1995
- Implementation 1995

## Population coverage

- |          |            |
|----------|------------|
| Pre-NHI  | 1995 (57%) |
| Post-NHI | 2003 (99%) |

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# Features of Taiwan National Insurance Coverage

- Compulsory universal coverage
- Uniform comprehensive benefits
- Financing by payroll tax and government subsidies
- Low finance rate (2003: 4.5% of gross wages)

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## Features of Taiwan Health Care Payment System

- Single payer
- Fee-for-services
- Low consumer cost sharing
- Mixed payment scheme: case payment, DRG, Global Budget

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## Features of Taiwan Health Care Delivery System

- No referral
- Private sector dominance
  - Doctors in private practice: 97%
  - Private hospitals: 85%
- Hospitals compete with clinics for outpatient services

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## A Decade of Achievement

- Equity
- Efficiency
- Satisfaction

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## Equity in Financing of Taiwan's NHI

- Measured by WHO's Fairness of Financial Contribution (FFC) index
- Equity in the financing of Taiwan's health care has improved\*:  
0.881 (1994) → 0.991 (1998)

Source: Bureau of National Health Insurance, Department of Health, Taiwan

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# Achievement of Taiwan National Health Insurance

Moving from health protection to social protection

- Health protection – access and utilization
- Social protection – avoid poverty due to illness, not lower basic standard of living

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# Efficiency in NHI Administration

- Electronic claim processing
- Smart-card (IC Card)
- Low administration cost (1.76% of total health expenditures)
- Slow down the rate of increase in NHI

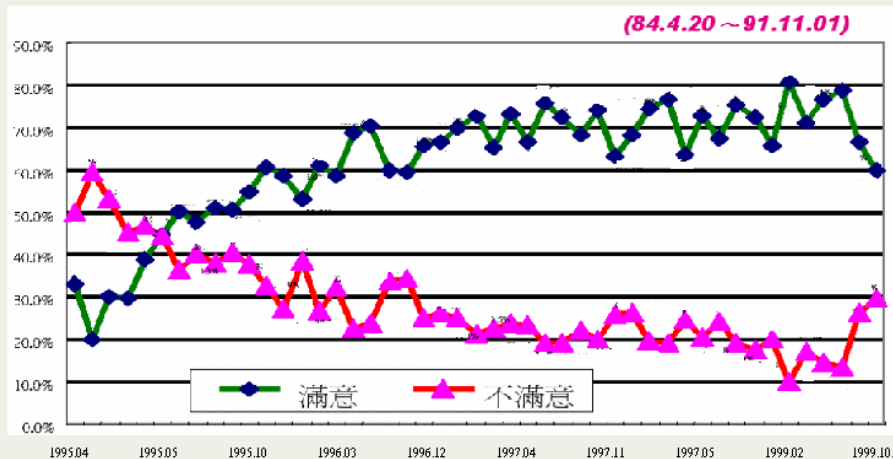
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# Impact of Taiwan NHI's Establishment on Total National Health Expenditure

<u>Year</u>	<u>NHE/GDP (%)</u>	<u>Increase NHE (%)</u>	<u>Increase GDP (%)</u>
1992	4.77	13.44	10.98
1993	4.88	13.39	10.85
1994	4.93	10.44	9.21
<b>1995</b>	<b>5.27</b>	<b>15.99</b>	<b>8.58</b>
1996	5.29	9.82	9.41
1997	5.27	8.06	8.47
1998	5.33	8.59	7.33
1999	5.46	6.37	3.93
2000	5.44	3.65	4.02

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Public Satisfaction with NHI



Satisfied--yellow  
Unsatisfied--red

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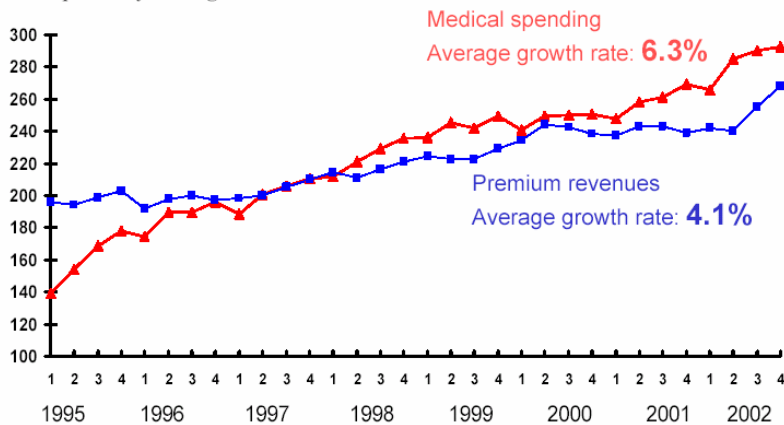
# Challenges

- Financial status
- Consumer excess use
- Provider efficiency
- Additional services

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## Trend of NHI Financial Status

Unit: quarterly average in NT\$bn



Source: Bureau of National Health Insurance, Department of Health, Taiwan.

## Excess Use of Outpatient Visits

Korea	8.8
Hong Kong	8.0
Taiwan	14.4
Canada	6.4
U.S.	5.8

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## Consumer Share of Total Health Spending

	<u>Taiwan</u>	<u>Korea</u>	<u>Japan</u>	<u>Hong Kong</u>
Public	66	56	78	54
Private	34	44	22	46

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# Consumer Concerns on Five Health Care Systems

(Australia, Canada, New Zealand, U.K., U.S.)

- Coordination of care: waste and conflicting information
- Patient safety: medication and medical errors
- Doctor-patient communication: MDs do not ask or explain
- Heavy reliance on medication: serious side effects and interaction effects

Blendon R. et al., *Health Affairs*, May/June 2003

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# Additional Services

- Prevention and Health Promotion
- Long-term care

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# Ways Forward

- Financing
- Demand side
- Provider side

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# Financing

## Revenue funding

- Generate more revenue – Tobacco Tax
- Higher premium or higher payroll base

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## Demand Side

- “No claim bonus” (refund one month premium) Western European experiments
- Higher risk sharing for lower payroll deduction
- Regulate private insurance market
- Higher copayment

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## Provider Side

- Key mechanism for translating funding and practice with outcomes
- Innovation on payment side – bonus payment according to quality measurement
- Risk contracting
- Global budget by individual hospital or by region
- Eliminate balance billing

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## What do we learn from comparing these two systems?

- Health system is a product of political, social, and economic systems.
- Health system reform is a dynamic process to balance among the competing goals of easy access, cost containment, and quality outcome.
- Financing and organizations are two key control knobs to achieve an efficient and effective health care system.