Editorials

Financing and organization of China's health care

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The development of a health-care system depends on a country's economic, political, social and cultural background. Because of China's transformation over the last 20 years from a socialist economy to a market economy, China's health-care services have been converted from social and public goods to market goods without government planning or intervention. Liu's article (*1*) in this issue clearly describes the transformation and its consequences for both urban and rural health-care systems. Differences in economic growth and in financing, organization and resources between urban and rural regions have made China a country with two health-care systems. The urban system has more resources and is better organized, but is faced with major financing and organization issues and concerns about cost-containment, whereas the rural system lacks resources and is not well organized, and difficulty of access causes concern.

Liu correctly points out that two key control points in health-care reform are organization and financing: they are interrelated and require coordination for health-care services to function efficiently and equitably. In China, however, the financing and administration of health services are segmented: the Ministry of Labour and Social Security is responsible for the urban health insurance sector, the Ministry of Health for the rural sector, and the Ministry of Civic Affairs for poor urban and rural households. The Ministry of Health is therefore in a weak position to lead the necessary reform of the health-care system at the central government level.

In towns, decentralized health insurance organizations manage health-care financing for at least half the population, and this structure can be built on to expand and reinforce the financing and delivery of health services at the local level. In rural areas, however, such facilities are lacking. Numerous rural health insurance experiments were launched to restore the cooperative medical system of the early 1960s, with support from UNICEF, WHO, the World Bank and other international organizations. Virtually none of these systems was sustained after the experiments ended, for several reasons:

- Insufficient support from the local or central government meant that farmers were essentially self-insured on a voluntary basis, resulting in financial hardship;
- The central government prohibits imposing additional taxes on farmers. Local officials were worried that insurance premiums could be interpreted as an additional tax;
- Low insurance premiums resulted in limited benefit coverage, in terms of low reimbursement rates (20–30%) for both outpatient and inpatient services;
- The services of village doctors and township hospitals are inferior in quality to those received in county or urban hospitals, so farmers preferred to travel to urban areas;
- Farmers were distrustful of the local government insurance fund management and worried that their insurance premiums might be diverted to other uses.

A new cooperative medical system under the Ministry of Health should organize a primary care service to use village doctors in a referral system. This could require financial incentives, such as capitation payments or prepaid services.

The budget currently provided by the central and provincial authorities is not sufficient to cover a large uninsured population or to provide health promotion and disease prevention activities. Because the central government has routine budgetary allocation, it may not be easy to shift monies to the health sector. One major untapped financial source is cigarette taxation, which contributes about 10% of central government revenue (*2*). The overall tax rate on cigarettes is relatively low: about 40% of the retail price, compared with the international median tax rate of about 66% (*3*, *4*). Portions of an additional tobacco tax — which could improve the health of the population by reducing cigarette consumption — could be earmarked for health-care insurance funds and health promotion and disease prevention for rural or low-income families. Tobacco taxes have successfully been used for health-care financing in, for example, Australia, Thailand and some states of the USA. The economic benefits of additional revenues from tobacco taxation for the central government and health care for the Chinese population greatly outweigh the negative economic impact on the tobacco industry and tobacco farmers (*5*).

During the last two years, especially following the outbreaks of severe acute respiratory syndrome (SARS), the Chinese Government has recognized the importance of investing in health; improving health-care services has become a key element in economic development plans. The long-term goal of the Chinese Government is to make China a "moderate well-being (Xiao Kon) society". By reforming the financing and organization of health care, China can establish a system that provides health protection (in terms of improved access to and utilization of services) and social protection (in terms of reduced poverty caused by illness) for its population. ■

1. Liu Y. China's public health-care system: facing the challenges. *Bulletin of the World Health Organization* 2004;82:532-8.
2. *China Statistical Yearbook*. Beijing: China National Statistical Bureau: 2000.
3. Hu T. Cigarette taxation in China: lessons from international experiences. *Tobacco Control* 1997;6:136-40.
4. Mackay J, Eriksen M. *The tobacco atlas.* Geneva: World Health Organization; 2002.
5. Hu T, Mao Z. Effects of cigarette tax on cigarette consumption and the Chinese economy. *Tobacco Control* 2002;11:105-8.

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