Examining Health Care in China and the U.S.

One of the interesting parts about school is the opportunity to explore different worlds, cultures and ideas. In this paper we have been able to examine the health care system of two very disparate countries. Although they are very different, China and the U.S. also share something very important. These two countries are two of the world’s individual juggernauts, one of economics and representing things so very ‘West’ and the other of population representing socialism and the Far East.

CHINA

Health care options in China

- State paid medicare (gongfei yiliao): This covers only those working for the governmental agencies and is the responsibility of the State Personnel Ministry.
- Labor medicare (laodong yiliao): This should cover all enterprises and is the responsibility of State Labor Ministry.
- Co-operative medicare (hezuo yiliao): This mainly covers the rural areas in China and is formed by rural residence on the basis of voluntary for the purpose of risk-sharing and helping each other.
- Social insurance (shehui baoxian): This kind of medicare system only exists in a few provinces and cities and is under direct control of local governments.
- Commercial insurance (shangye baoxian): This kind of medicare system at present only covers a very small portion of residence.

The fact is that currently in China, only less than 10% of the total population, say 79.2 million by the end of June of 2003\(^1\), most of who are employees of some state-owned enterprises and retired staff, have been covered by medicare and the rest of the 90% are basically not covered by any means of medical insurance. In rural areas only 12.56% of the population is covered by medicare to any certain degree, among which 6.5% are thru the form of co-operative medicare which is currently ineffective.

\(^1\) Source: People Net [http://www.people.com.cn/GB/shizheng/19/20020730/787776.html](http://www.people.com.cn/GB/shizheng/19/20020730/787776.html)
The trend of current health care system in China

For the state paid and labor system, the ratio of invoicing is gradually decreasing. It is predictable that in a couple of years these two kinds of medicares will only be maintained to cover the most basic medical needs. Also, the demographic coverage will also be shrinking with less and less state presence in the economy. For the co-operative medicare once very popular in rural areas (over 90% by the end of 1970s), its role is being weakened, even disappearing. However, until now the Chinese government could not find an effective and viable solution to compensate its role.

China’s health care goal for 2010

By 2010, reduce the maternal mortality ratio and infant mortality rate by one fourth and one fifth compared to those in 2000. During the same period, increase the average life expectancy by 1-2 years.

PROBLEMS IN THE HEALTH CARE SYSTEM

Pharmaceuticals

There is an overwhelmingly “high” price for medicine. In China, the pharmaceutical expenditures for outpatients and inpatients are 55.4% and 44.4% respectively of the total medical expenditures in 2002. While in US, the comparable average percentage is only 9.4% in 2000. According to a report by one Chinese customer’s agency, about 50% of the Chinese population who are ill do not “dare” to go to hospital. One of their concerns is the high pharmaceutical price. Though the absolute price of medicines in China, compared with international standard, is still low, we can not deny that there are many drawbacks in the system leading to the unreasonable high price of medicines. The main problems lie in monopolies in the distribution channel and state owned hospitals. In addition, narrow insurance coverage of private drugstores and the bundling and selling of medicines and providing medical service at the same time in hospital.

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2 Source: The National Health Care Development Statistical Report, 2002 Ministry of Health, P. R. China
3 Source: CMS at www.hcfa.gov/stats/nhe-oact/tables/nhe00.csv, 2002
4 Source: www.zaobao.com Nov. 5, 2003
Out of Pocket Costs –
Out of Pocket costs are currently a far too high a percentage of health care. In China at present, patients living in the rural area have to pay for about 90% of the medical expenditures out of their pockets, while the figure for urban patients is also as high as 60%.\(^5\) The weighted average is 63.4%.\(^6\) The drawback of the high rate of out of pocket payment is that the medical service provider could easily abuse the asymmetric information against patients and arrange overdose for the patients leading to unnecessary waste. Since this practice involves a profit it does happen. Consequently, the patients are less willing to visit medical service providers, which usually cause greater damages in the end. The entire system falls into a vicious circle.

What makes the situation worse is that the average income of farmers in China is only about one third of those living in urban areas. So the bottleneck of China’s health care coverage issue lies in her rural areas. The co-operative system is becoming less and less popular in China. The goal is to utilize the co-operative system for heavy diseases only in the rural areas by 2010. The Chinese government has recently committed to allocate at least RMB20 yuan (about 2 euros) each year per head as subsidies for all her middle and western rural residence in order to encourage the re-establishment of the co-operative system and increase the health sector infrastructure.

Concentration of Resources
Currently in China there is an irrationally high concentration of health care resources which is unsuitable to the current situations. For the state paid and labor system, the state and its related enterprises could not afford the ever-increasing medicare expenses. Part of the reason is that the main players in the system, say hospitals and distributors are still operating at very low efficiency with huge waste of resources. Another headache is the regional gap in economic development. Situations in the poorer areas are much worse than those regions which are further along in economic development. The inequality

\(^5\) Source: Chen Xiwen, The Development Research Center of the State Council (DRC), PRC, November 19, 2003
\(^6\) Source: Sun Binyao Chinese Academy of Social Science
exists between the urban and rural areas is as follows: the urban residences, which only stand for only 15% of the total population, enjoy 75-80% of all the health care service, among which two thirds are then allocated to big hospitals. While the vast 85% rural residences could only share less than a quarter of the resources.

**No laws to Protect Participants**

For co-operative medicare, the lack of the assurance of law makes the participants, mainly poor peasants feel insecure, and then increasing reluctant to participate in any health care plans. As to the funding, the state has not instilled enough financial support until recently. All these issues lead to the very limited coverage and functionality of the co-operative medicare system, which itself discourages its further expansion and development. Last but not least, there is no effective monitoring over the service providers, which means that the quality of the co-operative medicare system is not what it could be and becomes unattractive to anyone seeking health care.

**Results of Current System**

The statistics below show the results of the above inefficiencies. The gap of the ratio of total medical expenditure over GDP between developed countries (8%) (except US: 13%) and China (5.37%)\(^7\) is not that huge. There are more than three health care staffs per 1000 population in China. As per WHO\(^8\), the total health expenditure per capita of China in international dollars is 205 compared to US’s 4,499. However, the rate of total health care expenditure over GDP in China is already 5.3%, the level of Greece in 1993. Furthermore, the ratio has already surpassed 10% in China’s rural areas, similar to that of US as a whole in 1980s. Considering the extremely low cost of medical staff, we have to blame a lot on the low efficiency of medical system in China, especially in rural areas.

**U.S.**

**Current System**

- Private Insurance

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\(^7\) Source: WHO reports
\(^8\) Source: [www.who.int/country/chn/en](http://www.who.int/country/chn/en) Accessed on October 17, 2003
• State Funded Health Care
  o Medicare
  o Medicaid

PROBLEMS WITH THE CURRENT SYSTEM
We recognize that these are very broad categories, but since the system is way to large to analyze here we are going to focus on the part of U.S. health care which is most in need of improvement as well as the part that is closest to China’s Health care system.

Medicaid. Medicaid is a health care coverage program funded by the national government in for low income Americans. It currently has over 50MM beneficiaries

As far as it is able it is a good system which really helps the cover the poverty level Americans. However, there are some serious flaws in the system.

Eligibility
One of the flaws is the requirements for eligibility. The requirements are strict and very few people qualify. There are many people who we would certainly consider below an acceptable level. The current income level of Medicaid recipients can not exceed $748 and month and $1500 a month for a family of four. This is not anywhere near acceptable living wages where rent averages over $900 a month for 1 bedroom apartments, certainly not enough for living in most major cities.

Low Socioeconomic Status
Therefore, people who can not afford health insurance and are not covered by Medicaid are at a serious disadvantage in the current system. I will focus on two specific groups as examples of people with low socioeconomic status that are ignored by the system.
First, studies show that 1/3 of elderly immigrants have to rely on Medicaid instead of Medicare, and do not have access the same quality of programs as other elderly people

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9 Medicaid demographic statistics
10 Medicaid online application process
who are U.S. Citizens. When unable to get Medicaid (because of requirements of needed to work in the states for 40 quarters) senior immigrants join what is a much larger group of people who do not qualify for health insurance.

Secondly, another large disaffected socioeconomic group in the health care system is the group of younger African Americans. Currently 1 out of 11 African Americans reports not receiving health care for economic reasons compared to 1 out of 20 Caucasians. In addition, African Americans have a death rate that is 1.6 times higher than the Caucasian population\textsuperscript{12}. This inequality is disturbing and clearly unacceptable. And it also leads to what is mentioned above, the continued overuse of emergency rooms as the only form of obtainable health care.

These disaffected groups have only one alternative for receiving health care - the emergency care room of hospitals. And, that generally comes when they are already very sick. This is a very ineffective way to treat patients both from the health care network and the patient standpoint. Emergency rooms are the most expensive way for health organizations to treat people and health organizations would much rather treat the systems early with general practitioners. Frankly, the patients would be better off if their conditions were diagnosed early and had a chance to get better before getting to the serious stage required for an emergency room.

This inequality does more than harm the psyche of low socioeconomic groups it also harms the bottom line.

**Pharmaceuticals**

This is such a large well documented category that I will focus on only one small issue, and that is how the costs affect people in the lower socioeconomic category of health care consumers. Similarly, to China out of pocket costs are a big source of problems for low income consumers of health care. There is a tremendous increase in the trend of out of

\textsuperscript{12} “American Journal of Public Health” May 2003, Vol. 93 Issue 5
pocket costs in the U.S. in prescription drugs. They went from 15% of the out of pocket costs for patients to 30%. This can be a terrible burden and needs to be reduced.

Political Rationing of Resources
So much of the low income money in the states is spent on the elderly with fixed incomes. While this is important I believe that the tax dollars are not being allocated appropriately because of the strong voting power of these constituents. One poll stated that 25% of the voters in the next presidential election will be senior citizens\textsuperscript{\ref{footnote}}. This serious political power should not be used to inappropriately utilize resources.

RECOMMENDATIONS

Privatization
Any comparison of the U.S. and China would be remiss if it did not include a section on privatizing the health care sector since this is a main differentiator of U.S. health care. We believe that China would benefit greatly from making parts of its health care system privatized, but that the state should continue to be the main financing. We believe that China should privatize its care giving institutions. The reason for this is that it would make these institutions responsible towards their patients and dramatically improve their patient care. Currently, they are only responsible towards their bosses and their bosses are government officials. The system is corrupt and it is the patients who suffer. By making the care givers responsible for profits (and thus ultimately their customers) China can improve its health care.

Reducing the relatively high price of medicines.
China - In the field of distribution of medicines, China should abandon the existing approval system and adopt the registration system. Besides the dominant public capital, other forms of capital like private and foreign should also be allowed to invest in the distribution system to encourage competition. Also, it doesn't make any sense for the hospital to force the patient to buy the medicine at the same hospital. Customers should

\textsuperscript{\ref{footnote}}“Managed Healthcare” April 2001 ‘AAHP Advocates Tax Incentives on Medicare Pressure’
be endowed the decision right where to buy the prescribed medicine in wherever they want.

At the same time, the state should gradually lower the entry restriction for hospital and broaden the insurance coverage to non-state owned drugstores and hospitals. When all these measures are taken collectively could more competition-lead higher efficiency and lower cost for medicine be expected in China.

Another way to fight the unreasonable high medicine price is the stricter auditing of prescription. Since the “information” between hospitable/doctor and patients are often asymmetric, the government should play a more forceful ethical watchdog role fighting with immoral hospitals and doctors.

U.S. – One of the most effective measures the government has been able to take is to grant more freedom to the generic drug companies and we believe that it should continue to do so. In addition, Health Maintenance Organizations have been able to use their leverage to secure rebates and other forms of cost reduction which have had some success. It is a sticky issue without a concrete resolution because of the high cost or producing the drugs. However, pharmaceuticals are consistently averaging %20 profit margins so there does seem to be some give in that department.

**Financing**

China - The Chinese government could refer to the practice of many countries to channel part of the taxation from smoking to medicare, especially for rural areas. Another alternative is to issue state health care bond to collect money which method the Chinese authority has not tried yet. The major issue here is the financial creditability of the bond based on the efficient operation of the money. The government agencies have to strengthen their co-operate governance making the bondholders feel more transparency and being insured. Setting up the individual account for medicare is another method to collect money which has been adopted by a few cities in China but not widespread. The concern here again is the efficient and secure use of the fund.
In addition, many fund contributors suspect the security of the funds that have been deducted from their salaries. Some of the extremists even believe that the governments are using these funds to fill in the black hole in the financial system and they will never be able to reclaim the money when they get old. All the above methods are based on the trust of the people giving the money for the operators of the fund, who, in most cases in China, is the government or its related agencies.

U.S. - There are two ways that the U.S. government tries to subsidize low income health care. The first is through direct payments in the Medicaid program and the other is using tax breaks for workers to ‘buy’ health insurance from pre-tax dollars. However, both of these solutions have problems. First, federal funding is only so deep and as the budget deficit grows it becomes harder and harder for the government to allocate funds for any program. Although health care always is important clearly the supply is not inexhaustible nor does is currently cover everyone.

Secondly, the way that the tax breaks are structured dooms them to fail. Tax breaks gives employees the ability to pay pre-tax earnings for health care. This means they are not taxed on the dollars spent. However, since their tax brackets are relatively low the incentive to ‘give up’ money is not there. The cold truth is that unless they are sick at the time most people in this category would rather spend their money on things they need/want than health insurance. In addition they also know that they are able to get into the emergency room as a back up plan. Thus, while intentions are good the tax breaks are relatively ineffective.

Emergency Room
Both China & U.S. - In order to be effective in reducing the costs of health care it is important to address the issue of emergency room use. As mentioned above this is the most costly way of treating people. And the costs ripple downstream and health care costs are rocketing for everyone. In 2000 alone there was over $21.6 Billion in U.S.
uncompensated hospital care\textsuperscript{14}. The easiest way to address these costs is to get the patients in the door of health care centers before they are so sick they need an emergency room. Of course this is easier said than done.

However, governments can help themselves by not administering the health care program themselves. In addition states are starting to make it mandatory to belong to some type of managed care organization (or something along those lines HMO, PCCM etc.). This is fairly effective in getting people in the door of health clinics and the like. Studies show that people are more likely to go the doctor early if they have a primary care physician.\textsuperscript{15} By catching problems earlier and keep people from the emergency room thus lowering health care costs for everyone. Although this system is certainly far from perfect (retraining clients to go to doctors instead of emergency rooms is difficult), it is never the less effective and should be implemented further. It makes everyone’s dollar go further.

**Expand the portion of transfer payment**

In order to increase the system efficiency and strengthen the monitoring of resource allocation and utilization, the Chinese government should expand the ratio of transfer payment against total medical expenditure, which is too low at present – only about 10% in rural areas. Larger transfer payment could increase the accessibility of medical service in rural areas and press the service providers to increase efficiency. The international experiences have proved the effectiveness of this practice, i.e., paying the service providers per head or per treatment.

The formation of transfer payment in rural areas could only depend on the investment of the government, not commercial or coercive social insurance at present. If the government could allocate RMB200 yuan (about 20 euros), the total amount for 800 million rural residence is about 16 billion euros every year which the government could definitely not afford at present. So the government has to be careful about the sequence

\textsuperscript{15} “American Journal of Public Health” May 2003, Vol. 93 Issue 5
and priority of its goal and encourage the wider participation of peasants and other resources.

The sequence should be from service to medicine, the priority should be from primary health care service to hospitalized health care. In most parts of the town-level areas in China, the government could consider the elimination of hospitalized service and only provide general medical service. Those so-called “all-around” general physicians would only provide specialized service in principle. The farmers, with the financial support of government, contribute to the pool of primary medical service and sign annual contract with their preferred general physicians. The general physician will be paid upon his coverage of heads.

CONCLUSION

Although the countries China and the US are completely different there are some striking similarities in the health care for their low income citizens. Both countries have work to do in order to have equality in their respective health care systems. The most important of those being that each system needs to improve in how it serves health care to its citizens who have low socioeconomic status.