The medical savings account (MSA) model of health care financing is viewed as a health care cost containment strategy. Yet, health care expenditure in Shanghai has increased sharply since the adoption of the MSA system. This paper looks into the health care reforms in Shanghai, especially since the introduction of the MSA scheme.

From the Labor Insurance Scheme and Government Insurance Scheme to the Medical Savings Account scheme, ordinary Shanghai residents have not benefited from the most recent health care reforms. They have found medical care much less affordable. Disparity in access to health care access has become more evident than ever. Meanwhile, health care cost has increased sharply. China has benefited from an emphasis on prevention and primary care, but the government’s recent policies give a high priority to catastrophic disease. This is not a cost-effective approach. Shanghai’s health care system needs to break socioeconomic class boundaries if it is to construct a harmonious society. Shanghai’s decision makers and various stakeholders have the resources and wisdom to face the challenge.

Keywords: Cost containment; health care insurance; medical savings accounts; health care access; Shanghai.

1. Introduction

The escalation of health care expenses has become a common phenomenon in most countries in recent decades. How to contain health care cost, therefore, has become a universal concern. Various strategies were developed in different nations for coping with this pressing issue. Most governments turned to markets for help — privatizing health care facilities, for example, or sharing the financial burden with individual citizens through cost-sharing schemes and user fees (service charges). One of the strategies developed has been the medical savings account (MSA) scheme, first adopted in Singapore to contain health care cost and to prevent moral hazard. It is a method of cost sharing that has two components: (1) a compulsory savings account from which medical expenses are paid and to which contributions are made by both the individual and the employer; and (2) a high-deductible insurance plan that covers catastrophic medical expenses. Individuals are expected to take responsibility for their own health. They are encouraged to pay their own medical care cost from their own savings.
Since the implementation of the MSA scheme in 1984, health care cost in Singapore has been low — 3% or 4% of GDP (Hanvoravongchai, 2002). The experiment has attracted other governments to the well-performing Singaporean health care system. South Africa implemented MSA scheme in 1994 (Matisonn, 2000). The United States passed a law in 1996 allowing private insurance companies to offer MSA scheme. China also adopted the Singaporean model. Shanghai was the first major urban center that implemented MSA scheme in China, in 2001.

This paper will discuss health care in Shanghai, especially since its adoption of the MSA scheme. The discussion will include the impact on health care access and health care cost.

2. Shanghai and Its Health Care

Shanghai is one of the most dynamic cities in China today. With about 17 million residents in only 0.1% of China’s land, Shanghai used to provide one-fifth to one-fourth of the central government’s revenue. The percentage is one-ninth now. Currently, there are 7.45 million people employed in various sectors in Shanghai. Of these, 21.9% work in the state-owned sector, 33.2% in the collective-owned sector, 44.9% in the private sector, and 27.1% in foreign ventures and other sectors. Shanghai has seen an incredible expansion in its private businesses in the last two decades. Private businesses exceeded 50% of all enterprises in the city since the first quarter of 2002. It is a big change from the pre-reform era when almost all of the enterprises and firms were state-owned or collectively-owned.

Another major change alongside the emergence of private enterprise is the disappearance of the full employment policy. When Shanghai firms shifted the nature of their businesses from labor-intensive to technology- and/or capital-intensive production, the structural change took jobs away from many middle-aged workers. It also posed a great challenge to the young job seekers and millions of rural migrants. An alternative employment strategy for them has been to take whatever job is available. Often, these are low-wage, no-benefit jobs in the informal sector. However, Shanghai still has about one million people unemployed. This is a challenge to traditional employment-based social benefit programs, including health care coverage.

With 140 thousand health care professionals and widely available traditional Chinese medicine as well as new technology, Shanghai people’s health status is among the best in China. Table 1 shows a general picture of today’s population health in Shanghai. Life expectancy has reached 81 years of age, and about one-fifth of Shanghai residents are seniors (Shanghai Statistics Bureau, 2007). The obvious health care challenge in Shanghai is how to provide adequate and affordable care for the elderly and decent access to basic care for the large number of unemployed residents.

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Table 1. Shanghai at a Glance

<table>
<thead>
<tr>
<th>Index</th>
<th>Shanghai (2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land (km²)</td>
<td>6,340.5</td>
</tr>
<tr>
<td>Population (million)</td>
<td>16.74</td>
</tr>
<tr>
<td>Life Expectancy at Birth (years)</td>
<td>80.97 (M78.64, F83.29)</td>
</tr>
<tr>
<td>Infant Mortality (%)</td>
<td>4.01</td>
</tr>
<tr>
<td>Maternal Mortality (1/100,000)</td>
<td>8.31</td>
</tr>
<tr>
<td>Health Care Professionals (thousand)</td>
<td>140</td>
</tr>
<tr>
<td>60 Years and Over (%)</td>
<td>20</td>
</tr>
<tr>
<td>MSA Enrolment (million)</td>
<td>7.3</td>
</tr>
<tr>
<td>Retirees (million)</td>
<td>2.76</td>
</tr>
<tr>
<td>Registered Unemployment (%)</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Source: Shanghai Statistics Bureau (2006).

3. Pre-Reform: A Health Care Miracle

In the sphere of health, the health status of Shanghai residents has improved over the years since the establishment of the People’s Republic in 1949. Shanghai residents had low incomes but high welfare. Welfare programs included health care that was free or supplied at very low cost. They enjoyed full employment and lifetime employment guarantee. Most Shanghai adults were entitled to the Labor Insurance Scheme (LIS), the Government Insurance Scheme (GIS) or the Cooperative Health Care Scheme through their own employment or a family member’s employment. The LIS covered those who were employed in the state-owned enterprises, which also covered half of the cost of medical care for their dependents. The GIS covered those who worked in the government bodies and the state-run institutions. Local collectively-owned institutions and enterprises provided their employees with Cooperative Health Care Schemes (see Table 2 for details).

Table 2. Shanghai Employees’ Health Care Coverage Prior to Reform

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Work Unit</th>
<th>Health Care Scheme (LIS), Since 1951</th>
<th>Coverage for Beneficiary</th>
<th>Coverage for Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Enterprise</td>
<td>Labor Insurance Scheme (LIS), Since 1951</td>
<td>Unlimited including prescription drugs</td>
<td>Yes (50%)</td>
<td></td>
</tr>
<tr>
<td>Institution Government Insurance Scheme (GIS), Since 1952</td>
<td>Unlimited including prescription drugs</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local collective Large-scale enterprise/insurance Small-scale enterprise</td>
<td>Work Unit Labor Insurance Scheme</td>
<td>Unlimited including prescription drugs</td>
<td>Yes (50%)/No (or depends on employer’s ability)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Dong (2003).
These health care insurance schemes, illness prevention measures and a well-established health care delivery system ensured the improvement of Shanghai people’s health status. For example, Shanghai population’s life expectancy increased dramatically from barely above 40 years of age at the beginning of the 1950s to nearly 80 years of age by the year 2000 (see Figure 1). Both the infant mortality rate and the maternal mortality rate in Shanghai have declined over the years (see Figure 2).

The reduction of the infant mortality rate was particularly dramatic. It was 120 per thousand in the first days of the new People’s Republic. By the year 1956, the number was halved.

The complementarity of the full employment policy and employment-based health insurance schemes ensured the maximum coverage of the population. Almost everyone in Shanghai was covered. Although China was a low-income nation with limited health care resources, the health status of the Chinese population reached that of the middle-income countries by the
1970s. Emphasis on disease prevention made health care a high priority in the government’s agenda, which benefited the nation as a whole.

Health care expenditure started to escalate after the economic reforms at the end of the 1970s. The rise was especially great when the state allowed the market to play a role in almost all sectors in the 1980s. Shanghai’s health care expenditure has been rising steadily ever since. In 1990, per capita Shanghai household annual expenditure on health care was 11.40 yuan; in 1995, it increased to 112.82 yuan; and it reached 346.93 yuan in 1999 (Dong, 2003). This resulted mainly from three factors. First, the health care institutions were fully funded by the government, and the cost of personnel was not counted prior to the economic reform. Second, drug prices in Chinese hospitals were set by the government at a level lower than the cost. Third, life expectancy increased. An ageing population with more chronic diseases demands more medical attention.

Thus, finding a new way to finance health care became an urgent issue for the Chinese central and local governments. After they learnt that the Singaporean system was both economical and effective, the Chinese government adopted the same model in urban China. When the State Council issued the Decision on the Establishment of the Urban Employees’ Basic Health Care Insurance System in 1998 (State Council, 1998), Shanghai followed the guidelines to formulate its MSA scheme.

4. Post-Reform: The MSAs

As the first Chinese metropolis to implement the new health care policy, Shanghai started to introduce its MSA scheme in the spring of 2001 (Dong, 2003). Table 3 summarizes the main characteristics of the scheme.

Shanghai’s system combines two funds: Unified Plan (UP) and medical savings account (MSA) scheme. The unified plan is a citywide risk pool. It is designed to cover partial cost of the in-patient, emergency room care, the treatment of catastrophes, and the expenditures

<table>
<thead>
<tr>
<th>Table 3. MSA Scheme in Shanghai</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective of the scheme</strong></td>
</tr>
<tr>
<td><strong>Covered population</strong></td>
</tr>
<tr>
<td><strong>Enrolment principle</strong></td>
</tr>
<tr>
<td><strong>Holder of the MSA fund</strong></td>
</tr>
<tr>
<td><strong>MSA fund contributor</strong></td>
</tr>
<tr>
<td><strong>MSA fund contributions</strong></td>
</tr>
<tr>
<td><strong>MSA spending</strong></td>
</tr>
<tr>
<td><strong>Health care financing tiers</strong></td>
</tr>
</tbody>
</table>

Source: Dong (2006).

Drugs in China were mainly distributed in hospitals — each hospital has a pharmacy department.
Table 4. Shanghai Employees’ Medical Savings Account

<table>
<thead>
<tr>
<th>Age</th>
<th>% of Last Year’s Average Wage</th>
<th>% of Last Year’s Personal Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 and over</td>
<td>4.5</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Retirees 74 and under</td>
<td>4</td>
<td>Not applicable</td>
</tr>
<tr>
<td>45 to retirement</td>
<td>1.5</td>
<td>2</td>
</tr>
<tr>
<td>35–44</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Under 34</td>
<td>0.5</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Dong (2003).

between the deductible and the ceiling. As Table 4 shows, the usable amount differs according to the individual’s age (i.e., senior, middle-aged and young), personal income level and employment status (i.e., employed or retired). Among the insured, older and retired people receive the highest percentage of coverage.

Under the new health care financing system, the medical insurance funds are made up of payments by employers of an amount equal to 10% of their employees’ annual salaries, and by employees of an amount equal to 2% of their personal annual salary. The employee’s share is paid through payroll deductions (Hu, 2000).

The employment-based health care insurance system designed by the policymakers was aimed to offer certain health care benefits to employees of work units that joined the social risk-pooling Unified Plan. Since formal sector units are most likely to join the plan, the new health care insurance predominantly covers the employees in the formal sector and specifically in large-scale firms.

5. Shortcomings of the MSA Scheme

The MSA scheme in Shanghai has been in operation for more than six years. The shortcomings include entitlement exclusion, limited coverage, supplier-induced utilization, worsening doctor-patient relationship, no containment on health care cost, and absence of risk-pooling.

5.1. Entitlement exclusion

In Shanghai, only the employees of the work units that have joined the city’s Unified Plan are entitled to MSA scheme (Dong, 2003). Informal sector and small-scale firms tend to be left out. Thus, the MSA scheme excludes most employees from the informal sector, the unemployed and employees who are informally employed in formal sectors, such as migrants and the reemployed. These are marginalized social groups, with high health risk. Even though the Shanghai government has urged all work units to join the city’s Unified Plan, many employers do not have an incentive to do so (Dong, 2004). This is especially true for firms with relatively young employees and firms which are relatively small in size. Informally employed workers are outside the Medisave plan in Singapore too (Khaw, 2007). Only about two-fifths of the Shanghai residents are enrolled in the MSA scheme.
5.2. Limited coverage

The MSA scheme provides reduced benefits compared with the former Labor Insurance Scheme (LIS) and Government Insurance Scheme (GIS). The LIS and the GIS had almost no coverage limit on beneficiaries’ health care expenditures. The MSA deductibles and the patient’s share of the cost are too high for many. The deductibles are set as a percentage of the city’s average wage and not of the individual’s wage (see Tables 5 and 6). This is too high for the low-income groups, because Shanghai has severe income disparity.

Singapore’s income disparity is quite severe too (Department of Statistics, 2000). The Singaporean health care delivery system reflects the distribution of income. For example, poor patients can check in to a C-class ward, with less privacy and no air-conditioning, in order to pay less out-of-pocket. Rich patients can choose an A-class ward and enjoy their stay in the hospital. Most Shanghai hospitals do not distinguish wards by class. This is encouraging as far as equal access is concerned. The MSA scheme in Shanghai does provide incentives for patients to seek care in primary hospitals (community health care centers); where the patients’ out-of-pocket portion of the medical bill is smaller (see Table 5). However,

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Out-of-Pocket Before Cost-Sharing (% of Last Year’s Average Salary)</th>
<th>Patient Share of the Medical Care Cost (in Primary/Secondary/Tertiary Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Employed (%)</td>
</tr>
<tr>
<td>Retirees</td>
<td>2</td>
<td>—</td>
</tr>
<tr>
<td>45 years and older</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>34–44</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Younger than 34</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>New employee</td>
<td>10</td>
<td>100</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Age Group</th>
<th>Initial Out-of-Pocket Payment (% of Last Year’s Shanghai Average Wage)</th>
<th>Coverage Ceiling</th>
<th>Patient Share (% of In-Patient and Catastrophic Disease Care Cost)</th>
<th>Over Ceiling Out-of-Pocket (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirees</td>
<td>5</td>
<td>4 times of last year’s Shanghai average annual wage</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Other age groups</td>
<td>10</td>
<td>Same as above</td>
<td>15</td>
<td>20</td>
</tr>
</tbody>
</table>

because most patients demand high quality care services and want to see more qualified and trustworthy doctors, tertiary hospitals are always the most crowded health care settings in Shanghai.

5.3. Supplier-induced utilization

Since the implementation of the MSA scheme in Shanghai, many people do without health care even when it is necessary. In order to make profits, health care providers require patients to undergo both necessary and unnecessary diagnostic tests. Suppliers prescribe expensive drugs and extend the in-patients’ stays. Since patients do not usually have information and knowledge to decide what level of medical care they should acquire, they are dependent on their doctors’ judgments. Phua (2002) found this to be the case in Singapore as well. Arrow’s (1963) theory is still valid.

5.4. The doctor–patient relationship has worsened

The mass media in Shanghai have exposed numerous scandals related to health care and the financial difficulties people face in health care. Trust in doctors has been undermined in recent years. A survey result shows that the general public is not satisfied with the health care provided and the order of dissatisfactions are ranked as follows:

1st: The cost of obtaining health care is too high.
2nd: Many drugs are overpriced and doctors prescribe unnecessary medicines.
3rd: High-tech tests are being recommended by doctors when they are not necessary.
4th: Health care resources are being wasted.
5th: The doctors’ work ethic has declined, where many aim at financial gains through commissions and under-the-table payments.
6th: Hospitals too are profit-centered.
7th: Poor attitudes of doctors with insufficient care in their patients’ needs (Hao et al., 2002).

Another survey reveals that merely 43% of the patients think that they can trust their doctors. Only 26% of medical professionals think that there is mutual trust between the patients and doctors (Yin, 2004).

5.5. Health care cost is not contained

Statistics show that the MSA scheme in Shanghai has failed to halt the health care expenditure from escalating (see Figure 3). In fact, since the adoption of the MSA scheme, health care expenditure in Shanghai has risen sharply. In 2001, overall health care service rate dropped by 30%, but the health care expenditure was up by 10% (Dong, 2003). In the five years of MSA scheme practice, the Shanghai Health Care Insurance Bureau has accumulated a deficit of 2 billion yuan (Chen, 2007). The number of persons covered by the MSA scheme was less than the LIS and GIS. The enrollees receive significantly reduced coverage compared
with the LIS and GIS. The major reductions involve:

(i) Fewer people included — Most of the dependents of the LIS beneficiaries who used to receive partial coverage are now excluded. The unemployed and informally employed are mostly without coverage.

(ii) Cap on coverage — The new scheme has a ceiling on the individual’s health care expenditure, which is four times the average annual wage of Shanghai. Previously, the cover was not controlled.

(iii) Higher cost to consumer — Enrollees in the new scheme have to pay cost-shares and high deductibles. Previously, health care was free or with minor usage fees. The premiums contributed for the new scheme can only cover about 70% of the total outlay that is possible under LIS and GIS.

The government has continuously been reducing its financial input to health care. The individual’s share of health care cost has increased dramatically in the last two decades. The MSA strategy may have helped the government to pay less. Yet, the health care expenditure is rising sharply (see Figure 3). Since the implementation of the MSA scheme, the health care expenditure has gone up at an average annual rate of around 15.4% (Shanghai Statistics Bureau, 2006).

5.6. No risk-pooling

Since the MSA scheme relies on personal responsibility, and the medical savings accounts belong to each individual, healthy people should be able to accumulate solid medical savings for future usage. The unhealthy, however, would not have enough funds in their accounts for necessary care. It would be particularly difficult to pay for medical attention if they do not have outside resources. Those with chronic diseases and those who are among the long-term unemployed are usually unable to accumulate sufficient savings for necessary care. A study done by the Development Research Center (DRC) of the State Council of China shows that after the adoption of the MSA scheme, about 50% of Chinese people did not seek care when
ill (DRC, 2005). In Shanghai, people’s care-seeking behavior has also changed a great deal. Many people now choose to buy over-the-counter drugs at the pharmacies instead of seeing a doctor in the hospital.

5.7. Lack of health care funds

The operation of the MSA scheme in Shanghai has not been smooth. The Shanghai Health Care Insurance Bureau is not able to generate enough funds to operate fully. This has affected health care access for MSA enrollees. The Shanghai government used to spend 17%–19% of the city’s average salary bill on health care. The new system allows local governments to collect a proportion of the salary bill (6%–10%). This is much less than previous health care funding (Dong, 2003). Moreover, retirees make up about one-third of the enrollees in the MSA scheme in Shanghai. They are exempted from paying premiums. The large ageing population is, however, utilizing a significant proportion of the health care resources. The Shanghai Health Care Insurance Bureau does not have enough funds to pay the hospitals on time. Hospitals therefore are biased towards non-MSA clients when admitting in-patients (Dong, 2004).

6. Debate on the Limitations of the Original MSA Model

The shortcomings of the MSA scheme in Shanghai show that this scheme does not serve the population well. The MSA scheme is not the right choice for Shanghai. Considering the Singaporean experience with MSA scheme, it is clear that the scheme in Shanghai has inherited some of the weaknesses as well as strengths.

Critics have argued that the conceptual framework of the Singaporean health finance system is parsimonious and paternalistic (Barr, 2001). It has been called a system in which the government makes decisions for its people (Barr, 2001; Schmidt, 2004). The definition of Singapore’s “basic health care” excludes some procedures and illnesses. Singaporeans’ access to health care depends directly on their ability and willingness to pay (Barr, 2001; Hsiao, 2001).

The Singaporean government’s official calculations show that health care expenditure absorbed 3%–4% of the nation’s GDP. This is one of the lowest ratios among the developed countries. However, Singapore’s absolute expenditure on health care has increased by 11%–13% annually since the introduction of the MSA scheme (Barr, 2001). Whether or not Singapore has managed to contain the cost is debatable (Ham, 2001; Dong, 2003; Lim, 2004). In a country where nearly 75% of its population is ethnic Chinese, traditional Chinese medicine is excluded from Medisave reimbursement. It is evident that Singapore’s health care cost would be higher if the care provided in Chinese medical halls was included. According to Hanvoravongchai (2002), the Singaporean government’s health care budget increased from S$350 million in 1980 to nearly S$2 billion (S$1.932 billion) in 1999. With a 80:20 private-public health care cost-sharing (Kolesnikov, 2002), Singapore’s system of health care finance was ranked by the WHO at 6 out 191 nations overall, but at 101 in terms of fairness (Ham, 2001). In Singapore, no one was ever denied care for lack of money (Lim, 2004). Yet,
Box 1. Evaluation of the Medical Savings Account Scheme

<table>
<thead>
<tr>
<th>Efficiency:</th>
<th>high administrative costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity:</td>
<td>enrolment exclusion, lack of risk-pooling, gaps in coverage</td>
</tr>
<tr>
<td>Sustainability:</td>
<td>access affected by individual level of savings, lack of funds for operation</td>
</tr>
<tr>
<td>Responsiveness:</td>
<td>provider-induced choices of utilization</td>
</tr>
</tbody>
</table>

the Medisave scheme has no rich-poor flow of resources and is therefore unequal (Schmidt, 2004). Non-standard employees often lack coverage because their employers do not pay their Medisave premiums (Khaw, 2007).

Some say that the Singaporean system is a low-cost, high-outcome system. It offers the consumer a choice of providers and protects the quality of care (Taylor and Blair, 2003). Others argue that there is no risk-pooling, but instead an emphasis on personal responsibilities and cost consciousness (Ham, 2001). Provider-led spending has been described as a big problem (Schmidt, 2004). Patients are said to have been encouraged to upgrade from lower-to higher-priced beds, sometimes beyond their means (Phua, 1997). Although Singapore’s Medifund program, which acts as a safety net, has helped many of the poor to access health care with little financial burden, these financial supports are limited. For example, an average bill for C-class (open ward) in-patient care was S$858 in 2006, but the average Medifund subsidy per applicant was S$138 (Khaw, 2007). Most people still need to arrange funds personally for their medical care needs (Dong, 2007). In fact, Singaporeans see family ties as their “risk-pooling” resort (Schmidt, 2004; Reisman, 2005, 2006). It is the same in Shanghai (Dong, 2003). Singapore’s “healthy life expectancy” is 70 years of age. According to Tucci, this is at the lower end among developed nations (Tucci, 2004).

A standard way of evaluating any health care financing scheme is to look at its efficiency, equity, sustainability and responsiveness. When the MSA scheme is placed under these microscopes, the results are not entirely satisfactory (see Box 1).

7. Social Fragmentation in Health Care

The segregation of health care entitlements in Shanghai is considerable. Members in one household can have different entitlements to different health care benefits. In fact, the diversity in health care benefit entitlement reflects overall social disparity in Shanghai. Instead of a uniform health care plan, there are several different plans for different social groups and age groups. They include, but are not limited, to the following schemes:

(i) “Red Card” and “Blue Card” holders: each retired revolutionary veteran is given a Red Card, which entitles the holder to access free health care. Each senior official (bureau chief level and higher, in post or retired) has a Blue Card for access to health care at a

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4A Red Card holder only needs to pay 0.1 yuan as registration fee when seeking care.
token cost. This is similar to the Government Insurance Scheme. It offers full coverage without premiums.

(ii) Formal sector employees and retirees are partially covered through their MSAs.

(iii) Informal sector employees and rural migrants are mostly without cover, or have to pay high premiums in order to enrol in the MSAs.

(iv) Infants, primary school children, secondary and high school students, and registered Shanghai residents under 18 years of age are entitled to special basic insurance (in-patient and catastrophic). It covers 50% of medical care expenses and was implemented in September 2006.

(v) Students enrolled in colleges and universities in Shanghai can enrol to an insurance plan that covers in-patient and catastrophic illness. It pays 80% of the hospital bill (90% of the bill in a college or university clinic). There is a deductible for in-patient care. This plan was implemented in April 2007.

(vi) On 10 July 2007, the State Council issued The Guidelines for the Trial of the Urban Residents’ Basic Health Care Insurance (State Council, 2007). Shanghai is likely to design and implement its own scheme soon. The plan will be for catastrophic disease. Enrolment will be voluntary.

The poor and the near-poor are at high risk of ill health. They rely on the government’s policies for protection. Yet, recent health care policies have legitimized existing social inequalities. People who do not have comprehensive health care coverage have to forego treatment. This is so even for those who do not consider themselves as poor and have enrolled for MSAs (Dong, 2003; DRC, 2005). Being a patient is a luxury that they cannot afford.

A recent move by the central government was the attempt to provide some basic catastrophic coverage for all urban residents. Upon issuing the Guidelines for the Trial of the Urban Residents’ Basic Health Care Insurance, Premier Wen Jiabao stated that the new system mainly focused on the urban unemployed, especially school children, elderly people and the disabled. Urban residents who are not covered by the MSA scheme can apply to be enrolled in the new plan (Zhao, 2007). It is a very positive move. However, “voluntary enrolment” is likely to exclude poor people who have difficulty in paying the premiums. Also, the policy only covers catastrophic treatments. Most of the high risk population as well as the general public need primary and preventive care.

China gave a high priority to prevention and primary care in the 1950s and the 1960s. The country then had limited health care resources. Prevention and primary care were thought to be more cost-effective. Many people will not have to experience catastrophic illness if disease is diagnosed and cured in time. The assumption that most people can afford basic health care but not catastrophic disease treatment (Sun, 2007) is not true. A recent national health care service survey shows that nearly half of the people forwent necessary health care in 2003 (Ministry of Health, China, 2004). Some of them will experience more severe

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5A small amount of registration fee when visiting a doctor at a hospital, ranging from 0.1 yuan to a few yuans.
diseases later on. They will require more costly health care services. The postponement will certainly jeopardize the health status of the nation.

In order to cope with the implementation of the MSA scheme, the Civil Affairs Bureau of Shanghai launched a Medical Care Financial Aid Program at the end of 2000. From 2001 to April 2007, the program has provided 477 million yuan to 400 thousand poor Shanghainese. The program’s main target was people without medical insurance, especially the young and old from low-income groups. It also increased the annual maximum amount of assistance per patient from 5 thousand yuan to 15 thousand yuan in 2005. It handed out 60 thousand health care cards with a value of 500 yuan each so that low-income people can seek care in community hospitals. In a most recent move, the Civil Affairs Bureau of Shanghai extended its health care aid program to around 10% of the city’s population (Zhang, 2007).

8. Conclusion

The cost-sharing model has been widely viewed as a cost containment strategy, although there is no hard proof that it can achieve this. Shanghai’s experience shows that cost-sharing schemes have limited effectiveness. They have had only limited success in restricting demand. The providers’ response to a drop in the demand for health care would be supplier-induced demand: they would insist upon excessive usage of diagnostic and therapeutic services and of high-cost prescription drugs. In the end, overall health care expenditure would not be lowered, but patients’ out-of-pocket spending would be high. Evidence from both Shanghai and Singapore demonstrate that this can happen.

The Shanghai government is making efforts to provide reasonable health care coverage. However, the segregated system makes health care management a difficult task. Many Shanghai residents used to enjoy free or inexpensive health care. The adoption of the MSAs has made health care access more unequal. In order to construct a harmonious society, Shanghai’s health care system needs to cut through the socioeconomic boundaries. Moreover, preventive and primary care are cost-effective. They have to be included, if not emphasized, in social health insurance.

If there were no universal basic health care scheme on the horizon, and if MSA-style insurance were to continue, the Shanghai government would have to make sure that people under a certain income threshold had a basic health insurance package. These people would be exempted from premiums and deductibles. Otherwise, the vicious cycle of bad health-poverty would never end.

With Shanghai’s wealth and the wisdom of Shanghai’s leadership, a more reasonable health care system is achievable. The key variable is the willingness of the stakeholders and the decision-makers to expand on what they have constructed.

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