A STUDY TO INVESTIGATE THE ROLE OF DISPARITIES IN THE CHINESE HEALTH-CARE SYSTEM

XIULI HAN

Research Scholar of Lincoln University College, Malaysia. Email: xiulihan123@gmail.com

TUKIMIN BIN SANSUWITO

Lecturer of Lincoln University College, Malaysia.

SARINA BINTI JAMALUDDIN

Lecturer of Lincoln University College, Malaysia.

Abstract

The astonishing rise of China's economy bodies well for the country's population's health. When it comes to health care, economic growth can be both a boon and a bane. The latter includes growing inequities across the socioeconomic spectrum, rising healthcare expenditures, and a lack of efficiency in the health-care delivery system. The paper's main goal is to find out if China's healthcare system has any inequalities or inefficiencies. Next, it tries to figure out whether and how the New Rural Cooperative Medical Scheme (NCMS), a recently established social health insurance programme, addresses concerns with healthcare inequity and efficiency in China. Various analytical methods are used in this work, including the Concentration Index, Decomposition Analysis, Two-part Regression Analysis, and Differences-in Differences analysis. The China Health and Nutrition Surveys from 2004 to 2009 are utilized to compile the data. This paper's findings show that health and health care disparities are widespread in China, favoring those from higher socioeconomic status. Most of the health inequities for rural people are due to socioeconomic causes. The health situation of the urban poor is shockingly worse. In 2003, the NCMS was implemented in rural regions to help rural farmers have equal access to healthcare and financial security. Researchers found that even though NCMS coverage was at 97 percent in 2009, low-income people used informal care such as preventative care more often than high-income people. They may also struggle to pay for the care they require and be forced to spend a large portion of their salary on it. According to this study, the NCMS might worsen healthcare inefficiencies by leading to an increase in healthcare costs. The prereimbursement expenses per episode for NCMS members are substantially greater than those for the uninsured. Village clinics and township health centers-the backbone of the health system for impoverished rural farmers—see a greater increase in pre-reimbursement expenses than county and municipal hospitals.

Keywords: New Rural Cooperative Medical Scheme, pre-reimbursement, socioeconomic, inefficiencies, pre-reimbursement expenses, socioeconomic status.

1. INTRODUCTION

Poor people's health results are always and significantly worse (World Health Organization, 2008, World Health Organization, 1996). Some of the most important efforts made by governments throughout the globe to minimize health disparities are focused on eliminating socioeconomic disparities in health outcomes as well as inequities related to fairness of health finance, which have a direct impact on access.

Recent years have seen a lot of attention paid to the disparities in health and healthcare in China. Since China's market reforms began in 1978, the country's economy has grown at an incredibly rapid pace. The Chinese people's health has greatly improved as a result

of the country's rapid economic growth, but the disparity in wealth has led to expanding healthcare inequities. A rising collection of evidence shows that the gap between the affluent and poor in terms of health continues to increase (Akin et al., 2004, Gao et al., 2002, Liu et al., 2012b, Luo et al., 2009, Meng et al., 2012, Yip and Hsiao, 2009a). Statistics show that impoverished Chinese had higher death and morbidity rates than wealthy counterparts between 1980-2000; they also used less health services while having greater need (Centre for Health Statistics and Information, 2008). The majority of rural Chinese farmers were uninsured due to a lack of insurance coverage. Healthcare financing was dominated by OOP (out-of-pocket) expenditures that were expensive for most Chinese households in general and particularly for the poorest of the poor (Gu 2008).

Since the introduction of market-oriented reforms in the early 1980s, China's regional differences have grown. While some places have seen a major increase in economic activity and social and political change, others have seen a more gradual shift (Sun et al., 2011). The disparity in health status between urban and rural areas is growing, according to empirical findings.

People of rural areas in the transitional era, which is associated with rising inequalities in income and health care consumption between rural and urban populations. In urban regions, life expectancy is 74.2 years, but in rural areas, it is 69.6 years (Zimmer et al., 2010, Sun et al., 2011). China's differences in child health also extend to a wide variety of variables. As many as 123 infants died in rural areas in 2006 compared to just 26 in the wealthiest rural areas, a difference of nearly five times. There are significant discrepancies between urban and rural areas in terms of the health care systems and insurance policies, both of which are thought to contribute to disparities in health. These developments are linked to changes in health care finance and organization, notably a major fall in rural population insurance coverage and a more relaxed public health approach.

In various parts of China's health system, there has been growing criticism about the inefficiency of health care delivery. A series of national health reforms began in China's Ministry of Health in the early 1980s, which aimed to decentralize health administration duties and to enhance productivity by providing financial incentives to medical personnel. A strategy of "financial autonomy" was promoted to hospitals so that medicine and service profits could be used to offset the loss of government subsidies. All but a few hospitals have taken full responsibility for their own earnings and losses by the early 1990s. In all, it was anticipated that fees would pay 85 percent or more of the expenditures of state-owned hospitals (World Bank, 1997). In order to make a profit, these medical facilities responded by prescribing high-priced medications and performing high-tech operations on their patients. Costs for health care rose, as expected, and this posed a significant difficulty for rural residents who did not have access to any form of public health insurance at the time (SHI). Frugality and high medical expenditures were the primary factors cited by 45.8% of rural pinkun (poor) households in 2008. (Centre for health and information, 2008).

2. LITERATURE REVIEW

The country of China is the subject of this dissertation. For a variety of reasons, China is picked. "Serve the people," "remove social classes," and "equity" have all been utilised as guiding principles in China's social sector since it was the first and only country in East Asia to choose Socialism as its governing philosophy.

The study of health care fairness and efficiency in China is enhanced by an understanding of the country's long-term evolution of its healthcare system. Provisions for healthcare were initially based mainly on an egalitarian basis when the new republic was established in 1949. Following the market-oriented reform in 1978, China began to liberalize its health industry. In the 1980s, the traditional commune-based rural health insurance system began to crumble. The vast majority of Chinese citizens lacked health insurance coverage at the dawn of the twenty-first century, save for those in metropolitan areas who were legally employed in the commercial or public sectors. The cost of healthcare becomes prohibitively expensive for most people. Healthcare in China is plagued by "a flawed pricing structure, growing financial constraints and widening healthcare inequity," according to academic research (Huang, 2000).

With regard to evaluating new efforts, the nature and magnitude of the health equity difficulties that Chinese policymakers confronted at the start of the 2000s provide particularly rich background. Over the last few decades, the gap in health between the affluent and the poor has become wider. The impoverished Chinese have higher death and morbidity rates and use fewer health services than the poor in the United States (Centre for Health Statistics and Information, 2008) These disparities may be due to the fact that the poor face different limitations than the affluent, such as lower earnings, a lack of health insurance, and a lack of health expertise. People in urban slums and rural villages alike are at danger of water, sanitation, and hygiene-related illnesses due to a lack of basic requirements including access to safe drinking water and sanitary facilities (Hussain, 2003). Poor people in China, regardless of where they reside (urban or rural), have consistently lower health and fewer means to keep it that way (O'Donnell et al., 2008). This is alarming.

The health equity concerns of the 2000s prompted a variety of initiatives to be implemented. The launch of the NCMS was one of the most remarkable of these efforts. The programmer was originally tested in a few regions, and then quickly spread over the entire country. More than ninety percent of rural residents were reached in less than five years by the NCMS (Babiarz et al., 2012, Hao et al., 2010, Lei and Lin, 2009). Toward this end, the NCMS was highly specific. According to the original plan, the rural population, which accounts for about a third of all people, would be the first to benefit from universal health care.

A large majority of the people. According to the 2003 insurance policy paper, the NCMS should be used to ensure that all rural residents have equal access to healthcare, regardless of their gender, work position, education, preexisting conditions, or money. There was coverage for inpatient, outpatient and preventative therapies (Ministry of Health

China, 2002). A number of cost-effective outpatient therapies were left out of the NCMS when it was initially introduced in 2003 with the goal of providing rural farmers with financial protection against catastrophic inpatient care. According to Ministry of Health P.R. China et al., 2007, the programmer added several outpatient services to its benefit package. This addition was expressly designed to increase access to basic healthcare for all citizens.

3. RESEARCH GAP

It is impossible to judge China's healthcare system's equality and efficiency (Akin et al., 2004, Gao et al., 2002, Gao et al., 2001, Li and Yu, 2011; Liu et al., 2012a; Lu et al., 2007; Meng et al., 2012) without a thorough grasp of China's healthcare sector's history and changes. An overview of China's healthcare system and a full explanation of the social health insurance reform are presented in this section. When it comes to healthcare, it begins by looking at how the Chinese healthcare system has evolved over the decades. Finally, China's healthcare system and the issues encountered by policymakers in the 2000s are discussed in detail, followed by a review of the SHI system in China. The information in this chapter is critical to the remainder of the thesis's papers' comprehension.

China's Cooperative Medical Scheme (CMS) was the primary source of healthcare for rural people prior to the economic reforms of 1978, under which residents paid a nominal yearly fee to help finance basic treatments from Barefoot Doctors, most of whom worked for little or no compensation at the time. The programme played a vital part in ensuring that rural populations had access to basic health services and needed medicines at a relatively cheap cost, and it was hailed as a successful model in the developing world by the Chinese government (Zhang et al., 2010b, Ma et al., 2012). However, once the People's Collective Communes was disbanded in the late 1970s and early 1980s, China's rural health system, particularly the CMS, was no longer sustainable (Ma et al., 2012, Yan et al., 2011). 90% of rural farmers had access to basic health care and some financial insurance against catastrophic disease in the 1970s, but within a decade that percentage had dropped to 5%. In terms of health care, the rural dwellers were mostly on their own.

The Government Insurance Scheme (GIS) and the Labour Insurance Scheme (LIS) were the two primary components of China's urban social medical system when it was originally founded in the 1950s (LIS). Both of these plans were aimed at metropolitan dwellers. Central and municipal governments supported GIS, mostly for use by civil officials. Prescription medication could only be obtained by GIS beneficiaries by visiting one of many authorized hospitals. There was no payment for both outpatient and inpatient care services. When the company was started in 1951, its target audience was city workers. Some of the costs of a participant's family's healthcare were covered by this programmer, which was funded by their employer. In metropolitan areas, these two programmers were able to reach full coverage (Dong, 2009).

Health insurance for urban workers in Jiangsu and Jiangsi provinces was piloted by the State Council in 1994. In the subsequent years, China's social insurance system was

shifted to a payroll-related SHI. URI superseded GIS and LIS in 1998, after a four-year trial period in which this new system was tested. All metropolitan employers and workers were required to participate, and premium contributions were to be paid by both the employees and the employers. Employees contributed 2% of their monthly salary, while their employers contributed the remaining 6%. Health insurance for urban workers has been a major focus of the Urban Employees Insurance Initiative (UEI). In 1998, just 5% of the urban population participated, but by 2007, that figure had risen to 64.6 percent (Xu et al., 2007b).

All around the world, health disparities have been acknowledged as a concern. Several studies have addressed the idea that the health of an individual might be influenced not only by the amount of resources accessible to them, but also by the amount of resources available to them compared to their cohort or community (Wagstaff, 2005c, Wagstaff et al., 1993, Liu et al., 1999, Costa-Font et al., 2010). There has been a dramatic increase in economic inequality in China over the past 25 years, and researchers believe that financial differences are a major influence in the disparity of health outcomes (Chen, 2010, Zhao, 2006, Zhang and Eriksson, Zhang and Eriksson, 2010). Despite their greater need for healthcare, Chinese research shows that the impoverished have less access to it than the wealthy. According to O'Donnell et al., 2008b, Fang et al., 2010, Li and Zhu, 2006, the impoverished frequently spend more on healthcare as a percentage of their income than the more affluent.

4. RESEARCH OBJECTIVE & METHODOLOGY

There has been some emphasis devoted to the correlation between urban/rural residency and population health since China's urbanization trend has increased the number of people living in urban regions. According to previous research, health results in urban China were generally better. As an example, the rate of stunting in children was substantially lower in cities than in rural areas in China (Chen et al., 2007). Rural seniors were more likely than urban seniors to have functional limitations, and they were also less likely to have survived a follow-up period of two years (Zimmer et al., 2010). However, the results weren't always the same. Rural children were more likely to be stunted than their urban counterparts, according to a study conducted by Chen et al. (2007). Even while some intriguing results were found in the research cited above, these studies largely focused on comparisons between the average health of urban and rural populations, and most of these studies were descriptive in nature. Reported disparities in health outcomes between urban and rural populations due to wealth disparity are few and far between. Until far, only two studies have looked at the health disparities between rural and urban people in China because of wealth disparity. Several studies by Van de Poel et al. (2007, 2009) examined the association between urbanization and the spread of illnesses in China. According to one of his research, city dwellersmore prone to get non-communicable illnesses in China as a result of the country's rapid urbanization (2009). Van de Poel et al. (2007) showed that urban poor children had greater rates of stunting and death than their rural counterparts in another of their research on child health in 47 developing nations. The findings indicated that initiatives aimed at the urban poor were becoming increasingly important as the urban population rose. Both research employed older versions of the CHNS, thus more current analyses are needed to better understand income-related health disparities in urban and rural China.

5. DATA ANALYSIS & FINDINGS

For the first time, this thesis provides empirical evidence that SHI may be connected with rising costs in China. Affordability issues might arise as a result of the NCMS's overconsumption of pharmaceuticals and over-use of health services. Currently, the Chinese healthcare system is financed through an FFS system. Over-prescription of pricey pharmaceuticals and over-use of health services invoiced to the SHI are the primary sources of revenue for state-owned hospitals. Researchers have discovered that the NCMS is directly linked to rising healthcare costs in China, a fact that policymakers may now use to their advantage. Future reform alternatives, such as altering provider payment mechanisms, price restrictions, and so on, will be influenced by the findings of this research project.

In 1949, the People's Republic of China was established. Poverty, insufficient sanitation and housing issues plagued the country in the 1950s after centuries of feudalism, colonialism, Japanese invasion and civil war. As a result, the health of the populace was exceedingly poor and healthcare resources were extremely limited. There were few doctors and nurses, and basic sanitation and public health services were severely restricted. In 1949, life expectancy at birth was 37 years, infant mortality was around 250 per 1,000 live births, and maternal mortality was about 150 per 100,000. (Anson and Shifang, 2005).

Mao Zedong, the previous Chairman of the People's Republic of China, built a socialist regime based on Marx, Engels, and Stalin's communist philosophy after the country's creation. Mao made a concentrated effort to minimize inequities and achieve universal welfare by implementing a welfare social security system in order to improve the health of the population.

In 1959, the Ministry of Health developed innovative health policies. As part of the four principles, one of which clearly specified that healthcare should be provided on an equal basis, with the largest resources allocated to the lower socioeconomic class—"workers, farmers, soldiers"—the policies were founded on (Economic Intelligence Unit, 1998). A rural co-operative health insurance, which was managed on the basis of the People's Commune1 to cover healthcare at these "labor units," was also devised by Mao. There were 510,000 physicians, 1.46 million Barefoot Doctors2 (Chi Jiao Yi Sheng), and 2.36 million other health care professionals training during that time period (Wang, Zhang and Wang 2007:11). As soon as the Maoists came to power, basic health care standards began to rise rapidly. Survival and life expectancy more than doubled during the period of remarkable decline in neonatal mortality between 1952 and 1982. As a result, there was no matching increase in the economy, and these successes were dependent on the

allocation of extremely limited health resources and the prioritization of preventative public health. The Maoist health care system became a model for developing countries across the world in a variety of ways (World Bank, 1997).

6. CONCLUSION

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An analysis of inequality may be done using the total differential decomposition. It is possible to derive policy implications from these findings. The rural population, according to scientific evidence, is less likely to suffer from poor health among the younger, better-off, and more educated. Income disparity is also a major issue for the urban population. Additionally, educational attainment and employment position have a favourable impact on the total disparities in the population. For urban populations, 76.47 to 79.07 percent of disparities are driven by socioeconomic variables, according to the report. There is a strong correlation between income, employment position, and educational achievement and inequality. Between 48.19 percent and 77.78 percent of the disparity in income and

educational attainment among the rural population may be attributed to socioeconomic variables. A number of prior investigations have shown similar results. Income has a significant impact. According to a study by Wag staff et al. (2005c), child malnutrition in Vietnam was mostly influenced by wealth in the 1990s. Although growing incomes reduced malnutrition and hence lowered average malnutrition, rising incomes also directly increased relative inequality in malnutrition, amplifying the inequality in malnutrition related to income inequality, according to the authors' hypothesis. With this in mind, the 2008 National Health Service Survey found that income was a key driver of health outcomes (Center for Health Statistics and Information, 2008). People are sometimes reluctant to seek medical attention because they are either impoverished or do not have health insurance (Zhao, 2006). Maintaining sustainable development and relieving poverty need efforts to ensure fair access to healthcare and support for the poor and those with specific health needs. According to findings from this study, there is a need for better facilities in urban regions and support for the urban poor if health equity is to be achieved.

Education also has a significant role. There is a strong correlation between education and inequality, and in certain circumstances this correlation is greater than the "pure income impact". A study by Anson and Sun (2004) found a correlation between educational attainment and income in the United States.

China followed the same tendencies as other industrialized nations. Higher levels of education, higher income, and better job status were all linked to better health outcomes. Studying socioeconomic disparities in obesity, researchers Costa-i-Font et al. (2008) discovered that education was a significant factor in explaining obesity. Unobserved effects such as information transfer may have helped people become more health-conscious as a result of schooling, according to the findings of Costa-i-font et al. While some impacts, such as information transmission, may be more efficient, the translation of wealth into a better living environment and healthier food may be just as effective (Costa-Font and Gil, 2008). It was therefore advised that government policies should be coordinated, including the promotion or subsidization of information communication on healthy lifestyles. In the Chinese setting, these conclusions hold true. In order to reduce income-related health disparities, knowledge-based activities aimed at low-income individuals are likely to have beneficial effects (Costa-Font and Gil, 2008, Zhou et al., 2011).

According to this argument, China's healthcare system has critical disparities and inefficiencies. A number of policy suggestions are drawn from the empirical data given in these studies. Papers 2, 3, and 4 provide detailed policy suggestions for rural healthcare, whereas Paper 1 contains specific policy proposals for urban healthcare. The overall recommendations are policy recommendations for the Chinese health system.

The NCMS, or rural health insurance reform, is a primary focus of this thesis. Although the health insurance system has grown significantly, this thesis shows that rising questions about its effects on health equality and in particular whether it has enhanced equitable access and led to a reduction in OOP payment for patients exist despite this remarkable development (see Paper 2, Paper 3 and Paper 4). The following are a few specific policy proposals on how to enhance the insurance's architecture in order to fulfil its aim of enhancing equal access, fairness in funding, and decreasing health costs.

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10. Authors' contributions:

Xiumei Ma was principally responsible for the conception and design of the study. Tukimin Bin Sansuwito and Sarina Binti Jamaluddin supervised and monitored the project.

11. Ethics approval and consent to participate: NA (Not applicable).

12. Consent Patient for publication: NA (Not applicable).

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