

Impacts of the type of social health insurance on health service utilisation and expenditures: implications for a unified system in China

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Abstract

While moving towards unified social health insurance (SHI) is often a politically popular policy reform in countries where rapid expansion in health insurance coverage has given rise to the segmentation of SHI systems as different SHI schemes were rolled out to serve different populations, the potential impacts of reform on service utilisation and health costs have not been systematically studied. Using data from the Chinese Health and Retirement Longitudinal Study (CHARLS), we compared the mean costs incurred for both inpatient and outpatient care under different health insurance schemes, and the impact of different SHI schemes on treatment utilisation and healthcare costs using a Two-part Model. Our results show that Urban Employee Medical Insurance (UEI), which offers the most generous benefits, incur the highest total costs prior to reimbursement when compared to other SHI schemes. Our analysis also shows that utilisation of SHI did not show significant reduction in out-of-pocket (OOP) payments for outpatient care compared to the uninsured. We argue that, unless effective measures are introduced to deal with perverse provider payment incentives, the move towards a unified system with more generous benefits may usher in a new wave of cost escalation for health care systems in China.

Keywords: Social health insurance, China, utilisation, health cost, unification

Introduction

Social health insurance (SHI) has expanded rapidly as a leading health financing tool and has increased health population coverage to many health systems around the world, including an increasingly large number of developing countries (Hsiao and Shaw, 2007). For instance, the beneficiaries of Popular Health Insurance (PHI) in Mexico, one of the leading performers in SHI expansion among developing countries, increased from 5.2 million in 2004 at its launch, to 52.5 million in 2012 (Rivera-Hernandez and Galarraga, 2015). Likewise, in China, individuals with SHI made up less than 15% of the population in 1998 when SHI schemes were first introduced in the formal employment sector and; by 2011, coverage had extended to 95% (Yu, 2015). More importantly, such expansion has occurred not only in terms of the breadth of coverage in the population but also in the comprehensiveness of benefit packages and increased reimbursement rates (Wang et al., 2014).

One of the unintended consequences of this phenomenal expansion is the segmentation of the SHI system across different population covered. In the case of China, for instance, there are three separate schemes for different groups: the Urban Employee Medical Insurance (UEI) scheme covers urban residents with formal employment, the Urban Resident Medical Insurance (URI) scheme covers the urban unemployed, and the New Cooperative Rural Medical Insurance Scheme (NCMS) covers rural residents. Based primarily on an individuals' place of residence (i.e., rural or urban) and occupation, these three schemes differ considerably in terms of levels of premium, coverage of health services and reimbursement rates. Studies have found that health care utilisation is significantly lower among the rural population enrolled in NCMS, as compared to the urban population enrolled in other types of SHIs (Meng et al., 2015). Significantly, the reimbursement rate was found to be 10% lower and service coverage, less comprehensive for NCMS, as compared to UEI and URI (*ibid.*).

Critically, the segmentation of SHI has led to considerable disparities in access to health care and financial protection across different sections of population. Studies have found that

the NCMS had little impact on reducing out-of-pocket (OOP) payments among low income enrollees (You and Kobayashi, 2009; Yang and Wu, 2014); the URI scheme was also demonstrated to have driven up health costs without necessarily reducing OOP expenditures (Liu and Zhao, 2012).

<Table One about here>

<Panel One about here>

Since January 2016, the Chinese Government has begun to phase in the Urban and Rural Resident Medical Insurance (URRMI) scheme across different localities with the aim of merging both URI and NCMS and as a first step towards eventual integration of all existing SHI schemes under a single payer scheme in the near future. Establishing a unified SHI by 2020, with the aim to close the gap of rural/urban health disparity by improving the benefit packages for the rural subscribers, is one of the key priorities of China's health care reform (The State Council of People's Republic of China, 2016).

While it is typically assumed that unifying all SHI schemes to a single insurer system would help to reduce disparities in access and health costs across populations (Hussey and Anderson, 2003), the actual impacts of such unification, however, are far from certain based on the experiences of a number of countries (Atun et al., 2013; Economics Intelligence Unit, 2014; Cheng, 2003). While it is found that the unification of five SHI schemes in Turkey in 2008 led to improved access to care, greater fairness in financing and increased user satisfaction (Atun et al., 2013), experiences in some other Asian countries indicated that the initial stages of SHI integration could be embroiled with fiscal challenges. Indonesia's National health Insurance Scheme –'Jaminan Kesehatan Nasional' (JKN) – launched in January 2014 and aims to integrate various state-owned health insurance schemes into a single payer SHI, met with problems related to financial insolvency due to a surge in health care demand (Economics Intelligence Unit, 2014). Similarly, the expenditures of Taiwan's National Health Insurance (NHI), a government-run, single-payer health insurance scheme, outstripped its revenues during

the first few years. Although the NHI has made health care more publicly accessible, a study has shown that some doctors in Taiwan tend to over-prescribe treatments covered by the NHI scheme to generate more revenue for the hospitals to then multiply their revenue streams (Cheng, 2003).

The recent policy development in China towards a unified SHI system offers a unique opportunity to study how the expansion and improvement of the benefit packages of SHI may influence health expenditures. Moving from the current system of the co-existence of multiple SHI schemes varying greatly in benefits to a unified system may entail enormous cost implications that have so far received little attention. Drawing data from the China Health and Retirement Longitudinal Study (CHARLS), this study aims to examine the impacts of the degree of generosity of different types of SHI on utilisation of health services, total health costs as well as out-of-pocket health costs. Insights derived from this study may not only contribute directly to the policy discourse on current policy reform in China towards a single insurer scheme, but also improve our understanding on the cost and benefit calculations of various policy options in reforming SHI systems as policy-makers in many developing countries are grappling with the challenges in expanding SHI systems towards a more financially sustainable future (Reich, 2016; Hsiao and Shaw, 2007).

Methods

Data source

We drew data from the national survey of CHARLS for the years 2011 and 2013. Commissioned by the U.S. National Institute on Aging, the World Bank, and the National Natural Science Foundation of China, CHARLS is an ongoing, publicly available, internationally collaborative project that collects data from a nationally representative sample of Chinese residents aged 45 and above. This dataset is well suited for our analysis considering

that older adults and elderly populations have a higher propensity for health services, and the subsequent impacts on health costs may have more pronounced effects on them as compared to the younger population. Twenty-eight provinces and autonomous regions varying substantially in terms of geography, economic development, public resources and health indicators were included in the survey. The first round of CHARLS data collection was conducted in 2011, and a follow-up survey was conducted in 2013.

Variable specifications

Dependent variables

The dependent variables chosen for our analysis are: (1) binary variables of the occurrence of inpatient (in the past 12 months) and outpatient (in the past four weeks) visits, and: (2) continuous variables of the total health costs and out-of-pocket (OOP) costs of the most recent inpatient (in the past 12 months) and outpatient (in the past four weeks) visits. Total costs were defined as total inpatient costs before insurance claims were made; OOP costs were those paid by respondents after insurance claims were reimbursed. All costs were adjusted for inflation according to the Consumer Price Index (CPI) for health services in different provinces using 2011 as the base year (National Bureau of Statistics of China, 2013; National Bureau of Statistics of China, 2014).

Independent variables

The independent variables of interest for the present study are the SHI variables—UEI, URI, NCMS, URRMI and no insurance (individuals not enrolled in any health insurance schemes). Specifically, respondents were asked to report the type of insurance they had utilised for the most recent inpatient and outpatient visit.

Our analysis also controlled for a set of factors that may have influenced access/ costs of inpatient care. These included variables for health needs and for non-health needs among the sample population (Jones, 2007; O'Donnell et al., 2008). For health needs variables, our analysis controlled for individual variances that could affect health conditions such as age,

gender, self-reported health (SRH), and number of limitations in Activities of Daily Living (ADL). SRH was categorised into five groups: excellent, very good, good, fair, poor. Four dummies were created, with poor health being the reference category. ADL refers to routine activities that an individual tends to do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking), and continence. The number of self-reported ADLs is the aggregate measure of the severity of daily activity limitations.

For non-health need factors, we controlled for a set of socioeconomic variables. Per capita household expenditure was adjusted by household size and the demographic composition of the household (i.e., number of adults and children) using the Equivalence Scale in the past one month (Citro and Michael, 1995) (continuous variable in logarithm function). Education (four dummies, with no education as the reference category), , average per capita disposable income at the provincial level for year 2011 and 2013 (continuous variable), and region of residence (five geographical region dummies- North, Northeast, East, South Central, Southwest, and Northwest, with Northwest as the reference category) were included in the analysis.

We also controlled for health facilities which is a crucial supply-side factor that affects health utilisation and costs (Yang and Wu, 2014). Health facility variables were categorised into three groups (village clinics, community health centre and city hospitals) for outpatient analysis and two groups (village clinics, city hospitals) for inpatient analysis. Village clinics is the reference category. Table 2 provides summary statistics of the study sample.

<Table Two about here>

Empirical strategy

This study incorporated both descriptive and inferential analysis. Descriptive analysis entailed calculating the means and standard errors of the mean costs of inpatient and outpatient total costs as well as OOP costs across different health insurance utilisations.

Inferential analysis involved modelling insurance variables to estimate the utilisation and costs of healthcare for individual participants who reported a history of inpatient visits within the last 12 months and outpatient visits within the last four weeks. In particular, we estimated the determinants of inpatient care utilisation, total costs, and OOP costs for both inpatient and outpatient care using a Two-part model (2PM) (Jones, 2000; 2007; O'Donnell et al., 2008). The 2PM comprises firstly of a Probit Model to examine the probability of individual health insurance utilisation on whether the same individual had incurred any costs on a recent inpatient and/or outpatient visit as a proxy for health service utilisation, and second, an Ordinary Least Squares (OLS) model applied to determine the relationship between health insurance utilisation and health costs only to the population that incurred nonzero costs.

In modelling health care costs, both the 2PM and Heckman Selection Model (HSM) are frequently used to analyse limited dependent variables (Dow and Norton 2003; Norton et al. 2008). In our study, we chose to model both inpatient and outpatient utilisations and costs using 2PM. We had considered HSM but did not apply this model due to the following reasons. Theoretically, 2PM assumes that both seeking treatment and actual health costs incurred are independent and discrete decisions (Madden, 2008). On the contrary, HSM allows both decisions—seeking treatment, and health costs—to be influenced by distinct but correlated observable and unobservable factors (Jones, 2000; 2007). The potential health costs would have an impact on an individual's decision to seek treatment in the first place. Intuitively, both treatment seeking and health cost decisions for outpatient treatment are unlikely to be correlated as outpatient costs, relative to inpatient costs, and are less crucial in influencing an individual's treatment decision. Considering this theoretical reasoning, 2PM is more suitable to model outpatient care utilisation and costs as opposed to HSM. We also performed statistical tests to determine whether 2PM is a better model than HSM by generating the inverse mills ratio (IMR) for HSM. The performance of HSM depends on the collinearity between the IMR, which was estimated from the Probit Model for the probability of seeking outpatient care, and the costs of

outpatient care in the OLS regression model. The t-ratio test indicated that there was no collinearity between outpatient care decisions and costs, and the Spearman's rank-order correlation which is not statistically significant, suggested that there is no effect of selection. Our statistical tests substantiated our theoretical reasoning that 2PM is more suitable than HSM in modelling outpatient utilisations and costs in our analysis. For inpatient treatment, there is however a likelihood of the presence of unobserved factors that correlate both the decisions to seek treatment and health costs. This is due a common belief that inpatient costs are much higher than outpatient costs and may therefore hinder an individual's decision to seek treatment. Considering these latent factors, we could not conclude whether the zero inpatient costs were actual outcomes or missing potential outcomes due to an individual's reluctance to seek treatment (Dow and Norton, 2003). To make a statistical decision on which (2PM or HSM) is a better performing model for inpatient care utilisation and costs, we generated an inverse mills ratio (IMR) for HSM. The t-ratio test of this relationship indicated that there was no collinearity between an inpatient care decision and costs, and the Spearman's rank-order correlation indicated no effect on selection, hence established that HSM was not the appropriate model for this analysis (Jones, 2007). Here, we reported only the results of the 2PM for inpatient analysis. For all analyses, the computation of a variance inflation factor (VIF) was performed, and results indicated that multi-collinearity was not a problem. Ramsey RESET tests were also performed, and results showed that our models did not have specification problems.

Results

We first compared the mean total costs and OOP costs among different SHI participants for both inpatient and outpatient care. Figure 1 shows the mean of total and OOP costs for individuals who utilised different health insurance schemes at the most recent inpatient visit over the last 12 months. Individuals who utilised UEI, which is the most generous health insurance scheme, reported mean total cost of RMB10,421.60 (USD1,562.45), as opposed to

RMB4,707.00 (USD685.06) from individuals who had no health insurance. Individuals who utilised UEI, URI, URRMI and NCMS for their most recent inpatient visit reported a lower share of OOP costs as compared to their counterparts with no health insurance, judging from the relatively higher share of reimbursement that they were able to claim. Comparison of the mean total health costs for different SHI schemes also indicated that people who utilised UEI incurred significantly higher cost per inpatient episode as compared to people who utilised other SHI schemes and people with no insurance. Comparing the most recent outpatient visit cost for individuals who utilised different health insurance scheme, Figure 2 shows that individuals who utilised URI incurred the highest mean cost (RMB1,863.60 or USD279.39), followed by URRMI (RMB1,475.40 or USD221.19) and UEI (RMB1,4071.10 or USD2,109.66). This is in contrast to relatively lower mean scores reported by individuals who utilised NCMS (RMB929.70 or USD139.40), and an even lower mean reported by individuals who had no health insurance (RMB317.00 or USD46.14). As for OOP costs for most recent outpatient visit, health insurance utilisation reported higher costs than individuals with no health insurance, and Figure 2 also indicates that mean outpatient total costs for individuals with no insurance were significantly lower than those who could utilise SHI for their most recent outpatient visit. The results for outpatient OOP costs, though inconsistent with the inpatient OOP costs, were not surprising since previous studies report that health insurance schemes in China had not been able to reduce out of pocket payment among the enrollees (Wagstaff and Lindelow, 2008; Yang and Wu, 2014; Liu and Zhao, 2012).

<Figure One and Figure Two about here>

We subsequently attempted to disentangle the effects of different health insurance schemes of various generosity levels to both inpatient and outpatient care utilisations and health costs. We employed health insurance utilisation as the independent variable of interest. . We reported the results of the 2PM estimating the impacts of different health insurance schemes to an individual's decision to utilise both inpatient and outpatient treatment, as well as the

incurrence of inpatient and outpatient costs by comparing total costs before insurance reimbursement with OOP costs after insurance reimbursement in Table Three.

Results showed that, *ceteris paribus*, all health insurance participants were more likely to use inpatient care as compared to the uninsured. The results for UEI, URI and NCMS are statistically significant ($p < 0.01$). The magnitude of increase in using inpatient care for UEI, URI, and NCMS participants were 13.9%, 15.8% and 12.6% respectively as compared to the uninsured. Turning to the health costs, *ceteris paribus*, those who had utilised UEI, NCMS and URRMI incurred significantly higher total inpatient costs prior to insurance reimbursement as compared to the uninsured. In particular, per episode total inpatient costs ran approximately 72.2% higher for UEI participants as compared to the uninsured, suggesting that more generous insurance is more likely to induce higher health consumption for the users. Likewise, health insurance utilisations reduced out-of-pocket expenditures as compared to the uninsured, and the results were statistically significant for UEI and URI participants. No significant differences were observed for inpatient OOP costs between NCMS and URRMI participants when comparing to the uninsured.

In terms of outpatient care, the broad trend shows that across China, health insurance schemes do not have an impact on decisions to utilise outpatient care. UEI, URI and NCMS, for instance, indicated statistically significant reductions in probability of seeking outpatient care as compared to the uninsured ($p < 0.05$). This finding may appear bizarre, but further analysis of the data shows that on average, only about half of the health insurance enrollees ended up using health insurance in their most recent outpatient visit.¹ This suggests that health insurance has less influence on making outpatient care decisions as compared to inpatient care decisions. Findings for the costs incurred for outpatient care consequent to SHI utilisations corresponded with those of inpatient care, with UEI and NCMS participants shown to have incurred significantly higher total outpatient costs as compared to the uninsured. The reductions in OOP outpatient costs for UEI, URI and URRMI participants, were not significant when

compared to the uninsured. NCMS participants, however, incurred significantly higher OOP outpatient costs (approximately 17.6%) as compared to the uninsured ($p < 0.1$).

<Table Three about here>

We performed two sets of sensitivity analyses to check for robustness of our regression models. First, we replaced the five geographical regional dummies with 28 provincial dummies as an alternative way to control for geographical heterogeneity in China in the 2PM for both inpatient and outpatient treatment utilisations and costs. Second, we included age-squared as an additional control to the 2PM for both inpatient and outpatient utilisations and costs. Both sensitivity analyses correspond with our main results.

Discussion and conclusion

This study sheds light on the relationships between health insurance generosities and health seeking behaviours, and the subsequent health costs incurred among the adult population aged 45 and above in China. UEI, the health insurance scheme that endows its enrollees with the most generous benefits, tends to incur the highest total pre-reimbursement inpatient health costs than the other health insurance enrollees. The same situation in which the most generous SHI tends to incur the highest charges among patients with the same types of medical conditions has been reported in other countries such as Germany (Krobot et al., 2004) and Thailand (Ngorsuraches and Ungsopanit, 2004). In addition, studies conducted in the U.S. (Huttin, 2007), Korea (Suh et al., 2014), and Mexico (Rivera-Hernandez and Galarraga, 2015) also demonstrated that a patient's health insurance status did have some influence in determining their access to certain treatment regimens. Our findings suggest that more generous health insurance schemes such as UEI and URI tend to induce higher health consumption as compared to less generous health insurance schemes such as NCMS. The uninsured, likewise, incurred the lowest total mean health costs, which can be explained by their propensity to underutilise treatment due to lack of protection. Our findings point to a more marked effect of supplier-

induced demand – a phenomenon that has been widely documented in China due to the profit-driven nature of providers in the public health care landscape (Yip and Hsiao, 2009; Zhang et al., 2015) - for individuals with more generous health insurance schemes.

In terms of OOP payments, the participation in SHI schemes did not result in statistically significant differences in OOP payments for its participants in outpatient care as compared to participants with no insurance. The reductions of OOP payments in inpatient care, were only statistically significant for UEI and URI participants, but not for those insured under NCMS. Consistent with previous studies examining the effects of China's SHI on financial protection to its enrollees, our findings provide limited support to the claim that participation in SHI would lead to a reduction in OOP payment. (Yang and Wu, 2014; You and Kobayashi, 2011). More important, while it is politically popular to make SHI more generous, it should not be taken for granted that more generous SHI schemes will reduce the financial burden of those insured. The NCMS participants, notably, have shown to receive hardly any financial protection in terms of OOP payment reductions.

Since the launch of URRMI by the Chinese government in early 2016, there has been a strong push to merge this with the UEI scheme at the prefecture (county) level in China as the first step towards unification (He and Wu, 2016). Our findings have important policy implications for policy-makers in China and other developing countries that are contemplating a transition from a multiple-payer SHI system to a single payer SHI system that unifies all existing schemes. Contrary to conventional wisdom that a single payer SHI system that unifies all existing SHI schemes is more efficient (Hussey and Anderson, 2003), our findings suggest that a move towards a unified SHI scheme that is more generous than some of the existing SHI schemes may give rise to health expenditure escalation, which would result in cost burden to the government and individual participants, in part due to the perverse incentives inherent in the current fee-for-service provider payment system in China that reimburses health providers based on the quantity of services delivered. The over supplying of services and over prescribing

of treatment have become norms in medical practices as means to generate additional revenues for the providers.

In recent years, various cost control measures, such as the separation of revenue generation responsibilities and expenditure systems in the health facilities, introducing more transparent pharmaceutical procurement systems, and implementing national standard clinical guidelines were proposed as tangible measures that could be taken at institutional level to contain health costs in China (Tang and Bekedam, 2012). The effectiveness of these measures in overcoming perverse incentives is of critical importance to the success of the unification of SHI.

Besides the above policy options, governance mechanisms ought to be strengthened alongside institutional design reforms in the SHI system. In most countries, strengthening the accountability structures to detect fraud and abuse is a pivotal step in cost control. Experience in Taiwan demonstrated that building a monitoring system to detect malpractice, and ensure cost sharing is enforced on the population who did not have to pay for health care previously, stood as an effective check and balance in controlling cost (Lu and Hsiao, 2003). In addition, with the dramatic rise in public health expenditure as a percentage of total health expenditure in China from 33.6% in 2001 to 55.8% in 2014 (The World Bank, 2016), reconfiguring the incentive structures within the provider payment systems is another cost control measure that ought to be considered. Literature on provider payment system have generated a general consensus that controlling all other factors, prospective payment systems tend to contain cost better than retrospective payment systems (Jegers et al., 2002; Roberts et al., 2008). The Korean experience indicates that with increased health access and rising health demand under a unified SHI system, a shift towards a prospective provider payment system is inevitable (Kwon, 2009). A recent study that assessed three cities in China piloting mixed provider payment methods indicated that both a prospective (capitation and global budget) and retrospective (fee-for-service, case-based payment and unit flat rate) financing mix showed positive impacts on the

cost control of health care (Tang and Bekedam, 2012). These positive outcomes indicate that a gradual shift in provider payment system from the current fee-for-service provider payment method to prospective system such as capitation and global budget in China is the way forward.

As China moves towards the eventual policy goal of integrating SHI schemes into a unified system, many institutional design aspects of unification, which include resetting acceptable premium rates to different segments of the population, optimising cost-sharing levels in the form of deductibles and co-payments, and standardising service provisions across the country, warrant careful deliberations (Meng et al., 2015; Yu, 2015). There are also many macroeconomic challenges that are related to health policies in China that should be acknowledged. Rising health consumption within the population is a salient issue. With the current tax revenue that stands at 10-11% of GDP, much lower than many developed countries that stand at 20-30% of GDP (The World Bank Data, 2016), the question as to how China could strengthen tax revenue raising capacity to heighten its potential to finance the SHI system is a key challenge to the policy-makers. Likewise, an SHI system that ensures social solidarity necessitates the rich to subsidise the poor. Doing this without causing political backlash requires savvy political acumen. Over time, the government needs to find ways to effectively enhance premium revenue collection - especially from the self-employed and informal sector employees - to ensure political and fiscal sustainability of the system (Hsiao and Shaw, 2007). A unified SHI system that strictly observes cost containment also requires the government to effectively command its monopsony power and strategic purchasing. Solutions towards the challenges above, however, are beyond the scopes of this study.

This study possesses two limitations. While demonstrating that more generous health insurance schemes lead to higher total health costs, such a relation is at most associative. We acknowledge that there might be both observed and unobserved heterogeneities in terms of the design of different SHI schemes across different Chinese localities, and we have attempted to address this by incorporating regional controls in our main analysis, and provincial controls in

our sensitivity analysis. We find that the robustness of our findings is not affected. This approach may not be perfect, but is the best that we could endeavour due to limitations within the data. Besides, we acknowledge the limitation of using self-reported household survey data for our analyses, which could be subject to reporting bias. Our study provides an initial insight into the implication of a unified SHI system in China. Moving forward, the examination of the mechanisms that drive-up health costs for different SHI schemes would be a meaningful research endeavour. Understanding this could provide more profound policy insights to the policy-makers in the face of ongoing SHI reform and expansion in China.

Endnote:

¹ Details of this analysis are available upon request.

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Table One: Key features of NCMS, UEI, URI and URRMI

	NCMS	UEI	URI	URRMI
Date started	2003 (Pilot scheme was initiated in four provinces)	1998 (pilot scheme was initiated in 1994)	Pilot since 2007	Rolled out in phases since January 2016
Target population	Rural residents	Urban employee	Urban residents without formal employment	Urban residents without formal employment and rural residents
Enrollment	Participation is usually voluntary at household level but could be enforced once the county joins the NCMS.	Participation is mandatory for all urban residents with formal employment.	Voluntary (household level)	Voluntary
Coverage	805 million rural population	271 million urban employees	264 million urban residents	Those who are not covered under the UEI scheme
Risk pooling	County level	City level	City level	County level
Reimbursement rate, ceiling and deductibles	Deductibles, reimbursement rates, and ceilings are set by the county governments. The rates depend largely on the types of health providers.	Deductibles, reimbursement rates, and ceilings are set by the city government. The rates depend largely on the types of health providers.	City government sets the reimbursement rate, ceilings, and deductibles. However, deductibles, reimbursement rates, and ceilings are different for children, elderly, and other urban residents. These rates also depend on the types of health providers.	Deductibles, reimbursement rates, and ceilings are set by the county governments. The rates depend largely on the types of health providers.
Financing mechanism	In western and central China, the central government assisted the local government in providing finance for the scheme. In the more affluent eastern and coastal regions, financing the premium was mainly through local governments. Government subsidies increased from 42.1RMB in 2005 to 308.5RMB in 2012.	A total of 8% of employees' monthly payroll needs to be contributed to the scheme, with the employee paying 2% and the employer paying the remaining 6%.	In general, an annual premium provided by the government should be no less than 40RMB per year per person. In addition, the government provide extra subsidies to the disabled children, children from poor families, poor disabled elderly above 60. Insured urban residents who live in affluent provinces are likely to receive better benefit packages compared with those who live in less affluent provinces.	In the preliminary phase, financing mechanism differs in each county. Generally, premiums are financed via a combination of self-contribution and government subsidies.
Designated health facilities Covered services	All levels of public health facilities. Inpatient services, catastrophic outpatient services, some prevention care services.	All levels of public health facilities. Inpatient services catastrophic outpatient services, some prevention care services.	All levels of public health facilities. Mainly cover inpatient services and catastrophic outpatient services.	All levels of public health facilities. Inpatient services (up to 75%) and outpatient services.

Sources: Barber and Yao 2010; Shen 2014; Meng et al. 2015

Table Two: Summary statistics

Variable	Definitions	Inpatient (N=983)		Outpatient (N=1,224)	
		Mean	Std. Dev.	Mean	Std. Dev.
<u>Health Insurance utilisation</u>					
UEI	Dummy variable: 1, UEI; 0 otherwise	0.227	0.419	0.083	0.276
URI	Dummy variable: 1, URI; 0 otherwise	0.050	0.218	0.015	0.121
NCMS	Dummy variable: 1, NCMS; 0 otherwise	0.645	0.479	0.317	0.466
URRMI	Dummy variable: 1, URRMI; 0 otherwise	0.017	0.129	0.007	0.083
No insurance	Dummy variable: 1, No insurance; 0 otherwise	0.061	0.240	0.578	0.494
<u>Demographics</u>					
Male	Dummy variable: 1, male; 0 female	0.524	0.500	0.436	0.496
Age	Continuous variable: age of the respondent	61.862	9.717	60.613	10.026
Education: no formal education	Dummy variable: 1, no formal education; 0 otherwise	0.244	0.430	0.278	0.448
Education: elementary school	Dummy variable: 1, elementary school; 0 otherwise	0.397	0.489	0.412	0.492
Education: middle school	Dummy variable: 1, middle school; 0 otherwise	0.200	0.400	0.167	0.373
Education: high school & above	Dummy variable: 1, high school & above; 0 otherwise	0.159	0.366	0.143	0.350
Household per capita expenditure	Continuous variable: inflation-adjusted per capita household expenditure	23332.850	40352.230	21192.470	32567.190
<u>ADL & health status</u>					
# of ADLs	Count variable: number of limitations in activity daily living	0.232	0.840	0.206	0.806
Health status: excellent	Dummy variable: 1, excellent health; 0 otherwise	0.056	0.231	0.027	0.161
Health status: very good	Dummy variable: 1, very good health; 0 otherwise	0.166	0.373	0.096	0.294
Health status: good	Dummy variable: 1, good health; 0 otherwise	0.498	0.500	0.465	0.499
Health status: fair	Dummy variable: 1, fair health; 0 otherwise	0.232	0.422	0.332	0.471
Health status: poor	Dummy variable: 1, poor health; 0 otherwise	0.047	0.212	0.080	0.272
<u>Medical facilities</u>					
Hospital	Dummy variable: 1, hospital; 0 otherwise	0.801	0.400	0.359	0.480
Community health centre	Dummy variable: 1, community health centre; 0 otherwise	0.199	0.400	0.289	0.454
Village health centre	Dummy variable: 1, village health centre; 0 otherwise	-	-	0.339	0.473
<u>Health costs</u>					
Total cost per episode (inpatient)	Continuous variable: total inpatient cost for the most recent visit in the past 12 months	7970.824	10607.450	-	-
OOP cost per episode (inpatient)	Continuous variable: OOP inpatient cost for the most recent visit in the past 12 months	4525.725	6870.823	-	-
Total cost per episode (outpatient)	Continuous variable: total outpatient cost for the most recent visit in the past 1 month	-	-	543.729	1235.825
OOP cost per episode (outpatient)	Continuous variable: OOP outpatient cost for the most recent visit in the past 1 month	-	-	367.294	767.005
<u>Provincial/region and year</u>					
Provincial disposable income	Continuous variable: average disposable income at provincial level	15532.37	8891.932	13820.98	8923.884
Region: north	Dummy variable: 1, north; 0 otherwise	0.109	0.312	0.110	0.313
Region: northeast	Dummy variable: 1, northeast; 0 otherwise	0.073	0.260	0.041	0.198
Region: east	Dummy variable: 1, east; 0 otherwise	0.258	0.438	0.304	0.460
Region: south central	Dummy variable: 1, south central; 0 otherwise	0.256	0.437	0.242	0.428
Region: southwest	Dummy variable: 1, southwest; 0 otherwise	0.207	0.405	0.223	0.417
Region: northwest	Dummy variable: 1, northwest; 0 otherwise	0.089	0.285	0.068	0.252
Year	Dummy variable: 1, 2011; 0, 2013	0.512	0.500	0.743	0.437

Table Three: Two-Part Model for treatment utilisation and costs (inpatient and outpatient)

VARIABLES	Inpatient Care			Outpatient Care		
	Participation	Total costs	OOP costs	Participation	Total costs	OOP costs
UEI	0.591*** (0.199)	0.722*** (0.157)	-0.472*** (0.163)	-0.733*** (0.221)	0.865*** (0.198)	-0.196 (0.225)
URI	0.669** (0.263)	0.281 (0.210)	-0.379* (0.214)	-0.804** (0.326)	0.169 (0.474)	-0.290 (0.451)
NCMS	0.535*** (0.153)	0.504*** (0.135)	-0.031 (0.138)	-0.449*** (0.139)	0.590*** (0.101)	0.176* (0.098)
URRMI	0.271 (0.341)	0.463* (0.247)	0.046 (0.307)	-0.269 (0.535)	0.411 (0.366)	-0.076 (0.363)
Constant	0.745 (0.951)	5.561*** (0.627)	6.089*** (0.697)	3.124*** (1.124)	5.005*** (0.761)	5.355*** (0.759)
Observations	1,190	998	998	1,346	1,235	1,235
R-squared		0.336	0.292		0.343	0.298

Robust standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Notes:

a. The probit model for health service utilisation and OLS models for total cost and OOP cost controls for participant characteristics (gender, age, education), economic status (per capita household consumption expenditure), regional characteristics (average provincial disposable income and regional dummies) and activities of daily living (ADL) status, health status and provincial disposable income, with survey year 2011 as the reference.

b. The above full results and sensitivity analysis are available at the online appendices.

Panel One: Types of Social Health Insurance Schemes in China

• Urban Employee Insurance (UEI)

UEI is compulsory for all employees and their employers in the formal urban sector. The insurance premium is set at 8% of each employee's monthly wage, comprised of a 2% contribution from the employee and the remaining 6% from the employer. The expansion of UEI has been rapid and remarkable: participation increased from 118 million urban employees in 2005 to 271 million in 2012 (National Health and Family Planning Commission of China 2014). UEI has the most generous benefit package among the three SHI schemes.

• Urban Resident Insurance (URI)

The URI covers urban residents who are not employed in the formal sector (the self-employed, unemployed, old/retired, young children and primary and secondary school students) and is a voluntary enrolment scheme, where government subsidies have been used to encourage increased participation. The enrolment increased from 118.2 million in 2008 to 271.2 million as of 2012 (National Health and Family Planning Commission of China 2014).

• New Rural Cooperative Medical Scheme (NCMS)

The majority of the rural population has been covered by NCMS since 2003. Subsidised largely by central and local governments, NCMS is administrated at county level, and the individual participant's contribution to the premium is kept relatively low. NCMS coverage soon became a key performance indicator for prominent government officials. The benefit package of NCMS, rudimentary at the outset, has become more comprehensive over time largely due to a massive injection of government subsidies: annual government contribution to insurance premiums increased from 42.1RMB in 2005 to 308.05RMB in 2012. Since 2007, NCMS benefits have expanded, at first mainly covering catastrophic illnesses, but now including outpatient and preventive care (Xinhua 2012).

• Urban and Rural Resident Medical Insurance (URRMI)

URRMI was piloted in a few cities and has been rolled out in phases since January 2016. It was first established with the intention of integrating URI and NCMS schemes as the premiums of both schemes are heavily subsidised by the government, unlike UEI, which is contributory. URRMI is considered as the first move of the larger government initiative to integrate all existing SHI schemes under a single payer scheme in the near future (Xinhua 2016).

Figure One: Comparison of the mean of most recent inpatient total and OOP costs across different health insurance schemes (mean/standard error)

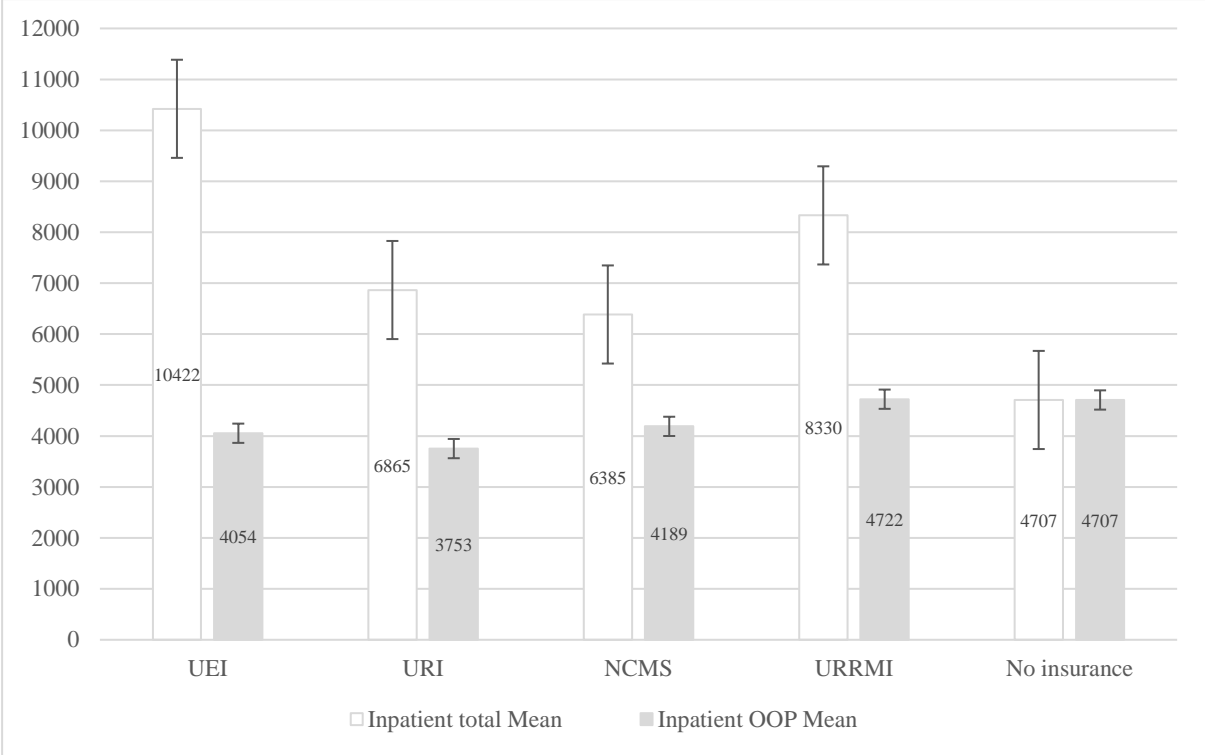


Figure Two: Comparison of the mean of most recent outpatient total and OOP costs across different health insurance schemes (mean/standard error)

