Health Reform in China: Progress and Challenges

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In the past three decades, China's economic reform has undoubtedly achieved a legendary success. During this period, China's per capita gross domestic product (GDP) increased from 379 RMB (US$219)1 in 1978 to 38,421 RMB(US$6086) in 2012, leading to impressive improvement in the standard of living for many Chinese.

However, this fabulous economic growth has not witnessed an emergence of a better and fair health care system in the country. The issue of healthcare has been largely neglected by the government for a long time until dramatic changes occurred in 2003.

China used to have a relatively good situation of health equity during the period of planned economy.

Marketization and the retreat of state in health care provisions after the 1990s had badly caused a decline of health equalities in the whole country.

In the rapid of economic transition from the 1990s to the early years of 21st century, China's plummeting levels of insurance coverage and soring medical costs reduced the chances of helping the poor out of poverty in the rural areas.

In an editorial of The Lancet (2006), it was said that:

" facing unsustainable health-care costs and a rapidly ageing population, the Government must reposition the health-care system to tackle future threats, while combating newly entrenched inequalities and, perhaps most difficult, satisfying the heightened expectations of an increasingly prosperous population."

Two major problems in Chinese health care system are:

First, the collapse of the Cooperative Medical System (CMS) in rural areas after 1980;

Second, the erosion of the Labour Insurance Scheme in urban areas.

In April, 2009 China eventually unveiled a far-reaching health care reform plan to spend 850 billion RMB (USD 125 billion) over the next three years to overhaul its medical care system, aiming to establish a universal basic health service system by 2020.

Within the huge health spending plan, 46% of the money will be allocated to health insurance programs, 47% to health care provisions, and 7% to public health.

Objectives of this Chinese version big bang health care reform in China:

Establish a universal basic health care service system toward *greater access, efficiency and quality*.

❖ Four pillars of the new health care reform:

*(1) Health care financing: wider insurance coverage and broader financial sources;

*(2) Health Care delivery: strengthening primary care services, establishing three tier system for health care delivery in rural areas and expanding dual referral urban hospitals and community health centers;

(3) Drug supply: providing an Essential Drug List (EDL) with government price control;

(4) Hospital reforms: separation of ownership and management and gradual elimination of drug margins.

Chinese government aims to provide significant subsidies to extend insurance coverage with a goal of achieving universal coverage by 2011, through increasing enrolment rates of the New Rural Cooperative Medical System (NRCMS) and the Urban Resident Basic Medical Insurance (URBMI).

On June 25, 2012, China Xinhua News Agency (Xinhua) published an official report on the new health care reform by emphasizing that the reform efforts have made obvious progress toward giving all the country's citizens access to basic medical services.

According to the report, China's central government invested 450.6 billion RMB (more than70 billion USD) in the country's medical care services. The annual government subsidy for urban and rural residents' insurance was increased from 80 RMB per head in 2008 to 200 RMB in 2011, and the sum had been raised to 240 RMB in 2012. And Chinese government promised more government investment in medical care services during its 12th Five Year Plan period (2011-2015).

Background:

* The old Rural Cooperative Medical System(RCMS) based on collective economy existed from 1950s to early 1980s;

* Inadequate health resources and scant government support fail the RCMS after economic reform

* Illness-induced poverty & high incidence of deferring treatment prevailed in rural areas;

*In 2002 the central government made a bold decision to fix its fragile medical care system by introducing the NRCMS in rural areas. One year later, the NRCMS pilot schemes were implemented in the selected provinces.

Progress of the New Health Care Reform in China: The NRCMS as an Example

Characteristics of the NRCMS:

* Mandatory implementation with a set participation rate;

* Farmers' voluntary participation is a must;

* A shared funding mechanism & differentiated reimbursement level

* Establishing a three-tier medical care system at the county level

Map of China


Heilongjiang
Jilin
Liaoning
BEIJING
Tianjin
Hebei
Inner Mongolia
Xinjiang
Gansu
Ningxia
Qinghai
Shanxi
Shandong
Henan
Jiangsu
Shaanxi
Shanghai
Tibet
Sichuan
Anhui
Hubei
Zhejiang
Chongqing
Jiangxi
Hunan
Guizhou
Fujian
Yunnan
Guangxi
Taiwan
Guangdong
Hong Kong
Macao
Hainan

Table 1 The Contribution Rates and Number of Participants in the NRCMS in Jiangxi Province (2004-2013)

Year	Famer (Yuan)	County (Yuan)	Regional (Yuan)	Prefecture (Yuan)	Central (Yuan)	Total (Yuan)	No. of Participants (Ten Thousand)	Annual Allocated Funds (Ten Thousand Yuan)
2004	10	3	3	4	10	30	216.37	9,074
2005	10	3	3	4	10	30	318.40	9,679
2006	10	3	3	14	20	50	1,221.00	57,750
2007	10	3	3	14	20	50	2,493.31	129,972
2008	10	3	3	34	40	90	2,990.17	270,068
2009	20	3	3	34	40	100	3,068.90	315,955
2010	30	3	3	54	60	150	3,144.95	475,229
2011*	40	_	_	92	108	240	3,238.76	777,301
2012	50					240	3,293.85	---
2013	60					280	3,358	

Source: The NRCMS Progress Report 2011,2012, 2013, the Bureau of Health, Jiangxi Province.

Table 2 Number of Participants and Participation Rate of NRCMS in Jiangxi Province (2003-2012)

Year	Number of Participants (Ten thousand)	Enrolment Rate (%)
2003-2004	216.37	87.45
2005	318.40	79.36
2006	1221.00	84.95
2007	2493.31	87.47
2008	2930.17	91.32
2009	3068.90	95.19
2010	3144.95	96.62
2011	3240.45	97.86
2012	3293.36	98.10

Table 3 Average Reimbursement Rate of Hospitalization Cost in Rural Areas (2003-2012)

Year	Average Reimbursement Rate (%)
2003-2004	23.96
2005	22.34
2006	29.63
2007	31.43
2008	41.27
2009	42.04
2010	42.67
2011	54.38
2012	56.14

- Learning from the previous experience of local governments forging matching funds, the central government adopts a bottom-up funding mechanism to run the NRCMS scheme.

This financing mechanism requires local government to match funds and guarantee a set-up enrolment rate of NRCMS. Then, the central fund will be channeled to provincial government.

- Compared to the initial stage of policy implementation, both the town-level and village cadres have realized that the NRCMS can help the farmers ease their financial burden when they become ill. Meanwhile, with the progress of the NRCMS, the farmers have more knowledge about health care services and reimbursement formula of medical treatment.

Some positive outcomes of the NRCMS:

First, a universal coverage of health insurance scheme has almost realised in the countryside;

Second, farmers' financial burden caused by illness can be reduced but the pressure will not necessarily be released completely;

Third, famers' illness-caused poverty is mitigated but still be likely to return the trap of poverty if they encounter catastrophic diseases;

Fourth, famers' (especially the elderly people) indicate their satisfaction with health policy reform launched by the central government, which in a way strengthens the legitimacy of the Party in dealing with the social.

Constraints of China's Health Care Reform

- **1. Dominance and institutional deficiency of public hospitals**

- Lack of competition between public and private hospitals due to dominance of the former;
- The complexity of ownership and difficulty of ownership reform;
- Inadequate budget and low incentive of public hospitals;
- Embeddedness of profit-making in hospital-running.

❖ 2. Low trust between patients and physicians

With the progress of economic growth, social transition and technological advancement, the patient-physician relationship is becoming more deteriorating than before.

- The health expenditure is still growing as the government and individuals spend more money than before, but it is meaningful only if citizens' health status is improved. More spending on health does not necessarily mean people become healthier.

Moreover, there is a healthy skepticism that local government health financing will encounter difficulties as soon as land economy cools down and government revenue shrinks.

❖ 3. Conflict between control of medical costs and improvement of medical services

At the first phase of the new health care reform, the patients' affordable accessibility to quality health services meagerly improves owing to the structured urban-rural inequality.

- **4. The portability of the NRCMS is still low while the pace of urbanisation and migration is rapid.**

- The current system doesn’t provide a portability of health insurance scheme that allows the famers to pay the medical bill by using their own insurance in urban areas. Thus, farmers who migrated to cities still have to confront the problem of inaccessibility. In future, an integration between urban and rural health insurance schemes should be realised.

In China, there has a highly mobile population of 163 million migrant workers, of which many of them are unable to access to local health services in the cities.

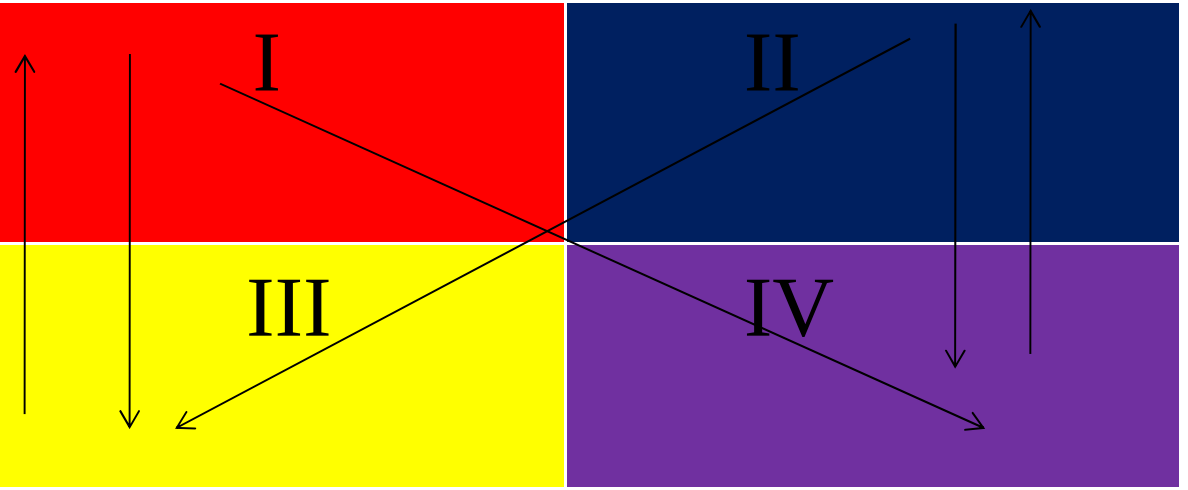
The migrant workers' health insurance package is usually locality-based that they can not reimburse their medical bills in the cities when they utilize urban health services.

In 2012 the central government launched a new policy initiative to reform public hospitals in a full scale in order to strengthen their functions as an effective provider of public goods (basic health care for citizens) in order to augment health equity and improve health efficiency in the country.

In April, 2014, Chinese government issued a new policy initiative to implement a market-based price mechanism of non-public health providers' medical services, which relaxes the price control of medical services in the private sector and stimulates more private hospitals to delivery quality health services in order to reduce the unequal distribution and unfair competition between public and private providers.

The Matrix of Orientation Change in Health Care Providers

Type	Public	Private
Non-profit	I	II
Profit	III	IV



- **Two key social events are profoundly influencing social protection system in China:**

- **(1) Aging;**

- **(2）Migration.**

- While *the government (or governance)* is still fueled by economic development, *market* is driven by profit-making and *family* is eroded by a declining power of care affected by the notorious one child policy, how can China find solutions to address an unimaginable problem of social protection for the elderly and migrant workers in urban areas?

- An "Elderly Rights Law," which took effect in China on July 1, 2013, requires adult children of elderly people to visit or keep in touch with their parents who are 60 and older, in addition to guarantee their financial and emotional needs are met. If children do not comply, they may have potential fines, lawsuits or jail punishment.

- According to the China National Committee on Ageing, by the end of 2013, the elderly population will reach more than 200 million, it is estimated that the elderly population will account for one-third of the total population by 2050.

- A drastic demographic transition has occurred in China since 1979, which is characterized by a low fertility and higher proportion of elderly people among the total population.

- **Causes:** 1) Socio-economic development;
- 2) The One-child policy;
- 3) Social and cultural change;
- 4) Urbanization, migration and mobility.

Table 1 Basic Demographic Statistics of Population Census in China

	1952	1964	1982	1990	2000	2010
Total Pop.(10,000)	59435	69458	100818	113368	126583	137053
Male	30799	35652	51944	58495	65355	68685
Female	28386	33806	48874	54873	61228	65287
Family Size	4.33	4.43	4.41	3.96	3.44	3.10
（3.02，2012）						
Aging Index(%)	4.41	3.56	4.91	5.57	6.96	8.87
Urban Pop.	7726	12710	21082	29971	45844	66558
Rural Pop.	50534	56748	79736	83397	80739	67415
Adjusted TFR				1.47	1.22	1.18

Table 2 Population Age Structure in China

Year	0---14(%)	15---64(%)	65+(%)	Dependency Ratio	Mean Age
1952	36.3	59.3	4.4	12.2	22.7
1964	40.7	55.7	3.6	8.7	20.2
1982	33.6	61.5	4.9	14.6	22.9
1990	27.7	66.7	5.6	20.1	25.3
2000	22.9	70.1	7.0	30.4	30.8
2001	22.5	70.4	7.1	31.6	32.3
2002	22.4	70.3	7.3	32.6	33.1
2003	22.1	70.4	7.5	33.9	33.9
2004	21.5	70.9	7.6	35.3	34.6
2010	16.60	74.5	8.9	34.2	35.2
2012	16.5	74.1	9.4	34.9	

- By the end of 2010, 28.6 million of older population over 60 received basic pension in rural areas.
- In 2013, nearly 51% of total population living in urban areas.

Unthinkable urbanization in China

Table 3 Population Growth Rate of Different Age Groups (2000-2004)

Age group	Average growth rate(%)
0---14	-3.38
15---64	1.71
65+	2.55
80+	4.65

Table 4 Regional Difference of Population Aging (2004)

Region	65+(%)
Shanghai	15.4
Chongqing	11.45
Beijing	11.12
Tianjing	10.79
Jiangsu	10.72
Zhejiang	9.78
Qinghai	5.89
Ningxia	5.67

* Pension and Financial Support for the Elderly

(1) Pension reform in urban areas is still in the process of integrating the employees of different sectors, while a universal rural pension scheme has been established to provide marginal monthly pension allowance starting from 55 RMB （ by the end of 2014, one million of farmers over 60 will be covered by this system while 460 million of farmers participated this system in 2012);

(2) Majorities of elderly people receive financial support from their adult children both in urban and rural areas.

According to a recent sample survey of China Health and Retirement Longitudinal Study (CHARLS) conducted by The Institute of Social Science Survey (ISSS), Peking University, 31.8% of elderly self-reported that their health status is poor or very poor and 38.1% of them have difficulties in daily living activities.

- The baseline survey of CHARLS was conducted in 2011, including about 10,000 households and 17,500 individuals in 150 counties/districts and 450 villages/resident committees all over China. The individuals will be followed up every two years. All data will be made public one year after the end of data collection. CHARLS adopts multi-stage stratified sampling.

- It is generalized that about 3.23 million of elderly living alone need special care although the proportion of those elderly is just 19% even lower than that of elderly living with spouse or other family members.

- The survey shows that 40% of elderly people (74 million) in the country suffer a relatively high level of depression symptoms (Gender difference: Female elderly is higher than male elderly).

- Other relevant information released by CHARLS indicates that:

- * 88.7% of elderly people received help from family members in daily living activities, but still 11.3% of the elderly (5 million) didn’t get any help from their family members;

- * 92.1% of urban elderly and 94% of rural elderly are covered by health insurance systems, but poor urban elderly people are more vulnerable in affording health care services.;

- * For elderly people both in urban and rural areas, medical care cost especially hospitalization fee is still a heavy financial burden for their families (rural elderly people have to pay almost 40% of medical bill when they are hospitalized);

- * The number of children among young old elderly groups is declining rapidly and more than half (53%) of the elderly people live either with their spouses or live alone.

- A shared care system has been promoted by Chinese government at the end of 2011, aiming to build a comprehensive social care services system based on a balanced function of care between family, community and institution (a part of the Twelfth Five-Year Plan, 2011-2015).

- The problem is more than a political accomplishment from local government perspective while fiscal situation is getting fragile in the restructuring process of economic growth.

- While social values have been stretched over time and social mobility has accelerated dramatically, both ideologies and practices of elderly care (filial piety, parent-child relations, living arrangement and etc.) have been changed in the context of aging and social transition in China.

- The new law may create potential impact on the future practices of eldercare in China, but it is very hard to change traditional culture heritage of respecting elderly people and adult children feel obliged to take care of their old parents in a short period.

- A missing link still exists between policy and practice of elderly care in China:
- * A gap between the top-down planning mechanism and the bottom-up service delivery system (for instance, the “9073” model of elderly care promoted by the government);
- * A gap of care services between urban and rural areas;
- * A gap between the polity-driven policy formulation mechanism and the needs-based care services delivery system;
- * A gap between a static perception of elderly care and a dynamic change of aging culture (for example, it is necessary to redefine the concept of dependence and retirement in the new context of post-industrial society).

Possible solutions:

* Reform the pension system in time and integrate the fragmented systems to make them portable and sustainable;

* Design and develop accessible multiple types of elderly care services both in urban and rural areas;

* Improve the quality of institutional care facilities and care services in rural areas by standardizing service formula, strengthening staff training and augmenting social work professionals;

- * Raise the level of rural pension allowance and the minimal living standard scheme through more fair distribution of public finance between urban and rural areas;

- * Relax and someday in future abolish one child policy in the country.

When economic growth declines and social expectations escalate, social policies are more desirable to achieve the goal of equity and social justice in terms of intra-class solidarity and government-society cooperation.

New development strategy of Chinese new leaders:

- * Refining social security system and promoting social policy is an economic issue;
- * Establishing an integrative universal social security/social welfare system is a must of effective urbanization;
- * Strengthening governance by the rule of law;
- * Holding a determined mind to fight against corruption

(To fight off the tiger and the fly at the same time,老虎苍蝇一起打).

Given the complexity of Chinese society, unpredictable of global economy and political ecology, it will be a long march for China to be fully modernized and prosperous.

And certainly, social policy can make a difference!

Thank you!