Health System and Policies of China

Yang Cao, PhD
Associate Professor
China Pharmaceutical University
Nanjing, China

Transformation of Healthcare Delivery in China
The timeline of the medical and health system reform

First stage (1949 to 1978):
Establishment of three systems

- **First stage (1949 to 1978):** Establishment of three systems
  - The labor insurance medical system
  - The rural cooperative medical service
  - The socialized medicine

1. **First stage** (1949 to 1978): Establishment of three systems
   - Employees
   - National staff
   - Farmers

2. **Second stage** (1978):
   - Government-led low level development of the public welfare
   - Attenuation of the medical and health public welfare

3. **Third stage** (2003):
   - Return of the medical and health public welfare

In 1949
In 1978
In 2003
**Achievements**

- Achieved low level but wide coverage of the national medical insurance system
- Significantly improved the level of people's health
  - Increased the average life expectancy from 35 years before 1949 to 68 years in 1978

**Deficiencies**

- Limitation of financial resources resulted in the slow development of medical technology
  - *Became difficult for patients with serious illnesses to get effective treatment*
- Medical and health services could not meet the increasing demand
- The gap in medical insurance levels between urban and rural populations became huge
The second stage (1978 to 2003):

Out-of-pocket costs soar as healthcare delivery expands

Achievements

- The number of medical institutions increased significantly
- The quality of hospital equipment improved
- By the late 1980’s, the problem of “difficult to see a doctor” was basically solved
Deficiencies

• Government’s investment in public health was seriously insufficient

• In 1980, government health investment accounted for 1/3 of the total healthcare expenditures, but by 1990, it dropped to 1/4

• Enrollment in the rural communities under the policy of cooperative medical insurance program dropped drastically from 90% to 4.8%

Deficiencies

• Medical and health policies gradually moved away from the government umbrella

• Increased inequality of basic medical insurance between rural and urban populations

  – In 2000, rural residents (2/3 of population) represented only less than 1/4 of total health expenditure
Deficiencies

- The soaring medical expense made it hard for people to bear
- In 1980, personal health expenditure accounted for less than 23% of total individual health expenses
- By 2000, this proportion had reached to 60%
- From 1989 to 2001, the growth rate of health care costs was twice the growth rate of urban residents per capita income; but three times the growth rate of rural residents per capita income.

The third stage (2003 to present):

Re-establishment of the public medical and health insurance system
Achievements

- Re-established the dominance of the government in providing public health and basic medical services
- Addressed the medical insurance coverage for rural residents
- Resource allocation shifted from urban centers to community and rural hospitals
  - Medical resource allocation between urban and rural areas moved towards balance
- National essential drug system reduced the financial burden to both the individuals and the government

The new medical system reform (2009)

- The urban employee basic medical insurance
- The urban resident basic medical insurance
- The new rural cooperative medical system
Over 95% of the entire population

### Accelerating the basic medical insurance system

- In 2014, the annual individual insurance subsidy increased from ¥10 to ¥320 (nearly $53)
- Addressing the problems of employees and retirees that come from business closures and bankruptcies
- University students are also included in the urban resident medical insurance system
Raising the standard of the basic health insurance

• Maximum reimbursement for medical insurance for urban employees increased to six times of the average wage of local employees (nearly $47K)

• Maximum reimbursement for medical insurance for urban residents increased to six times of the local residents’ disposable incomes (nearly $27K)

• Maximum reimbursement for the new rural cooperative medical insurance rose to six times or more of the local farmers’ per capita net income (nearly $9K)

Promote equalization of the basic public health services

• Providing residents with basic public health services

• Establishing a nationwide unified health records

• Preventing and controlling the major diseases

• All costs of public health agencies are now covered by the government budget
Goals for equalization of basic public health services

- Every person is entitled to the same basic public health services; examples:
  - Free hepatitis B vaccines for age 15 or under
  - Physical examination for children under 3 years old
  - Provide guidance and other services for the prevention and treatment of diseases

Developing grassroots medical institutions

- Public Health Service funds will pay ¥20 per person per year for preventative care
- Will build 2,000 county-level hospitals and 29,000 rural hospitals
- Will establish clinics in every rural community
- Will establish and renovate 3700 urban community health service centers and 11,000 urban community health service stations
Guiding principles of the new health care reform

- Guarantee basic healthcare coverage for everyone
- Strengthen grassroots medical delivery systems

Challenges and way forward
Thank you!