2.3.2. China

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Introduction

The reforms launched in China in the late 1970s opened the way for extraordinary economic development: in the last quarter of the 1900s the Chinese economy grew at a rhythm of 9% per year. This exceptional economic development was accompanied by an overall, marked improvement in the conditions of life among the population even though deep inequalities still persisted, especially the historical disparities between urban and rural areas. Ninety nine per cent of the 130 million Chinese people who survive on less than a dollar a day live in the countryside, furthermore, the income gap between urban and rural populations has increased considerably since the mid 1980's and now stands at 3.2:1. Students in rural areas attend school for, on average, three years less than do children in urban areas, while illiteracy, which is now below 10% in coastal areas, is still over 20% in some regions of the hinterland[1].

This imbalance is reflected in the health sector too. Here, as a result of reforms carried out in the 1970s the number of people with no health insurance has escalated enormously and, at the same pace, so too has the cost of health services supplied by both public and private providers[2]. The result is that a growing number of Chinese families are finding it increasingly difficult to get treatment (because of economic barriers) and may even risk financial ruin if they do so (because of the high cost of health services). The rural areas have been particularly hard hit. In 2005, 80% of the rural population had no health insurance, while in urban areas, 50% were still without. Moreover, medical infrastructures and professional resources are concentrated in the towns and cities (**Table 1**[3] [4]). Main health indicators too, reflect this deep, marked imbalance (**Table 2**[5]).

In April 2003, while visiting Guangdong during the SARS crisis, the Chinese President Hu Jintao, spoke of the need to construct a more harmonious society, balancing economic and social development. This concept of a harmonious society soon entered and became part of Chinese government strategy. Health began to be a priority target for government action. In 2006, Hu himself had promised Chinese people that "the government will play a larger role in public health, with the aim of ensuring that all have access to essential health services so as to improve their health and well-being". Beijing also committed itself to raising the percentage of GDP destined for the health sector and, between 2006 and 2007, Central government did increase the health budget by 87%[6].

This is the setting within which the New Rural Cooperative Medical Scheme (NRCMS) has been developing since it was first started in 2003.

Table 1. Differences between rural and urban areas in health spending, government funding and health system resources 2005.

	Total health spending per capita RMB	*Government funding: current expenditure per capita (2002) RMB*	*Doctors per 1,000 inhabitants*	*Beds per 1,000 inhabitants (county hospitals or above)*
Urban areas	1,122	73	1.81	3.46
Rural areas	318	14	0.68	1.43
National average	662	30	1.21	2.45

Sources: Ministry of Health, CPR, Statistical yearbook - Health 2007, June 2007; UNDP, China Development Report 2005, October 2005.

Table 2. Differences between rural and urban areas in health indicators (2006).

	Life expectancy at birth (years)	*Infant mortality (x1,000 live births)*	*Maternal mortality (x100,000 live births)*
Urban areas	74	9.1	25.0
Rural areas	69	21.6	53.8
National average	71	19.0	47.7

Sources: Ministry of Health, CPR, Statistical report on development in the health sector in 2006, May 2007.

Rural Health Reform: the role of the New Rural Cooperative Medical Scheme (NRCMS) and results so far

The most important element in the reform is the new NRCMS, which seeks to provide affordable medical insurance. Its main features are:
– voluntary participation based on family units;
– diverse funding sources (user, government, collective sector);
– focus on IP services;
– managed at the County level.

By the 31st March 2007, NRCMS was covering 78.8% of the rural population. Currently the minimum annual per capita health insurance contribution is 100 Yuan (= 11), of which 20 Y uan are paid by the user and 80 by the government. In the Eastern Provinces, the entire government quota is paid by the Local Authorities, while in the Central and Western Provinces 40 Yuan live births) of this quota are paid by central government. Usually, the individual's contribution goes into a family prepayment account to be used to pay outpatient (OP) costs, while the government contribution subsidised a social risk fund to be used for inpatient (IP) fees, which are only partially reimbursed (between 25% and 40%). Between 2003 and 2005 there was a 20-30% increase in medical examinations and IP admissions in the first Counties to implement NRCMS. During the 2007 National Conference on NRCMS, delegates from Hebei, Yunnan and Jiangxi confirmed the trend when

they reported an increase of about 20% in accessing health services in the period 2005-2006[7]. However, deductibles and high co-payments are still a major barrier to accessing health care for the Poor. According to a recent study by the World Bank, the utilisation of the health service by the poorest 10% of the population has not increased after NRCMS implementation[8]. This is hardly surprising if one considers that in 2006 the average cost of hospitalisation was **2.241 Yuan** in County hospitals and **3.387 Yuan** Prefecture-level City Hospitals, while an agricultural worker's yearly income was on average, about **3.600 Yuan** per person.

It is difficult to make an all encompassing evaluation about the real degree of financial protection of the population. If one takes the indicator used by the Chinese Authorities, the incidence of cases of impoverishment due to catastrophic illness, then NRCMS performance seems positive. One good example is Jiangxi where, the Authorities reported, two years after the adoption of the Scheme, there had been a decrease in the number of cases of impoverishment due to illness of around 40% (from 47% to 27% of the total of cases of poverty studied)[9]. On the other hand, according to the World Bank study mentioned above, between 2003 and 2005, NRCMS did nothing to reduce the high level of out of pocket expenses (direct payments by patients), nor the risk of catastrophic medical expense (≥ 10% of the average income of users). Although the low degree of financial protection can, in part, be blamed on low levels of reimbursements, the same results have been noted for urban medical insurance schemes, which have proved equally unsuccessful in reducing the risk of catastrophic expenses for health care[10]. Indeed, the root of the problem is often considered to lie in the Fee For Service (FFS) method of payment adopted; patients pay separately for each service, which encourages the health providers to offer a lot of many services, many of which may be costly and / or useless.

NRCMS: dynamics of development and harmonization with other health initiatives

1) *Financing and defining the packet:* since 2003 the minimum government subsidy has risen considerably, while the individual's premium has changed very little (10 Yuan until 2007; 20 Yuan from 2008). The main increases in state funding have come since 2006, when the minimum subsidy was raised from 20 Yuan to 40 Yuan per capita, which made it possible to extend the benefits to more people. In recent years, both the percentage reimbursed and the reimbursement ceiling have risen, deductibles have been reduced and coverage for outpatient services widened (for a practical example see Table 3, Dingzhou Prefecture NRCMS reimbursement plans 2006 / 2007). In 2008, the Eastern Provinces started paying a higher contribution, 80 Yuan per head, while the poorer Areas of the hinterland will not have to start paying the higher charges until mid-2009[11]. The recommendation made by the WHO that both Maternal and Child health care and prevention should be included in the packet of services offered[12]. Apart from generally inadequate reimbursements for maternity and total exemption from vaccination costs in some Counties, it would seem this recommendation has, so far, been a dead letter.

Table 3. RCMS: Differences before and after 2006 in levels of deductibles and reimbursements (Dingzhou Prefecture, Hebei Province).

	Deductibles *(RMB)*			*Reimbursements (%)*			*Maximum reimbursement (RMB)*	*Reimbursement for in-hospital delivery (RMB)*
structure	THC	C/CH	HLH	THC	C/CH	HLH	all structures	all structures
pre 2006	150	500	2,000	50	45	35	15,000	150
post 2006	100	350	2,000	60	50	40	16,000	200

THC: Township Health Centre: C/CH: City/County Hospital; HLH: Higher Level Hospital; 10 Yuan = 11 Euro
Source: Dingzhou Prefecture Health bureau adjusts NRCMS reimbursement standards

Each county usually decides for itself which services should be put into the health insurance packet, but this is gradually changing, and Provincial governments are beginning to take over the task. The first Province to create a common packet was Guangxi, where, in January 2007, the Provincial Authority drew up a health insurance plan to be adopted in all the Counties under its jurisdiction.

2) *Reform of the method of payment:* notwithstanding that the method of payment is still FFS, some Counties are trying out a rudimental model of Diagnosis related Groups (DRG) – basically a forfeit payment system for IP treatments. In 2003, in Zhenan, a poor county in Shaanxi province, 54 diagnoses were selected to test out the new system of payment, for which the ceilings on expenditure were also set at different levels according to the type of medical structure. In the case of an appendectomy, the cost was set at no more than 1,000 Yuan in township health centres and 1,200 Yuan in the county hospital, with reimbursements of 50% and 60%, respectively. The use of the DRG method in Zhenan has resulted in a noticeably higher rate of reimbursements than the national average: 38% as against 25% (2004). Furthermore, it has cut medical costs. Similar results have been obtained in Lindian County (Heilongjiang) too, where the real reimbursements for hospital expenses are as high as 46%, while in the neighbouring counties of Baoqing and Linkou, which still adopt FFS, it is only 30%[13]. There is strong resistance to reforming the method of payment, especially on the part of the providers. However, during the 2008 National conference on NRCMS, top civil servants at the Ministry of Health were in favour of introducing a method of payment such as a flat rate or DRG for hospital services[14].

3) *Management:* both the administration of funds and applications for reimbursements, normally carried out by County NRCMS offices, is often delegated to private insurance companies. Encouraged by central government, these companies are being drawn in for two reasons: on the one hand it is difficult to find people with the required skills and, on the other, delegating tasks costs less than setting up

a dedicated office. Any extra costs are a problem for local governments who have to pay these administrative costs out of their own budget and cannot use any if the NRCMS funds which are destined only to be used for reimbursements.

Harmonization with other tools of health care: Medical Financial Assistance (MFA) and urban Basic Medical Insurance (BMI)

1) *Integration with Medical Financial Assistance (MFA):* this was introduced in 2000 with the aim of offering economic support to poorer users in the case of illness. It began to be integrated with the Cooperative Scheme when MFA activities in rural areas began to focus on:
– individual premium payments on behalf of poorer users;
– payment of extra reimbursements on top of the NRCMS reimbursement for poor users.

In 2006, MFA paid individual premium to 10 million users, and it encouraged many of the most disadvantaged people to join the scheme (currently, 30 million people live below the official government poverty line which is set at 690 Yuan per capita, per year).

Together with the standard NRCMS reimbursement the MFA extra payment means that coverage can reach 60% of the medical expenses incurred, but this still does not seem to have made much difference to the amount of use the worst off people make of health services[15]. Indeed, most poor people cannot afford the high co-payment. Furthermore, the MFA funds destined to help enrol poor people in the Scheme are put into the same social risk fund as other monies, so are often used to reimburse the better-off users, who have enough money to be able to pay their part of any hospital bills.

2) *Integration with urban Basic Medical Insurance (BMI):* the BMI which currently covers 170 million urban workers, is financed by contributions equal to 8% of yearly wages, from firms and employed workers. In 2007, the average annual premium was about 1,000 Yuan per capita, with standard reimbursements for hospital admission between 50% and 80%. Many authorities support the idea of integrating BMI with NRCMS, the WHO *in primis.* Indeed, such harmonization is considered essential given both the high levels of internal migration (there are at least 120 million migrant workers) and the current massive migration towards urban centres (by 2025, 60% of the population of China will be living in towns and cities). However, according to the Minister of Health, Gao Qiang, "the integration process is desirable […] but cannot be realised in the short term". The main obstacle to merging the two systems is the fact that they are often adopted in areas which are very different in terms of development, this means that there will be or is a wide gap (per capita) in levels of contributions and benefits. Even though there is, as yet, no clear centralised policy, some Local Authorities are trying out innovative models: for example in Jiading, a district in Shanghai, where administration of the NRCMS funds is entrusted to the Labour and Social Security Office. Here, insur-

ance for rural residents is financed as follows: by users (49%), collective sectors and local firms (38%), local government (13%), with a per capita annual premium of 267 Yuan (2005)[16].

In the solution adopted by Jiading, the organisational structure is similar to that of the BMI and individual premiums are closer to those for urban insurance: this could offer a possible model for future integration of BMI and NRCMS. However, a contribution based half on individual premiums would be impracticable in many rural areas as most are considerably poorer than the countryside around Shanghai, where the average income of agricultural workers / small farmers is almost three times higher than the national average for their sector (9,138 Yuan per capita, against 3,587 Yuan).

Conclusions

The RCMS has proved to be moderately efficacious in increasing access to health services. However, there are still serious doubts about equality of access and financial protection. Increased contributions from the government, the integration of NRCMS and MFA and trying out alternative to the FFS form of payment are all steps in the right direction, but the government must invest even more resources and, at the same time, find a way of completely reforming payment methods.

But it will probably take some time before an integrated health insurance system is fully set up. The high degree of decentralisation (financial and decision-making) of health services and the wide gap between the levels of urban and rural development make it difficult to harmonise BMI and NRCMS. Recent statements by the Minister of Health, Chen Zhu, have spotlighted this process of integration as one of the priorities for development within the health sector[17], which leads one to think that experiences such as that cited above (see para.: NRCMS: dynamics of development and integration with other health welfare initiatives") will soon be repeated in other parts of China, as a step in the process of creating a national health insurance system for all.

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