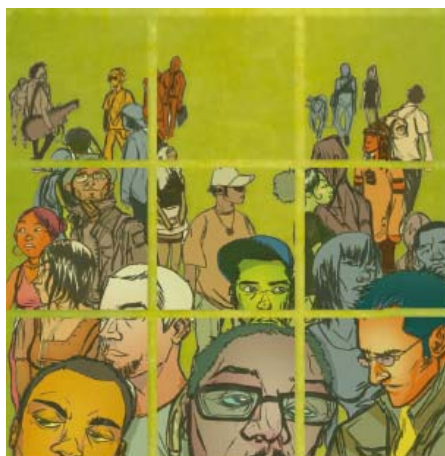




Universal Coverage of Health Care in China: Challenges and Opportunities

Meng, Qingyue & Tang, Shenglan

**World Health Report (2010)
Background Paper, 7**



© World Health Organization, 2010
All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters. All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The findings, interpretations and conclusions expressed in this paper are entirely those of the author and should not be attributed in any manner whatsoever to the World Health Organization.



Universal Coverage of Health Care in China: Challenges and Opportunities

World Health Report (2010) Background Paper, No 7

Meng Qingyue¹ and Tang Shenglan²

¹ Center for Health Management and Policy, Shandong University; Peking University China Center for Health Development Studies, China

² World Health Organization, Geneva, Switzerland

1 Background

In April of 2009, China's government announced its blueprint for health system reform and development for the next decade in an official policy document entitled "Guidelines for Deepening Health Systems Reform". The aim of the reform is to establish universal coverage (UC) that provides "safe, effective, convenient, and affordable basic health services" to all urban and rural residents.

Between 1950 and 1980 China's health care system provided basic health care to almost all the country's population through public health network and urban and rural health insurance schemes. Despite government promises to implement WHO's primary health care strategies designed to achieve "Health for All by 2000", the economic reforms of the late 1970s brought significant change to the way the system was run. While the government continued to invest in health, market-oriented financing mechanisms were implemented to fund both curative and preventive care. As a result health services became unaffordable and inaccessible for disadvantaged populations (Tang et al. 2008).

By the late 1980s, the rural health insurance scheme had collapsed. Urban health insurance schemes were also crippled by the rapid rise of medical costs and the inefficiency of state-owned enterprises - their main financiers (Liu 2002). Since then, the lack of coverage provided by the health insurance system and inadequate government support for essential public health programs have been identified as the main obstacles to universal coverage. Public dissatisfaction with health sector performance along with emerging public health problems, notably SARS in 2003, became driving forces for reform. A number of critical reviews, especially a report by the Development Research Centre of the State Council, have also been important in highlighting the need for change.

UC policy in China is the outcome of protracted discussion and debate regarding the main challenges faced by the domestic health system as well as trends in international health care development. Core government policy regarding the establishment of a harmonious society makes the issue of equity in health and health care of paramount importance. Improving people's access to basic health care has thus become a guiding principle in development policies, and the needs of vulnerable populations have received particular attention. Policy formulation has also been supported by international health projects such as the World Bank Health VIII Project and Department for International Development

(DFID) Urban Health and Poverty Project.

The new round of health sector reform announced in 2009 is backed by strong political and financial support, notably from a high level committee at the central level which is overseeing implementation. In addition to the regular health budget, 850 billion Chinese Yuan (US\$ 126 billion), has been committed for the funding of reform activities between 2009 and 2011.

To achieve the goal of UC, a series of strategies and measures are proposed, summarized as “four beams and eight pillars”(*Si Liang Ba Zhu*). The “four beams” comprise: - public health care; medical care; health insurance; and essential drugs.

Public health system reform is designed to achieve the equitable provision of basic public health programs to all residents. The reform of the medical system will focus on improving health care quality and efficiency. Health insurance, which includes the new rural cooperative medical scheme (NCMS), the urban employee-based basic medical insurance scheme (UEBMI) and the urban resident-based basic medical insurance scheme (URBMI), will be strengthened by increasing government financial support and improving management. Finally, a system will be established to ensure the provision of essential drugs of a reasonable price and quality.

The “four beams” will be supported by eight pillars - concrete strategies and policies, covering areas such as financing, human resources, regulation, and information. With regard to health financing, both supply and demand sides will be supported by public funding. Priority will be given to the subsidizing of primary health providers and public health programs. On the demand side, government subsidies to health insurance schemes, especially the NCMS and URBMI, will be augmented on a continuous basis to benefit all people, but especially the vulnerable. To improve the distribution of qualified health care professionals, policies for training and encouraging health professionals to work in remote areas are to be reformed.

In China, the core issue in UC is to extend coverage to disadvantaged areas and populations. The next section describes the current status of universal coverage to illustrate the main challenges. Section 3 summarizes a number of policies and actions undertaken by the Chinese government and international organizations with a view to achieving the UC goal.

2 Situation analysis of universal coverage

Coverage can be analysed in terms of breadth, depth, and height, with breadth indicating coverage in terms of population; depth indicating coverage in terms of service provided; and height indicating coverage in terms of the extent of financial protection. A universal coverage system can be evaluated as effective when the above three dimensions are completely filled. This section uses the above framework in describing the UC situation in China.

2.1 Coverage of health insurance schemes

From the mid-1950s, health insurance schemes were introduced both in urban and rural areas. In cities, the health insurance schemes covered those working in the government sector and enterprises. However, most of the non-salaried people in urban areas were excluded from the schemes. Encouraged by the government, the rural health insurance scheme was operated with support from the collective economy, reaching a high point in coverage in the late 1970s of nearly 90%. Those health insurance schemes encountered difficulties in operation from the early 1980s, because of disorganization in the collective economy in rural areas and the transformation of state-owned-enterprises.

From the late 1990s, the government started to reform urban employee-based medical insurance schemes by increasing the premium level and consolidating the funds of separate organizations. The NCMS was established in 2003 and was mainly subsidized by the government. This was a departure from previous rural health insurance schemes in terms of finance. From 2007, the government decided to establish a health insurance scheme for urban non-salaried residents, especially for children and old people. In addition to the social health insurance schemes, the medical assistance program, supported by the government, was put in place in 2003.

2.1.1 Population coverage

In 2008, 87% of the total Chinese population was covered by various social health insurance schemes with the UEBMI covering 15% of the total population, URBMI 4%, and NCMS 68%.

Statistics on population coverage by urban and rural areas from different sources shows a rapid increase in coverage over the past decade for the rural population (Table 1). In 2008, nearly 90% of the rural population was covered by the NCMS, while 65% of the urban residents were covered by urban health insurance schemes. After the NCMS was set up in 2003, its coverage of the population expanded rapidly, jumping from 8 million of the rural population in 2003-2004, to 179 million in 2005, 815 million in 2008, and 833 million in 2009 (MoH) – representing an expansion from 3% to 90% in five years. The lower coverage rate of urban residents achieved by the URBMI was mainly due to a shorter implementation period and also reflected the greater challenges it faced, notably the enrolment of rural-to-urban migrants.

Table 1: Population coverage of health insurance schemes by urban and rural area

Schemes	1998	2003	2008
Urban health insurance schemes (%)	52.5	49.6	64.8
Rural health insurance scheme (%)	4.7	3.1	89.4

Data source: modified from National Health Services Survey in 1998, 2003, and 2008

2.1.2 Coverage of health care benefits

UEBMI covers both outpatient and inpatient health services. The NCMS covers both outpatient and inpatient care in about 70% of the NCMS counties, the other 30% offering coverage for inpatient care only. The URBMI in principle covers inpatient care only. All three schemes include reimbursed drug lists. In general, the health care and drug packages covered by the UEBMI are more generous than the other schemes, because of its sound financing base (employer/employee contributions); the NCMS and URBMI schemes rely heavily on government subsidy.

The UEBMI drug and health care package are developed and implemented by the municipal cities which are the unit of fund pooling. The design and implementation of the health care package and drug lists is mainly the responsibility of each of the NCMS counties that are the unit of fund pooling and management. There is a big gap in the number of drugs covered by the different schemes, with an average of 2,000 drugs covered in the urban health insurance schemes, and just 400 in the list covered by the NCMS.

2.1.3 Financial protection of the health insurance schemes

The NCMS has seen a rapid growth in premiums since its inception. On average, 30 CNY (US\$ 4.40) per capita (20 CNY from government and 10 CNY from individual premium payment) was collected between 2003 and 2005. This increased to 50 CNY and 100 CNY in 2006 and 2008, respectively. Government subsidy comprises 80% of the premiums (half from central government and half from local government in the western and middle provinces). However, the per capita premium level for the NCMS in most rural areas is around ten times lower than for the UEBMI scheme.

As shown in table 2, per capita premium in the NCMS was 100 CNY, compared to 1,400 CNY for the UEBMI, in 2008. The premium level for the URBMI was somewhere between the NCMS and UEBMI levels – an average of CNY 350. Figures in Table 2 are averages (premiums vary among many municipal cities and rural counties). Central government allocates more funds to subsidize URBMI and NCMS schemes in low-income provinces located in the west and middle regions.

Reimbursement rates also differ between the three schemes. For example enrollees covered by the UEBMI scheme can claim higher reimbursement, reflecting the higher premiums paid as well as their greater capacity to pay medical expenses.

Table 2: Arrangements of health insurance schemes in 2008

Schemes	UEBMI	URBMI	NCMS
Premium per capita (CNY)	1,400	350	100
Ceiling (CNY)	100,000	80,000	20,000
Reimbursement rate (%)	72	50	40

Source of data: based on reports from the National Health Services Survey in 2008 and from Ministry of Human Resources and Social Security.

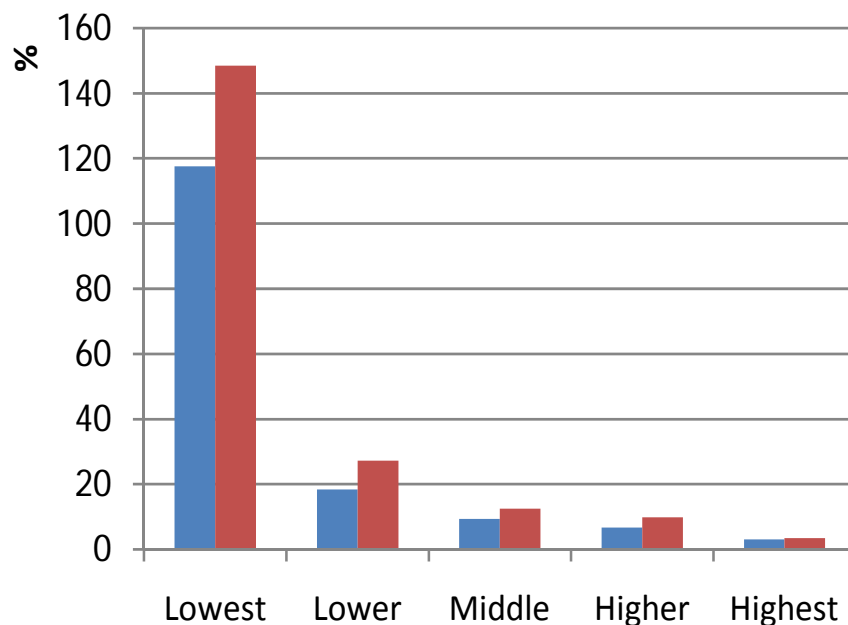
The impact of the health insurance schemes on health care utilization is evident, with utilization rates increasing especially among low-income populations. It was also found that unmet needs for health care services (defined as having needs for health care but not using any health services in a defined time period) reduced after the implementation of NCMS in rural counties. For example, unmet inpatient care needs were reduced from 34.7% in 2003 to 27.9% in 2008 (CHSI 2009).

The impact of the NCMS scheme on the financial burden of healthcare is thus seen to be inconsistent, revealing a complex relationship between changes in financial access, utilization, and medical

expenditure. Wagstaff et al (2008) found that the NCMS increased total medical expenditure (for all income quintiles) without reducing catastrophic expenditure (for all but the poorest). A recent study using data from the National Health Services Survey reports that the NCMS reduced by 50% the households suffering catastrophic medical expenditures in 2008 (Zhang YH, 2009). Wu (2009) found that compared with the NCMS, the UEBMI can significantly reduce out-of-pocket payments for old people, based on the data from the national survey.

Figure 1 illustrates annual out-of-pocket medical payments (for inpatient care) per insured as a proportion of average per capita disposable incomes of the NCMS-covered people of five different income groups from a study in Shandong and Ningxia. For all NCMS insured, the proportions increased from 2006 to 2008. The lowest-income insured and the lower-income insured experienced the greatest increase in rates at 30.8% and 8.7% respectively, while rate increases for other income groups were 3.1% or less. Average out-of-pocket medical payment per enrollee per year for the lowest-income insured exceeded average annual disposable income for this group in both years.

Figure 1: Annual out-of-pocket medical payments (for inpatient care) per insured as a proportion of per capita disposable incomes (%)



2.1.4 Observations

From the above analysis of the coverage of health insurance schemes, we reach following observations.

- China's health insurance schemes in both rural and urban areas have developed rapidly over the past decade in terms of population coverage, especially in rural areas. This rapid development creates a sound foundation for an equitable financing model designed to provide people with financial protection when they suffer illness.
- Urban and rural health insurance schemes are operated separately and reveal significant differences in premium collection and risk protection. The integration of the urban and rural health insurance schemes will remain a challenge if the difference in the premium levels of the schemes cannot be narrowed.
- As coverage reaches a higher proportion of the population, priorities need to focus on coverage of depth and height. Policy makers and insurance administrators need to identify appropriate ways to select cost-effective health care services for the benefit package.
- Development of health insurance schemes need to be accompanied by improvements in health delivery and human resource systems. Appropriate incentives are required for health providers to ensure cost-effective, quality care.

2.2 Coverage of essential public health programs

Increases in life expectancy and the reduction of infant and maternal morbidity in China are largely the result of cost-effective interventions within the public health programs. However, there are still significant disparities in health status between regions, urban and rural areas, and among population groups (Tang et al 2008). These disparities can be attributed in part to differences in the coverage provided by essential public health programs.

In this section, we focus on three types of health program - project immunization, maternal health care (ante-natal and post-natal care), and management of non-communicable diseases (NCDs) - to illustrate coverage differences in public health care.

2.2.1 Population coverage of selected public health programs

Table 3 shows immunization coverage for five vaccines (for children) broken down by area. Although the coverage is over 90% for almost all vaccines, coverage in the wealthy region (East coastal

provinces) is always higher than in the other two regions. Coverage of vaccinations of DAT, Pertussis, and Tetanus was less than 90% in the poor area (Western provinces) (CHSI 2009). It should be noted that because of the large populations involved, a small difference in the percentage covered can reflect big differences in the number of unimmunized children.

Table 3: Population coverage of immunization programs in 2008 (%)

Vaccines	Total	East	Middle	West
BCG	98.8	99.3	98.7	98.4
DAT, Pertussis, and Tetanus	90.7	93.2	91.2	88.5
Polio	92.4	94.5	90.6	92.3
Measles	92.1	91.5	93.8	91.4
Hepatitis B	93.3	95.6	93.7	91.5

Source of data: CHSI 2009

The coverage of maternal health services has increased rapidly with the introduction of a number of important interventions. The proportion of women receiving no ante-natal care during their pregnancy fell from 25.3% in 2003 to 5.6% in 2008. As shown in Table 4, the coverage of ante-natal health care has reached a high level but there are some differences in coverage between the eastern, middle, and western regions – with poor provinces getting the lowest coverage rates (CHSI 2009). Meanwhile the coverage of post-natal health care was lower than ante-natal care in all regions, with the lowest coverage in the middle provinces.

Table 4: Population coverage of maternal health care in 2008 (%)

Health care	Total	East	Middle	West
Ante-natal	94.4	97.6	94.9	91.5
Post-natal	56.9	62.7	43.0	61.2

Source of data: CHSI 2009

Chronic non-communicable diseases (NCDs) have become a major public health problem in both urban and rural areas. In 2008, for example, 270 million NCD patients were registered and 80% of deaths were caused by NCDs. Over the past decade, the incidence of hypertension and diabetes has doubled.

Table 5 shows management rates (managed cases/total cases within a community) of hypertension and diabetes. NCD case management is usually conducted by primary health providers in China. Less than 50% of hypertension and diabetes cases were managed by health providers in 2008 (CHSI 2009).

About 54% of hypertension cases never received blood pressure tests by doctors, 30.2% of hypertension cases were not aware of their condition before diagnosis; only 24.7% of the cases took drugs as advised by physicians, and the effective control rate was only 8.0% of total hypertension cases (CHSI 2009). A recent study revealed that the prevalence of diabetes was higher among urban residents than among rural residents (11.4% vs. 8.2%) (Yang et al 2010).

Table 5: Population coverage of management rates of hypertension and diabetes in 2008 (%)

NCDs	Total	Urban	Rural
Hypertension	43.8	57.5	28.1
Diabetes	46.3	61.9	21.1

Source of data: CHSI 2009

2.2.2 Dosage levels in the public health programs

Of course high population coverage is not the same as high coverage in terms of service provided. For instance, for children under five years old, the recommended dosage of vaccinations for DAT, Pertussis, and Tetanus is five according to the national guidelines. But on average only 3.37 doses per immunized child were actually provided in 2008 (CHSI 2009).

Maternal health care provides another example. According to the requirements of the Ministry of Health, pregnant women should have a minimum of 5 ante-natal examinations. However, as reported, only 78.5% of women in urban areas and 43.9% of women in rural areas who received ante-natal health care received 5 or more antenatal care examinations in 2008.

Moreover, some crucial services procedures were not provided in ante-natal examinations, including weight measurement, blood pressure test, and urine analysis. It is a similar story with post-natal examinations. The minimum number of visits recommended by the Ministry of Health after childbirth is three per childbirth. In reality, only 22.0% of women received this level of post natal care in 2008 (CHSI 2009).

2.2.3 Financial protection of the public health programs

Public health programs could cut medical costs by reducing and controlling the prevalence and severity of both infectious and non-communicable diseases. Disadvantaged populations benefit most

from the improved coverage provided by public health programs because they are most vulnerable to public health problems and least able to pay for treatment. Many studies undertaken over the past two decades have shown the positive impact of essential public health programs (including immunization, maternal health care, and control of NCDs) on medical expenditures for providers and users of health care (Sturm 2002;).

2.2.4 Observations

- Public health programs are crucial for improving the health status of populations and have been sustainably operated in China for several decades.
- The population coverage of major public health programs has increased and some of those programs (notably immunization) have reached the level of universal coverage.
- Control of NCDs is low, especially in rural area. NCDs are a major source of health problems and financial burdens.
- Quality of public health delivery needs to be improved in line with increases in population coverage. Public health programs should ensure adequate provision of a high standard of health care; for example post-natal care visits, including the provision of appropriate procedures in each of the visits.
- A number of factors influencing coverage of public health programs, including the quality of health workers, financing policies, cooperation between health providers, and regulations, need to be considered in addressing the challenges of UC.

3 Efforts and actions related to universal coverage

China has enacted several initiatives to develop universal coverage including joint projects with international organizations. This section summarizes selected key actions, policies, or efforts that relate to health system development. A sub-section is dedicated to outlining contributions from international agencies in promoting the development of China's health policies.

3.1 Government led actions on the financing of clinical services

Besides operating health insurance schemes in both rural and urban areas, the government also supports a medical assistance program (MFA) for the poor. Both the new health insurance schemes

(NCMS) and MFA were introduced in 2003 when the central government turned its development strategy from a GDP-centred to people-centred policy. NCMS and MFA are two strategies designed to close the health security gap between rural and urban areas and between the rich and the poor.

3.1.1 NCMS

In introducing the NCMS, the government aims to reduce illness-related financial burden and increase the affordability of medical care for rural populations. In order to encourage enrolment and sustain the operation of the NCMS, the central government allocates subsidies to different regions according to their level of economic development. Over the past years, an average of 80% of premiums has been subsidized by the government, with 20% coming from individual farmers. In the new health reform plan, the government has promised to increase subsidies to the NCMS on a regular basis to sustain the scheme. Per capita premiums increased from 30 CNY (US\$ 4.40) in 2003 to 150 CNY (US\$ 22.20) in 2010. Premier Wen Jiabao has promised to increase premiums to the level of 300 CNY (US\$ 44.40) per capita in 2012.

NCMS guidelines are issued by the central and provincial governments. Rural counties handle the administration of insurers developing and implementing concrete NCMS plans. In each county, an NCMS management office, staffed with 5-8 administrators, is set up to manage the NCMS operations. A rural county has an average population of half a million people.

Central government guidelines encourage the NCMS to cover mainly inpatient care. However, at present, most NCMS schemes cover both outpatient and inpatient services as a way of encouraging enrolment and also because it helps to stop minor health problems becoming more serious.

Fee-for-service is the major payment system in the NCMS, which could be one of the reasons for the rapid rise of healthcare costs. In recent years, experiments with alternative payment methods including capitation, DRGs, case-base payment, and fixed charges have been organized in some counties in order to control cost escalation (Meng 2008).

As mentioned before, the NCMS has reached a high level of population coverage. Due to low premium levels, however, NCMS co-payments are high and financial risk protection is thus limited.

3.1.2 Medical Financial Assistance (MFA)

Since its launch in 2003, the MFA has been committed to protecting the poor from the financial risks associated with high-cost diseases. Both rural and urban areas are covered by the MFA. Central and local governments are responsible for allocating funds, and subsidies from central government are concentrated on poor provinces (western and middle provinces). In addition to the few cities, including Shanghai, Guangzhou and Beijing, which piloted the MFA, the World Bank and DFID have piloted similar programs in the Health VIII and UHPP projects (see below).

The MFA targets mainly people living below the poverty line. Target populations are identified by the county (district in urban areas) Department of Civil Affairs in collaboration with community government organizations. The beneficiaries of the MFA can also receive subsidies for their contribution to NCMS and URBMI premiums. They can also claim reimbursement from the MFA if they cannot afford co-payments in the NCMS and URBMI schemes. MFA has been a crucial source of financing for the poor to pay NCMS premiums and copayments.

Government subsidies to the MFA have continuously increased since it was first started. In 2003, the urban MFA received 210 million CNY (US\$ 31 million) from the central government. This was increased to 300 million CNY (US\$ 44 million) in 2005 and 420 million CNY (US\$ 62 million) in 2006, respectively. Provincial and county (municipal and district) governments allocate matching funds for the MFA and develop their operational plans.

3.2 Delivery and financing of public health services

In general, public health services have been delivered effectively by public health providers over the past six decades. This was especially true prior to the 1980s when those services were publicly funded. Basic preventive care including immunizations, maternal and child health care, health education, and monitoring of infectious diseases were provided by village clinics (and by community health stations in urban cities), township health centres (and by community health centres in cities), and county (district) Centres for Disease Prevention and Control.

User fees were introduced in the mid 1980s and health providers were encouraged to run profitable

health care operations. This had a significant effect on the provision of essential public health programs.

The new health sector reform is designed to improve coverage of public health programs through the implementation of two types of public health programs and services. These are defined as an essential public health care package and key health programs for priority health problems.

3.2.1 Essential public health care package

Government run health care facilities began to deliver an essential public health package in late 2009. The rationale behind this measure was to gradually achieve equality in the provision of essential public health programs to the whole population. The current package includes nine categories of services, including health information system, health education, immunization, prevention and control of infectious diseases, child health promotion, maternal and geriatric health care, chronic diseases management, and the management of severe cases of mental health problems. These services, selected on the basis of an assessment of current health needs, are being delivered from primary health care facilities, including village and township clinics in rural areas, and community health centres in urban areas.

Because chronic diseases have become a serious public health problem in both rural and urban areas, the essential public health care package includes a new focus on prevention and early-stage interventions for NCDs, including mental health.

The Chinese government also intends to establish a medical records system over time that will enable the exchange of medical information among clinical providers and will also support epidemiological analysis. By the end of 2009 a medical records system was in place, covering 30% of the urban and 5% of the rural population.

In 2009, 15 CNY (US\$ 2.2) per capita was allocated to cover the operating costs of the public health care package. This funding is additional to the regular health budget already allocated to cover the salary of health workers. The central government will increase the subsidy to 20 CNY (US\$ 3.0) per capita in 2010. The central government also allocates subsidies to economically disadvantaged areas to the extent that those places can ensure provision of the essential public health service package as

defined by the central government.

In addition to the nationwide implementation of the essential public health package, China has identified key public health priorities to be addressed through services delivered by specialized providers such as CDCs and general hospitals. A case in point is Hepatitis B. In 2009, the Government began to provide immunizations to all children under 15 years of age. Other priorities include screening for cervical and breast cancer for women aged between 15 and 59, hospital childbirth, and ensuring the intake of folic acid for women during pregnancy. Other services include cataract surgery for poor patients, a cooking stove manufacture initiative to prevent fluorine poisoning, and the construction of sanitary toilets. All the above programs are fully supported with government funding.

3.3 Training health professionals for rural areas

The distribution of health resources is one of the key determinants for the coverage and quality of health care services. Major resources, including health workers, hospital beds, and facilities are under-allocated in rural and poor areas. At present, for example, most village doctors have no formal medical education, and have simply received some basic training before being assigned to work and operate the clinics. According to a national health services survey, about 60% of outpatient visits in rural areas were provided by doctors in village clinics. The lack of qualifications among health workers in rural health facilities affects the provision of satisfactory health care to the rural population. Ensuring that health workers in rural health facilities, particularly at the village level, have the necessary technical skills and abilities remains a crucial challenge in improving access to quality health care.

3.3.1 Education of health professionals for rural area

In 2004, Mr Gao Qiang, the Minister of Health at that time, announced policy designed to ensure the education of medical students in rural areas. According to this policy, student graduates from rural secondary school were to be recruited into medical colleges for five-years of medical education. After training, they were expected to go back and work in rural areas, non-compliance resulting in the revocation of their certificates for medical practice. Unfortunately this policy ran into bureaucratic

obstacles from other ministries and was abandoned. In the new round of health sector reform, measures to enhance the education and training of health workers for rural and remote areas were proposed. The Ministry of Education has included training for general practitioners for rural areas in its 2010 work plans. The training cost is covered by the government.

Some provinces started education programs to strengthen the technical capacity of rural health workers in 2009. Students enrolled in these education programs are asked to sign a contract with the county health bureau that commits them to working in rural health facilities for at least five years after graduation. The education costs are covered by the provincial government.

3.4 International assistance programs.

Some international organizations have played a crucial role in assisting the formulation of universal coverage policies and programs by providing technical and/or financial resources. The World Health Organization, with its focus on mobilizing technical assistance and policy development for member countries, has a unique influence on China's health policy. The World Bank, UNICEF, UNDP, DFID, Ausaid, and other organizations also help China in health policy making and practice. The World Bank has implemented 11 health programs in China, covering a wide range of areas including a recent health policy development program in rural areas. Two programs that are closely related to universal coverage policy and equity in health care systems are described below.

3.4.1 Health policy support project (HPSP)

HPSP was designed by the government of China, DFID, and WHO and launched in 2005. Financial support was provided by DFID with £6 million, while WHO provided technical assistance. The aim of the HPSP was to facilitate the development of an efficient, equitable, and quality health care system through research, knowledge management, capacity building, and the strengthening of government intersectoral communications and coordination. The implementation of the HPSP coincided with the development of China's health reform policy framework. This four-year project finished in 2009 and achieved a number of outputs, including:

- Evidence generation. HPSP supported a number of research projects focusing on analysis and policy development relating to equity in health and health care. Those projects generated evidence suggesting innovative approaches to improving access to health care. For example, the study on essential basic health care supported by HPSP provided policy makers with the methods required to implement strategy to establish a national essential public health package.
- Knowledge management and translation. HPSP supported the establishment of a platform for knowledge management and translation through the Center for Health Statistics and Information of the Ministry of Health. This platform organized activities focusing on systematic reviews and preparation of policy briefings to assist program managers and policy makers. Universal coverage, primary health care, and performance of health system were the main topics.
- Capacity building. Two types of capacity building activities were supported by HPSP: raising awareness of key issues concerning health system development among relevant government stakeholders, including strengthening skills to utilize evidence for policy making; training health systems researchers in providing quality evidence and translating research findings into policy practice.
- UC experiments. HPSP supports two experiments in universal coverage in Weifang in Shandong province and Yinchuan in Ningxia province. The experiments focused on reforming health financing, establishing an essential public health package, the development of primary health system and payment systems. Lessons and experiences from these pilot areas were incorporated into the design of national plans.

3.4.2 Urban Health and Poverty Project (UHPP)

UHPP was a project supported by the United Kingdom which started in 2002 and ended in 2007 and had two primary purposes: the first, to improve community health care systems by providing experience and learning opportunities; the second, to test a medical assistance scheme based on the development of the community health care system. UHPP covered four cities located in the eastern and western provinces. When UHPP started up, a lot of practical issues had to be addressed with regard to community health care development because, at that time, central government policy was focused on economic development, and nation-wide medical assistance schemes were absent.

UHPP supported the development of community health care in project cities through the training of policy-makers and health practitioners, the conduct of research projects, consultancy, and study tours. The capacity of community health care system was significantly improved as a result.

UHPP played a crucial role in facilitating the formulation of national policy with regard to a medical assistance program. Experiences in piloting medical assistance in UHPP project cities, including the

identification of beneficiaries, the design of the benefit package, contract arrangements with health providers, and evaluation, have been drawn on extensively by the central government in putting together the medical assistance programs.

4 Challenges and opportunities

China has made a promising start in its efforts to construct a universal health care system. However, attempts to achieve universal coverage in such a vast and diversified country are bound to face challenges. How China's government addresses those challenges can provide useful lessons for other developing nations.

4.1 Challenges

It is not easy to realize UC in a short period because of the big gaps in health care coverage between regions, urban and rural areas, and population groups. The following specific challenges need to be taken into consideration:

- China is a big country characterized by varied levels of economic and health development. Determinants of health and health care often lie outside health sector. Efforts to reduce disparities need to be made by all relevant sectors.
- Despite the fact that the central government supports the development of a people-centred ideology in governance, local governments are still focused on economic development. As a result health and healthcare are not always at the top of the political agenda in many areas of the country. This may lead to proposed health reform policies and actions not being sufficiently and effectively implemented.
- China is still poor in terms of its average per capita resources. UC requires increased investment from both government and individuals. Health care services delivered by the UC system cannot exceed the availability of resources. Thus government is faced with the perennial problem of how to mobilize and sustain resources for the health care system.
- UC in China emphasizes the provision of primary and cost effective health care mainly supported by public funding. This involves a shift in the allocation of health resources from tertiary hospitals to community health systems and from expensive pharmaceuticals to generic drugs. This reallocation may be resisted by strong stakeholders.

-

4.2 Opportunities

While there are many challenges, there are also reasons for optimism regarding the achievement of the UC system in China.

- The development concept. China's central government has changed its development policy from GDP-centred to a broader coordinated concept which includes non-economic sectors such as health and education. Even if local governments need time to catch up, this new direction represents a welcome change
- The established health care system. Over the past six decades, China has established a health care system through which basic health care can be provided if current health resources can be adjusted and redistributed. It provides a foundation which, through the strengthening of human resources, governance, and regulation, can offer accessible quality health care.
- The influence of the public's voice. Public complaints have been more important than was previously the case in influencing policy making and changes. The current health sector reform is partially a result of public pressure. Government should do its utmost to achieve its aims and to implement promised policy in order to avoid public dissatisfaction.
- Stable and rapid economic development. China's economic development is stable and fast, which provides the financial conditions necessary to operate and sustain health programs that move towards a UC system. The government is likely to continue increasing financial support for the health sector if economic development and growth is maintained.

Acknowledgment

Dr Cris Tunon from WHO Beijing Office is gratefully acknowledged for his insightful comments and suggestions on the earlier draft of the background paper.

References

- CCPC and the State Council (The Chinese Communist Party Committee and the State Council). Guidelines for Deepening Health Systems Reform. Beijing, 2009-03-17
- CHSI (Center for Health Statistics and Information, Ministry of Health). National Health Services Report. Beijing, 2009
- Liu Y. Reforming China's urban health insurance system. *Health Policy* 2002;60:133–150
- Meng Q. Provider payment system reform in China: a updated review. World Bank AAA report, 2008
- Sturm D. The Effects Of Obesity, Smoking, And Drinking On Medical Problems And Costs. *Health Affairs*, March/April 2002; 21(2): 245-253
- Tang S, Meng Q, Chen L, Bekedam H, Evans T, Whitehead M. Tackling the challenges to health equity in China. *The Lancet* 2008; 372: 1493-501.
- Wagstaff A, Lindelow M. Can insurance increase financial risk? The curious case of health insurance in China. *Journal of Health Economics* 2008;27:990–1005
- Wang L, Wang Y, Wu Z, et al. Emergence and control of infectious diseases in China. *The Lancet* 2008; Oct 34-41
- WHO. Sustainable health financing, universal coverage and social health Insurance. Ninth plenary meeting 2005, Eighth report
- Wu J. The impact of social health insurance schemes on health care utilization and medical burdens. Research report from the National Health Services Survey. 2009
- Yang G, Kong L, Zhao W, et al. Emergence of chronic non-communicable diseases in China. *The Lancet* 2008; Oct 42-50
- Yang W, Lu J, Weng J, et al. Prevalence of Diabetes among Men and Women in China. *The New England Journal of Medicine* 2010 march 25
- Zhang YH. The impact of NCMS on medical expenditures of inpatient care. Beijing: unpublished technical report from National Health Economics Institute, 2009.