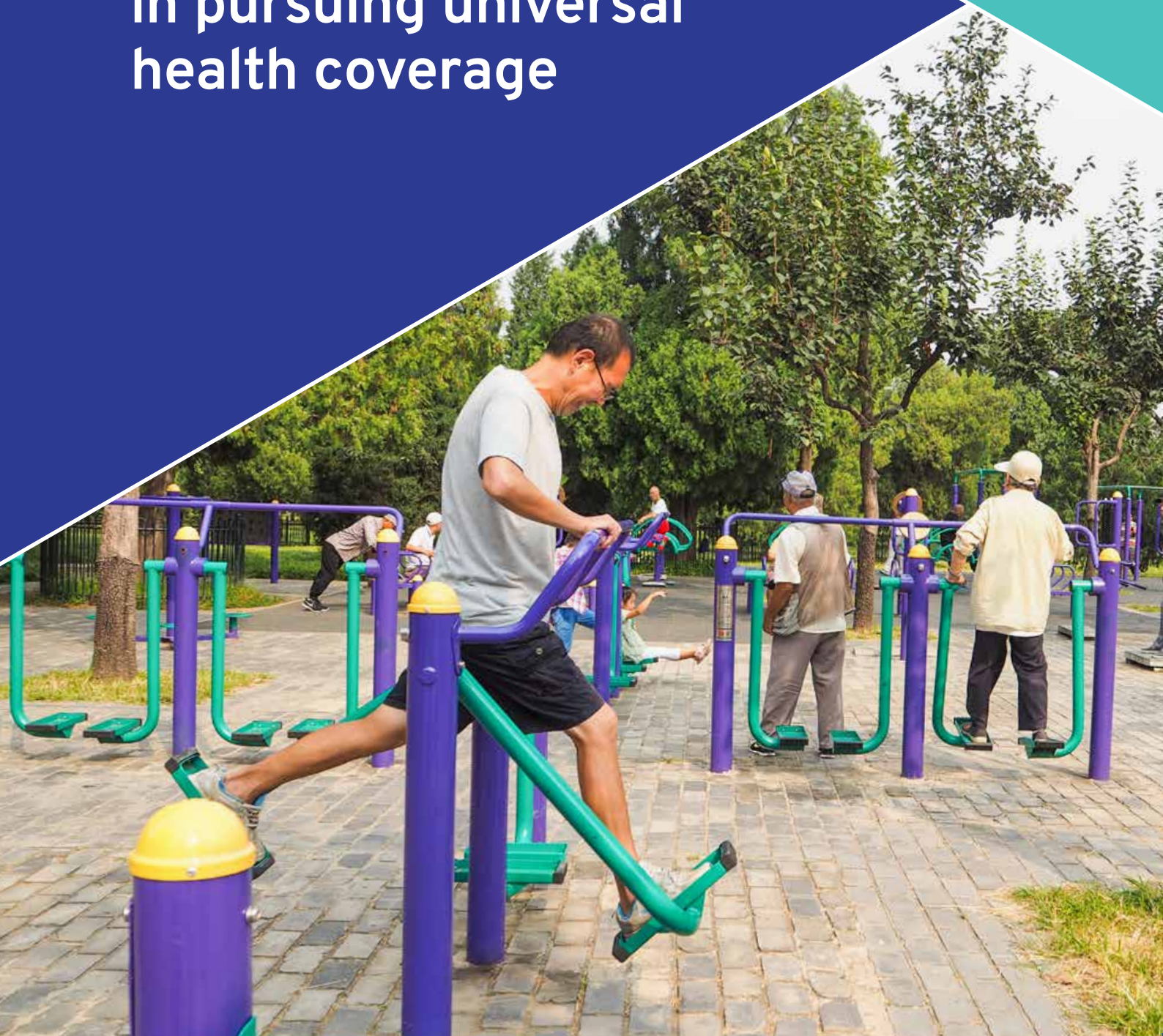
International Labour Organization

Funded by the European Union

China's experience in pursuing universal health coverage



China's experience in pursuing universal health coverage

First published 2025.

ISBN: 9789220420881 (print); 9789220420898 (web PDF)
DOI: https://doi.org/10.54394/OPGO4545

Also available in Chinese: *迈向全民医疗保障的中国经验*, ISBN: 9789220420904 (print); 9789220420911 (web PDF)

Printed in China

Front cover: Elderly working out on the public equipment in the park of the Temple of Heaven, Beijing, 2017. © Shutterstock

Contents

List of figures

▶ Glossary

Population covered by basic medical insurance schemes refers to the total number of persons enrolled in basic medical insurance for employees and basic medical insurance for rural and non-working urban residents at the end of the reporting period.

Population covered by basic medical insurance for employees (EBMI) refers to the total number of active workers and retirees enrolled in basic medical insurance for employees in accordance with national regulations at the end of the reporting period. The scheme is implemented based on the combination of risk and financial pooling and individual accounts or on complete risk and financial pooling.

Population covered by basic medical insurance for rural and non-working urban residents (RBMI) refers to the total number of persons enrolled in basic medical insurance for rural and non-working urban residents at the end of the reporting period, including adults, students and children.

Basic medical insurance participation rate refers to the ratio of the population enrolled in basic medical insurance schemes to the population eligible to be enrolled, that is, effective population / eligible population × 100 per cent.

Enterprises, public institutions and government agencies refer to different types of organizations registered in the People's Republic of China in line with the laws.

In-service/retirement ratio is the ratio of active workers participating in basic medical insurance for employees to retirees enrolled in the scheme.

Flexibly employed workers (flexible workers) include self-employed individuals without employees, freelancers, and those who have not terminated their social insurance relationship after unemployment, among others.

Workers in new forms of employment (NFE workers) refer to individuals employed through digital platforms, primarily including online delivery workers, ride-hailing drivers, internet marketers and others.

Fund payment ratio for medical expenses in insurance-covered services (as listed in the basic medical insurance catalogue) is calculated as the total payment by each fund divided by the total medical expenses covered by insurance, multiplied by 100 per cent.

Maternity allowance refers to the benefit paid for participants in the maternity insurance scheme in line with regulations during the reporting period, including benefits (wage replacement) for insured female workers on maternity leave and for family planning surgery leave.

Diagnosis-Related Group (DRG) is a system where hospitalized patients are categorized into several groups based on their disease, diagnosis, age, gender, etc. Each group is further divided into levels according to the severity of the disease and the presence of complications or comorbidities. Corresponding payment standards are established for each level, and hospitals are reimbursed according to these standards.

Diagnosis-Intervention Packet (DIP) is a complete management system established with the support of big data, classifying patient data through the common characteristics of "disease diagnosis + treatment modality". DIP seeks to form a standardized position for each disease-treatment modality combination of the full-sample case data in a certain region, objectively reflecting the severity of the disease, the complexity of the treatment, resource consumption and clinical behaviours. DIP can be applied in medical insurance payments, fund supervision and other fields.

E-certificate for medical insurance/medical insurance code is an electronic medium for identification of all insured persons based on the basic information database of medical insurance, issued by the national medical insurance information platform. Supported by authentication technology, insured persons can use the e-certificate to access various online medical insurance services, such as medical insurance business handling, individual account enquiry, medical consultation, and medicine purchasing and payment.

▶ Abbreviations

CPC	Communist Party of China
DRG	Diagnosis-Related Group
DIP	Diagnosis-Intervention Packet
EBMI	Basic medical insurance for employees
EU	European Union
GDP	Gross domestic product
ILO	International Labour Organization
ISSA	International Social Security Association
MOHRSS	Ministry of Human Resources and Social Security
NBS	National Bureau of Statistics
NDRC	National Development and Reform Commission
NFE	New forms of employment
NHC	National Health Commission
NHSA	National Healthcare Security Administration
NPC	National People's Congress
NRCMS	New rural cooperative medical scheme
RBMI	Basic medical insurance for rural and non-working urban residents
RCMS	Rural cooperative medical scheme
SCIO	State Council Information Office
UHC	Universal health coverage
URBMI	Basic medical insurance for non-working urban residents
WHO	World Health Organization

▶ Acknowledgements

This technical note was developed by Ms. Gui CAO (Chinese Academy of Labour and Social Security), with guidance from Mr. Liqiang ZHANG (National Institute of Healthcare Security, Capital Medical University).

It has benefitted from the technical inputs of Mr. Ruben VICENTE ANDRES (Social Protection Project Manager) and Ms. Jie ZHOU (National Project Coordinator) of the ILO Country Office for China and Mongolia (CO-BEIJING), as well as Ms. Marielle Phe GOURSAT, social health protection expert at the ILO Decent Work Technical Support Team for East and South-East Asia and the Pacific (DWT-Bangkok).

The authors extend their gratitude to the National Healthcare Security Administration of China for their careful review and valuable comments during the drafting process.

This publication was developed with the support of the International Labour Office (ILO), as part of the EU-China project "*Improving China's Institutional Capacity towards Universal Social Protection (Phase 2)*," funded by the European Union. Its contents are the sole responsibility of the authors and do not necessarily reflect the views of the European Union or the ILO.

▶ Executive summary

This technical report was commissioned by the ILO in the context of the EU-funded project "Improving China's institutional capacity towards universal social protection (Phase 2)". Medical security is a crucial component of social security, and China has made significant strides in extending universal health coverage in recent years. Systematically summarizing China's experiences will provide valuable references for other countries exploring the possibility of universal health coverage and contribute to the advancement of global health protection.

The report is structured into four sections: an overview of the development of China's multi-tier medical security system, the design of China's basic medical insurance system, the results of expanding universal health coverage, and the challenges, key experiences, and recommendations for advancing China's universal medical insurance.

China is committed to establishing and improving a multi-tier medical security system. Through the enactment of a series of laws and regulations, the coverage of basic medical security in China has expanded from urban employees to rural residents, and then to urban residents. This expansion has increased coverage from small to large populations and enhanced the level of protection from low to high. Ultimately, China has established a three-tiered basic medical security system comprising basic medical insurance, critical illness insurance, and medical assistance to mitigate the burden on the public. Additionally, commercial health insurance, charitable assistance and mutual medical aid along with basic medical security, constitute a multi-tier medical security system.

The basic medical insurance system in China includes employee medical insurance and resident medical insurance. In terms of **coverage**, employee medical insurance covers all employees of organizations, self-employed individuals without employees, part-time workers not covered by their employers, and other flexibly employed persons. Resident medical insurance covers all urban and rural residents except for those who should be covered by employee medical insurance or those who are entitled to other forms of protection according to regulations. By the end of 2023, China's basic medical insurance covered 1.33 billion people, accounting for 94.6 per cent of the total population.

In terms of **benefit** design, both employee and resident medical insurance schemes include thresholds (deductibles), caps (ceiling amount for eligible expenses), and fund payment ratios. The fund payment ratios for hospitalization expenses within the catalogue are approximately 80 per cent for employees and 70 per cent for residents. For outpatient expenses, the fund payment ratio for the employee scheme is not less than 50 per cent, with a commonly set cap. The benefit level for the resident scheme is generally lower than that of the employee scheme.

In terms of **financing**, employee medical insurance is funded by contributions from both employers and employees. The employer contributes 6 per cent of the monthly salary, while the employee contributes 2 per cent. No further contributions are required after retirement. In 2023, the per capita financing for employee medical insurance was 6,182 yuan. Resident medical insurance is financed through flat-rate individual contributions and government subsidies. In 2023, the per capita financing for resident medical insurance was 1,098 yuan.

In terms of **service provision**, there were 1.07 million healthcare institutions in 2023, including 38,400 hospitals, 1.02 million primary healthcare institutions, and 12,100 specialized public healthcare institutions. The number of beds in healthcare institutions per 1,000 population was 7.23, the number of licensed (assistant) physicians per 1,000 population was 3.40, and the number of registered nurses per 1,000 population was 4.00. In 2023, there were 520,000 designated medical institutions and 485,000 designated retail pharmacies nationwide for medical insurance.

In terms of **strategic purchasing**, the total revenue of the National Basic Medical Insurance Fund in 2023 was 3.35 trillion yuan, with 2.29 trillion yuan from the employee medical insurance fund and 1.06 trillion yuan from the resident medical insurance fund. The 2024 edition of the National Medical Insurance Medicines Catalogue includes a total of 3,159 Western and traditional Chinese medicines.

In 2023, China's per capita life expectancy reached 78.6 years. The national maternal mortality rate fell to 15.1 per 100,000, and the infant mortality rate dropped to 4.5 per 1,000 live births. These major health indicators have generally placed China at the forefront of middle- and high-income countries, achieving a remarkable health leap rarely seen in human history.

Despite the significant achievements of China's universal health coverage, the system still faces challenges such as achieving full coverage, ensuring adequacy and fairness of benefits, addressing inadequacies in the financing mechanism, dealing with low-level fund pooling, and managing the rapid growth of medical costs, which increase pressure on the medical insurance fund.

Reflecting on the past, China's basic medical insurance has covered over 1.33 billion people, achieving nearly universal coverage. This success was primarily due to the Chinese government's strong political will to enhance citizens' well-being, its growing economic strength and robust financial support, broad public backing, adaptation of international experiences to local conditions, and the rapid development of medical insurance informatization. Moving forward, it is essential to accurately identify the uninsured, improve benefit adequacy, establish a fair and uniform benefit guarantee mechanism, and develop a stable and sustainable financing mechanism.

▶ Introduction

The *Universal Declaration of Human Rights*, adopted by the United Nations General Assembly in 1948, stipulates that everyone has the right to social security, laying a foundation for the establishment of today's international legal framework for social security. Fundamentally, universal health coverage (UHC) is an important goal proposed on the basis of human rights and actual human needs.

The International Labour Organization (ILO) adopted the Social Security (Minimum Standards) Convention, 1952 (No. 102), which established the minimum requirements for social security systems, including coverage of medical care. The subsequent Medical Care and Sickness Benefits Convention, 1969 (No. 130) and Recommendation (No. 134), as well as the Maternity Protection Convention, 2000 (No. 183) and Recommendation (No. 191), set higher standards for medical, sickness, and maternity protection. The Social Protection Floors Recommendation, 2012 (No. 202), supplemented Convention No. 102 and the subsequent higher standards by proposing two dimensions for bridging coverage gaps and achieving universal coverage: extending coverage horizontally to uncovered populations and vertically to higher levels of protection and more comprehensive benefits. International labour standards have established a series of guiding principles in the field of social health protection, including universal protection, collective financing, adequacy and predictability of benefits, and the primary responsibility of the State. As early as 1944, the ILO's Medical Care Recommendation (No. 69) called for the provision of medical services to all people through social insurance, social assistance, and public health services.

In 2005, the 58th World Health Assembly formally introduced the concept of UHC, meaning that all people should have access to the full range of quality health services that they need, when and where they need them, without financial hardship (WHO, 2024). Following the conclusion of the Millennium Development Goals, the United Nations established the 2030 Sustainable Development Goals (SDGs) in 2015, where UHC was set forth to promote the health and well-being of people of all ages (SDG Target 3.8), encompassing population coverage, service coverage, and financial protection.

Although the Chinese government has not yet ratified Convention No. 102, it has consistently pursued the spirit and principles of the Convention by prioritizing the protection of people's health in its development strategy, achieving positive progress in the pursuit of UHC. With six years remaining until the completion of the SDGs, summarizing China's experiences in advancing universal health coverage can contribute with valuable insights and strength to the ongoing development of global health initiatives.

Women practicing the traditional fan dance in the park, Luannan County, Hebei Province, 2021. © Shutterstock

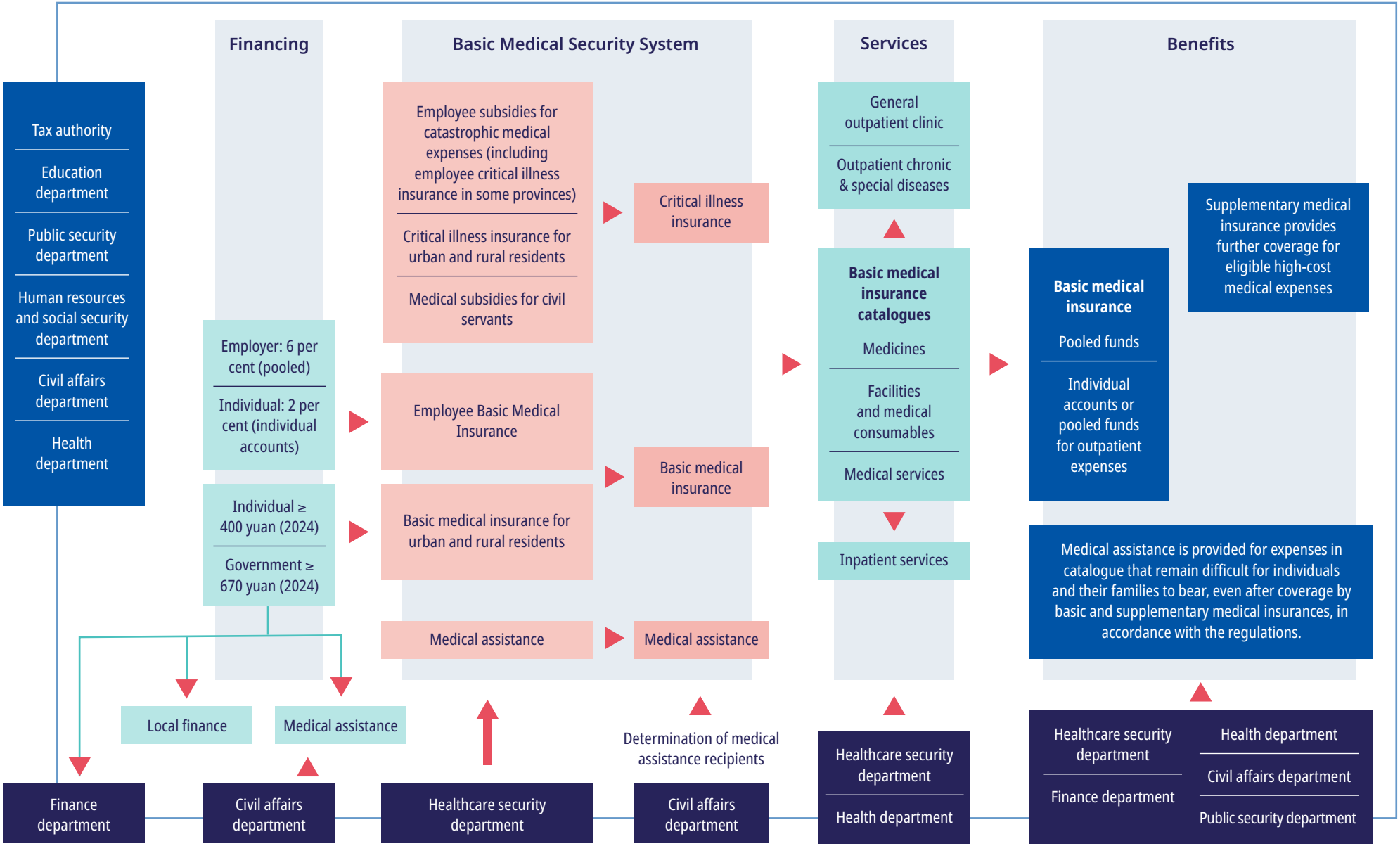
1 China's efforts to improve the multi-tier medical security system

1.1 Framework of China's medical security system

A social health protection system is essential to UHC – a globally shared goal – for people of all ages. According to *the Social Insurance Law of the People's Republic of China*, *the Interim Measures for Social Assistance* and other national laws and regulations, as well as decisions and plans of the Communist Party of China (CPC) Central Committee and the State Council, China has established a three-tiered **basic medical security system** comprising **basic medical insurance, critical illness insurance, and medical assistance** to mitigate the burden on the public (see figure 1). Basic medical insurance consists of **basic medical insurance for employees (EBMI)** and **basic medical insurance for rural and non-working urban residents (RBMI)**.

In order to meet the diversified health needs of its population, China has additionally set up commercial health insurances, charitable assistance, mutual medical aid, which, together with the basic medical security system, constitute a multi-tier medical security system. From urban employees to rural and urban residents, China's basic medical security system has seen an expansion of coverage providing higher level of protection and enhanced administrative services (SCIO, 2024). By the end of 2023, over 1.33 billion people were covered by China's basic medical security (NHSA, 2024a), accounting for 94.6 per cent of the country's total population (NBS, 2024). China has established the world's largest basic medical security system.

▶ **Figure 1. Framework of financing, services and benefits of the basic medical security system (as of 2024)**



1.2 Legal and policy framework for a universal medical security system

China has promulgated a series of laws and regulations to support the development of a universal medical security system (see annex 1).

On the institutional side, the 2010 ***Social Insurance Law of the People's Republic of China*** (henceforth referred to as the *Social Insurance Law*) provides fundamental legal guarantees for the improvement and development of the basic medical insurance system and clarifies the basic framework and principles of the social insurance system, a step towards the goal of establishing UHC. ***The Law of the People's Republic of China on Basic Medical and Health Care and the Promotion of Health*** enacted in 2020 stipulates the rights and obligations of citizens to participate in basic medical insurance in accordance with the law. In 2021, the National Healthcare Security Administration (NHSA) released ***the Medical Security Law (draft for public comment).*** This programmatic and comprehensive law on medical security underscores that China's medical security system is beginning to be formally anchored in legislation.

In the field of medical and healthcare, the ***Opinions of the Central Committee of the Communist Party of China and the State Council on Deepening the Reform of the Medical and Healthcare System,*** issued in 2009, made specific regulations and arrangements for the goal, principles, overall structure and key tasks of the reform of the medical and healthcare system. It proposed to "establish a basic medical security system covering urban and rural residents", which provided a favourable external environment and an opportunity for rapid development, enabling China to achieve UHC at a fast pace.

In May 2018, following a new round of **national institutional reform**, the National Healthcare Security Administration was established, marking the beginning of a new phase of comprehensive deepening of healthcare reform. The Chinese government has introduced a series of major reform measures, including top-level design, regulations for the use and supervision of basic medical insurance funds, reform of individual accounts for employee medical insurance, promotion of city-level pooling, centralized procurement of medicines and medical supplies, expansion of payment trials based on Diagnosis-Related Groups (DRG) and Diagnosis-Intervention Packet (DIP), and the establishment of a medical insurance benefits list system (Zheng, 2021). These measures have led to the maturation and high-quality development of the basic medical security system.

In March 2020, **the CPC Central Committee and the State Council** jointly issued the ***Guidelines on Deepening the Reform of the Medical Security System*** **(henceforth referred to as the Guidelines).** This makes clear the goal of developing a sustainable multi-tier social security system that covers the entire population in both urban and rural areas, with clearly defined rights and responsibilities and appropriate support levels. The *Guidelines* also highlighted the development by 2030 of a medical security system centred on basic medical insurance and underpinned by medical assistance, with supplementary medical insurance, commercial health insurance, charitable donations, and mutual medical aid under co-development.

The issuance of the *Guidelines* marks the beginning of a new development phase in China's medical security system reform, aiming to fully establish a high-quality, sustainable medical security system with Chinese characteristics (Zheng, 2022). In 2021, **the General Office of the State Council issued *the 14th Five-Year Plan for Universal Medical Security*** to further refine the implementation of the *Guidelines* in the next five years. In July 2024, **the CPC Central Committee issued *the Decision of Fully Deepening Reforms and Promoting Chinese Modernization.*** This *Decision* proposes improvements to the social security system, including refining the mechanisms for financing and benefits adjustment of basic old-age insurance and medical insurance. It also aims to enhance social security schemes for flexibly employed workers (flexible workers), migrant workers, and workers in new forms of employment (NFE), expand the coverage of unemployment, work-related injury, and maternity insurances, and remove household registration restrictions on enrolment in social insurance schemes at the workplace. Additionally, it seeks to improve policies concerning the transfer and renewal of social

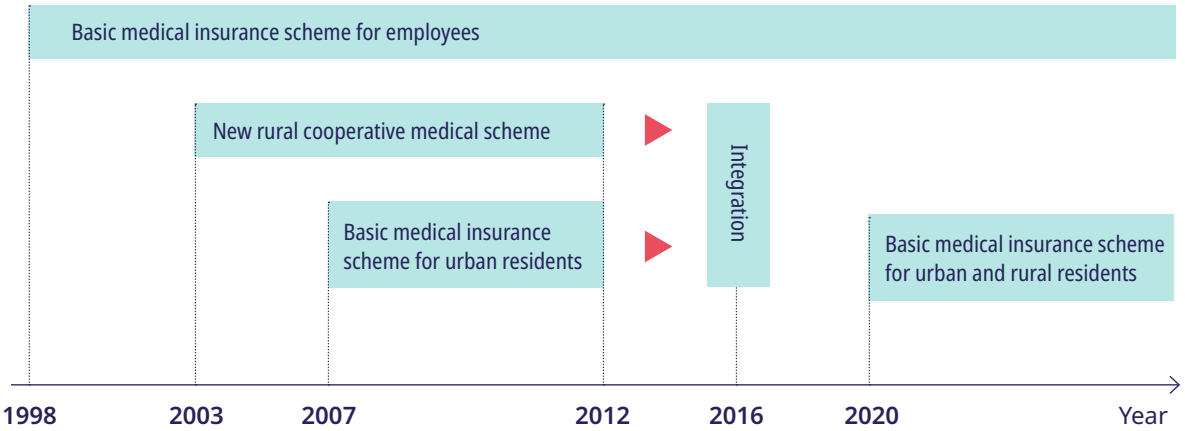
insurance entitlements and to fully leverage the supplementary protection role of commercial insurances. The *Decision* also calls for advancing provincial-level pooling of basic medical insurance, deepening the reform of medical insurance fund payment methods, refining critical illness insurance and medical assistance schemes, and strengthening the supervision of medical insurance funds.

1.3 China's path towards universal coverage of basic medical security

In the early years of the founding of the People's Republic of China, the State established, on the basis of a planned economy, labour medical insurance for enterprise employees and publicly funded medical insurance for staff of government agencies and public institutions. Following socialist market economic reforms, China embarked on the transition from free labour and publicly funded medical insurance schemes to a social medical insurance system (Lu, 2022). In December 1998**,** the State Council released a **Decision** to establish basic medical insurance for urban employees, emphasizing the principle of local management, meaning that it would be administered within each pooling area. In 2002, enterprise employees and staff of government agencies and public institutions were covered by basic medical insurance (Li, 2022; Sun, 2018).

The rural cooperative medical scheme (RCMS) was introduced in 1957 in the context of the rural collective economy, but it was largely dismantled with the reform of the rural household contract responsibility system. In 2003, the General Office of the State Council released a **Decision** proposing to pilot a voluntary **new rural cooperative medical scheme (NRCMS)** focusing on medical insurance for critical illness. As stipulated, the new pilot programme was organized, guided and supported by the government, targeted to rural residents on a voluntary basis and financed by individuals, the collective and the government. The *Decision* also proposed the goal of "establishing an NRCMS that basically covers all rural residents throughout the country by 2010". Having included urban employees and rural residents in the coverage of basic medical insurance, in 2007, the State Council issued ***Guidelines on the establishment of a pilot basic medical insurance for non-working urban residents*** (URBMI), which was financed by insured households and government subsidies. With the establishment of these schemes, China extended basic medical insurance coverage from urban employees to rural and urban residents (see figure 2).

▶ **Figure 2. Schematic diagram of the development of the basic medical insurance system**



As the system evolved, the per capita financing levels of the URBMI and NRCMS gradually converged, thus in 2012, localities in the country began to explore how to integrate the two schemes to promote a more equitable structure. In January 2016, the State Council issued the ***Opinions on integrating the Basic Medical Insurance Schemes for Urban and Rural Residents***, integrating the scope of coverage, financing policies, benefits lists (catalogues), the management of designated institutions and medical insurance funds of the two existing schemes. Two schemes EBMI and RBMI within the framework of the basic medical insurance system facilitated funding of the system and improved the level of benefits for the insured population. In November 2016, the Chinese Government was granted the "ISSA Award for Outstanding Achievement in Social Security" by the International Social Security Association (ISSA), signifying that China's achievements in reform and development of universal medical insurance were recognized worldwide. In 2019, the General Office of the State Council issued the Opinions stipulating that **maternity insurance** should be implemented in conjunction with the EBMI, and that the funding of the two schemes should be merged into one account and managed in a unified manner.

To improve financial protection, the State has established, in addition to basic medical insurance, **critical illness insurance for rural and non-working urban residents** (hereafter referred to as critical illness insurance), **subsidies for catastrophic medical expenses for insured employees** (including critical illness insurance for employees implemented in some provinces), and medical subsidies for civil servants.

In 2010, to enhance medical security for rural residents and reduce the burden of critical illnesses on farmers, the former Ministry of Health issued the Opinions on pilot work to improve medical security for rural children. The pilot programme prioritized critical illnesses that threaten children's health, incur high costs, and have good prognoses with treatment, such as acute leukaemia and congenital heart disease.

In 2012, National Development and Reform Commission (NDRC) and five ministries jointly issued the ***Guidelines on the development of critical illness insurance for rural and urban residents***, clarifying that critical illness insurance for urban and rural residents is an institutional arrangement that provides additional coverage for high medical expenses incurred by patients with critical illness, on top of basic medical insurance. Based on the pilot programme, in 2015, the General Office of the State Council issued the ***Opinions on fully implementing critical illness insurance for urban and rural residents***. This document requested the full implementation of critical illness insurance, providing additional coverage for high medical expenses incurred by urban and rural residents due to critical illnesses, ensuring that people do not fall into financial hardship because of illness.

In terms of **medical assistance**, in 2003, the Ministry of Civil Affairs and other ministries jointly issued the ***Opinions on the implementation of medical Assistance in rural areas***, which stipulated the establishment of a medical assistance system for rural residents. In 2005, a pilot medical assistance scheme was started in urban areas. In 2008, a unified medical assistance system for urban and rural residents was fully implemented. The State Council issued ***the Opinions on further improving medical assistance system and fully implementing medical assistance for critical illness*** in 2015 and the ***Opinions on further improving medical insurance and assistance for critical illness*** in 2021. It was proposed that medical assistance should fairly cover urban and rural residents and employees who face heavy medical expenses, with categorized assistance based on the type of recipients.

A nurse at Jiangxi People's Hospital replacing dialysate for uremia patients, Jiangxi, 2012. © Shutterstock

2

Design of China's basic medical security system

2.1 Population coverage

In 2021, the **NHSA issued the *Opinions on establishing a medical insurance benefits list system* (henceforth referred to as the benefits list),** clarifying the eligible persons for each scheme in the basic medical insurance system, and the policies of subsidies for enrolment. All employees, self-employed individuals without employees, part-time workers not covered through their employers, and other forms of flexible workers are entitled to participate in the EBMI. **Enrolment is mandatory for employees and voluntary for other workers**. Employees participating in EBMI simultaneously participate in maternity insurance, which covers employers and their employees. The **RBMI** is a **voluntary enrolment** insurance scheme covering all urban and rural residents except those who are eligible for enrolment in the EBMI or for other types of coverage in accordance with the regulations. Citizens have the right and obligation to participate in basic medical insurance according to the law. Individual contributions need to be paid annually in a lump sum during the centralized enrolment period at the place of household registration or residence. Part-time workers and other flexible workers can choose to participate in either EBMI or RMBI. In August 2024, the General Office of the State Council issued ***the Guidelines on improving the long-term mechanism for basic medical insurance enrolment* (Henceforth referred to as the long-term mechanism for enrolment)**, easing household registration restrictions on enrolment. Specifically, megacities are required to remove the household registration restrictions on enrolment in the EBMI for flexible workers, migrant workers, and NFE workers. Primary and secondary school students and pre-school-aged children are entitled to participate in the RBMI in the place where they live. The Guidelines

also stipulate that newborns can be enrolled in the RBMI with a birth medical certificate instead of waiting for household registration. Online application for medical insurance codes allows for immediate insurance coverage upon birth.

In terms of **critical illness insurance**, EBMI participants (including retirees) are requested to simultaneously participate in catastrophic medical expense subsidies/critical illness insurance. RBMI participants are automatically covered by critical illness insurance. When insured individuals seek medical treatment, especially during hospitalization, if their personal expenses exceed a certain amount, generally not higher than 50 per cent of the average disposable income of residents in the pooled region from the previous year, critical illness insurance is automatically activated (SCIO, 2024; NHSA, 2021).

Medical assistance covers impoverished individuals, low-income households, and those who have fallen back into poverty due to illness.

2.2 Benefit design

Medical service expenses incurred by participants receiving basic medical services at designated medical institutions should be mainly covered by the basic medical insurance fund and co-payments by individuals (National People's Congress, 2020). The fund is used to cover general outpatient medical care, outpatient treatment for chronic and special diseases, and inpatient care concerning, respectively, medicines, service facilities, and diagnosis and treatment items that are covered by basic medical insurance (see figure 1). Both EBMI and RBMI set thresholds (deductibles), caps (ceiling amount for eligible expenses), and fund payment ratios. The individual account of the EBMI can be used to pay for outpatient expenses at designated medical institutions, medicines purchased at pharmacies, and expenses below the deductible line, while pooled funds of the EBMI and the RBMI are mainly used to cover inpatient and outpatient medical expenses within the range of the deductible line and the ceiling amount.

Maternity benefits, including maternity allowance and maternity-related medical care, are primarily provided through maternity insurance. EBMI participants receive a maternity allowance (paid maternity leave) and reimbursement for maternity-related medical expenses. RBMI participants do not receive a maternity allowance but can get reimbursement for their maternity-related medical expenses through RBMI.

Critical illness insurance under RBMI is an additional layer of protection within the basic medical insurance framework, providing further coverage for high medical expenses incurred by RBMI participants. **Catastrophic medical expense subsidies for employees** (including critical illness insurance in some provinces) provide further coverage for high medical expenses incurred by insured employees (SCIO, 2024; NHSA, 2021). The duration of basic medical insurance benefits is consistent with the enrolment period. In principle, the maximum payment limit for the EBMI plus subsidies for catastrophic medical expenses for employees, and for the RBMI plus critical illness insurance, is about six times the average annual wage of local employees and the per capita disposable income of local residents respectively (NHSA, 2021).

To enhance the mutual aid efficiency of the fund, in 2021, the General Office of the State Council issued the ***Guidelines on establishing and improving the mutual aid system for covering outpatient medical expenses under the basic medical insurance for employees*** **(henceforth referred to as Outpatient Mutual Aid)**. It clearly stipulates that employers' contributions are fully included in the pooling fund, and the amount transferred from the pooling fund to retirees' individual accounts is standardized, and the family mutual aid function of employees' individual accounts is strengthened. By 2024, all provinces have achieved mutual aid across pooling regions within the province for employees' individual accounts. The scope of mutual aid has been expanded to include spouses, parents, children, siblings, grandparents, and maternal grandparents of the insured employees. Insured persons can add their close relatives online to achieve mutual aid. The 'Outpatient Mutual Aid' clarifies that on the basis of ensuring outpatient chronic and special disease medical

security, the general outpatient expenses for common and frequently occurring diseases will gradually be included in the scope of the pooling fund payment, improving the outpatient benefits for insured persons.

To meet the public's needs for **cross-region medical settlement**, since 2018, the NHSA has expanded inter-provincial settlement services from inpatient expenses to include general outpatient expenses and outpatient treatment expenses for chronic and special diseases. Medical settlement services have also gradually extended from within pooled regions to cross-region settlements within the province and inter-provincial settlements.

2.3 Financing mechanisms

The **EBMI** is financed by contributions from employers and employees, with around 6 per cent of the payroll paid by the employer and 2 per cent of the individual wage paid by the employee on a monthly basis (see table 1). The scheme is established on the basis of a **combined** model, meaning that individual contributions go into individual accounts and employers' contributions, into pooled funds. **The contribution base** increases with the income level of employees. For participation in maternity insurance, employers pay the contributions, with no individual contributions required. In 2023, the per capita financing for employee medical insurance was 6,182 yuan.

As for **the duration of the contribution period**, EBMI participants who reach retirement age and meet the required contribution years no longer need to pay contributions and will continue to be protected by basic medical insurance. The required contribution period varies across provinces. For example, it is 30 years for men and 25 years for women in Shandong and Guangdong, while in Zhejiang, 20 years are required.

▶ **Table 1. Financing mechanisms for the EBMI and RBMI**

Core element	EBMI	RBMI
Sources of funding	Contributions from employers and employees.	Government subsidies and individual contributions.
Funding standard	Employer: around 6 per cent of the payroll. Employees: 2 per cent of their wages.	Flat-rate contributions, which are adjusted annually.
Level of pooled funds	Generally, at the municipal level, and in some areas at the provincial level.	Generally, at the municipal level, and in some areas, at the provincial level.

Source: *Opinions of the NHSA and the Ministry of Finance on the establishment of medical insurance benefits list system*, *Social Insurance Law of the People's Republic of China*, and so forth.

The RBMI is funded through a combination of **individual contributions** and **government subsidies**, with government subsidies being the primary source of funding **(see figure 1)**. Government subsidies, provided at both central and local levels: the central Government subsidizes localities in accordance with the regulations, providing subsidies to the western and central regions of 80 per cent and 60 per cent of the per capita government subsidy standard, respectively, and to provinces and cities in the eastern region, according to a percentage of the per capita government subsidy standard (NHSA, 2024b). Minimum standards for government subsidies and individual contributions are adjusted annually by the State. In 2023, the national government subsidy for the RBMI fund totalled 661.3 billion yuan, or 62.5 per cent of the scheme's fund revenue in that year (Ministry of Finance, 2024). In 2023, the per capita financing for resident medical insurance was 1,098 yuan. Individuals are required to make annual lump-sum contributions during the centralized enrolment period in **the place of household registration or where they reside**. To stay covered by RBMI, participants must keep making contributions. A waiting period is set for those who suspend their contributions and who are not enrolled

in the scheme on time. For medical assistance recipients, such as impoverished individuals and low-income households, their individual contributions for RBMI enrolment are subsidized according to regulations.

With regard to risk and financial pooling, in the same region, pooling funds for the EBMI and RBMI have been established separately. At present, both EBMI and RBMI have achieved municipal pooling and are pursuing and promoting provincial-level pooling. To date, 17 provinces (autonomous regions and direct-administered municipalities) in the country have promoted provincial-level pooling of basic medical insurance. Of these, seven provinces - Beijing, Tianjin, Shanghai, Chongqing, Hainan, Qing Hai and Tibet (EBMI) - are adopting a financial system that unifies the fund revenue and expenditure, and 11 provinces - Shanxi (RBMI), Jiangxi, Sichuan, Tibet (RBMI), Ningxia, Fujian (EBMI), Shandong (EBMI), Liaoning, Anhui, Shaanxi and Xinjiang (EBMI) are adopting the provincial-level adjustment funds.

The funds for **critical illness insurance for urban and rural residents** are commonly allocated from RBMI funds.

Revenues of the medical assistance funds primarily come from central, provincial, and local financial allocations, special lottery public welfare funds, and social donations. Most regions set the medical assistance pooling fund at the county level. Each year, finance departments at all levels formulate a budget for medical assistance. Based on these budgets, the Ministry of Finance and the NHSA allocate central funds for urban and rural medical assistance. Provincial finance departments, along with their healthcare insurance administrations, distribute these central subsidies to municipal or county finance departments, which then allocate the funds to their social insurance accounts.

Enrolment subsidies are directly allocated to the social insurance fund accounts in pooling regions, based on medical assistance lists from relevant authorities. Medical assistance fully subsidizes those in special hardship and provides flat-rate subsidies for those in difficulty, including subsistence allowance recipients and those who have fallen back into poverty. Provincial governments set the standards for these flat-rate subsidies based on local conditions (NHSA, 2021).

For medical expense assistance, recipients only make the pre-defined co-payment when receiving medical care at hospitals. The designated medical institutions cover the other medical costs and declare them to the local medical insurance administration. After the claim is examined and approved, the administration requests payment from the finance department, which then allocates the funds to the medical institution.

2.4 Service provision

Basic medical and healthcare services comprise **basic public health services** and **basic medical services. Basic public health services** are provided by the State free of charge (NHC, 2024). Governments at the county level and above provide basic public health services through the establishment of specialized public health institutions, primary-level healthcare institutions and hospitals, or through the purchase of services from other medical and healthcare institutions (NPC, 2020). **Basic medical services** are mainly provided by government-run medical and healthcare institutions. The State encourages medical and healthcare institutions run by the private sector to provide basic medical services (NPC, 2020).

2.5 Strategic procurement

In 2021, the State Council issued the ***Opinions on promoting the normalization and institutionalization of centralized medicine procurement***, and the NHSA, along with seven other departments, released the ***Guiding opinions on the centralized procurement and use of high-value medical consumables***. These initiatives marked the start of nationwide, institutionalized bulk procurement of high-value medical supplies and medicines. By December 2024, 10 batches of medicines and 5 batches of high-value medical supplies had been procured. Provinces conducted these procurements independently or through alliances, promoting national joint

procurement. Efforts were made to include village clinics in basic medical insurance settlements and to introduce bulk-purchased medicines into grassroots medical institutions, private hospitals, and retail pharmacies. This aimed to reduce the cost burden of classic medicines with expired patents and create space for new medicines in the insurance system (NHSA, 2024e). Since its establishment, the NHSA has adjusted the national medical insurance medicine list seven times, adding 835 medicines, including 530 through negotiation and 38 through bidding, enhancing medicine accessibility and upgrading the pharmaceutical industry (NHSA, 2024e).

2.6 Responsibilities of relevant departments

In May 2018, the NHSA was established, consolidating medical insurance-related responsibilities previously managed by various ministries and commissions. This included the management of EBMI, RBMI, and maternity insurance by the Ministry of Human Resources and Social Security (MOHRSS), as well as the long-term care insurance pilot programme. It also integrated the new rural cooperative medical scheme from the former Ministry of Health, medical assistance from the Ministry of Civil Affairs, and the management of medication prices and medical and health services from the NDRC. This centralization has enabled China to achieve unified management of national medical insurance implementation (Zheng, 2020; Wang, 2018).

The main responsibilities of the NHSA are specifically to: formulate and implement basic medical insurance policies, plans and standards; supervise and manage relevant medical insurance funds; implement reform of the medical insurance payment method; organize the formulation, supervision and implementation of medical insurance benefits lists ("catalogues") and payment standards, fees, price policies, bidding and procurement; handle the administration of medical insurance and development of information systems; encourage participation, interpret policy, and undertake policy advocacy.

Some of these functions are carried out by the relevant authorities (see figure 1).

- The **departments of finance** are responsible for the review of the number of insured persons and the allocation of government subsidies, the supervision of income and expenditure, and the management of basic medical insurance funds. They also undertake the review and preparation of the draft budget and final account of basic medical insurance funds, the timely grant of government subsidies at all levels, and the implementation of the social security strategic reserve fund.
- The **departments of public security, human resources and social security, and education** play an important role in the RBMI enrolment of newborns, enrolment at the place of residence, and the matching of information on unemployment insurance recipients and insured university students.
- The **departments of civil affairs and others** assume responsibility for identifying medical assistance recipients.
- The **medical insurance administrations** mobilize and guide social resources to support medical assistance in accordance with the law.
- **The health commissions** are responsible for optimizing the allocation of medical resources, strengthening the supervision of medical institutions, and together with the medical insurance administrations, promoting reasonable and moderate growth of medical expenses in line with the level of economic and social development and medical insurance financing, and public affordability.
- According to the *Reform programme for the national and local tax collection and administration*, **tax authorities** have taken charge of the collection of all social insurance contributions since 2019. At the same time, they have strengthened data matching with medical insurance administrations and assisted in increasing enrolment in medical insurance.
- **Public security departments** enhance cooperation with **health commissions and medical insurance administrations**, jointly cracking down on illegal and criminal acts concerning medical insurance funds.

A nurse in intensive care unit, Luannan County, Hebei Province, 2015. © Shutterstock

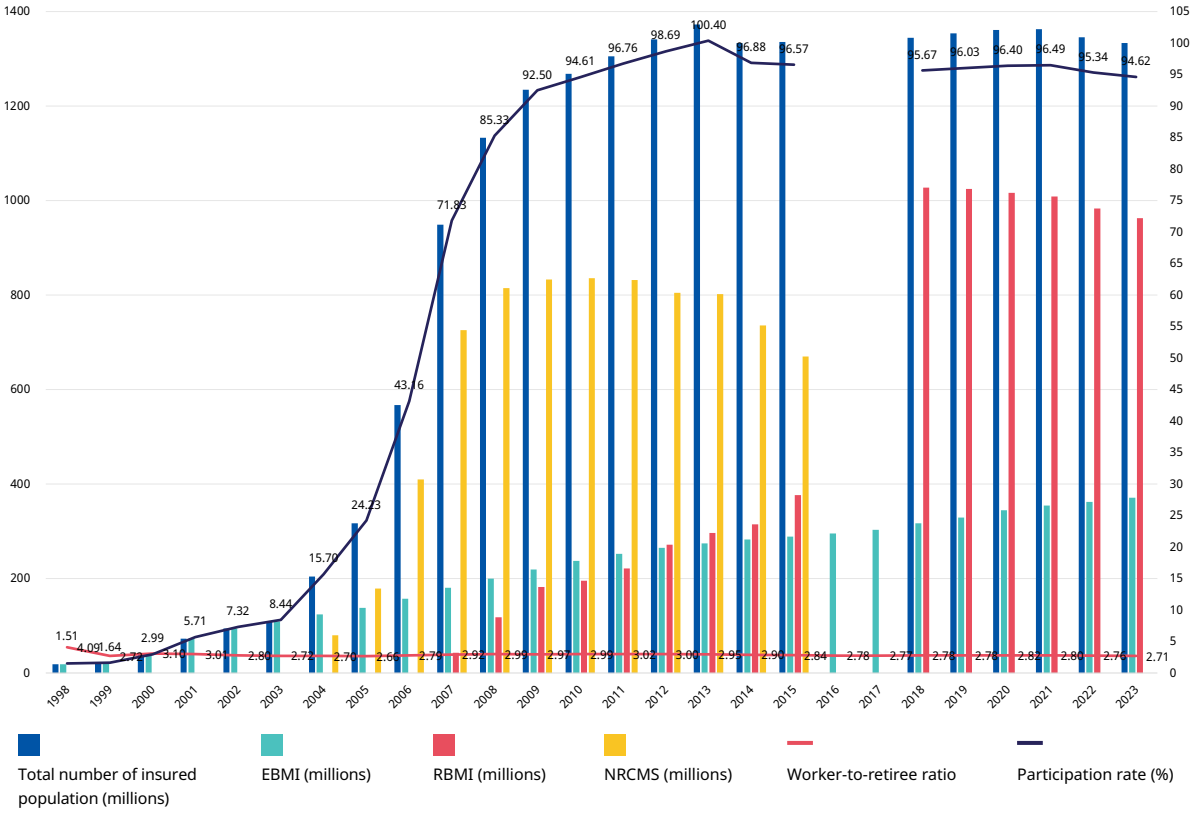
3

Outcome of universal coverage of basic medical security in China

3.1 Population coverage

In 1998, the number of people covered by China's basic medical insurance was only 18.79 million, or a participation rate of 1.51 per cent. The number surged to 949 million in 2007, or 71.83 per cent, with the establishment of the NRCMS and the URBMI, indicating that the two schemes played a significant role in extending coverage of basic medical insurance. In 2009, the NRCMS saw full coverage of rural residents and the URBMI was implemented nationwide, with coverage of both schemes remaining stable at over 95 per cent from 2011 onwards. In 2013, the Report on the Work of the Government declared that "**a basic medical insurance system that covers the whole population is taking shape**, with over 1.33 billion people being covered by different medical insurance schemes". In 2022, the nationwide unified medical insurance information platform was fully established, eliminating duplicate enrolments. In 2023, the number of people covered by maternity insurance and long-term care insurance nationwide reached 249 million and 183 million, respectively (NHSA, 2024a). Overall, since the establishment of the NHSA in 2018, the total annual enrolments for basic medical insurance have stabilized at around 1.35 billion people, with an enrolment rate of approximately 95 per cent (SCIO, 2024). **Thus, China has achieved near-universal coverage of basic medical insurance.**

▶ **Figure 3. Overview of basic medical insurance coverage in China**



Source: *China Statistical Yearbook 2024; China Medical Security Statistical Yearbook 2024.*
Note: *Data for 2016 and 2017 were incomplete due to the merger of the NRCMS and URBMI in 2016.*

3.2 Benefit improvement

According to the *China Statistical Yearbook (2024)*, the share of **individual cash expenditure on health** as a percentage of total health expenditure was 28.78 per cent in 2016, down from 55.87 per cent in 2003 and it has since plateaued, totalling 27.33 per cent in 2023.

3.2.1 EBMI benefit

For **inpatient services** under EBMI, in principle, the annual **deductible** should not exceed 10 per cent of the average annual salary in the pooling region. The deductible for critical illness insurance should not exceed 50 per cent of the previous year's average per capita disposable income of the residents in the region. Basic medical insurance covers around 75 per cent of eligible expenses **above the deductible and below the ceiling amount**. Critical illness insurance covers at least 60 per cent. Deductibles, ceiling amounts and fund payment ratios vary across medical institution levels. In 2023, the fund payment ratio for EBMI inpatient expenses was 84.6 per cent, with 83.5 per cent, 87.4 per cent, and 89.4 per cent for tertiary, secondary, and primary institutions, respectively (NHSA, 2024a). In principle, the maximum payment limit for the EBMI plus subsidies for catastrophic medical expenses for employees, is about six times the average annual wage of local employees (NHSA, 2021).

For **general outpatient services**, the annual **deductible** ranges from 0 to 1,800 yuan, with a median of 200 yuan. Deductibles are either fixed or based on hospital levels. For example, in Beijing, the deductible for active employees is 1,800 yuan and 1,300 yuan for retirees. In Hainan, the deductible is 10 yuan for primary, 50 yuan

for secondary, and 100 yuan for tertiary medical institutions. Most provinces have a **fund payment ratio** of at least 50 per cent for outpatient expenses within the catalogue. Regarding the **maximum payment limit**, Beijing and Shanghai do not have a cap, while most provinces do. For instance, in Hainan, the cap is 1,500 yuan for active employees and 2,000 yuan for retirees; in Ningxia, it is 4,000 yuan for active employees and 4,500 yuan for retirees (Zhu, 2024).

3.2.2 RBMI benefit

For **inpatient services** under RBMI, the **deductible** is usually a percentage of disposable income (e.g., 3 per cent in Shandong, 5 per cent in Zhejiang, 10 per cent in Jilin) or a percentage of average inpatient costs (e.g., 10 per cent in Hubei), or fixed amounts based on hospital level and frequency (e.g., 300 yuan/year for primary, 600 yuan/year for secondary, 800 yuan/year for tertiary institutions in Hainan). The deductible for critical illness insurance should not exceed 50 per cent of the previous year's average per capita disposable income. Assistance thresholds are generally removed for low-income and special hardship individuals. Basic medical insurance covers around 70 per cent of **eligible expenses above the deductible and below the ceiling**, with variations across hospital levels. In 2023, the fund payment ratio for RBMI inpatient expenses was 68.1 per cent, with 63.2 per cent, 72.4 per cent, and 80.8 per cent for tertiary, secondary, and primary institutions, respectively (NHSA, 2024a). Medical assistance covers at least 70 per cent for low-income and special hardship individuals. The fund payment ratio and actual reimbursement rate for RBMI inpatient expenses are both lower than those under EBMI. In principle, **the maximum payment limit** for the RBMI plus critical illness insurance, is about six times the average per capita disposable income of local residents.

For **general outpatient services**, there is usually no deductible or a low deductible, with a low annual cap. In Beijing, the deductible is 100 yuan for primary institutions with a 55 per cent fund payment ratio, and 550 yuan for secondary and above institutions with a 50 per cent fund payment ratio. The annual outpatient cap is 5,000 yuan. In Yunnan, the fund payment ratio for general outpatient expenses is at least 50 per cent for primary institutions and 25 per cent for secondary and above institutions, with an annual cap of at least 400 yuan. For **chronic and special diseases**, outpatient medications for conditions like hypertension and diabetes are covered by insurance.

Since the comprehensive establishment of the **critical illness insurance for urban and rural residents** in 2015, RBMI participants can receive reimbursements for eligible high medical expenses through the critical illness insurance after the basic medical insurance reimbursement. In 2023, the reimbursement rate was increased by more than 15 percentage points on top of the reimbursement covered by the RBMI fund.

In 2023, national expenditure on medical assistance was 74.6 billion yuan, and 80.2 million people were enrolled in basic medical insurance with the help of subsidies from the medical assistance fund. Outpatient and inpatient subsidies were handed out 153.4 million times, with an average amount of 1,241 yuan and 132 yuan per time, respectively, nationwide. The central Government allocated 29.7 billion yuan for medical assistance subsidies. Data show that in 2023, various medical insurance assistance policies cumulatively benefited the low-income rural population with 186 million instances, alleviating their medical burden in the amount of 188.35 billion yuan (NHSA 2024a).

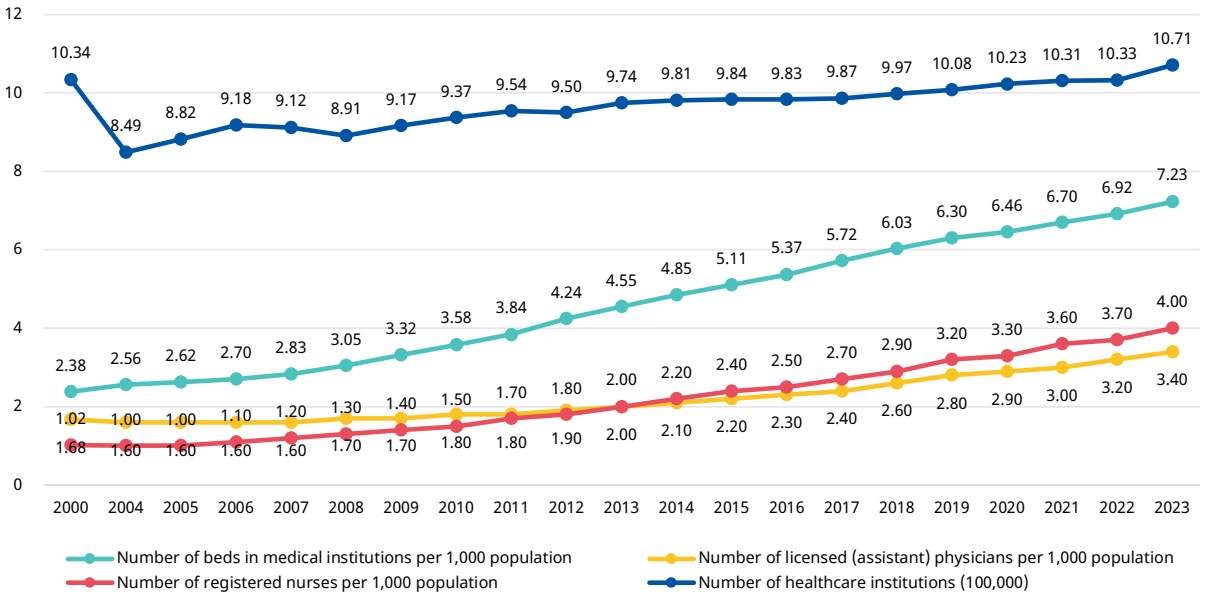
3.3 Service provision

China saw a large increase in the number of medical and health institutions, hospital beds, licensed (assistant) physicians, registered nurses and other medical resources between 2000 and 2023. The number of medical and health institutions rose from 1.03 million in 2000 to 1.07 million in 2023, which included 38,355 hospitals, 1,016,238 primary-level medical and health institutions and 12,121 specialized public health institutions (see annex 2). In terms of medical facilities, there were 3,855 tertiary hospitals (of which 1,795 were further evaluated

as Level A), 11,946 secondary hospitals, 13,252 primary hospitals and 9,302 unclassified hospitals. In 2023, the number of beds in medical and health facilities per 1,000 inhabitants, and the number of licensed (assistant) physicians and registered nurses per 1,000 inhabitants were 7.23, 3.40 and 4.00, respectively, an increase from 2.38, 1.02 and 1.08 in 2000. China's medical and health services system has continued to improve, dramatically enhancing the availability and accessibility of medical services to the population.

The number of designated medical institutions and retail pharmacies for basic medical insurance sharply increased between 2018 and 2023, from 193,000 and 341,000, respectively, to 520,000 and 485,000. This has enhanced accessibility to medical services and made it more convenient for the public to seek medical treatment and purchase medicines.

▶ Figure 4. Overview of medical and health resources



Source: *China Statistical Yearbook 2024.*

The basic medical insurance system has reduced the medical expense burden on the general public, while also rapidly increasing the utilization rate of medical services. In 2023, the number of diagnostic and treatment services provided by medical and health institutions and the number of hospital admissions reached 9.55 billion and 302 million, respectively, up from 2.15 billion and 59.91 million in 2002, a 4.5-fold and 5-fold increase. In 2023, insured employees enjoyed benefits 2.53 billion times, a 20.45 per cent increase from the previous year. This included 2.18 billion outpatient visits, 270 million chronic disease treatments, 80 million hospitalizations, and 2.3 billion pharmacy purchases. Insured residents enjoyed benefits 2.61 billion times, a 21.1 per cent increase from the previous year, including 2.08 billion outpatient visits, 340 million chronic disease treatments, and 200 million hospitalizations. The hospitalization rates for both EBMI and RBMI patients have risen rapidly. For insured employees, the rate increased from 13.5 per cent in 2012 to 21.86 per cent in 2023, and for insured residents, it grew from 12.33 per cent to 25.34 per cent.

In 2023, the number of designated medical institutions connected across provinces reached 550,400. Throughout the year, the number of cross-province direct settlements for inpatient services, general outpatient services, and outpatient chronic disease treatments reached 11.25 million, 85.99 million, and 3.31 million person-times, respectively. The types of outpatient chronic diseases eligible for cross-province direct settlement increased from 5 to 10 (SCIO, 2024). Additionally, a medication guarantee mechanism for outpatient treatment of hypertension and diabetes was established.

With regard to maternity insurance, data on maternity insurance entitlement were further standardized and unified in 2023, with prenatal check-ups and family planning included in the data. In 2023, 28.34 million maternity insurance benefit payments were made, an increase of 10.65 million payments, or 60.2 percent, over 2022. In terms of long-term care insurance, more than 1.34 million people from 49 pilot cities received the benefits, with 8,080 designated institutions and almost 302,800 care workers (NHSA, 2024a).

3.4 Strategic procurement

With the establishment of the NHSA, the role of managing funds for the EBMI, URBMI and NRCMS schemes and for medical assistance – previously carried out by different authorities – was integrated into the NHSA, thus strengthening the mutual aid capacity of pooled funds. Recent years have witnessed continuous growth in funds revenue. In 2023, the aggregate revenue from national basic medical insurance funds reached 3.35 trillion yuan, of which 2.29 trillion yuan was from the EBMI fund and 1.06 trillion yuan from the RBMI fund. Revenue from long-term care insurance reached 24.36 billion yuan. In the same year, national basic insurance (including maternity insurance) funds expenditure totalled 2.82 trillion yuan (117.72 billion yuan from the maternity insurance fund), with a current balance of 504.03 billion yuan and a cumulative balance of 3.4 trillion yuan in the pooled fund. In addition, total expenditure from the long-term care insurance fund was 11.86 billion yuan (NHSA, 2024a).

Since its establishment, the NHSA has reformed the pharmaceutical procurement system and initiated national negotiations for the medical insurance medicine list, achieving strategic purchasing. The list is updated annually, with the new version typically implemented at the beginning of the following year. The number of Western and traditional Chinese medicines increased from 2,196 in 2016 to 3,159 in 2024 (NHSA, 2024d; SCIO, 2024), covering types of medications that account for over 90 per cent of the medication expenses in public medical institutions (SCIO, 2024). The quality of listed medicines has significantly improved, especially for cancer, rare diseases, hypertension, and diabetes, with many new mechanism and new target medicines included (People's Daily, 2024). Negotiations for inclusion have become an important pathway for high-value innovative medicines, enhancing patient affordability. Additionally, advanced medical equipment and technologies, such as medical examinations, ultrasound, computed tomography (CT) scans, magnetic resonance imaging (MRI), painless surgeries, and minimally invasive surgeries, are now covered by medical insurance (SCIO, 2024). Furthermore, 31 provinces and the Xinjiang Production and Construction Corps have included assisted reproductive technologies, such as in vitro fertilization (IVF), in the medical insurance coverage. Centralized procurement of medicines and high-value medical consumables has effectively improved accessibility (People's Daily, 2024).

China's basic medical insurance, which represents about 2 per cent of the gross domestic product (GDP), covers approximately 40 per cent of the country's total medical and health expenses. This funding supports medical care for roughly one-sixth of the world's population and provides economic backing for the efficient allocation of medical resources. It also helps regulate diagnoses and treatments for both medical practitioners and patients.

3.5 Improvement in people's health

The establishment of the medical insurance system has significantly contributed to improvements in health in both urban and rural areas of China. According to the China Statistical Yearbook, China's per capita life expectancy increased from 71.40 years in 2000 to 78.6 years in 2023. Average life expectancy for men was 75.37 years and for women 80.88 years in 2023, up from 69.63 years and 73.33 years, respectively, in 2000. The substantial increase in per capita life expectancy reflects the better health of China's population. The national maternal mortality rate and the infant mortality rate, which reached as high as 1,500 per 100,000 and 200 per 1,000, respectively, before the founding of New China, dropped to 15.1 per 100,000 and 4.5 per 1,000, by 2023, according to the 2023 Statistical Bulletin on the Development of China's Health and Wellness Sector. Urban and rural maternal mortality rates, the under-five mortality rate and the neonatal mortality rate have seen sharp decreases, with a clear trend of improvements in health conditions in rural areas. Overall, major health indicators in China are now among the highest for upper-middle-income countries, a massive health achievement.

Doctors discussing a patient's condition, Beijing, 2016. © ILO

4

Challenges, experiences and prospects for China's medical insurance

4.1 Major challenges facing the development of universal medical insurance coverage

4.1.1 Persistent gaps in universal coverage and enrolment quality issues

The participation rate in China's basic medical insurance has remained steady at around 95 per cent since 2011, signifying that UHC has very nearly been achieved. However, progress has slowed since coverage was vastly expanded, with around five per cent of the population still to be reached – the "last mile" – in order for China to achieve full universal coverage. The EBMI and the RBMI constitute the country's two basic medical insurance pillars, with the RBMI covering more than 70 per cent of the population, or nearly three times the number of people enrolled in the EBMI. There is a need to improve the enrolment quality of both schemes.

With continued urbanization, large-scale population flows between urban and rural areas and between regions, as well as the growth of the Internet+, digital economy and new forms of employment, the number of **EBMI** participants reached 371 million (271 million active workers) in 2023 (NHSA, 2024a). However, there were approximately 470 million were employed in urban areas during the same year (NBS, 2023), meaning that more than around 200 million urban employed persons were not enrolled in the EBMI. Small business owners

without employees, part-time workers not covered by their employers, and other types of flexible workers are eligible to participate in the EBMI on a voluntary basis rather than a compulsory one. However, flexible workers often face challenges such as unclear employer liability, high mobility, generally low and unstable levels of income, and the burden of paying both personal and employer contributions. These factors have reduced their willingness to participate in the EBMI, resulting in many eligible workers either not enrolling in the scheme or opting for the RBMI instead. In addition, impacted by the aging population and declining birth rate challenges, the ratio of active workers to retirees has shown a downward trend, dropping from 4.09 in 1998 to 2.71 in 2023.

Although government finance has played a major supporting role for the **RBMI**, covering over 70 per cent of the insured population, the continuous rise in medical expenses has led to reasonable adjustments in individual contribution standards in recent years to ensure the expenditure on insured benefits. However, under voluntary enrolment, some able-bodied people and rural-urban migrant workers have chosen not to enrol or renew their insurance (Qiu and Wang, 2020), putting greater pressure on enrolment and the expansion of coverage, further fuelling uncertainty regarding sustainability of the scheme. At the same time, although the enrolment rate of rural low-income populations within the national monitoring scope remains stable at over 99 per cent (NHSA, 2024a), and some individuals are covered by other systems, a small number of people are still unwilling to enrol despite consistent mobilization efforts.

4.1.2 Inequities in benefits and insufficient level of protection

China's basic medical insurance system follows a dual structure that combines the EBMI and RBMI schemes. Although there are unified lists of services and items that are covered and the same policies on designated management, the two schemes have clear disparities in terms of financing mechanisms, financing levels and benefits provided. Furthermore, under the hierarchical management structure, pooling regions have greater autonomy in decision-making on medical insurance, resulting in variations in medical insurance schemes and relevant policies among different regions. Each region largely utilizes government subsidies and medical insurance funds raised to provide medical insurance benefits, and the better the regional economy performs, the higher the level of the benefits. Due to the "fragmentation" of the system and the lower level of the pooled fund, the benefits of both the same scheme and different schemes show relatively large gaps in different regions, directly affecting fairness among different groups.

In recent years, the proportion of inpatient expenses covered by the pooled funds of EBMI and RBMI has stabilized at around 80 per cent and 70 per cent, respectively. For outpatient expenses, EBMI covers no less than 50 per cent, with a common cap set, while RBMI provides lower level of benefit. When facing major illnesses, expenses exceeding the cap and those not covered by the scheme catalogue can still impose a heavy financial burden on families.

4.1.3 Inadequate financing mechanisms and low levels of pooled funds

The current basic medical insurance system still suffers from challenges such as the lack of sound financing mechanisms, putting the equitable and sustainable running of the system at risk. As for the **EBMI**, although the reform of the mutual aid mechanism for covering outpatient medical expenses has reduced individual contributions, individual accounts still constitute a quarter of the total financing. This, to some extent, affects the mutual aid capacity of the fund. The termination of contributions by retirees and their former employers and the net decrease of the working-age population (MOHRSS, 2021) have led to a decline in EBMI contributors amid a continued expansion of benefit recipients, posing a huge challenge to the financing of the EBMI. In the case of the **RBMI**, while the flat-rate contributions are convenient in terms of payment collection, they foster financing inequity between high-income and low-income earners and are thus not a stable mechanism for financing growth. Meanwhile, in recent years, the ratio of government subsidies to personal contributions has

been declining, resulting in a higher proportion of personal contributions. This also affects the sustainability of funding for the RBMI to a certain degree.

Overall, the EBMI and RBMI schemes have established separate pooled funds mostly at the municipal level. The small size of the pooled funds limits the role of basic medical insurance in risk-sharing. In addition, influenced by the financial system, most regions have established medical assistance pooling at the county level, resulting in significant disparities in the level of protection across different regions.

4.1.4 Financial strain on medical insurance funds due to rapid growth in medical expenses

According to data from China's seventh population census in 2020, the number of people aged 60 and above in China was more than 264 million, or 18.70 per cent of the total population, an increase of 5.44 percentage points from 2010. The number of people aged 65 and above was 190.64 million, or 13.50 per cent of the total population, up 4.63 percentage points compared with 2010. This indicates a rate of increase for the two age groups of 2.51 and 2.72 percentage points, respectively (NBS, 2021). The aging of China's population has been gradually accelerating, bringing dual risks to the medical insurance fund: on the financing side, the number of contributors to the system is decreasing as the in-service/retirement ratio is declining. On the expenditure side, chronic, non-communicable diseases can be controlled to a certain extent through surgical or pharmacological treatments, spurring medical demand. For example, total medical expenses incurred by retirees, who constitute around one quarter of EBMI participants, account for nearly 60 per cent of total medical expenses, four times that of active workers, and over 60 per cent of both inpatient medical expenses and expenses for outpatient treatment for chronic and special diseases. This "scissor gap" has put enormous pressure on the sustainability of the financing of the medical insurance system (Zhang et al., 2023).

With the advent of economic and social development, the rapid increase and application of new medicines, materials, technologies and equipment, the introduction and growing popularity of medications for rare diseases as well as cellular therapy, gene therapy, and so forth, more diseases have shifted from being "incurable" to "treatable and controllable" (Xi, 2022). Innovations in models such as Internet+ healthcare and telemedicine have made it easier to access medical services and purchase medicines. The inclusion of new technologies and medicines in basic medical insurance has enabled more people to benefit from technological advances and has contributed to further augmenting demand for medical and healthcare services. However, the disparity in the distribution of medical resources between urban and rural areas has led to an influx of insured patients to tertiary hospitals for medical treatment, resulting in a continued rise in medical expenses and increasing pressure on the revenue and expenditure of the medical insurance funds.

4.2 Experience in achieving universal medical insurance coverage

China's rapid achievement of covering 1.33 billion people and attaining near-universal coverage, starting from a low level of basic medical insurance coverage, can be largely attributed to the Chinese Government's political will to commit to improving the well-being of its citizens, its growing economic strength and strong financial backing, broad public support, and the ability to learn from international experience in a context-specific manner.

4.2.1 Political will to improve the well-being of citizens

China has not yet ratified the Convention No. 102, but the Chinese government is committed to gradually incorporating the principles of Convention No. 102 into its social security laws and policies, continuing to enrich, standardize and improve China's social security system in line with international standards. Moreover, the Chinese Government actively supports the implementation of the health-related goals written into the

2030 Agenda for Sustainable Development at the global, regional and national levels, and is willing to strive to ensure UHC, leaving no one behind.

In 2009, the Government invested 850 billion yuan in a new round of reform of the medical and healthcare system and proposed, for the first time, the overall goal of the reform, which was to "establish a sound basic medical and healthcare system covering urban and rural residents", specifying that rural and urban residents would be fully covered by the basic medical insurance system by 2011. In 2010, the introduction of the *Social Insurance Law* established the framework of China's medical insurance system. Since the 18th CPC National Congress, China has put the protection of people's health in a more prominent position and formulated the *Outline of the "Healthy China 2030" Plan*, elevating the building of a "Healthy China" to the level of a national strategy. Thus, China entered a new stage of fully establishing a medical insurance system with Chinese characteristics. The establishment of the NHSA in 2018 has provided an organizational foundation for China's medical insurance system to move towards maturity, propelling the health sector to achieve all-round progress and historic achievements.

4.2.2 Economic and social development and strong financial support

China's focus on economic development, underpinned by the principles of efficiency and equity, have led to a dramatic surge in GDP and per capita GDP. In 2023, China's GDP reached 126.06 trillion yuan, accounting for about 17 per cent of the global economy and ranking it second in the world in GDP terms. In 2019, per capita GDP in China reached 70,078 yuan, exceeding US$ 10,000 for the first time. In 2023, per capita GDP topped 89,358 yuan (US$12,681), signifying that China has attained upper-middle-income status (www.gov.cn, 2024; Qiushi.org, 2024). The elimination of absolute poverty in 2020 and the booming economy have created space for the development of UHC in China. In addition, total health expenditure as a percentage of GDP rose to 7.2 per cent in 2023 from 4.6 per cent in 2000 (NHSA, 2024c) while the per capita government subsidy standard for the RBMI has increased massively, to 670 yuan in 2024 compared to 20 yuan in 2003. The State's financial subsidy accounts for two thirds of the RBMI fund, and this support has played a significant role in the expansion of coverage towards UHC. Government finance provides support for both the supply and demand sides, thus contributing to the formation of a virtuous circle between the medical insurance system and the medical services system.

4.2.3 Adapting international experience to local conditions

Having established a social insurance system and faced with challenges in further advancing its basic medical insurance system, China continues to learn from international experience, while adapting it to a local context. China is working to establish provincial-level pooling and provincial-level transfers of funds, developing the mutual aid system for covering outpatient medical expenses and promoting the reform of the DRG payment method, among other things, in order to continually adjust and improve its multi-tier medical insurance system. While learning from international experience, China has progressively reformed the medical insurance system, implementing reform measures in pilot areas and gradually scaling them to the whole country. Such reform has always been adapted to socio-economic development and affordability according to local conditions, and has gradually raised the level of benefits, therefore gaining broad public support. At the same time, the basic medical insurance system utilizes the technological dividends brought about by information technology to spur reform and reduce the cost of medical insurance administration, making scheme enrolment, settlement and supervision of funds more efficient and effective.

4.2.4 Rapid development of medical insurance standardization and informatization

Since its establishment, NHSA has prioritized the standardization and informatization of medical insurance to modernize governance. By March 2022, a unified, efficient, compatible, convenient, and secure national medical insurance information platform was fully operational. This milestone in informatization and standardization provides robust technical support for decision-making, governance, and delivering precise, high-quality, and efficient medical insurance services to the public.

The national medical insurance information platform offers practical functions including enrolment, information inquiry, benefit application, and business handling. It also provides features such as medical insurance codes, mobile payments, electronic prescription transfers, and cross-region medical treatment and transfer of entitlements. By September 2024, 1.39 billion people held social security cards, covering 98.3 per cent of the population. Of these, 1.03 billion had electronic social security cards, covering 73.4 per cent of the population. Additionally, 1.17 billion people activated their medical insurance codes, allowing them to use their phones or other devices for medical treatment and reimbursement without a physical card (SCIO, 2024).

4.3 Policy recommendations for achieving universal medical insurance coverage

4.3.1 Accurately identify uninsured persons and improve the quality of enrolment

Enrolment in medical insurance is a prerequisite for ensuring that people receive basic medical protection. With the help of the national medical insurance information platform and the medical insurance code, it is recommended to: standardize the collection of basic information on scheme participants and conduct real-time verification of their enrolment in the scheme; enhance information-sharing between medical security, public security, human resources and social security, education and civil affairs departments to accurately identify and analyse enrolment gaps, reduce duplicate enrolments and effectively expand insurance coverage.

For the **EBMI**, attention should be given to flexible workers and NFE workers in order to encourage their participation in the scheme and ease their financial burden. Specifically, it is recommended to implement the policy shift from "enrolment at the place of household registration" to "enrolment at the place of residence"; utilize the tax system and the mechanism for unified collection of basic medical insurance contributions by tax authorities; and leverage information technology to effectively identify the insured individuals and their income. These measures would help improve the enrolment rate in the EBMI and reduce the State's financial burden. For the **RBMI**, awareness raising on participation should be effectively carried out, contribution payments strengthened, and the flat-rate contributions should be adjusted to rate-based contributions.

Additionally, by leveraging the family mutual aid policy of EBMI individual accounts, savings in these accounts can be used for family members to participate in RBMI and pay medical expenses. To improve the quality of insurance coverage, flexible workers and NFE workers should be motivated to participate in EBMI instead of RBMI, thereby gradually increasing the proportion of EBMI participants. If the total amount of government subsidies remains roughly unchanged, the per capita funding level for residents will increase due to fewer participants, thereby reducing the funding and benefit gap between the two systems.

4.3.2 Promote the establishment of an equitable and unified mechanism for benefits management

To promote a fair and standardized medical insurance system, it is recommended to strictly **implement** the

national benefits list and the unified policy formulation and adjustment. In terms of **regional coordination,** efforts should focus on achieving provincial-level pooling and fund transfers building on municipal pooling, coordination between the pooling level of medical assistance and basic medical insurance to enhance mutual assistance and the risk-resistance capacity of both funds, and balancing benefit disparities across different cities within provinces, with the goal of establishing a fairer universal medical insurance system.

To **improve the level of overall benefits and ease the burden on individuals**, it is necessary, on the one hand, to further leverage the role of pricing mechanisms for medical services and medical insurance payments to strengthen diagnosis and treatment and encourage informed decision-making on medical services. At the same time, it is recommended to make full use of the strategic purchasing power of the medical insurance fund to increase the fund's effectiveness and efficiency. On the other hand, focus should be placed on establishing a robust mechanism for unified management of outpatient medical expenses while maintaining stable inpatient reimbursement. This would enhance general outpatient protection for insured individuals and reduce their medical burden. It is also recommended to appropriately increase the Government's input on medical expenses in order to reduce the share of individual expenditure on healthcare. Additionally, special attention should be given to pregnant women and other vulnerable groups. The reimbursement rate for prenatal and maternity-related medical expenses should be increased. For unemployed couples, timely assistance should be provided through the medical assistance system for pregnant women who still face significant financial burdens after basic and critical illness insurance reimbursements.

4.3.3 Establish a sound, stable and sustainable financing mechanism

It is recommended to explore a dynamic financing mechanism linked to the level of socio-economic development, residents' disposable income, and household affordability, and to set reasonable contribution rates to establish a stable growth mechanism for financing basic medical insurances. For the **EBMI**, the multi-channel financing mechanism should be broadened in response to the aging population challenge. For the **RBMI**, individual contributions should be moderately raised as government subsidies are increased, promoting a reasonable sharing of financing responsibilities between the government and individuals. A start can be made with the exploration of differentiated tiered payment systems, gradually transitioning to income-based contributions as personal income accounting systems improve. To **expand sources of finance**, policies on commercial medical insurances and social charitable donations within the multi-tier medical security system should be improved. Finally, taxes on alcohol, tobacco, sugar-sweetened beverages, and other unhealthy products could be set or raised to supplement basic medical insurance funds, thereby reducing basic medical insurance fund expenditures by improving individual health.

Annex 1: Laws and policies on China's basic medical security system

Name of the law/document	Released by	Year of enactment	Key implications for the reform
Social Insurance Law	Standing Committee of the National People's Congress (NPC)	2010	Providing a legal base for basic medical insurance
Basic Medical and Health Care and the Promotion of Health Law	NPC Standing Committee	2020	Clarifying citizens' rights and obligations related to healthcare
Medical Security Law (Draft for Public Comment)	NHSA	2021	A programmatic and comprehensive law on medical security (pending enactment)
Decision on establishing a basic medical insurance system for urban employees	The State Council	1998	Establishment of medical insurance for employees
Decision on establishing a new rural cooperative medical scheme	General Office of the State Council	2003	Establishment of a new rural cooperative medical scheme
Opinions on the implementation of rural medical assistance	Ministry of Civil Affairs and other authorities	2003	Establishment of rural medical assistance schemes
Opinions on establishing a pilot urban medical assistance scheme	General Office of the State Council	2005	The establishment of an urban medical assistance scheme
Guidelines on the pilot programme of basic medical insurance for urban residents	General Office of the State Council	2007	Establishment of a basic medical care guarantee system for urban residents
Guidelines on the development of critical illness insurance for urban and rural residents	Former NDRC and six other ministries	2012	Establishment of a critical illness insurance system
Opinions on further improving the medical assistance system and fully carrying out medical assistance for critical illness	General Office of the State Council	2015	Improvement of medical assistance system
Opinions on fully implementing critical illness insurance for urban and rural residents	General Office of the State Council	2015	Full implementation of the critical illness insurance for urban and rural residents

Name of the law/document	Released by	Year of enactment	Key implications for the reform
Opinions on integrating the basic medical insurance schemes for urban and rural residents	The State Council	2016	The merger of URBMI and NRCMS into RBMI
Opinions on expanding the pilot programme of the State-organized centralized procurement and use of medicines	NHSA and eight other ministries	2019	Expanded service coverage and reduced prices of medicines
Opinions on fully promoting the merger of maternity insurance and basic medical insurance for employees	General Office of the State Council	2019	The merger of maternity insurance and EBMI
Circular of the list of pilot cities for diagnosis-related groups payment	NHSA and 3 other ministries	2019	Launch of DRG payment pilot programme
Circular of the issuance of pilot work on diagnosis-intervention packet payment	General Office of the NHSA	2020	Launch of DIP payment pilot programme
Opinions on promoting the normalization and institutionalization of centralized medicine procurement	General Office of the State Council	2021	The nationwide normalization and institutionalization of centralized medicine procurement
Guiding opinions on the centralized procurement and use of high-value medical consumables	NHSA and 7 other ministries	2021	The nationwide implementation of centralized procurement for medical consumables
Regulation on the supervision and administration of the use of medical security funds	General Office of the State Council	2021	The first administrative regulation in the field of medical security
Opinions on improving critical illness insurance and medical assistance system	General Office of the State Council	2021	Improvement of critical illness insurance and medical assistance
Opinions on the establishment of a medical insurance benefits list	NHSA and Ministry of Finance	2021	Establishment of a medical insurance benefits list
Guidelines on establishing and improving the mutual aid system for covering outpatient medical expenses under the basic medical insurance for employees	General Office of the State Council	2021	Establishment of a mutual aid system to address gaps in outpatient benefits, and give full play to the effectiveness of the fund's mutual assistance

Name of the law/document	Released by	Year of enactment	Key implications for the reform
Circular of further improving the direct settlement of cross-provincial medical expenses covered by basic medical insurance	NHSA and the Ministry of Finance	2022	On-the-spot settlement of cross-provincial medical expenses
Guidelines on improving the long-term mechanism for basic medical insurance enrolment	General Office of the State Council	2024	Improving the structure and the quality of basic medical insurance enrolment
Circular of steadily expanding the types of outpatient chronic and special diseases covered by direct settlement of cross-provincial medical expenses	General Office of the NHSA, in conjunction with the General Office of the Ministry of Finance	2024	Expanding the coverage of outpatient chronic and special diseases under on-the-spot, cross-provincial settlement, and enhancing the effectiveness of administrative services

Annex 2: Overview of medical and healthcare institutions in China in 2022 and 2023

Type of institution		2022	2023
Total		**1,0329,18**	**1,070,785**
Hospitals		36,976	38,355
	Public hospital	11,746	11,772
	Private hospital	25,230	26,583
	Tertiary hospital	3,523	3,855
	Secondary hospital	11,145	11,946
	Primary hospital	12,815	13,252
	Unclassified hospital	9,493	9,302
Primary medical and healthcare institutions		979,768	1,016,238
	Community healthcare centre	10,353	10,070
	Community healthcare clinic	26,095	27,107
	Township health centre	33,917	33,753
	Village clinic	587,749	581,964
	Medical room (infirmary)	282,386	318,938
Specialized public health institutions		12,436	12,121
	Centre for disease control and prevention	3,386	3,426
	Institute for specialist disease control	856	823
	Maternal and child health institution	3,031	3,063
	Health inspection institute (centre)	2,944	2,791
	Family planning technical services	787	473
Other institutions		3,738	4,071

Source: *2023 Statistical Bulletin on the Development of Health and Wellness in China*

Annex 3: Overview of health workforce in China, 2005–2023

Year	Number of health technical personnel per 1,000 population	Number of licensed (assistant) physicians per 1,000 population	Number of registered nurses per 1,000 population
2005	3.5	1.56	1.03
2006	3.6	1.6	1.09
2007	3.72	1.61	1.18
2008	3.9	1.66	1.27
2009	4.15	1.75	1.39
2010	4.39	1.8	1.53
2011	4.58	1.82	1.66
2012	4.94	1.94	1.85
2013	5.27	2.04	2.04
2014	5.56	2.12	2.2
2015	5.84	2.22	2.37
2016	6.12	2.31	2.54
2017	6.47	2.44	2.74
2018	6.83	2.59	2.94
2019	7.26	2.77	3.18
2020	7.57	2.9	3.34
2021	7.97	3.04	3.56
2022	8.27	3.15	3.71
2023	8.87	3.4	4

Source: *China Statistical Yearbook 2024*

Bibliography

Chinese Government Official Website (www.gov.cn). 2024. "China's economic strength to achieve historic leap." https://www.gov.cn/zhengce/jiedu/tujie/202409/content_6973312.htm

——. 2024. "The 2024 edition of the national medical insurance medicine catalogue released, adding 91 new medicines - enabling insured individuals to access more new and high-quality medications." https://www.gov.cn/zhengce/202411/content_6989980.htm

Li Zhen. 2022. "Historical Logic and Realization Path of Reforming Basic Medical Insurance Participation Mechanism." *Journal of Jinan* (Philosophy & Social Science Edition) 44 (11): 69–79.

Lu Quan. 2022. "Research on the Change of China's Medical Insurance Management System: Perspective of Inter-Governmental Relations." *China Administration* (02): 77–82.

Ministry of Finance. 2024. "2023 Final Accounts of the National Social Insurance Fund Revenue." http://yss.mof.gov.cn/2023zyjs/202408/t20240830_3942820.htm.

Ministry of Human Resources and Social Security (MOHRSS). 2021. "Circular on the Issuance of the 14th Five-Year Plan for the Development of Human Resources and Social Security." http://www.mohrss.gov.cn/SYrlzyhshbzb/zwgk/ghcw/ghjh/202107/t20210702_417552.html.

National Bureau of Statistics (NBS). 2021. Communiqué of National Population Census. https://www.stats.gov.cn/sj/tjgb/rkpcgb/qgrkpcgb/.

——. 2024. "Statistical Communiqué of the People's Republic of China on the 2023 National Economic and Social Development." https://www.stats.gov.cn/sj/zxfb/202402/t20240228_1947915.html.

National Health Commission. 2024. "Circular on the Work of Basic Public Health Services in 2024." http://www.nhc.gov.cn/jws/s7874/202409/33132b328d804634858b54b4681db5a0.shtml.

National Healthcare Security Administration (NHSA). 2021. "Opinions of the NHSA and the Ministry of Finance on the Establishment of a Medical Insurance Benefits List." https://www.nhsa.gov.cn/art/2021/8/10/art_104_6537.html.

——. 2024a. "The Statistical Communiqué of the People's Republic of China on the 2023 National Medical Security Development." http://www.nhsa.gov.cn/art/2024/7/25/art_7_13340.html.

——. 2024b. "Circular of the National Healthcare Security Administration, the Ministry of Finance and the State Taxation Administration on the Work Arrangement for Basic Medical Insurance for Rural and Non-Working Urban Residents in 2024". https://www.nhsa.gov.cn/art/2024/8/26/art_104_13632.html.

——. 2024c. *The China Statistical Yearbook on Medical Security 2024*. Beijing: China Statistics Press.

——. 2024d. "Notice of NHSA and MOHRSS on the Issuance of the National Medicine Catalogue for Basic Medical Insurance, Work Injury Insurance, and Maternity Insurance (2024)". https://www.nhsa.gov.cn/art/2024/11/28/art_104_14886.html.

——. 2024e. "The Tenth Batch of National Centralized Medicine Procurement Launched: Enhancing Medication Quality for Patients and Increasing High-Quality Supply". https://www.nhsa.gov.cn/art/2024/12/12/art_14_15097.html

People's Daily. 2024. "Annual participation rate of basic medical insurance stable at around 95 percent, with over 1.33 billion participants, China has weaved the world's largest medical protection network." http://paper.people.com.cn/rmrb/html/2024-09/29/nw.D110000renmrb_20240929_4-02.htm.

Qiu Yulin, Wang Zhaoxi. 2020. "From Existence to Excellence: Connotation and Path of High-Quality Development of Medical Insurance System." *Journal of Huazhong University of Science and Technology* (Social Science Edition) 34 (04): 55-62.

Qiushi.org, 2024. "Economic output ranking second in the world indicates the significantly enhanced comprehensive national strength." http://www.qstheory.cn/laigao/ycjx/2024-10/08/c_1130207400.htm.

State Council Information Office (SCIO). 2024. Press conference on the series "Promoting High-Quality Development" held by the SCIO. http://www.scio.gov.cn/live/2024/34646/index_m.html.

Standing Committee of the National People's Congress. 2020. Law of the People's Republic of China on Basic Medical and Health Care and the Promotion of Health. Beijing: China Law Press.

Sun Shuyun. 2018. "Innovation and Development of China's Medical Security System within the 40 Years of Reform and Opening up." *Gansu Social Science* (05): 21–28.

Wang Dongjin. 2018. "A Major Initiative to Effectively Strengthen the Role of Government in Medical Insurance to Better Safeguard People's Health and Well-being - Perception on the Formation of the National Healthcare Security Administration." *China Medical Insurance* (04): 1–4.

World Health Organization (WHO). 2024. "Universal Health Coverage." https://www.who.int/health-topics/universal-health-coverage#tab=tab_1.

Xi Jinping. 2022. "Advancing High-Quality and Sustainable Development of China's Social Security Programs," https://www.mohrss.gov.cn/SYrlzyhshbzb/dongtaixinwen/shizhengyaowen/202204/t20220416_443993.html

Zhang Liqiang, Zhu Ming, Li Xiang, et al. 2023. "Reflections on Sound, Stable Sustainable Financing and Operation Mechanisms." *China Medical Insurance* (05): 5–13.

Zheng Gongcheng. 2020. "Development Ideas and Key Tasks for China's Medical Security System during the "14th Five-Year Plan" Period." *Journal of Renmin University of China* 34 (05): 2–14.

——. 2021. "Fully Deepening the Reform of Medical Security System: Progress, Challenges and Advancement." *Administrative Reform* 2021 (10): 12-25.

Zheng Gongcheng, Zhao Mingyue. 2022. "Future-Oriented Construction of High-Quality Medical Security System." *Journal of the Party School of the Central Committee of the Communist Party of China* (National School of Administration) 26 (06): 108–117.

Zhu Minglai, Niu Yan. 2024. "Thoughts and Analysis on the Reform of the Employee Outpatient Mutual Aid Security Mechanism." *China Insurance* (11):6-10.

ILO Country Office for China and Mongolia
1-10 Tayuan Diplomatic Office Building
14 Liangmahe Nanlu
Beijing 100600, China
T: +86 10 6532 5091
E: beijing@ilo.org
W: ilo.org/beijing