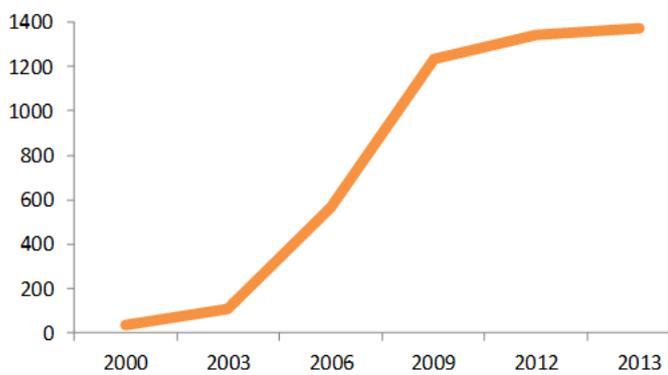


People's Republic of China

Between 2003 and 2013, the number of people covered by the health insurance system in China increased by ten times and has now achieved universal coverage (96.9 per cent of the population).

Figure 1. Expansion of health insurance coverage from 2000 to 2013: Number of insured people (millions)



Source: China Statistical Yearbook 2009 & 2014.

The current health insurance system is composed of three main schemes: (1) Health Insurance for Urban Workers (HIW), (2) Health Insurance for Urban Residents (HIUR) and (3) Health Insurance for Rural Residents (HIRR).

National social protection floors (SPFs) guarantee access to essential health care and basic income security for children, persons of working age and older persons.

185 countries have adopted the Social Protection Floors Recommendation, 2012 (No. 202), an approach to achieve universal social protection.

This note presents a successful country experience of expanding social protection.

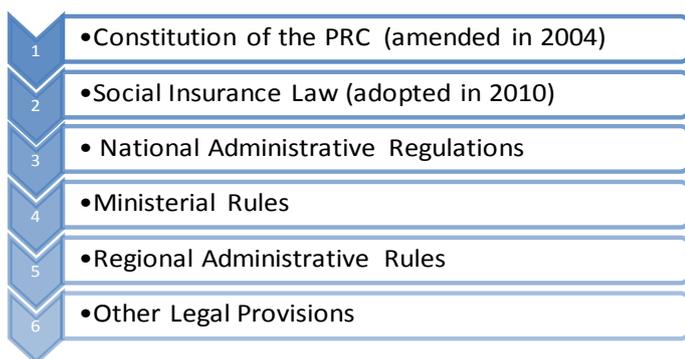


Main lessons learned

- China's experience shows that universal health protection can be achieved in less than ten years.
- Political will and government commitment are necessary for the rapid expansion of health protection. In particular, increasing government expenditures is indispensable for providing rural and other vulnerable groups of the population with meaningful health protection.
- An increase in health insurance coverage contributes to boosting demand for health-care services. It is therefore necessary to ensure that a sufficient number of skilled health workers and quality health-care facilities are equally available and accessible to all in need.
- Introducing cost effectiveness measures and financial incentives to use community-based and other local health services ensures the long-term financial sustainability of the system.
- Universal coverage contributes to social and economic development by enhancing the purchasing power of households, improving the health status of people and productivity of workers, and creating employment in the health sector and beyond.

1. What does the health protection system look like?

Legal aspects: The legal framework of China's health protection system is briefly depicted below.



Financing: The HIW is mainly financed by employer and employee contributions. Employers and employees contribute 6 per cent and 2 per cent of the reference payroll, respectively (MOHRSS, 2015).

The HIUR and HIRR are voluntary insurance schemes that cover 1.1 billion people (NBS, 2014). These schemes are funded by both government subsidies and contributions of the insured. As shown in Table 1 the Government subsidizes a major part of these schemes.

Table 1. Average contribution and subsidy for HIUR and HIRR in 2015

Year 2015	Average annual contribution	Average annual subsidy
HIUR & HIRR	CNY 120 per person	CNY 380 per person

Source: MOHRSS, NHFPC and MOF, 2015.

In addition, the Government covers health insurance contributions for poor families.

Benefits: The benefit packages of the three schemes, although different, have all been gradually improved over the last decade. Under the HIUR and HIRR benefit packages, for instance, more than half of the insurable medical costs are covered up to a maximum set by each programme (MOHRSS and NHFPC, 2015).

Comparatively, HIW provides a more comprehensive benefit package that provides financial protection for on average 81 per cent of insurable costs (MOHRSS, 2015). As a general rule for poor families, the Government covers part or all of their out-of-pocket (OOP) payments. Supplementary benefits are paid to those with higher OOP or severe diseases. As a result, the level of OOP as a

share of national health expenditures has declined from 60 per cent in 2001 to 33.9 per cent in 2013 (NBS, 2014). The reduction is more striking under the HIRR.

Table 2. HIUR and HIRR benefits in 2015

	HIUR (2014)	HIRR (2013)
Benefits as % of insurable cost for hospitalization	70	75
Benefits as % of insurable cost for outpatient care	50	50
Minimum ceiling of annual benefits	6 times the average annual regional income per capita of CNY 60,000	CNY 80,000

Note: Insurable cost is the cost of the benefit package covered by HIUR and HIRR.

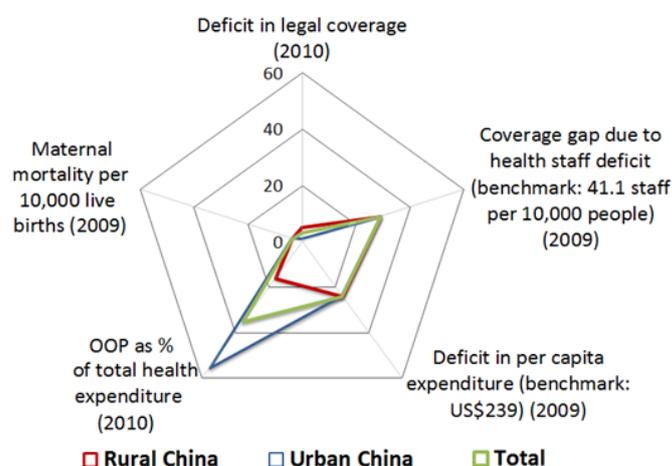
Source: MOHRSS and NHFPC, 2015.

Institutional arrangements for delivery: At the national level, the Ministry of Human Resources and Social Security (MOHRSS) is responsible for the global performance of the HIW and HIUR, whilst the National Health and Family Planning Commission (NHFPC) supervises the operations of the HIRR. They cooperate with each other as well as with other related national and regional authorities.

The regional funds of the HIW, HIUR, and HIRR are in charge of the daily operations of the health insurance system. A network of contracted public and private health providers and pharmacies provides the services.

Third-party payment mechanisms have been established between the contracted health providers and insurance schemes. Thus, insured patients only pay their share of OOP after every medical visit. The remaining cost is later invoiced by the health providers to the insurance scheme.

Figure 2. Deficits in effective access to health care (2011 or latest available year)



Source: Based on Scheil-Adlung, 2015a.

Access to health care: According to Recommendation No. 202 universal health protection should be based on entitlements prescribed by law and constitute services that meet certain criteria such as availability, accessibility and quality. As shown in Figure 2, only 3.1 per cent of the population was not affiliated to any scheme in 2010. Moreover, the maternal mortality ratio in 2009 was low with only 3.7 deaths per 10,000 live births. However, access to services was still hampered for some 20 per cent of the population due to deficits in the health workforce and funds. OOP remained high, with a national average of around 35 per cent of total health expenditure and an urban average of 55 per cent.

2. How was this major progress achieved?

A series of events led the extension of health coverage:

- The decision to create a health insurance programme for rural people was jointly made by the Central Committee of the Communist Party of China (CPC) and the State Council in 2002. As a follow-up, the HIRR was launched in 2003 to progressively cover all 800 million rural people (NBS, 2014).
- In 2007, the State Council adopted a policy to pilot a health insurance programme for urban children, students and residents with no health insurance. This policy gave way to the HIUR in the same year.
- “Universal access to basic health care” was set by the CPC in 2007 as an integral part of the national strategic objective to build a moderately prosperous society by 2020 (Hu, 2007). The progress towards universal health protection was thereby accelerated.
- Due to the high level of government financial support to HIRR and HIUR, these two voluntary schemes have helped achieve universal health insurance coverage.
- From 2003 to 2013, the total number of licensed doctors, registered nurses and pharmacists increased significantly from 34.8 to 52.7 per 10,000 residents (NBS, 2014). This increase has reduced the coverage gap due to health staff deficit that is highlighted in Figure 2.

3. What are the main results and impact?

Outcomes: Based on legislation and affiliation to health insurance schemes, universal health protection was achieved in China in 2012 (NBS, 2014).

Impact on people’s lives: Universal coverage has enabled more people to seek medical treatment when in need. As a result, the average number of outpatient consultations per person per year went up from 1.7 times in 2003 to 5.4 times in 2013 (NHFPC, 2003 and 2013; NBS, 2014).

Consistently, the national health indicators have improved too. For instance, infant mortality and maternal mortality rates were reduced by 60 per cent and 49 per cent, respectively, over 2000-12. Life expectancy at birth increased from 69 years in 1990 to 75 in 2012 (World Health Organization, 2015).

Impact on the economy: The improved health status of the population has positively impacted workers’ productivity. Reductions in OOP payments have minimized the risk of households falling into poverty. Meanwhile, universal coverage has increased the demand for health-related goods and services. This new market has generated new employment and growth. In 2013, the State Council issued a guideline to facilitate the development of these new goods and services.

4. What’s next?

Affordability: Despite a gradual decrease of OOP, the level of medical costs borne by insured persons is still considered high, especially for those with low incomes, severe diseases or disabilities. In 2015, the Government launched HIRR and HIUR supplementary programmes for those with severe diseases with the aim of reducing OOP expenditures to less than 50 per cent of the total medical cost (MOHRSS and MOF, 2015). Moreover, there is a significant lack of long-term care protection for older persons as very strict and means-tested eligibility criteria apply (Scheil-Adlung, 2015b).

Availability: Despite reforms to increase and improve the supply side of health care, health services are still overly concentrated in hospitals in large cities. To promote equal access to quality health care, more investment in the rural areas and at the grassroots level is required.

Portability: Patients using health-care facilities outside their region of health insurance still have to pay the full bill first before applying for reimbursement from their own regional health insurance fund. Third-party payment mechanisms should be extended beyond regional borders. Many regions are starting their experiments in portability.

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Building Social Protection Floors

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