HEALTH REFORM IN CHINA: RECENT DEVELOPMENTS

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Executive Summary

1. The rapidly ageing population has made China's health system ever more important. The health system is also critical for restoring economic activities particularly after the outbreak of COVID-19.

2. A major guideline for health reform was released by the State Council in 2009 to improve affordability and accessibility of health care.

3. After the 2009 reform, social insurance has been expanded to cover more than 95% of the population. Government inputs for public health services have also been significantly increased.

4. The government share of total health expenditure almost doubled to 30.4% in 2020 compared to 17.9% in 2005.

5. Despite the reforms, the Chinese health system still needs to content with an affordability problem. Out-of-pocket expenditures continued to account for about 28% of health expenditure in 2020.

6. Accessibility remains a concern. The share of outpatient service provided by primary care clinics has declined in recent years and regional variation in accessing health care is large.

7. Further, public health infrastructure such as intensive care unit has been underinvested. After the outbreak of the COVID-19 pandemic in early 2020, the public health system in Wuhan had been stressed.

8. Recent government initiatives to address these issues include first, the setting up of the National Healthcare Security Administration (NHSA) in March 2018 to integrate the management of all health insurance programmes.

9. Second, subsequent to the establishment of the NHSA, the government has released new initiatives to control drug expenditure, which accounted for a large share of health expenditure, and established the National Administration for Disease Control and Prevention, a vice-ministerial level government agency.

10. The restructuring of the bureaucracy is expected to address the problem of underinvestment in infectious disease prevention.

11. Governance of public hospitals and primary care remains a major issue to be addressed.

12. With the many unaddressed issues, further reforms to the public health system will be important. Many county-level hospitals and local governments are short of resources and lack incentives to finance infrastructure upgrading.

HEALTH REFORM IN CHINA: RECENT DEVELOPMENTS

QIAN Jiwei*

Growing Importance of the Health System

1.1 China's rapidly ageing population and increasing income level have put the spotlight on China's health system. Total health expenditure in China reached RMB7.23 trillion, or about 7.1% of gross domestic product (GDP) in 2020 compared to about four per cent in 1997.[1] With an increasing income level, people are more willing to spend on health care. For example, in 2013, healthcare expenditure accounted for 6.9% of total household consumption in China while the rate increased to 8.8% in 2019.[2]

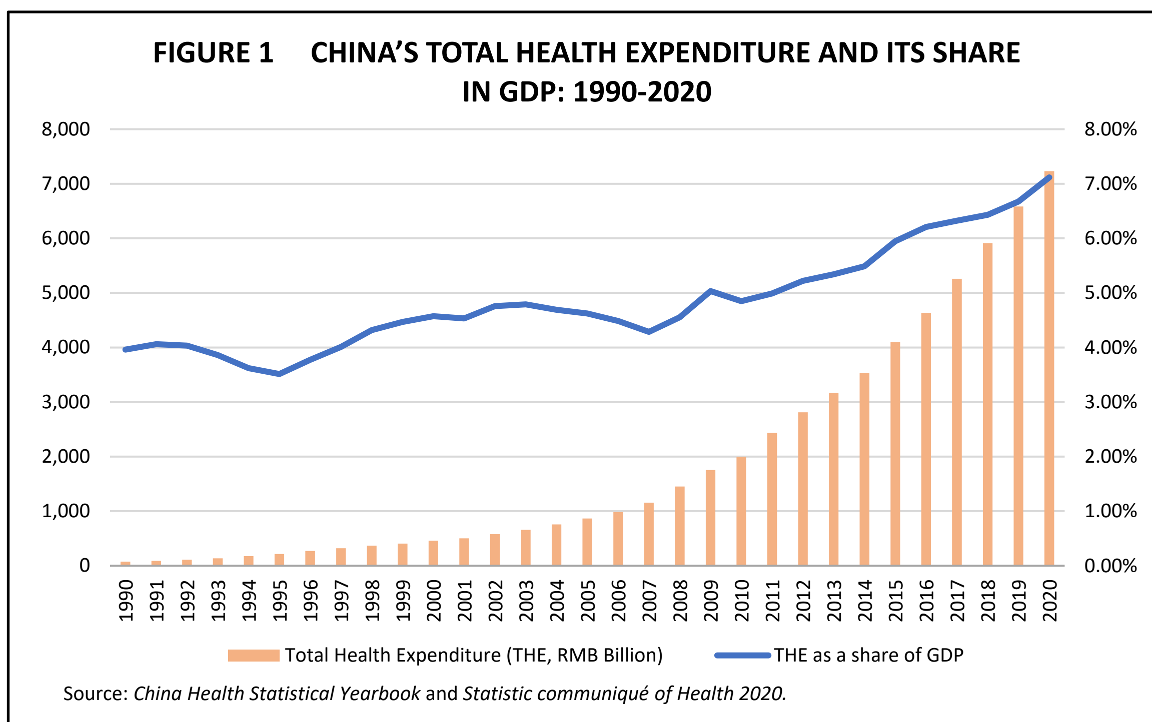

FIGURE 1 CHINA'S TOTAL HEALTH EXPENDITURE AND ITS SHARE IN GDP: 1990-2020

Source: *China Health Statistical Yearbook* and *Statistic communiqué of Health 2020.*

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1 http://www.nhc.gov.cn/guihuaxxs/s10743/202107/af8a9c98453c4d9593e07895ae0493c8.shtml, accessed 4 March 2022.

2 *China Statistical Yearbooks*, various years.

1.2 Further, the capacity of the health system in dealing with the COVID-19 crisis will have much bearing on economic growth in China, making the role of the health system in China under COVID-19 ever more important.

1.3 While the recent round of health reform (since 2009) has improved affordability and accessibility of health care, reforms of the health system will still be needed in the areas of public hospital governance, health financing and public health infrastructure upgrading among others.

1.4 Before the mid-2000s, China's health system faced three major issues. First, out-of-pocket expenditure had been high as the coverage of health insurance was low. By the year 2000, out-of-pocket payment accounted for 60% of total health expenditure. Further, by 2001, only about 23% of urban workers had enrolled themselves in social health insurance scheme, a much lower percentage than for pension programmes (45%).[3] In the rural areas, health insurance schemes were supported by contributions from within a commune. However, after the 1980s, almost all rural health insurance schemes had been scrapped when the household responsibility system was replaced by the commune system.

1.5 Second, government inputs to the health system were very low before the mid-2000s, making up about 15% of total health expenditure in 2000, much lower than the approximately 40% share in the mid-1980s.[4]

1.6 Third, doctors in public hospitals had strong incentives to seek profit. With decreasing fiscal inputs from the government, health service providers, most of which are publicly owned, had difficulty funding health services. To make up for the shortfall, public hospitals were allowed to raise funds by selling some drugs at a 15% mark-up and providing a range of services which was not price regulated.

1.7 A comprehensive guideline for health reform covering all major aspects of the health system was released in April 2009 by the State Council. Initiatives include

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[3] Qian, J. (2021). *The Political Economy of Making and Implementing Social Policy in China,* Palgrave Macmillan.

[4] http://ww2.usc.cuhk.edu.hk/PaperCollection/Details.aspx?id=6617, accessed 4 March 2022.

increasing government health inputs, expanding health insurance, and reforming public hospitals and the pharmaceutical sector.[5]

1.8 The health reform, according to the guideline, aimed to build a health system that would be accessible and affordable to all Chinese citizens by 2020. The government would play a lead role in this system while market mechanism through competition or procuring would also be useful. Local pilot programmes were encouraged for all major policy arenas and would be pivotal for future health reform.

1.9 The guideline also stipulated the gradual implementation of reform. Simpler tasks such as introducing social insurance, establishing networks of primary care clinics and launching local pilot reform were slated for the first phase between 2009 and 2011. Tasks such as public hospital reform and payment method (between insurers and hospitals) reform, which are more complicated tasks, had been scheduled for the following phase.

1.10 In the guideline, the first phase of the health reform would have to accomplish five tasks between 2009 and 2011: (i) achieve universal coverage of social health insurance by 2011; (ii) establish an essential medicine system that defined a set of essential medicines that was the most effective and sold without price markup in publicly owned primary care clinics; (iii) set up networks of primary care clinics by upgrading the infrastructures of 2,000 county hospitals, over 30,000 township health centres and over 14,000 urban community health centres. The training of general practitioners for these primary care clinics also topped the agenda of the Chinese government; (iv) increase government inputs for public health services, in particular for lower income regions, to ensure equal access to basic public health services across regions; and (v) implement pilot reform for public hospitals. The reform of governance for public hospitals was highlighted. Revenue from drug sales would be decoupled from public hospital's revenue gradually. The government would increase the amounts of subsidies allocated to public hospitals.

5 Qian, J and Blomqvist, Å, (2014). *Health Policy Reform in China: A Comparative Perspective,* World Scientific Publishing, Singapore.

1.11 Other reforms including public hospital reforms have been introduced since 2012. In 2012, the State Council announced that public hospitals in 311 pilot counties would undergo reforms.[6] Since 2015, county level reform has been expanded to all counties nationwide.[7]

1.12 From May 2012, public hospitals have started to remove the 15% price mark-up for the sale of drugs.[8] By the end of 2017, all public hospitals removed the price markup.[9] To compensate for the financial losses after the removal, these public hospitals are allowed to raise the fee for health services.

1.13 Payment method reform is a reform for reimbursing hospitals. Some pilot reforms have been initiated. In Shanxi and Gansu provinces, since 2016, the fee-for-service payment method has been replaced by a payment method called Diagnosis-Related Groups (DRG) in which hospitals are reimbursed according to a fee schedule based on the type of disease. In Sichuan, payment method reforms have been implemented in all public hospitals.[10]

Achievements and Challenges after the 2009 Reform

2.1 The 2009 health reform did make some major achievements. The reform saw a dramatic increase in government input. The annual growth rate of government health expenditure between 2008 and 2020 reached 16.3% on average. Fiscal subsidy for public health increased from RMB15 per capita in 2009 to RMB79 per capita in 2021.[11] Government share of total health expenditure almost doubled to 30.4% in 2020 compared to 17.9% in 2005.

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6 http://www.chinanews.com/jk/2012/06-26/3988344.shtml, accessed 3 March 2022.

7 http://www.mof.gov.cn/zhengwuxinxi/zhengcefabu/201505/t20150511_1229838.htm, accessed 3 March 2022.

8 *Caixing* Magazine, 11 June 2012.

9 http://www.gov.cn/guowuyuan/2018-01/05/content_5253309.htm, accessed 4 March 2022.

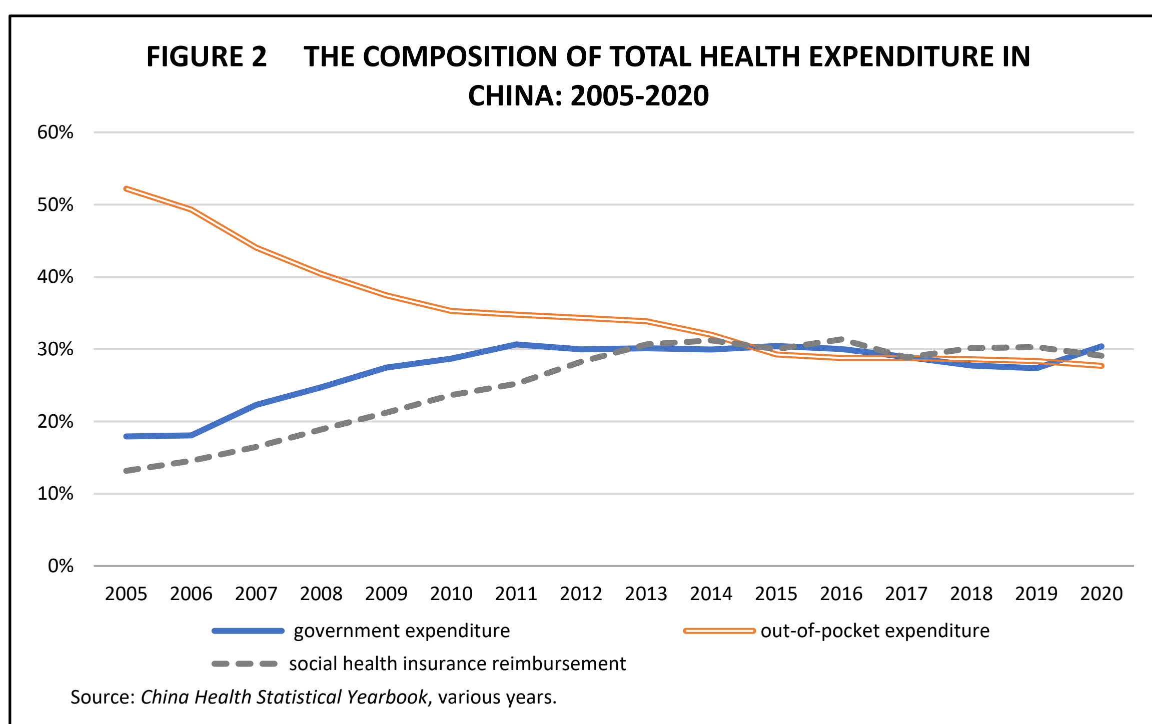
10 http://finance.people.com.cn/n1/2016/0524/c1004-28373383.html, accessed 2 March 2022.

11 http://www.gov.cn/xinwen/2021-07/14/content_5624865.htm, accessed 4 March 2022.

2.2 There is also an expansion of social health insurance in both urban and rural areas. Social insurance in health financing expanded greatly in the mid-2000s with the introduction of the New Cooperative Medical Scheme (NCMS) and the Urban Resident Insurance (URI) schemes for rural and urban residents respectively. By 2011, 95% of urban and rural population was covered by various social health insurance plans. Reimbursements from social health insurance funds increased from 11% of total health expenditure in 2005 to around 29% in 2020.

2.3 With the increasing share of government and social insurance expenditure, out-of-pocket health expenditure decreased from about 60% in 2000 to about 27.7% in 2020 (Figure 2).

FIGURE 2 THE COMPOSITION OF TOTAL HEALTH EXPENDITURE IN CHINA: 2005-2020



Source: *China Health Statistical Yearbook*, various years.

2.4 The achievements however cannot dwarf the challenges. First, affordability remains a serious concern. Out-of-pocket expenditures still accounted for about 28% of health expenditure in 2020. The annual growth rate of out-of-pocket expenditure continued to be in double digits (about 10.8%) between 2008 and 2020.

2.5 In particular, drug revenue remains a major revenue source for service providers. Drug revenue still accounted for 32.7% of service-related revenue in public

hospitals in 2018, compared to 46.6% in 2010.[12] For urban community health centres, the drug revenue accounted for 64.8% of service-related revenue in public hospitals in 2018, compared to 67.6% in 2010.[13]

2.6 Second, accessibility is a concern given the increasing imbalance of demand for healthcare services in hospitals and primary care clinics. The share of outpatient service provided by primary care clinics had also dipped from 61% in 2010 to 52% in 2019.[14]

2.7 Primary care clinics remain under-developed and regional inequality in accessing health care is large. There are still huge regional variations in accessing primary health care. In 2020, there were 3.1 general practitioners per 10,000 residents in Beijing compared to only 2.0 in Guizhou.

2.8 Another index for measuring the disparity of accessibility across regions is government health expenditure which covers health infrastructure investment and expenditure of human resources. Figure 3 shows the distribution of government health expenditure per capita across 27 cities of different sizes in the Yangtze River Delta region in 2019. Clearly, government health expenditure per capita in Shanghai, as the largest city in the region, has by far the highest level of government health expenditure per capita in the region (about RMB2,000 per capita).

2.9 Third, under the decentralised social insurance system, the portability of social insurance across cities has yet to be resolved; many workers have difficulties claiming social insurance benefits after relocating to another city.[15]

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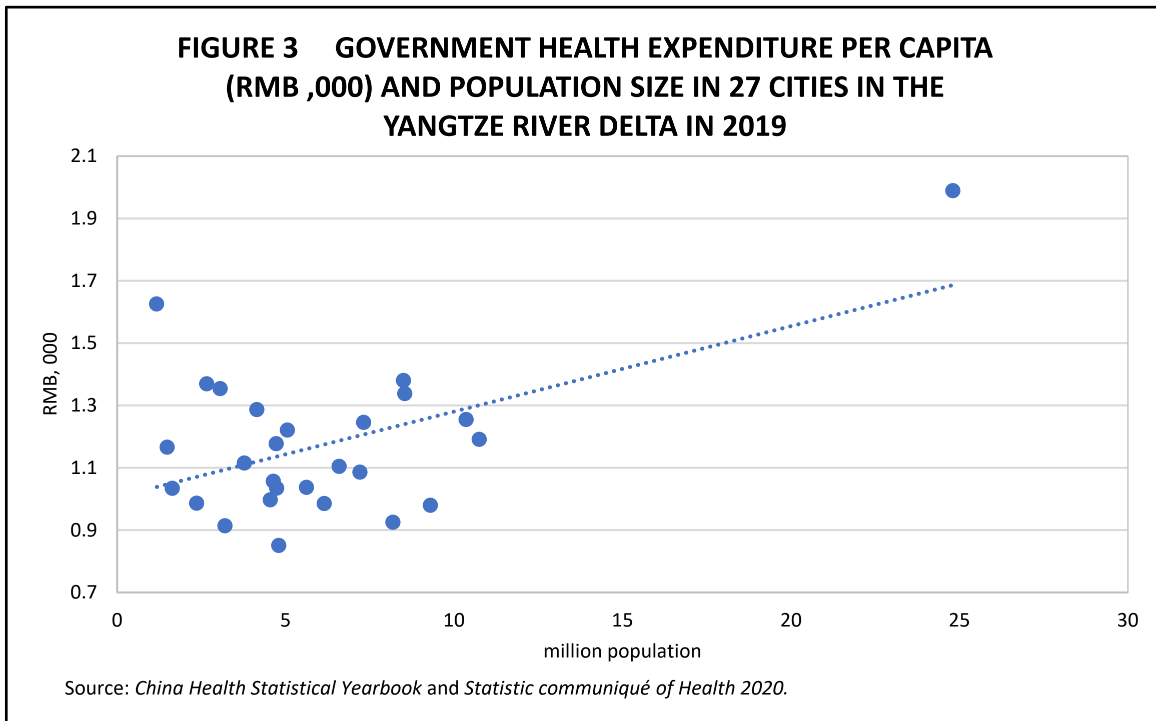
12 *China Health Statistical Yearbooks*.

13 *China Health Statistical Yearbooks*.

14 Qian, J. (2021). "The Challenge of Allocating Resources for an Effective Health System in China", working paper, National University of Singapore.

15 For example, see a recent report https://www.mj.org.cn/mtjj/202004/t20200427_225831.htm, accessed 31 January 2022.



Source: *China Health Statistical Yearbook* and *Statistic communiqué of Health 2020.*

2.10 Social health insurance is largely managed by the prefecture-level government and sometimes even by the county-level governments. For example, in 2019, Xuzhou, a prefecture-level city in Jiangsu province, managed social insurance funds for urban basic employee health insurance, and urban-rural health insurance and employment insurance among other things.[16] Pizhou, a county-level city under Xuzhou, also managed the same set of social health insurance funds as Xuzhou.[17]

2.11 Fourth, the financial situation of public hospitals remains a serious concern. Fiscal subsidy is low, leaving public hospitals with no choice but to rely on revenue generated from service provision and drug sales.

2.12 The payment method reform has been not very effective and health expenditure in public hospitals has surged. As the reimbursement from social health fund accounted for about 30% of total health expenditure, paying hospitals from social insurance fund is important to control the rise of health expenditure. The fee-for-

[16] Budget report 2019, Xuzhou city, downloadable from http://yjsgk.jsczt.cn/front/glwj/pdf_show.do?uuid=b0bf720b216a49bf8f78c2f558dc3316, accessed 12 March 2022.

[17] http://yjsgk.jsczt.cn/front/glwj/pdf_show.do?uuid=11df6d96aabe4afab1bde0110e405a61, accessed 12 March 2022.

service method, which induced profit-seeking behaviour of service providers, has not been totally eliminated.[18]

2.13 Fifth, public health infrastructure such as intensive care unit (ICU) has been underinvested. ICU beds per 100,000 population in China was about 3.6,[19] much lower than Singapore's 11.4 or Germany's 25.[20] For instance, the public health system in Wuhan came under great stress when the COVID-19 spread like wildfire within weeks of the outbreak.[21]

2.14 The Chinese Centre for Disease Control and Prevention (CCDC) is the main bureaucracy providing such public health services. Before the COVID-19 spread, the input for public health had already been decreasing (Figure 4).

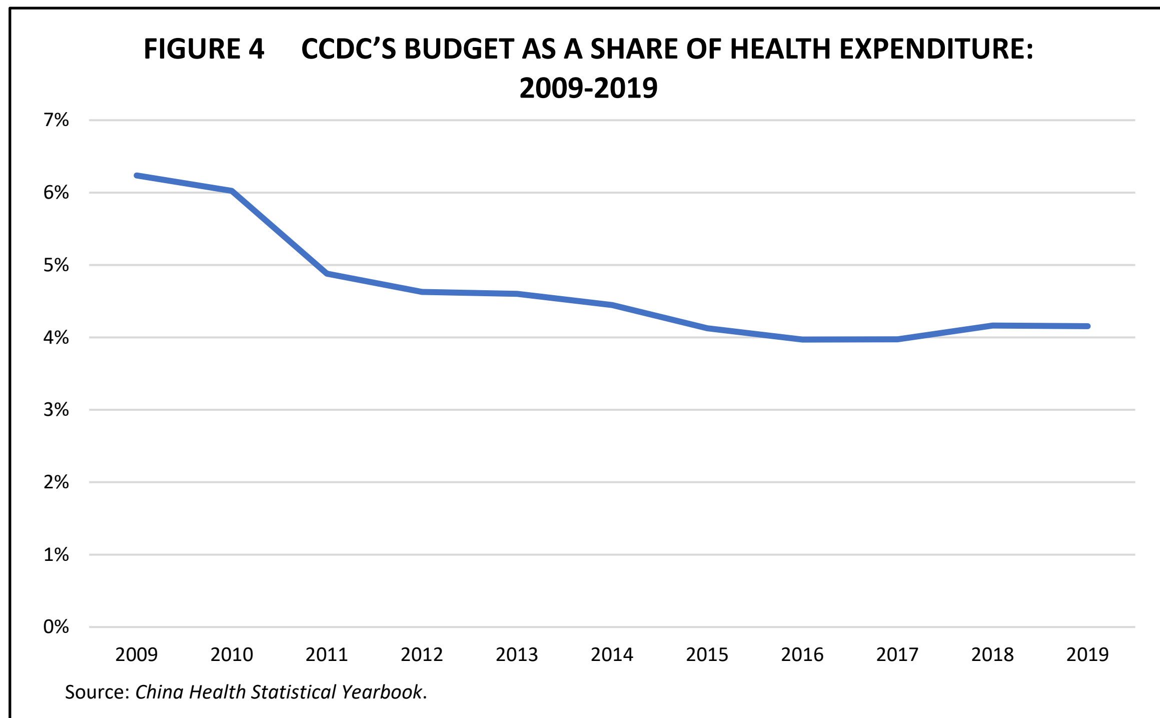


FIGURE 4 CCDC'S BUDGET AS A SHARE OF HEALTH EXPENDITURE: 2009-2019

Source: *China Health Statistical Yearbook*.

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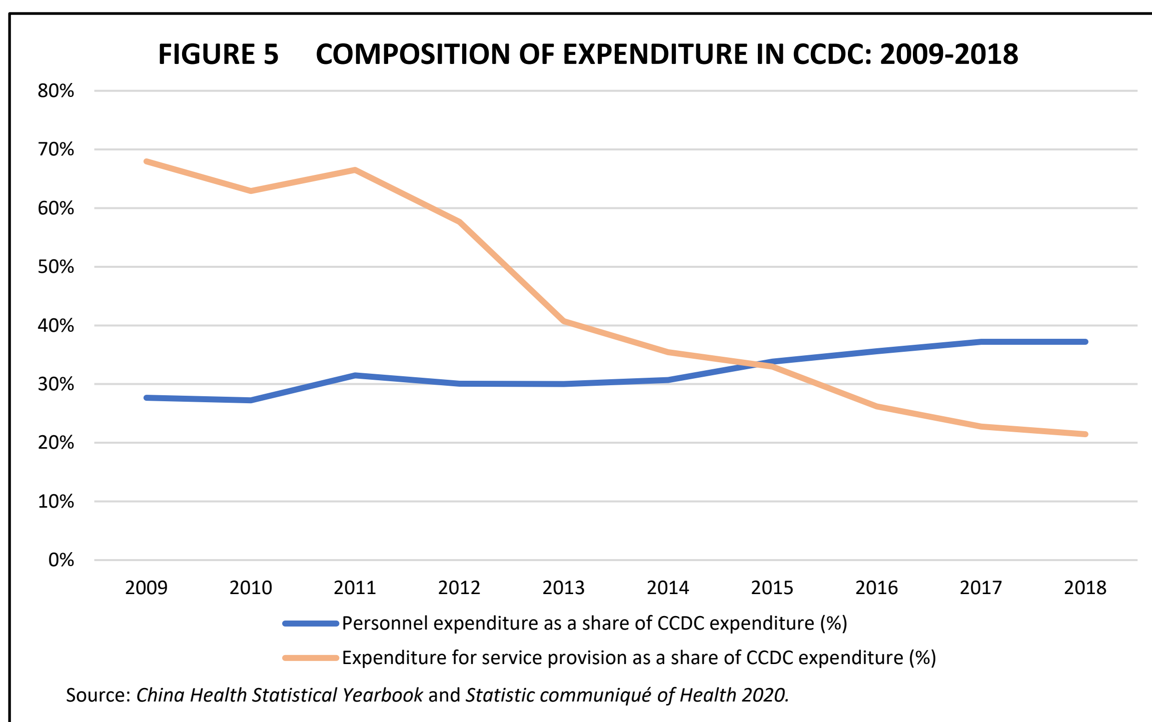
[18] Gu, H, and Wu, D. (2021). "Connotation and Strategic Conceptualization of the High-Quality Development of the Essential Healthcare Security System During the 14th Five-Year Plan Period", *Management World*, 9, 158-167.

[19] https://www.forbes.com/sites/niallmccarthy/2020/03/12/the-countries-with-the-most-critical-care-beds-per-capita-infographic/?sh=532164947f86, accessed 8 April 2022.

[20] https://www.hkmj.org/abstracts/v28n1/64.htm, accessed 8 April 2022.

[21] Qian, Jiwei (2020), "China's Health Initiatives In the Covid-19 Outbreak", *EAI Background Brief*, No. 1511.

2.15 The share of the CCDC budget for service provision has also decreased in recent years (Figure 5) while the share of the budget spent on personnel increased. This suggests that the volume of public health service provision by CCDC is likely to decrease.



Recent Initiatives to Reform the Health System

3.1 Given the various issues, several government initiatives have been introduced. A new government agency, the National Healthcare Security Administration (NHSA), was set up in March 2018 to integrate the management of all health insurance programmes and achieve the portability of health insurance schemes across regions.[22]

3.2 The agency now handles the procurement and payment for healthcare services and drugs under all social health insurance schemes to facilitate a move towards a single-payer system.[23]

22 http://www.nhsa.gov.cn/art/2021/10/26/art_26_7224.html, accessed 4 April 2022.

23 Gu, E and Page-Jarrett, I. (2018). "The top-level design of social health insurance reforms in China: Towards universal coverage, improved benefit design, and smart payment methods", *Journal of Chinese Governance*, 3(3), 331-350.

3.3 After the establishment of the NHSA, the government released new initiatives to control the expenditure on drugs. The consolidation of procurement under NHSA allows the agency to negotiate with pharmaceutical companies to include some expensive drugs in the reimbursement list but at large discounts.[24]

3.4 From November 2018, social insurers could procure 25 drugs collectively for public hospitals in 11 major cities.[25] Unlike in previous government procurement reforms, a quota in terms of quantity for public hospitals has been set for each drug.[26] The collective negotiation between insurers and pharmaceutical companies inevitably leads to lower drug prices. In 2019, collective procurement was applied nationwide.[27]

3.5 More support was also given to the development of private health insurance to further reduce the financial burden of patients. People in over 70 cities can now join a flat-rate supplementary health insurance plan, Insurance Benefitting the People, *Huimin Bao,* run by private insurers.[28] In many of these cities, local branches of NHSA release the policy which allows enrollees to pay the premium of *Huimin Bao* from their individual social health insurance account.[29]

3.6 In May 2020, NDRC along with other ministries released a guideline on upgrading infrastructure to deal with public health emergencies. A county-level public hospital should now allocate 2-5% of beds as ICUs.[30] For urban cities with a population of less than one million, total ICU beds should be between 60 and 100. For cities with population between one million and five million, ICU beds should be between 100

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[24] http://www.nhsa.gov.cn/art/2021/12/7/art_38_7447.html, accessed 4 March 2022.

[25] https://www.yicai.com/news/100315590.html, accessed 4 March 2022.

[26] https://www.cgdev.org/sites/default/files/CGD-procurement-background-china-case.pdf, accessed 4 March 2022.

[27] http://www.news.cn/2022-02/16/c_1128382896.htm, accessed 4 March 2022.

[28] https://finance.sina.com.cn/tech/2021-01-12/doc-ikftssan5260043.shtml, accessed 18 March 2022.

[29] http://www.xinhuanet.com/fortune/2020-12/21/c_1126885099.htm, accessed 4 March 2022.

[30] https://www.ndrc.gov.cn/xxgk/zcfb/tz/202005/P020200522360052470224.pdf, accessed 4 March 2022.

and 600. For cities with a population of more than five million, number of ICU beds required is at least 600.[31]

3.7 In May 2021, a vice-ministerial level government agency, the National Administration for Disease Control and Prevention, was established. The restructuring of the bureaucracy is expected to address the problem of underinvestment in infectious disease prevention.[32]

3.8 In 2018, the central government released a major document to encourage hospitals to provide internet-based healthcare services. Hospitals are encouraged to share data such as medical records to support the referral system. Remote healthcare service provision in the future should cover primary care clinics.[33] In December 2020, the State Council released a guideline to allow health insurance to reimburse telemedicine services to some extent.[34]

3.9 To support primary care clinics and sharing of resources among them, the government has promoted the formation of conglomerates comprising different levels and types of primary care facilities. "Health conglomerates" (医疗联合体) of public hospitals and clinics have been established in some local pilots to improve the referral system. The private sector is also allowed to invest in public hospitals. Patients require a referral from a community health centre before they can visit higher level hospitals. For example, in Shanghai, all government-owned primary care clinics since 2020 have been required to join a health conglomerate headed by a major hospital.[35]

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[31] https://www.ndrc.gov.cn/xxgk/zcfb/tz/202005/P020200522360052470224.pdf, accessed 4 March 2022.

[32] See article 13 in the government action plan for health reform initiatives in 2021, http://www.gov.cn/zhengce/zhengceku/2021-06/17/content_5618799.htm, accessed 18 March 2022.

[33] http://www.gov.cn/zhengce/content/2018-04/28/content_5286645.htm, accessed 4 March 2022.

[34] http://www.nhsa.gov.cn/art/2020/12/15/art_37_4056.html, accessed 4 March 2022.

[35] https://www.shanghai.gov.cn/nw41435/20200823/0001-41435_54747.html, accessed 4 March 2022.

3.10 In December 2021, the State Council released a document to promote Sanmin pilot reform nationwide.[36] Since 2012, revenue from selling medicines is no longer included in public hospitals' operating revenue in Sanming city of Fujian province. The reimbursement to doctors is also not set based on the revenue from the sale of drugs but by the service volume. In 2014, the revenue of selling medicines accounted for about 22% of total public hospital revenue in Sanming, compared to about 37% in Fujian on average.[37]

3.11 Sanmin pilot reform in Fujian was highlighted for integrating the functions of different government bureaus into a single agency. The 2021 guideline released by the State Council also underlined the importance of integrating local governance of health insurance, healthcare service provision and pharmaceutical issues.[38]

Achievements of Recent Health Reform Initiatives

4.1 The recent health reform has been effective in certain areas. Drug prices for instance have come down after the collective procurement reform and negotiation between NHSA and pharmaceutical companies. By the end of 2021, about 250 drugs had been included in the reimbursement list and prices had been cut by half on average.[39] According to a news conference hosted by the State Council, 234 types of drugs were procured by NHSA between 2018 and early 2022, making up about 30% of total drugs used by public hospitals. The prices of these drugs procured under the reform have been slashed by 53% on average.[40]

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36 http://www.nhc.gov.cn/tigs/s7850/202112/59a0b62f76d744a38741a03141bd83b4.shtml, accessed 4 March 2022.

37 *South Reviews* (*Nanfengchuang*), no. 7, 25 March 2015, pp. 46-49.

38 http://www.nhc.gov.cn/tigs/s7850/202112/59a0b62f76d744a38741a03141bd83b4.shtml, accessed 4 March 2022.

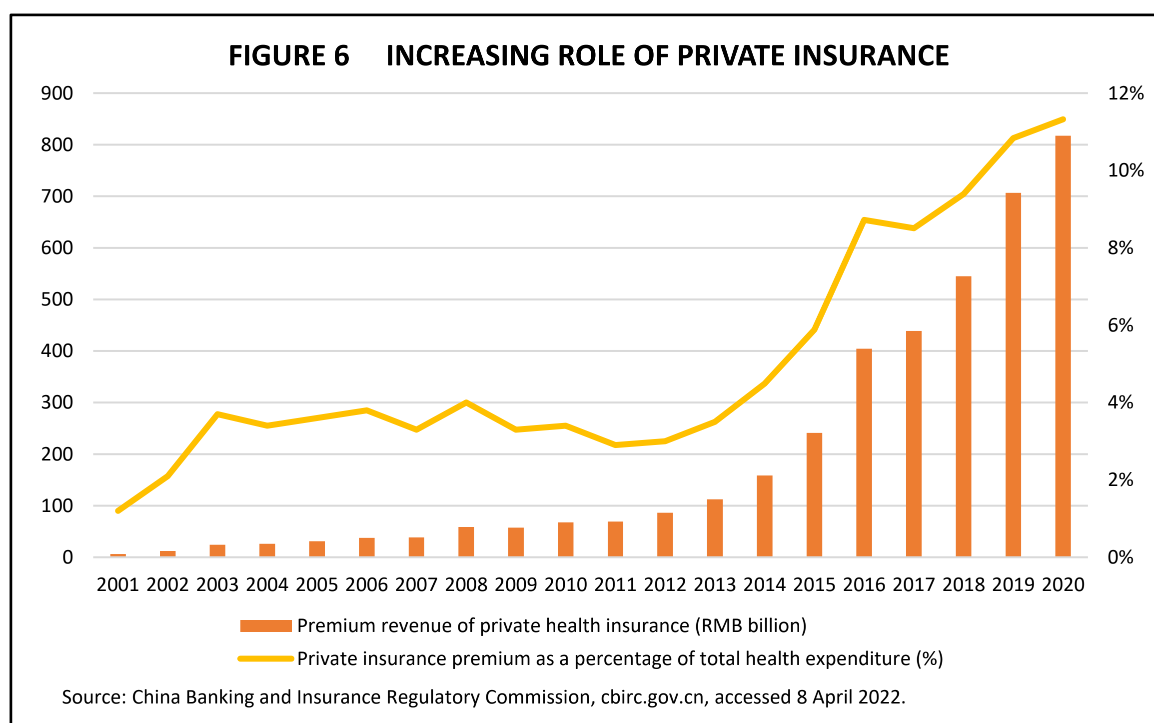
39 http://www.nhsa.gov.cn/art/2022/3/4/art_7_7927.html, accessed 4 March 2022.

40 http://www.gov.cn/zhengce/2022-02/12/content_5673241.htm, accessed 4 March 2022.

4.2 Inter-region portability of social health insurance has also seen improvement. In 2021, over 4.4 million and 12.5 million patients claimed cross-province inpatient and outpatient reimbursement respectively from NHSA.[41]

4.3 Since the reform, private health insurance has now been more widely accepted after having been its doldrums for a long time. The percentage of private insurance premiums in overall health expenditure was only 3.7% in 2003 and fell to 3.5% in 2013.[42] After 2016, private insurance has played a larger role in health financing in China. The share of private insurance premiums in overall health expenditure increased to over 11.3% in 2020 (Figure 6).

FIGURE 6 INCREASING ROLE OF PRIVATE INSURANCE



Source: China Banking and Insurance Regulatory Commission, cbirc.gov.cn, accessed 8 April 2022.

4.4 Telemedicine has taken a leap in recent years. Ali Health now has 90 million active users, more than five million of which are reported to be suffering from chronic diseases.[43]

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41 http://www.nhsa.gov.cn/art/2022/3/4/art_7_7927.html, accessed 4 March 2022.

42 Qian, Jiwei (2017), *The Rise of the Regulatory State in the Chinese Health-Care System*. Singapore: World Scientific.

43 https://www.sohu.com/a/503365012_100302690, accessed 4 March 2022.

4.5 The ease of telemedicine has prompted some local governments to collaborate with major digital platforms in providing health services via the internet. Since 2018, Alibaba has collaborated with Zhejiang provincial government to create a unified digital health record platform[44] and in 2019, the two parties created a hospital digital platform for conducting remote medical treatment.[45]

4.6 Concomitantly, in 2018, another tech giant, Tencent, the operator of WeChat, collaborated with Shenzhen's Municipal Health Commission to create an AI health database to apply its own WeChat QR code for enabling access to medical records.[46]

4.7 On primary care, the networks are expanding. The number of urban community health centres increased from 5,903 in 2010 to more than 9,200 in 2020, while government subsidies for these clinics increased from RMB10.9 billion to RMB81.3 billion, an average annual growth rate of over 22%.[47]

Remaining Issues

5.1 While recent government initiatives have made significant progress in healthcare provision, they may not be comprehensive enough to cover all areas. First, governance of public hospitals and primary care is a major issue. The efforts to promote the development of primary care clinics by the formation of conglomerates might not lead to the desired results as the incentives of primary care providers and hospitals are not being taken into account fully.

5.2 Primary care providers may have less incentive to control cost and improve quality since they are no longer independent practitioners. Hospital managers are reported

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[44] Zhao X. (2017). "Zhejiang Provincial Health Commission and Alibaba's strategic collaboration: Exploring digital health new style health", *Xinhua*, http://www.xinhuanet.com/fortune/2017-05/16/c_1120983171.htm, accessed 18 March 2022.

[45] Wei J. (2019). "First in China 'service+supervision' Internet hospital platform formally launched", Zhejiang Online Health, https://health.zjol.com.cn/ycxw/201901/t20190122_9307762.shtml, accessed 18 March 2022.

[46] *Tencent Technology*. (2018). "Deep collaboration in Internet+health: Shenzhen health commission and Tencent build together 'data health Shenzhen'", https://tech.qq.com/a/20180530/022271.htm, accessed 18 March 2022.

[47] *China Health Statistical Yearbooks*, various years.

to have abused their authority in encouraging doctors to refer patients from primary care clinics to the hospital for the higher service fees charged.

5.3 Second, county-level hospitals and local government's capacity and incentive in investing on public health infrastructure upgrading (e.g. ICU beds) would need to be addressed. Many county-level hospitals are short of resources to finance the upgrading. However, more resources allocated to public health implies that less resources would be available for generating service revenue for these hospitals.

5.4 Similarly, as local government has been entrusted with the task of financing primary care clinics and county level hospitals, many county-level governments face fiscal constraints.

5.5 Third, public hospitals face similar concern. After removing the price mark-up for drug sales, new sources of funding are required. However, to date, there is no clearly defined method to finance public hospitals. Further, the effectiveness of payment method reform in public hospitals has yet been assessed.

5.6 Fourth, regional inequality to healthcare access should be addressed as health resources may be overconcentrated in major cities. For example, in cities in the Yangtze River Delta, social health insurance has been portable across cities since 2020.[48] A social insurance contribution history in other cities is recognised by the local social insurance office. This initiative might further increase the attractiveness of Shanghai compared to other cities as people can have even better access and more affordable healthcare services in Shanghai, compared to other cities in the region.

5.7 This illustrates that, given regional development policies, health resources are likely to be concentrated in the major cities in the region.

[48] Qian, J. (2021). *The Political Economy of Making and Implementing Social Policy in China,* Palgrave Macmillan.

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