International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Profile: China

December 2021

1. Introduction

Since China initiated economic reforms in 1978, GDP growth has averaged almost 10 per cent a year (World Bank 2021b). Today, China is an upper middle-income country, and the world's second largest economy, with a GDP per capita of approximately US$10,500 in 2020 (World Bank n.d.). According to latest World Bank data from 2016, 0.6 per cent of the population lived under the international poverty line of less than US$1.90 a day (World Bank 2021a). In February 2021, President Xi Jinping announced that China had eradicated extreme poverty, with nearly 100 million people lifted out of poverty over an eight-year period. However, in recent years, growth has slowed due to structural constraints, including a declining labour force, reduced productivity and diminishing returns on investment. Moreover, while income inequality has improved substantially over the last decade, it remains relatively high.

Demographic changes in China have led to health challenges related to urbanization and industrialization, population ageing, non-communicable diseases, and life style and environmental risk factors (WHO 2015). To address these challenges, in 2009, the government launched comprehensive health system reforms to extend social health insurance coverage and promote universal access to health services (Meng et al. 2019). These reforms presented goals, priorities and strategies to improve access to affordable and equitable health care and essential medicines (Wang et al. 2019), and re-affirmed the government's role in the health system. Despite substantial progress in this area, the health system in China remains complex and somewhat fragmented, which is exacerbated by high population density and diversity across regions. Furthermore, despite noteworthy decreases in out-of-pocket (OOP) spending and increased subsidies for the poor and vulnerable, catastrophic health expenditure remains a challenge.

To bolster efforts to achieve Universal Health Coverage (UHC), in 2016, China issued the 13th five-year plan for health reform, setting forth the policy priorities and strategies for health reform for the following five years. In the same year, the Chinese Government announced the "Healthy China 2030" agenda in an effort to provide universal health security for all citizens by 2030 (Zhao et al. 2019). Concerted efforts have also been initiated to improve the financial efficiency, effectiveness and sustainability of the overall health system, strengthen primary care and improve public hospitals (Meng et al. 2019).

2. Context

In the 1980s and 1990s, the provision of social health protection in China was characterized by low population coverage and limited overall financial protection. OOP payments reached 60.1 per cent of current health expenditure in 2000, with government general health expenditure representing only 22 per cent of current health expenditures (WHO n.d.). To facilitate reforms initiated in 2009, government expenditure on health tripled from 2009 to 2017, alongside enhanced subsidies for vulnerable groups and the consolidation of schemes for rural and urban residents (World Bank 2021b).

Reforms have driven efforts to extend coverage to the entire population through China's existing health protection schemes: Urban Employee Basic Medical insurance (UEBMI), which was launched in 1998; the New Rural Cooperative Medical Scheme (NRCMS), initiated in 2003; and Urban Resident Basic Medical Insurance (URBMI), which was first implemented in 2007. The NRCMS and URBMI schemes for rural and urban residents were merged in some regions from 2016, which was extended nationally in 2018 to form the Urban Rural Resident Basic Medical Insurance (URRBMI), implemented under the National Health care Security Administration (NHSA). Since 2019, the unified nationwide basic medical insurance scheme for urban and rural residents (URRBMI) has been fully implemented, replacing the previous URBMI and NRCMS schemes. The consolidation was initiated in order to unify coverage, pooling mechanisms, benefits, reimbursement rates and fund management (Pan, Xu, and Meng 2016).

In addition to URRBMI and UEBMI, two supplementary schemes are in place to cover catastrophic costs: Catastrophic Medical Insurance (CMI), which was first piloted in 2012 and then implemented nationally in 2015 for rural and urban residents (only a very few areas covered employees); and Medical Financial Assistance for the Poor (MFA), launched in 2003 in rural areas, expanded to urban areas in 2005, and has now unified coverage in urban and rural areas.

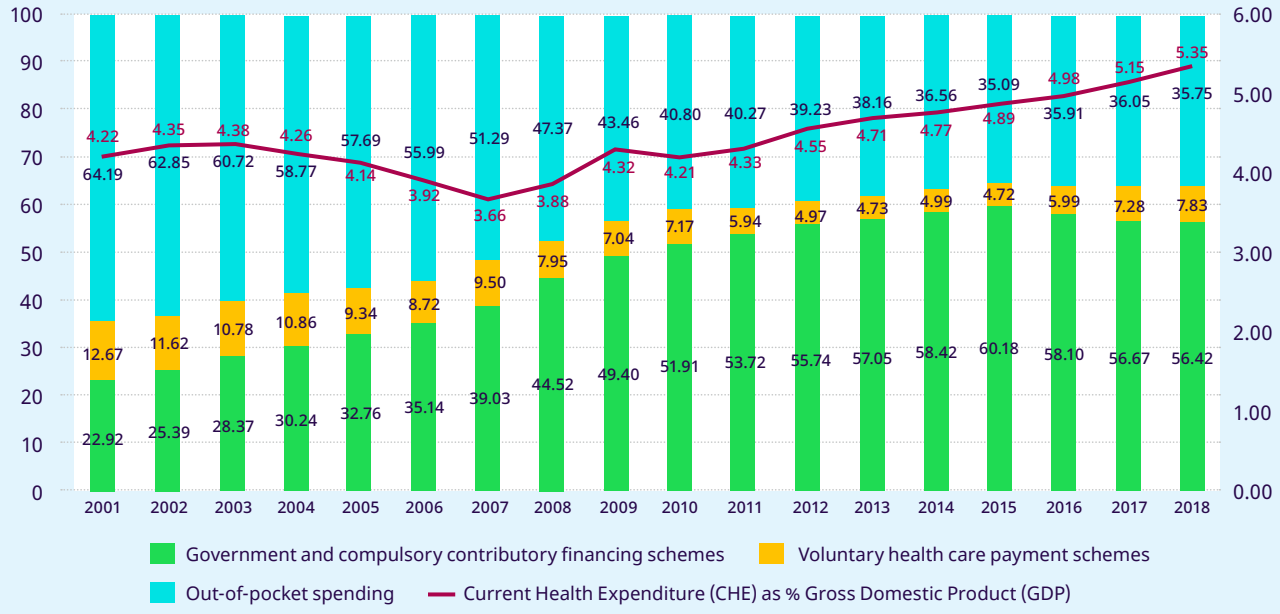
3. Design of the social health protection system

Financing

The expansion of the health insurance schemes was accompanied by an increase in public investment into the health system, which served to significantly reduce OOP spending. Today, China's health system is primarily financed by general taxation, social health insurance contributions, OOP payments, and private insurance premiums (Zhao et al. 2018). In 2018, per capita spending on health was US$500.5, equal to 5.34 per cent of GDP (WHO n.d.). In the same year, government schemes and compulsory contributory health care financing schemes accounted for 57.95 per cent of health expenditure, OOP spending accounted for 35.07 per cent, and voluntary health care payment schemes accounted for 6.98 per cent, with total spending on social health insurance accounting for 38.46 per cent of health expenditure (WHO n.d.). In 2020, the total income of the national basic medical insurance funds (including maternity insurance), accounted for approximately 2.4 per cent of the year's GDP. [1]

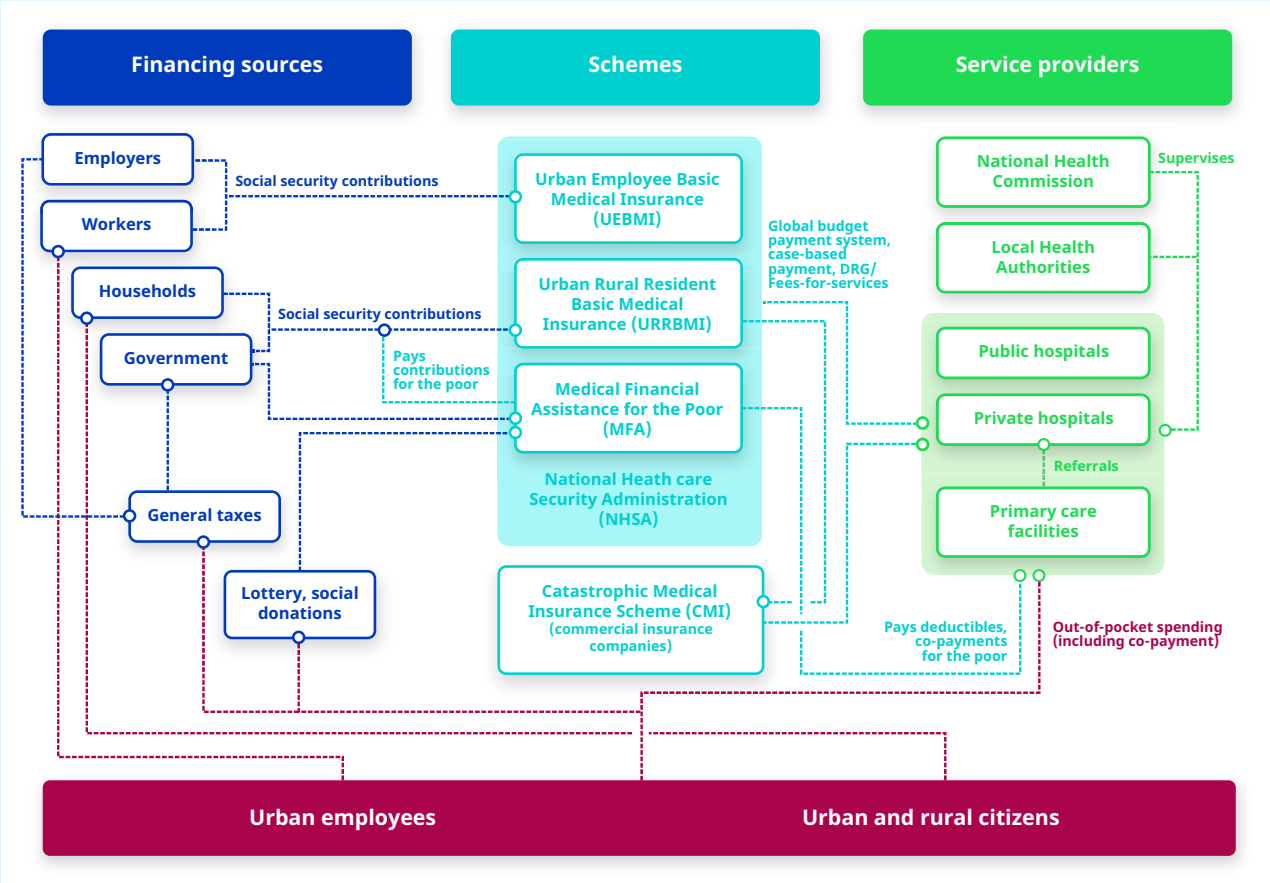
[1] Information (in Mandarin) sourced from 2020 data available on official NHSA website, available at: http://www.nhsa.gov.cn/art/2021/6/8/art_7_5232.html.

▶ Figure 1. Current health expenditure in China by financing scheme



Source: Adapted from WHO Global Health Expenditure Database.

▶ Figure 2. Overview of main financial flows of the social health protection system in China



Source: Authors.

The UEBMI scheme for urban employees is financed by employers and employees through payroll contributions and from the local government (Zhao et al. 2019). Contributions are collected on a monthly basis. Employers are responsible for transferring contributions to UEBMI. The specific contribution rate is decided by local governments, but generally, the employer contributes about 6 per cent of the salary and the employee contributes around 2 per cent (Xu et al. 2018). In 2014, employers contributed 64 per cent and employees contributed 36 per cent of UEBMI revenues (Liu, Vortherms, and Hong 2017). The total expenditures of UEBMI amounted to 1.782 trillion Chinese Yuan (CNY), equal to around US$253.3 billion, in 2018 (National Bureau of Statistics of China 2020).

In contrast, contributions for the URRBMI scheme for urban and rural residents are financed by individuals and central and local governments, and has been harmonized within localities since the merger, with no distinction between urban and rural areas. In 2021, NHSA set the average per capita contribution of URRBMI at no less than CNY900 (US$139.6) and the per capita financial subsidy at no less than CNY580 (US$90.0), with individual contributions up to CNY320 (US$49.6). According to regulations, the central treasury provides subsidies to local governments in stages, granting subsidies at 80 per cent and 60 per cent for western and central regions respectively, and subsidizing provinces in the eastern region in accordance with a certain percentage (much lower than the first two). [2]

Contributions to URRBMI are collected annually, and the contribution standard is a minimum, with local governments authorised to adapt it according to their own financial situation and for different population groups. In 2021, the contribution standard of URRBMI in Beijing is CNY1,970 (US$305.5) per person for children and students (with a government subsidy of CNY1,645 or US$255.1); CNY2,790 (US$432.7) per person for residents of working age (with a government subsidy of CNY2,210 or US$342.8); and CNY4,600 (US$713.5) per person for residents over 60 (with a government subsidy of CNY4,260 or US$660.7).[3]

According to the 2019 National Medical Security Development Statistical Bulletin published by NHSA, the per capita funding for URRBMI in 2019 was CNY781 (US$121.1) with the per capita government subsidy at CNY546 (US$84.7). [4]

As for the two supplementary assistance schemes, the CMI scheme for catastrophic expenses is financed by funds from the URRBMI (CNY36 or US$5.81 per year per capita, or 0.2 per of average income) (Dou, Wang, and Ying 2018). Local health care security bureaus can decide to increase the amount allocated from URRBMI fund. The MFA scheme for the poor on the other hand is primarily financed by the government, welfare lotteries, and social donations (Fang et al. 2019).

▶ Governance

The Social Insurance Law of 2010, formally enacted in July 2011, was the first comprehensive social insurance law in China (ILO 2016). The law defines the basic framework and principles of the social insurance system (Casale and Zhu 2013). Along with medical care, it also provides for old-age pension, employment injury, unemployment and maternity benefits. When enacted, it provided the legal basis for UEBMI, URBMI and NRCMS. Its last amendment in 2018 provides a legal basis for the combined implementation of maternity insurance and UEBMI. The Law of the People's Republic of China on the Promotion of Basic Medical and Health Care, which came into effect in June 2020, clearly stipulates that citizens have rights and obligations to participate in basic medical insurance according to the law. It also specifies financing arrangements, including the fact that basic medical service fees shall be paid primarily by the basic medical insurance funds and individuals (Chapter VII, article 82). Furthermore, it outlines the responsibility of employers and staff members to pay basic medical insurance contributions for employees in accordance with the provisions issued by the state. Urban and rural residents must pay basic medical insurance premiums in accordance with the provisions.

In addition to laws, the establishment and reform of China's medical insurance system relies heavily

[2] Information (in Mandarin) sourced from 2020 data available on official NHSA website, available at: http://www.nhsa.gov.cn/art/2021/6/8/art_7_5232.html.

[3] In line with the Notice of the Beijing Municipal Medical Security Bureau and the Beijing Municipal Finance Bureau on Adjusting the Funding Standards and Related Policies of the Basic Medical Insurance for Urban and Rural Residents in 2021, available (in Mandarin) at: http://ybj.beijing.gov.cn/zwgk/2020_zcwj/202010/t20201012_2108344.html.

[4] Information (in Mandarin) sourced from 2019 data on NHSA (National Healthcare Security Administration) website, available at: http://www.nhsa.gov.cn/art/2020/6/24/art_7_3268.html.

on departmental regulations. UEBMI follows the Decision of the State Council on Establishing the Urban Employees' Basic Medical Insurance System issued in 1998. The most important basis for the establishment of URRBMI is the Opinions of the State Council on Integrating the Basic Medical Insurance Systems for Urban and Rural Residents, issued in 2016. CMI was established in accordance with the Opinions of the General Office of the State Council on Comprehensively Implementing Critical Illness Insurance for Urban and Rural Residents, implemented in 2015.

Before the establishment of the NHSA, the management responsibilities of the medical security system were scattered among multiple ministries. Specifically, UEBMI and the former URBMI were managed by the Ministry of Human Resources and Social Security; the former NRCMS was the responsibility of the Health and Family Planning Commission, which is now called the National Health Commission. Following the establishment of NHSA in 2018, all functions related to medical security have been integrated into this agency. NHSA is in charge of both policy formulation and fund supervision of UEBMI and URRBMI. MFA is now also managed by NHSA, but was previously overseen and implemented by the Ministry of Civil Affairs (MOCA) and its local counterpart agencies (WHO 2015). However, the actual operation of funds is mostly undertaken by municipal health care security bureaus and a few county-level health care security bureaus. China has committed to raising the fund management level to the provincial level during the 14th Five-Year Plan period.

CMI on the other hand is managed by commercial insurance companies, which have been selected by the government through a tendering process (Dou, Wang, and Ying 2018). CMI is currently provided by 16 commercial insurance companies (Li and Jiang 2017). The scheme operates under two models: (i) the "handle agent model", whereby local governments pay an annual administration fee of 1—5 per cent of fund volume (not formal data) from the government fiscal income, with the government essentially purchasing CMI management services from health insurance schemes; and (ii) the "organize" model, whereby governments provide CMI funds to private health insurance schemes and set profit rates in the contract, sharing profits (money from CMI funds) and risks between CMI and private health insurance schemes.

▶ Legal Coverage and eligibility

Access to social security benefits in China, including health benefits, as long been tied to residence. The household registration system, or hukou, divides the population according to place of residence (rural or urban) and subsequently determines the range of social security and social services available to people such as health care, pension, and education. When initially established, eligibility for UEBMI depended on employment status and household registration type, and only covered employees and retirees formally employed in urban areas, on a mandatory basis. Both employees in informal employment (also known as flexible employees in China) and internal rural migrants formally employed in urban areas (but registered as rural) could not benefit from the UEBMI. Since 2004 a series of reforms [5] have been introduced with the attempt of addressing the issues of inequity generated by the hukou system and to expand coverage to migrants from rural areas in formal employment in urban areas and "flexible" workers at par with other urban workers employed in the formal economy but with limited success (Jaramillo 2022), notably due to the high level of contributions required from those workers. [6] During the COVID-19 crisis, the Government took a number of measures on the "flexible employment" system [7] with the aim of allowing those workers to independently enrol in the UEBMI or URRBMI. Documentation on the implementation of this 2021 reform however remains unavailable at the time of writing this profile.

[5] See Guiding Opinions of the General Office of the Ministry of Labour and Social Security on the Participation of Basic Medical Insurance by Urban Flexible Employment, 2003 and Opinions of the State Council on Further Promotion of Reform of the Household Registration System, 2014.

[6] According to an ILO study conducted before the COVID-19 crisis: ""For flexible employees, the major problem is excessively high threshold of the current medical insurance. [...] For example, according to the provisions of Liuzhou, comprehensive medical premium for flexible employees is equivalent to 9.5% of the average income of the previous year, inpatient medical premium 4%, far exceeding what individuals can afford." See: Microsoft Word - Study on FlexibleEmploymentPolicy.doc (ilo.org).

[7] See Guiding Opinions of the Ministry of Human Resources and Social Security, the National Development and Reform Commission, the Ministry of Transport, and Other Ministries and Commissions on Protecting the Labour Rights and Interests of Workers Employed in New Forms, 2021. Accessible at: 李克强主持召开国务院常务会议 决定将部分减负稳岗扩就业政策期限延长到今年底 确定进一步支持灵活就业的措施等 (mohrss.gov.cn).

In addition to workers in informal employment and the self-employed (who can choose to enrol in one of two of the basic schemes), URRBMI covers all non-working residents in both urban and rural areas. This includes pre-school children, students, the disabled, elderly people without pensions, and the unemployed. From the perspective of departmental regulations, enrolment remains voluntary [8] and beneficiaries enrol on an individual basis.

Regarding the two supplementary schemes, CMI provides additional protection to rural and urban residents enrolled in URRBMI with critical illnesses, and those who incur OOP expenses that are higher than the average disposable income per capita. More than a billion people in China were eligible to receive benefits from the CMI in 2017. Individuals who are not able to afford the contribution rates for social health insurance schemes or who cannot cover their co-payments – based on levels defined by region – are eligible for MFA. The scheme focuses specifically on the poor, low-income patients with severe illnesses, persons with severe disabilities and senior citizens from low-income families (The Commonwealth Fund 2020). Eligibility for assistance is related solely to the income and medical expenses of beneficiaries, regardless of their registration with URRBMI or UEBMI.

▶ Benefits

UEBMI benefits are defined positively, covering outpatient and inpatient services, and services at designated pharmacies. The scope and standard of basic medical services of UEBMI are regulated by a national basic medical insurance drug list, a list of diagnostic and therapeutic terms, medical service standards, and related management measures. Some emergency dental services and optometry services are covered, but most of these services are generally financed through OOP payments (The Commonwealth Fund 2020). Home care and hospice care are also excluded from the benefit package, as well as daily necessities and equipment such as wheelchairs (WHO 2015). The adjusted *National Basic Medical Insurance, Work Injury Insurance and Maternity Insurance Drug Catalog* (2020) defines the drugs covered by the insurance schemes. It includes a balanced mix of Western and Chinese medicines (1,426 are Western medicines and 1,374 are Chinese patent medicines).

Through the UEBMI scheme, benefit policies for outpatient services and inpatient services are set separately. Before 2021, outpatient expenses were usually paid by personal accounts [9] or in cash, and were directly paid by the fund only in a few areas (such as Beijing and Shanghai). This policy has been under reform since 2021, with the intention of reducing the size of personal accounts and paying outpatient expenses by the fund. As for inpatient services, in principle, the UEBMI deductible is controlled at about 10 per cent of the average annual salary of local employees, which was CNY400–1,200 (US$59–178) in 2017 (Xu et al. 2018). Expenses below the deductible are paid from the personal account or in cash.

The UEBMI schemes apply deductibles, co-payments, and ceilings as cost-sharing mechanisms, with cost-sharing applied to "eligible medical expenditure," including delivery. Insured patients pay their co-payment to the health facility after a visit, while the remaining cost is invoiced by the health providers to the scheme. Basic medical services at outpatient facilities, hospital admissions, and services at pharmacies authorized by UEBMI are eligible for immediate reimbursement through the beneficiary's insurance card (WHO 2015).

The ceiling amount is six times the average annual wage of local employees (Hu et al. 2019). A nominal reimbursement ratio is currently set by the pooling area (usually by municipal area), ranging between 60—95 per cent in different areas. The reimbursement ratio is also based on the hospital level — the higher the hospital level, the lower the reimbursement ratio. In 2019, the nominal reimbursement ratio for inpatient services under UEMBI reached 85.8 per cent; first, second, and third-level hospitals reached 89.3 per cent, 87.2 per cent, and 85.0 per cent, respectively; and the actual reimbursement ratio for inpatient care under UEBMI was 75.6 per cent. [10] Excess

[8] The State Council of the People's Republic of China. 2017. available at: http://www.gov.cn/zhuanti/2017-03/07/content_5174479.htm.

[9] When the UEBMI scheme was established, it imitated the mode of the basic pension insurance scheme and adopted a partly-funded system, with a pooled fund and personal accounts. The personal account fund is composed of all personal contributions and about 30 per cent of employers' contributions. Personal account funds can only be used to pay for eligible medical expenditures, usually including general outpatient expenses, drug purchase expenses at designated pharmacies, and other OOP expenses.

[10] Information (in Mandarin) sourced from 2019 data on NHSA (National Healthcare Security Administration) website, available at: http://www.nhsa.gov.cn/art/2020/6/24/art_7_3268.html.

costs can be insured by commercial insurance companies or the MFA.

URRBMI benefits are also defined positively. The list for basic medical services of URRBMI is slightly different from that of UEBMI, including inpatient and outpatient services but not designated pharmacies. The scope and standard of basic medical services under URRBMI follows the same lists of drugs, diagnostic and therapeutic terms, medical service standards, and related management measures. Similar to the UEBMI, most dental and optometry services, as well as home care, hospice care, daily necessities and wheelchairs are excluded (WHO 2015).

The biggest difference in benefit design between the UEBMI and URRBMI is that the latter does not include personal accounts, so both outpatient and inpatient expenses under URRBMI are paid by the fund or in cash. As is the case for the UEBMI, URRBMI applies deductibles, co-payments and ceilings as cost-sharing mechanisms, and cost sharing is applied to the same eligible medical expenditures as UEBMI. The specific standards of cost-sharing are determined by the pooling areas, which causes large regional differences.

With the exception of some cities with high benefit levels (Beijing, Shanghai and Shenzhen for example), the fund's payment for outpatient expenses is very low, with annual ceilings ranging from CNY100—400 (US$15.5—62.1). As for inpatient services, the deductible varies between areas and increases with the level of the hospitals. For example, in the western city, Chongqing, the deductible for first, second, and third-level hospitals is CNY100 (US$15.5), CNY200 (US$31.0) and CNY800 (US$124.2), respectively; in the Eastern City, Beijing, the deductible for first, second, and third-level hospitals is CNY300 (US$46.6), CNY800 (US$124.2), and CNY1,300 (US$201.8) respectively; and in the central city, Harbin, the deductible for first, second, and third-level hospitals is CNY240 (US$37.2), CNY480 (US$74.5), and CNY720 (US$111.7) respectively. Expenses below the deductible are paid in cash.

According to central unified requirements, in principle, the ceiling amount for URRBMI combined with CMI should reach around six times the per capita disposable income of local residents. A nominal reimbursement ratio is also set by the pooling area (usually municipal area), ranging between 45 per cent and 90 per cent in different areas. Again, the reimbursement ratio is also based on the hospital level. In 2019, the average nominal reimbursement ratio for inpatient services under URRBMI reached 68.8 per cent, first, second, and third-level hospitals reached 77.5 per cent, 72.1 per cent, and 63.6 per cent respectively, and the actual reimbursement ratio for inpatient care under URRBMI was 59.7 per cent. [11] Excess costs can be insured by commercial insurance companies, CMI or MFA.

Defined positively, CMI benefits include any services resulting in health expenditure exceeding the beneficiary's individual income from the previous year (WHO 2015). CMI also applies deductibles, co-payments, and ceilings as cost-sharing mechanisms, and cost sharing is applied to the same eligible medical expenditures as UEBMI and URRBMI. In principle, the CMI deductibles should not be higher than 50 per cent of the per capita disposable income of residents in the pooling area for the previous year. Subsistence allowance recipients and extremely poor people are exempt from deductibles, and for regions that do not have the conditions, deductibles should not exceed 5 per cent of the per capita disposable income of residents in the pooling area during the previous year, with exemption gradually being explored. For low-income family members and severely ill patients from poor families, deductibles are set at about 10 per cent and 25 per cent of the per capita disposable income of residents in the pooling area in the previous year, respectively. The nominal reimbursement ratio for CMI should not be less than 60 per cent. The ceilings of CMI are determined by the pooling area, and are not subject to national unified restrictions.

MFA provides additional protection by financing contributions to the social health insurance schemes, individual deductibles and co-payments and reimbursing OOP payments for the poorest portion of the population, after receiving reimbursement from one of the basic social health insurance schemes (The Commonwealth Fund 2020). The scheme prioritizes inpatient care expenses, and the specific benefit package is determined by the locality (usually at the county level).

[11] Information (in Mandarin) sourced from 2019 data on NHSA (National Healthcare Security Administration) website, available at: http://www.nhsa.gov.cn/art/2020/6/24/art_7_3268.html.

Provision of benefits and services

A network of contracted public and private health providers and pharmacies provides services to UEBMI and URRBMI members. Members can also use out-of-network health services (even across provinces), but they have to pay higher co-payments to do so (The Commonwealth Fund 2020). Contracting is delegated to the pooling area. In 2018, there were 33,009 hospitals, 34,997 community health service centres, 36,441 township health centres, 622,001 village health clinics, and 18,033 specialized public health institutions (National Bureau of Statistics of China 2020). Following the 13th Five-Year Plan for Economic and Social development (2016–2020), the government sought to reform the referral system as part of broader health policy reforms. According to the referral reform policy, patients are encouraged to seek care at primary health facilities. If they go directly to secondary and tertiary hospitals without a referral, the reimbursement rate is lower than it is for the provision of services at primary health facilities. In addition to increasing government health expenditure, reforms have promoted the development of the private health sector through policies allowing private health facilities to enter more areas of service provision (WHO 2015).

The fee-for-service (FFS) approach has historically been the main provider payment mechanism in China, which has led to over-payment for drugs, costly high-tech diagnostic tests, and under-payment for less costly basic services, such as consultations (Dou, Wang, and Ying 2018). In 2009, the government decided to replace FFS with other provider payment mechanisms such as the global budget payment system (GBPS) and case-based payments, which have been implemented in most provinces. In 2017, the government decided to fully implement a payment system based on diagnostic related group payments (DRGs) and to further reduce the use of FFS, signaling the implementation of provider payment reform nationwide (Dou, Wang, and Ying 2018). Early evidence suggests that changes in provider payment mechanisms have had positive effects on provider behaviour (Yang and Wu 2017). In 2020, NHSA also promoted a local version of China's case-based payment reform called the Diagnosis-Intervention Packet (DIP) which has now been piloted in more than 70 cities.

4. Results [12]

Coverage

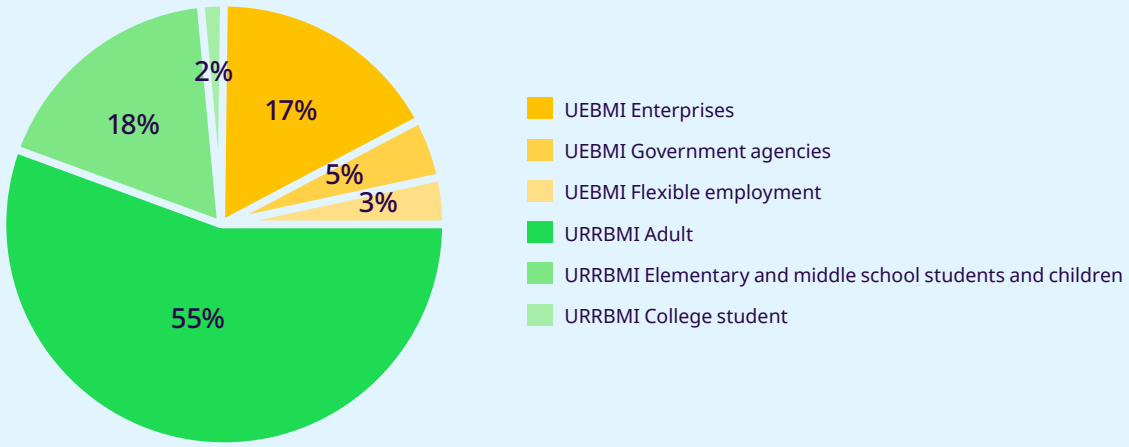
Extension of population coverage has been made possible over the years through considerable government subsidies to the urban and rural resident schemes, which are now combined into the URRBMI. The former URBMI and NRCMS schemes both contributed to significantly extending coverage of workers in the informal economy, supported by government subsidies and strong encouragement for this population group to join the schemes. As noted above, workers in the informal economy can now choose to enroll in UEBMI or URRBMI.

Today, the social health insurance participation rate in China has stabilized at more than 95 per cent, with the two basic medical insurance schemes covering more than 1,361.31 million people, among which 75.6 per cent are covered by URRBMI (which constitutes the largest scheme) and 24.4 per cent are covered by UEBMI. [13] Within UEBMI, employees and retirees comprise 73.8 per cent and 26.2 per cent of the insured, respectively. Employees are primarily from enterprises (67.7 per cent), while government employees represent 18.5 per cent of the UEBMI membership, and workers in flexible employment account for 13.8 per cent. Within URRBMI, adults, school students and children, and college students account for 73.8 per cent; 24.2 per cent and 2.0 per cent of membership, respectively.

[12] The present case study presents a system overview based on a desk review and expert consultations, it is not an in-depth institutional assessment of the system against ILO standards and no original empirical research was conducted specifically for the purpose of its development.

[13] Information (in Mandarin) sourced from 2020 data available on official NHSA website, available at: http://www.nhsa.gov.cn/art/2021/6/8/art_7_5232.html.

▶ **Figure 3. Composition of UEBMI and URRBMI membership**



Source: Author of NHSA reports.

Population coverage of the UEBMI increased in 2020, with the number of employees and retirees covered rising by 15.3 million or 4.6 per cent compared to 2019. As a result of population ageing, the employee-retiree ratio has been continually decreasing over the years, with three employees for every one retiree in 2012 compared to 2.82 in 2020. The membership of the URRBMI seems to have been impacted by the pandemic, with a drop of 0.8 per cent compared to 2019, equivalent to almost 10 million people.

As for the supplementary schemes, in 2015, CMI benefits were claimed by 11 million people, who received benefits of more than US$4.3 billion (H. Li and Jiang 2017). In 2020, the MFA spent CNY54.69 billion (US$8.49 billion), accounting for 0.05 per cent of GDP and 0.22 per cent of the national general public budget expenditure, which subsidized basic medical insurance for 99.84 million people (6.9 per cent of the total population) and provided outpatient and inpatient assistance to 84.04 million people (5.82 per cent of the total population). [14] In 2020, the total spent on hospitalization assistance and outpatient assistance through the scheme was CNY1,056 (US$163.9) and CNY93 (US$14.4), respectively.

▶ Adequacy of benefits/financial protection

The expansion of social health insurance coverage in China has significantly reduced OOP expenditures as a share of current health expenditure, which decreased from 64 per cent in 2001 to 36 per cent in 2018 (WHO n.d.) and is projected to decrease further to 25 per cent by 2030 (Fu et al. 2018). However, catastrophic expenditures still place a heavy burden on vulnerable households. Notably, OOP expenses for URRBMI members are higher and more likely to lead to catastrophic health spending than for those enrolled in UEBMI (Fang et al. 2019). In 2013, OOP expenditure per inpatient admission represented 33 per cent and 30 per cent of the annual disposable income for population groups covered by NRCMS and URBMI (now consolidated into URRBMI), respectively (Fang et al. 2019). A recent study found that social health insurance status increases the probability of patients making informal payments to doctors in China, with some variation between population groups and between social health insurance and private health insurance (Liu, Bao, and He 2020). The authors of the study suggested that the pursuit of both cost savings and quality of care may drive patients to make informal payments.

[14] Information (in Mandarin) sourced from 2020 data available on official NHSA website, available at: http://www.nhsa.gov.cn/art/2021/6/8/art_7_5232.html.

The CMI and MFA schemes have been effective in supplementing the basic social health insurance schemes and provided extra financial protection to a range of vulnerable groups. Specifically, CMI reduced the average proportion of OOP expenses after reimbursement from basic social health schemes by about 10 per cent, and in 2017, through MFA, 4 per cent of the population received subsidies to pay for their social health insurance premiums. However, as noted above, despite government efforts to provide additional financial protection through these supplementary schemes, catastrophic health spending among the poor is still an issue for many households; to exacerbate this, the prevalence of the fee-for-service payment approach has resulted in cost escalation (Yang and Wu 2017).

▶ Responsiveness to population needs

- Availability and Accessibility

The expansion of social health insurance schemes in China has improved access to health care, and reforms have contributed to decreasing inequity in population health (Liu, Vortherms, and Hong 2017). In particular, evidence suggests that the integration of the previously separate rural and urban schemes has reduced inequity in reimbursements between high-income and low-income populations, with the consolidated URRBMI scheme contributing 37.5 per cent to reducing inequality in inpatient service utilization (Myint et al. 2019). However, so far, the integration of NRCMS and URBMI schemes seems to have had no noteworthy effects on the probability of unmet hospitalization needs (Zhao et al. 2019). Despite consolidation efforts, fragmentation of health insurance schemes and differences in their financial mechanisms and funding sources remain, with variations in benefit packages and reimbursement rates resulting in barriers to equal health care access (Li et al. 2017). For example, enrolees in the URRBMI have more limited benefit packages and lower reimbursement rates than those registered under the UEMBI, which leads to discrepancies in access to health care and financial protection between population groups.

Nonetheless, over the years, the proportion of individuals who reported a need for hospital admission but did not seek inpatient care has decreased, declining from 29.6 per cent in 2003 to 17.1 per cent in 2013 (Liu, Vortherms, and Hong 2017). The average number of outpatient visits per capita increased from 1.7 in 2003 to 5.9 in 2017, increasing by 3.6 percentage points for former NRCMS members and 7–13 percentage points for former URBMI members (now URRBMI members). For UEBMI members, the probability of outpatient treatment increased by 12.6 per cent (Liu, Vortherms, and Hong 2017). Despite this overall increase in health care utilization over the years, there is some evidence to suggest that certain groups lack access to household registration, which prevents them from claiming full citizenship rights, including social welfare and formal identity documentsdespite multiple attempts at centrally-directed household registration reforms, (Vortherms 2019),.

- Quality and acceptability

In line with 2009 reforms, China has invested considerable public funds in strengthening health services, including building and renovating primary health care (PHC) facilities, procuring equipment, expanding public health services, and strengthening training and continuing medical education (Fang et al. 2019). However, increasing the quality of PHC in China remains a challenge. This has been attributed in part to limited capacity among PHC providers as a result of insufficient training opportunities; notably, in 2010, only 5.6 per cent of doctors in township health centres had a formal medical education (five years of medical school), which increased to 10 per cent in 2017 (Meng et al. 2019).

Limited capacity of PHC practitioners has been cited as a common reason for patients to bypass PHC institutions when they require care, and despite efforts to address this, evidence suggests that outpatient visits to PHC institutions have notably declined over the years (Li et al. 2020). Further shortfalls contributing to this issue include a lack of integration between clinical care and the public health service, as well as between different health sectors, and deficient continuity of care throughout the system as a whole; to compound these challenges, the widespread fee-for-service model incentivises unnecessary testing and treatments (Li et al. 2020). However, evidence suggests that provider payment reforms have reduced costs and the irrational use of drugs and antibiotics, which suggests some improvements to quality of care (Liu, Vortherms, and Hong 2017).

Despite PHC deficiencies, a 2015 study found that overall satisfaction with tertiary health care in China is reasonably high (Sun et al. 2017). The areas with the highest satisfaction rates were diagnosis and treatment for outpatient care and

nursing care for inpatient care. Outpatients were least satisfied with long waiting times, while inpatients were least satisfied with the food. The patient-doctor relationship was the strongest predictor of overall satisfaction (Sun et al. 2017). An earlier National Health Attitudes Survey (2012–2013) found that the population groups most likely to be satisfied with health services were older people, those in better health, people who have social health insurance, and those who feel that their insurance is adequate for their needs (Duckett and Munro 2016). With regards to rural medical services, according to a 2019 study, overall satisfaction scores averaged 3.61 out of 5 for outpatients and 3.80 out of 5 for inpatients (Liu and Mao 2019). Patients were most satisfied with medical service attitude and illness explanation and least satisfied with waiting times and medical expenses. Satisfaction with medical technology and trust in physicians were identified as the strongest predictors of patients' satisfaction with rural medical services (Liu and Mao 2019).

▶ 5. Way forward

By expanding social health insurance schemes and reaching near universal population coverage, China has been successful in improving access to health services and reducing OOP spending. However, as noted above, many challenges remain related to the quality of PCH and to inequities generated by the fragmented delivery and financing of China's health insurance schemes. Facilitating a well-coordinated and integrated health system with a focus on primary care is therefore greatly needed to strengthen the health system in China and achieve better health outcomes (Meng et al. 2019). Building the capacity of the health workforce is key to this endeavour. As such, government efforts should continue to focus on incentives to attract and retain qualified health professionals in the PHC system (Li et al. 2020).

Reducing OOP spending for urban un-employed persons, the self-employed and rural populations is also crucial. This will require the eventual consolidation of the entire social health insurance system to integrate risk-pooling levels and equalize benefit packages through increased government funding (Fang et al. 2019). To this end, the NHSA has been working to reduce the difference in benefits between schemes and regions, and began to gradually implement a nationally unified list of medical insurance benefits in 2021. The goal is to eliminate regional differences within each scheme as much as possible and reduce the differences between the two main schemes after three years. More broadly, in June 2021, the NHSA started soliciting public comments on the Draft of the Medical Security Law, which is expected to fill the gaps in China's medical security laws and address medical security reform and development.

To better meet the needs of vulnerable populations, increased funding should be more effectively channelled to the poor. This can be achieved by connecting benefit eligibility to household disposable income as opposed to an absolute threshold; it has also been proposed that medical aid should be extended to cover those who incur catastrophic health expenses after catastrophic medical insurance reimbursements, and OOP expenses for the extremely poor should be capped (Fang et al. 2019). To ensure that such measures are sustainable, further steps must be taken to increase health system efficiency, strengthen primary care, and control provider behaviour through payment system reforms (Fang et al. 2019).

▶ 6. Main lessons learned

- Government subsidies have contributed to high population coverage through China's social health protection schemes, with population coverage reaching 97 per cent in 2017. This was reinforced by a high level of government commitment to universal coverage at an early stage, which has been institutionalized through the inclusion of coverage rates in the performance indicators of governments at each level into annual health care reform assessment indicators.
- High population coverage is not sufficient to provide adequate protection. A narrow benefit package and low reimbursement rates (except in the case of the urban employee scheme), high deductibles and co-payments, and limited portability of benefits for rural-to-urban internal migrants have resulted in low effective coverage and limited financial protection

for members of social health insurance schemes.

- Portability of social health insurance benefits is fundamental to securing adequate financial protection. Ensuring the proper implementation of hukou reforms and flexible employment reforms is crucial to ensure greater equity in access, as well as aligning benefit packages across schemes. Furthermore, the decentralized policy decision-making power is causing significant variations between medical insurance policies and posing equity issues. Since 2021, the NHSA has been initiating reforms to promote the gradual unification of the financing and benefit policies of all pooling areas.
- Fee-for-service, which has historically been the main provider payment mechanism in China, is not optimum in term of cost-control; It has led to increased use of drugs and costly high-tech diagnostic tests, and reduced use of less costly, basic services, which has driven cost escalation and inappropriate treatments. In a context high pressure to contain costs, the initiation of provider payment reforms in 2009, along with the implementation of a case-based payment system, has had positive effects on provider behaviour. Furthermore, since its establishment, the NHSA has actively promoted the centralized procurement of medicines and consumables, including price negotiations for costly medicines. This has led to a substantial drop in the cost of medicines, representing a shift from the passive purchasing practices employed in the early days of medical insurance, to the promotion of the strategic purchasing role of medical insurance.

©ILO/Nguyen Viet Thanh

References

Casale, Giuseppe, and Changyou Zhu. 2013. *Labour Administration Reforms in China*. Geneva: International Labour Office.

Dou, Guanshen, Qun Wang, and Xiaohua Ying. 2018. 'Reducing the Medical Economic Burden of Health Insurance in China: Achievements and Challenges'. *BioScience Trends*. 12 (3): 215–19.

Duckett, Jane, and Neil Munro. 2016. 'Are Chinese People Satisfied with Their Health Care System?' Glasgow: University of Glasgow.

Fang, Hai, Karen Eggleston, Kara Hanson, and Ming Wu. 2019. 'Enhancing Financial Protection under China's Social Health Insurance to Achieve Universal Health Coverage'. *BMJ*, June, l2378. https://doi.org/10.1136/bmj.l2378.

Fu, Wei, Shuli Zhao, Yuhui Zhang, Peipei Chai, and John Goss. 2018. 'Research in Health Policy Making in China: Out-of-Pocket Payments in Healthy China 2030'. *BMJ* 360 (k234): 1–3.

Hu, Shanlian, Anke-Peggy Holtorf, Kalman Wijaya, Jiangjiang He, and Diana Brixner. 2019. 'Value-Based Evaluation of Chinese Provincial Health Insurance Policy Schemes'. In *Evaluation of Health Programs [Working Title]*. IntechOpen. https://doi.org/10.5772/intechopen.84373.

ILO. 2016. 'Extending Health Coverage to All: People's Republic of China'. Geneva: International Labour Organization.

Jaramillo, Eduardo. 2022. 'China's Hukou Reform in 2022: Do They Mean It This Time?' Center for Strategic and International Studies. *New Perspectives on Asia Blog*. (blog). 20 April 2022. https://www.csis.org/blogs/new-perspectives-asia/chinas-hukou-reform-2022-do-they-mean-it-time-0.

Li, Hongmei, and Lixin Jiang. 2017. 'Catastrophic Medical Insurance in China'. *The Lancet* 390 (10104): 1724–25. https://doi.org/10.1016/S0140-6736(17)32603-X.

Li, Xi, Harlan M Krumholz, Winnie Yip, Kar Keung Cheng, Jan De Maeseneer, Qingyue Meng, Elias Mossialos, et al. 2020. 'Quality of Primary Health Care in China: Challenges and Recommendations'. *Lancet (London, England)* 395 (10239): 1802–12. https://doi.org/10.1016/S0140-6736(20)30122-7.

Li, Yang, Yinjun Zhao, Danhui Yi, Xiaojun Wang, Yan Jiang, Yu Wang, Xinchun Liu, and Shuangge Ma. 2017. 'Differences Exist across Insurance Schemes in China Post-Consolidation'. Edited by Harry Zhang. PLOS ONE 12 (11): e0187100. https://doi.org/10.1371/journal.pone.0187100.

Liu, Gordon G., Samantha A. Vortherms, and Xuezhi Hong. 2017. 'China's Health Reform Update'. *Annual Review of Public Health* 38 (1): 431–48. https://doi.org/10.1146/annurev-publhealth-031816-044247.

Liu, Jinlin, and Ying Mao. 2019. 'Patient Satisfaction with Rural Medical Services: A Cross-Sectional Survey in 11 Western Provinces in China'. *International Journal of Environmental Research and Public Health* 16 (20): 3968. https://doi.org/10.3390/ijerph16203968.

Liu, Ning. 2020. 'Does Health Insurance Coverage Reduce Informal Payments? Evidence from the "Red Envelopes" in China', 11.

Meng, Qingyue, Anne Mills, Longde Wang, and Qide Han. 2019. 'What Can We Learn from China's Health System Reform?' *BMJ*, l2349. https://doi.org/10.1136/bmj.l2349.

Myint, Chaw-Yin, Milena Pavlova, Khin-Ni-Ni Thein, and Wim Groot. 2019. 'A Systematic Review of the Health-Financing Mechanisms in the Association of Southeast Asian Nations Countries and the People's Republic of China: Lessons for the Move towards Universal Health Coverage'. Edited by David Hotchkiss. *PLOS ONE* 14 (6): e0217278. https://doi.org/10.1371/journal.pone.0217278.

National Bureau of Statistics of China. 2020. 'China Statistical Yearbook 2019'. 2020. http://www.stats.gov.cn/tjsj/ndsj/2019/indexeh.htm.

Pan, Xiong-Fei, Jin Xu, and Qingyue Meng. 2016. 'Integrating Social Health Insurance Systems in China'. *The Lancet* 387 (10025): 1274–75. https://doi.org/10.1016/S0140-6736(16)30021-6.

Sun, Jing, Guangyu Hu, Jing Ma, Yin Chen, Laiyang Wu, Qiannan Liu, Jia Hu, Christine Livoti, Yu Jiang, and Yuanli Liu. 2017. 'Consumer Satisfaction with Tertiary Healthcare in China: Findings from the 2015 China National Patient Survey'. *International Journal for Quality in Health Care*, January, intqhc;mzw160v1. https://doi.org/10.1093/intqhc/mzw160.

The Commonwealth Fund. 2020. 'Chinese Health Care System Profile'. 2020. https://international.commonwealthfund.org/countries/china/.

Vortherms, Samantha A. 2019. 'China's Missing Children: Political Barriers to Citizenship through the Household Registration System'. *The China Quarterly* 238: 309–30. https://doi.org/10.1017/S0305741018001716.

Wang, Li, Zhihao Wang, Qinglian Ma, Guixia Fang, and Jinxia Yang. 2019. 'The Development and Reform of Public Health in China from 1949 to 2019'. *Globalization and Health* 15 (1): 45. https://doi.org/10.1186/s12992-019-0486-6.

WHO. 2015. 'People's Republic of China Health System Review'. 7. Health Systems in Transition, Volume 5. WHO Regional Office for the Western Pacific. https://apps.who.int/iris/handle/10665/208229.

———. n.d. 'Global Health Expenditure Database'. Accessed 15 October 2021. https://apps.who.int/nha/database.

Word Bank. n.d. 'China Data'. The World Bank Data. Accessed 15 October 2021. https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=CN.

World Bank. 2021a. 'Poverty and Equity Brief: China'. Global Economic Prospects. The World Bank Group. https://doi.org/10.1596/978-1-4648-0483-0_ch2_EAP.

———. 2021b. 'The World Bank in China: Overview'. 2021. https://www.worldbank.org/en/country/china/overview.

Xu, Junfang, Jian Wang, Madeleine King, Ruiyun Liu, Fenghua Yu, Jinshui Xing, Lei Su, and Mingshan Lu. 2018. 'Rural–Urban Disparities in the Utilization of Mental Health Inpatient Services in China: The Role of Health Insurance'. *International Journal of Health Economics and Management* 18 (4): 377–93. https://doi.org/10.1007/s10754-018-9238-z.

Yang, Wei, and Xun Wu. 2017. 'Providing Comprehensive Health Insurance Coverage in Rural China: A Critical Appraisal of the New Cooperative Medical Scheme and Ways Forward'. *Global Policy* 8 (March): 110–16. https://doi.org/10.1111/1758-5899.12209.

Zhao, Cuirong, Chao Wang, Chengwu Shen, and Qian Wang. 2018. 'China's Achievements and Challenges in Improving Health Insurance Coverage'. *Drug Discoveries & Therapeutics* 12 (1): 1–6.

Zhao, Miaomiao, Baohua Liu, Linghan Shan, Cui Li, Qunhong Wu, Yanhua Hao, Zhuo Chen, et al. 2019. 'Can Integration Reduce Inequity in Healthcare Utilization? Evidence and Hurdles in China'. *BMC Health Services Research* 19 (1): 654. https://doi.org/10.1186/s12913-019-4480-8.

Supported by LUXEMBOURG AID & DEVELOPMENT

This profile was prepared by Marielle Phe Goursat (ILO), Zhang Yuhui (China National Health Development Research Center) and Ying Zhao (Chinese Academy of Labour and Social Security), with the support of Henrik Axelson, Luis Frota and Christina Morrison (ILO).

Contact information

International Labour Organization
Social Protection Department
Route des Morillons 4
CH-1211 Geneva 22
Switzerland

ILO Regional Office for Asia and the Pacific
United Nations Building
Rajdamnern Nok Avenue
Bangkok 10200
Thailand

T: +41 22 799 7239
E: socpro@ilo.org
W: www.ilo.org/asia
www.social-protection.org

ISBN 9789220359280 (print)
ISBN 9789220359297 (PDF)