Quick Health Financing Stats for China

Basic statistics (2013, WHO Global Health Observatory)	**China**
Population	1.3 billion
GDP per capita (USD)	$7,152
Total health expenditure per capita (USD)	$367
Total health expenditure as % of GDP	5.6%
Government health expenditure as % of total government expenditure	12.6%
Government health expenditure as % of total health expenditure	55.8%
OOP spending as % of total health expenditure	33.9%

DEMAND-SIDE PROGRAMS

In this framework we define demand-side UHC programs as programs that aim to reduce economic barriers and expand access to more and better services.

Many major national, demand-side health system programs either target a specific population (*poor and vulnerable people*, the *non-poor informal sector*, or the *formal sector*) or have distinct design features depending on the beneficiary's economic and work status. Therefore, this matrix includes questions specific to the program's design features for each specific population.

		Program 1	**Program 2**	**Program 3**	**Program 4**
Identify each major, nation-wide program / system that aims to reduce economic barriers and expand access to more and better health services for the population, and when the program started or was reformed. List one program per column.		**New Rural Cooperative Medical Scheme (NRCMS)** Piloted 2003-2005; rolled out in 2006-2011	**Urban Employment Basic Medical Insurance (UEBMI)** Piloted in 1994, rolled out in 1998	**Urban Resident Basic Medical Insurance (URBMI)** Piloted in 2007; rolled out in 2009	**Medical Assistance Program** Piloted 2003-2005; rolled out in 2006-2011
Population Covered: • How are beneficiaries identified and targeted? • What are the eligibility rules?	Poor/vulnerable	"Voluntary" enrollment of rural residents. Local government enrolls households based on national targets. Over 98% coverage. Includes 802 million people, or 62% of the population (in 2011).	N/A	-Urban residents not covered under formal employment scheme. Includes 296 million people, or 17% of the population (in 2011). Coverage estimated at 93% (in 2012). -Targeting is difficult because this population is not well defined.	-Pays premium for poor people to enroll in NRCMS -Helps cover premiums and copayments for poor enrollees in URBMI. -Enrollment is free and voluntary. Covers approximately 87 million people, which the Ministry of Civilian Affairs identifies as poor. 48.3 million people enrolled in the NRCMS, 15.5 million people enrolled in URBMI. -Coverage close to 100% (*although numbers in source documents don't add up*)
	Non-poor informal sector		N/A		N/A
	Formal sector employees		Urban residents employed in the formal sector, with coverage over 94% to 97% in 2011/12 (depending on source). -Includes about 274 million people, or 19% of the population.	N/A	N/A
Services and Benefit	Poor/vulnerable	-About 58% of counties include	N/A	-About 80% of cities include general	-As per other schemes.

		Program 1	Program 2	Program 3	Program 4
entitlements • Summarize the services or benefit entitlements for each population group. • Specify whether the services or benefits are defined in the form of a positive list, a negative list, or not explicitly defined. • How are benefit packages selected? • How are they updated over time? For example, health technology assessment.	Non-poor informal sector	general outpatient care in benefit package, with about 83% covering outpatient care for chronic conditions (for 2011). -Reimbursement rates for outpatient care tend to be low. -Items on fee-for-service schedule are reimbursable (positive list) subject to copayments and deductibles. -List of essential medicines is used, defined by the Ministry of Health (MoH)(widely viewed as not scientifically rigorous process), with provinces adding supplemental drugs. -Local authorities can refine the benefit package based on local needs and resource availability.	N/A	outpatient care in benefit package, with about 90% covering outpatient care for chronic conditions (for 2011). -Reimbursement rates for outpatient care tend to be low. -Items on fee-for-service schedule are reimbursable (positive list) subject to copayments and deductibles. -List of essential medicines is used, defined by MoH (widely viewed as not scientifically rigorous process), with provinces adding supplemental drugs. -Local authorities can define a benefit package based on local needs and resource availability.	N/A
	Formal sector employees		-Items on fee-for-service schedule are reimbursable (positive list) subject to copayments and deductibles. -Local authorities can define a benefit package based on local needs and resource availability. -More comprehensive benefit package than other two schemes. The formulary used for this scheme was the basis for the other schemes, but was shrunk for the other two schemes.	N/A	N/A
MANAGING MONEY/ FINANCING UHC					
Financing sources	• Government source of revenue (e.g., taxes) for this program? Earmarked taxes, sin taxes, general taxes? • Mandatory contributions by formal sector workers (payroll taxes)? • Beneficiary premiums? • Beneficiary cost sharing at the point of service? • Provide specific information about any separate features of the beneficiary contribution model covering poor and vulnerable people, the non-poor informal sector, and the formal sector (if applicable). • Summarize how each source of financing is collected.	-Total premium is 300 yuan *per person* (although enrollment is at household level) -Households pay Y60, local government pays Y120, central government pays Y120. -Most schemes have a deductible and copayments by patients.	-Employers contribute 6% to 8% of average salary and employees contribute 2% to 3% of their salary. -Average premium in Y2,230 (in 2012). -Employees contributions and 30% of employer contributions go to a medical savings account (for outpatient care), the remainder goes into a pool for inpatient care. -Collected via payroll tax. -Funding is about six times greater than for the other two schemes.	-Total premium is Y300 per person in 2011. -Households pay 30% of premium (in 2013)	-Financed by national, provincial, and local governments. National government provided about 80% of funds in 2011.

		Program 1	Program 2	Program 3	Program 4
Risk pooling	• Is there one national pool, separate national risk pools for distinct beneficiary groups, or subnational level pools? • Are the poor cross-subsidized by higher income people? Discuss for each program.	-Pooling occurs at the county level. About 2,852 separate pools (average population of 300,000).	-Pooling occurs at the prefecture/municipal (city) level. About 333 separate risk pools.	-Pooling occurs at the prefecture/municipal (city) level. About 333 separate risk pools.	-At same level as other schemes.
		The large number of risk pools (over 3,000) has resulted in different benefit packages and degrees of risk protection across pools. Local managers set benefits, reimbursement rates, deductibles, etc. as per local conditions, often largely based on affordability. Opponents argue that this has resulted in inequity and inefficiencies. On the other hand, local implementation has led to high coverage rates and some degree of innovation.			
Financial management	• What institution manages the program? • How does the program remain solvent? • Are there mechanisms in place, such as caps or utilization review that maintain the financial viability of the system?	-Managed nationally by the MoH (now called National Health and Family Planning Commission); managed locally by the Bureaus of Health. -Ceiling liability is set at eight times the income of local farmers (differs by county), but no less than Y60,000. -Ceiling does not apply to a set of 20 'major diseases.' In other places, expenditures in excess of a second cap (Y300,000) will be reimbursed. -No mandatory deductibles but widely used at local level in practice. -Deductibles tend to be set at about 10% of income.	-Pooled funds managed by Ministry of Human Resource and Social Security. -Ceiling liability is set at six times average salary of employee in the city (differs by city). -No mandatory deductibles but widely used at local level in practice.	-Pooled funds managed by Ministry of Human Resource and Social Security. -Ceiling liability is set at six times 'disposable income of city residents' (differs by city). -Ceiling does not apply to a set of 20 'major diseases.' In other places, expenditures in excess of a second cap (e.g., Y300,000) will be reimbursed. -No mandatory deductibles but widely used at local level in practice.	- Overall, managed by the Ministry of Civil Affairs. -Pooled at the local level, with pool management by the Bureau of Civil Affairs (BoCA).
Financial protection	• Financial protection for households: are there caps on cost sharing or other safeguards that protect households against impoverishment due to health costs?	-On average in 2012, reimbursed about 55% of inpatient costs. - On average in 2012, reimbursed about 50% of outpatient costs.	-On average in 2012, reimbursed about 75% of inpatient costs. -Outpatient costs paid out of individual medical savings plan.	-On average in 2012, reimbursed about 55% of inpatient costs. - On average in 2012, reimbursed about 50% of outpatient costs.	-Disbursed funds equivalent to 9% to 11% of inpatient costs, indicating that the poor still pay over 33% of inpatient fees (applies to urban residents; rural residents only receive premium support).
Provider payment	• Describe the payment mechanisms used to pay primary health care (including preventive and promotive care). • Describe the payment mechanisms used to pay for hospital level care. • Are payments tied to quality of care, and if so, how does this work? • Do the systems contract private providers or private health plans? If so, describe the payment mechanisms incorporated into contracts.	**-Highly variable across local units.** -National Development and Reform Committee establishes prices; in practice, the three schemes face different prices for the same services. Insurance companies tend to operate as 'payer' rather than 'purchaser.' -Many counties have systems in place where patient pays only their share of the bill at discharge. For counties without this service, the enrollees pay the full bill, and then claim the money back from the NRCMS office, the Bureau of Human Resources, and Social Security (BoHRSS, the counterpart of the NRCMS Office under the URBMI), and/or the BoCA (the pooling agent for the MA program) at their city/county of enrolment. -Payment systems are defined locally. About 30% of counties/cities use fee-for-service payments. Other areas use a variety of different payment mechanisms (mainly diagnosis-related groups, case-based payment, and global budgets). -Fee-for-service tends to underpay for basic services and overpay for laboratory/high-tech diagnosis technologies. -Hospitals are run as state-owned for profit enterprises, with just under 10% of revenues due to direct government subsidies. -Some drugs exempt from copayment, others incur 10% copayment, and drugs off formulary receive no insurance reimbursement. -Patients can receive insurance benefits only within the designated health institutions, but the power of the health insurance authority to regulate health care providers has been weak – regulatory power rests with the MoH. -Only a few localities have data to track individual providers' diagnostic and prescription behaviors.			

SUPPLY-SIDE PROGRAMS

In this framework we define supply-side UHC programs as nationwide programs that aim to reform and upgrade the production of health services.

		Program 1	Program 2	Program 3	Program 4
Identify each major, nationwide program / system that aims to reform and upgrade the production of health services. List one program per column.		N/A			
Human Resources	• Summarize design features of programs aiming to improve distribution of health workers, retention of health workers, or outreach by health workers.	- Primary health care physicians are given a capitation payment to provide basic public health services, including providing immunization; prenatal and well-child care; regularly visiting home-bound patients; monitoring a set of infectious diseases, including tuberculosis; maintaining records of, and monitoring, the health condition of all patients with high blood pressure and diabetes and health education. Reportedly, the program is not well monitored. The government subsidizes some priority drugs. - However, hospitals provide over 90% of outpatient visits. In the long-term, China hopes to move towards more primary care outside hospitals and gatekeeping. The 2009 health reforms allocated RMB 60 billion to establish or renew primary care facilities, mostly in under-served rural areas in Western China, but Chinese patients do not have faith in primary health care and often by-pass it. China is currently giving priority to training five-year medical school graduates as family physicians, but results of this effort are years away.			
Managerial Flexibility	• Do managers of facilities or at subnational level have the flexibility to hire and fire, manage money, procure commodities? Summarize design features of programs aiming to improve managerial flexibility in public facilities.	Most hospitals are publically owned but profit-driven and lack an explicit mission. Some attempts at management reform (or selling to private sectors) have been conducted at local level, but little coordinated national agreement has been reached on how to reform hospital management.			
Private Providers	• Summarize design features of programs aiming to increase participation of or oversee quality of private providers.	Not discussed in the literature reviewed; a relatively small sector.			
Health Care Provision / Accreditation and Other Regulation of Quality	• Summarize design features of programs aiming to accredit health facilities or regulate quality of service provision in another way.	Quality of care is a big concern in China; over prescription of antibiotics, IV medicines, and unnecessary prescriptions are often cited as the most common problem. Drafting the essential drugs list was one measure taken to try to rationalize these behaviors. Regulation of hospitals remains under auspices of MoH, not under health insurance. Many studies reviewed cited this area as one of the main future challenges for China.			
Health Care Provision / Integrating the Health System	• How is beneficiary care coordinated across levels of care? Is there a system of referrals and counter-referrals and the information system to manage this? Please describe.	Little gatekeeping present; patients regularly self-refer to the hospital level.			
ACCOUNTABILITY IN THE HEALTH SECTOR					
Accountability	To what extent is health sector governance characterized by decentralization and regulation, or what *Going Universal* refers to as "arm's length" relationships-an actor who delegates the task (e.g., MoH, purchaser of health services) and a separate actor who is responsible for carrying it out (e.g., local government; service providers)? Summarize the governance structure of the health sector and features of the purchaser-provider split, where one exists.	-Central government sets guidance and goals, and provides funding. Local government charged with implementation, with room for differences between localities, especially in terms of defining how they pay hospitals, defining benefit packages, etc. Central government started in the early 2000's with goals of broad enrollment with shallow benefits. Over time, benefits have increased (e.g., expanding to outpatient care) and likely will grow in the future. -Multiple agencies are involved in implementation across and within different schemes. Relations and coordination can be complicated. The medical assistance program usually has a coordinating body with representatives from multiple government agencies and, sometimes, civilians. -Hospitals are independent from insurance companies, and represent a force powerful enough to block reforms in some areas. -The government is trying to revitalize primary health care, providing per capita payments to primary health care doctors independent of insurance to perform specified basic public health functions. -There is little to no gatekeeping, and patients often self-refer.			