Universal Health Insurance Reform in China: Challenges, Responses, and the Way Forward

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ABSTRACT

This article uses a refined version of historical institutionalism to critically examine the complex interplay of forces that shape the health insurance reform trajectory in China since the mid-1980s, problems that plague the current multi-layered social medical insurance system and solutions to these problems. It shows that achieving universal health coverage (UHC) requires the government to ensure financing equity between urban and rural insured participants, access to affordable health care and the financial sustainability of medical insurance funds. Facing the challenges of rapidly aging population, the government implements a pilot scheme that integrates medical and nursing care for the elderly and a pilot long-term care insurance scheme for disabled elderly. It is expected that these two pilot schemes can provide better financial protection and quality of medical services for the elderly.

KEYWORDS

Aging Population, Basic Medical Insurance, Financial Sustainability, Long-Term Care Insurance, Moral Hazard, Social Pooling Fund, Universal Health Coverage, Zero-Markup Policy for Essential Drugs

INTRODUCTION

Since the mid-1980s, the problem of rising medical costs and the combing forces of population ageing and the burden of non-communicable diseases (NCDs) have driven the Chinese government to establish a multi-layered social health insurance system with an aim of providing affordable and sustainable health care for its population. In late October 2017, Minister for Human Resources and Social Security Yin Weimin said in the 19th CPC National Congress press conference that China had already achieved universal health insurance coverage for its population of over 1.3 billion people (http://finance.sina.com.cn, 2017 October 22). In reality, however, many insured people still have difficulties in accessing a range of essential services and face high out-of-pocket medical expenses. Meanwhile, the uninsured people lack access to basic and affordable health care. The government still has a long way to go to achieve universal health coverage (UHC), which refers to all people having access to needed health services without suffering financial hardship (World Health Organization, 2013, p. xi).

Health insurance reform in China has been explored and examined in many Western and Chinese studies. But the processes of health insurance reform and forces that shape the reform trajectory have not been completely understood. The relationship between UHC and health insurance reform has not been explored clearly. In order to fill the existing research gaps, this study uses a refined version of historical institutionalism to examine forces that shape the trajectory of health insurance reforms in China since the mid-1980s and problems that plague the current multi-layered social medical insurance system. It also examines ways to solve such problems and achieve UHC.

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BACKGROUND

Rapidly ageing population (Hsu et al., 2015), rising medical costs (Augustovski et al., 2011) and the burden of NCDs (Bristol, 2014, p.1) have driven governments worldwide to find ways to achieve UHC. According to World Health Organization (WHO), there are three dimensions of UHC: (1) the breadth of coverage; (2) the depth of coverage; and (3) the height of coverage (World Health Organization, 2008, pp. 25-6). The breadth of coverage refers to ‘the proportion of the population that enjoys social health protection’ (World Health Organization, 2008, p. 25). The depth of coverage refers to the provision of the range of essential services that can effectively address people’s health needs (World Health Organization, 2008, p. 26) while the height of coverage refers to the portion of healthcare costs covered by pooled funding and pre-payment mechanisms (World Health Organization, 2008, p. 26). In recent years, UHC has become a key global health objective advocated by WHO and the World Bank (Cheng, 2015, p.1) and has been adopted by many countries as a national aspiration (Reich et al., 2016, p. 811). It is believed that UHC can improve the health and well-being of people (World Health Organization, 2013, p. xi), and “is necessary for economic growth and development” (Cheng, 2015, p. 2). Nevertheless, it is not an easy task to achieve UHC around the world. According to the 2017 UHC Global Monitoring Report, there were still 808 million people spending over 10 per cent of their household total income on out-of-pocket medical expenses (World Health Organization and the World Bank, 2017, p.24) and “97 million people were impoverished by out-of-pocket health spending at the $1.90-a-day poverty line” (World Health Organization and the World Bank, 2017, p.40). In December 2017, Tokyo Declaration on Universal Health Coverage was adopted by high-level government officials from various countries to reaffirm their commitments to accelerate progress towards UHC by 2030 (World Health Organization, 2017).

There is neither a single model nor a single correct path to achieve UHC. Due to resource constraints and differences in political, economic, social and historical contexts, the timetable, the pace, the process and the approach to achieve UHC vary among developed and developing countries. International evidence shows that UHC is achieved gradually and over many decades (Carrin et al., 2008; Savedoff and Smith, 2011). The study of Savedoff and Smith (2011, p. 45) found that Chile and Malaysia achieved UHC at least 20 years later than Sweden and Japan, but they reached comparable levels of population health by spending smaller shares of their income on health services. The study of Reich et al. (2016) categorized 11 countries into four groups based on their pace of attaining UHC. Bangladesh and Ethiopia belonged to Group 1 countries because they were still in the agenda-setting stage of attaining UHC (Reich et al., 2016, p. 812). Indonesia, Vietnam, Ghana and Peru belonged to Group 2 countries, which had initial programmes in place but “coverage gaps remain[ed] in access to services and financial protection” (Reich et al., 2016, p. 812). Thailand, Brazil and Turkey belonged to Group 3 countries, which had achieved many UHC policy goals but faced the challenges in sustaining coverage (Reich et al., 2016, pp. 811-2). Japan and France belonged to Group 4 countries, which had achieved UHC but continuously adjusted their national policies to meet changing circumstances and solve the problem of rising costs (Reich et al., 2016, pp. 811-2). The above studies show that achieving UHC is a long-term process and an ongoing task with different development stages.

Like its country counterparts, China puts UHC high on its reform agenda. Its effort to reform the health care financing system began in the mid-1980s when the central government encouraged local government to explore different payment methods to reduce skyrocketing medical costs. In 1994, the pilot medical insurance model implemented in the cities of Zhenjiang in Jiangsu province and Jiujiang in Jiangxi province paved the way for the establishment of the multi-layered basic medical insurance system. The multi-layered basic medical insurance system consists of four schemes: (1) a mandatory Urban Employee Basic Medical Insurance (UEBMI) Scheme; (2) a voluntary New Rural Cooperative Medical System (NRCS); (3) a voluntary Urban Resident Basic Medical Insurance (URBMI) Scheme; and (4) the Critical Illness Insurance Scheme (CIIS). Although the government claims that China has already achieved universal health insurance coverage, China still lags behind in terms of the depth and the height of coverage.
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