China’s Blueprint for Health Care Reform

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In early April 2009, the Chinese government released a Guideline and an Action Plan on health care reform. By 2020, China plans to establish a functioning system that is affordable and accessible. In sharp contrast with the retreat of the state from the health care sector since the 1980s, the Chinese government is now willing to play a much larger role in providing basic health care to its citizens, rural or urban.

SINCE THE 1980s the Chinese government has been retreating from the health care sector, resulting in an ailing health care system that is largely unaffordable and inaccessible to ordinary Chinese people. In 2005 a report by the Development Research Centre of the State Council declared China’s previous health care reforms as basically unsuccessful, giving rise to a heated public debate on whether China should fundamentally reform this system.

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In 2006, China formed a Health Care System Reform Coordinating Small Group under the dual leadership of the National Development and Reform Commission and the Ministry of Health. After three years of hard work, in early April 2009, China unveiled a much anticipated blueprint for a new health care system. It also announced a more detailed three-year action plan from 2009 to 2011. These two documents show China’s political will to overhaul the existing system and establish a new one by 2020.

The Guideline on Deepening the Reform of Health Care System, jointly issued by the Central Committee of the Chinese Communist Party and the State Council, for the first time clearly defines basic health care as a public service provided to all Chinese citizens. By 2020, China will have a health care system providing “safe, effective, convenient and affordable” health care services for both urban and rural residents. Currently about 200 million Chinese are not protected by any medical insurance.

As a first step, the central and local governments will spend 850 billion yuan ($124 billion) by 2011 to kick start the new health care reform, in addition to the regular health budget, which totalled 227 billion yuan in 2007. The newly increased expenditure is not part of the four trillion yuan stimulus package that China plans to spend in the next two years.

The guideline and the action plan are a result of three years of extensive consultation and debate. As many as 16 government agencies had their representatives in the Health Care System Reform Coordinating Small Group. In part because so many government agencies have a stake in the health care system, it is extremely difficult to force compromise or build consensus even within the small group itself. Thus, the small group is in extensive consultation with the private sector, the academic community and even the international organisations to make the process unusually open and inclusive.

Hotly debated issues included the nature of basic health care (private good versus public good), the funding sources for basic health care (insurance versus public finance), the allocation of government subsidy (public hospitals and clinics versus health care receivers), and the main provider of health care (public institutions or a mix of public and private providers).

The two documents announced in early April provide a definitive answer to some of the debated issues, but leave the door open for further discussion on some others. To the extent that there is wide support for universal medical insurance and a strong call for
substantially increasing government expenditures on health care, the two documents clearly define basic health care as a public service to be financed jointly by the central and local governments.

Some compromise was reached for the allocation of government healthcare expenditures, with two thirds of the newly increased 850 billion RMB going to health care receivers (through subsidised insurance programmes) while one third to health care providers (particularly grassroots level hospitals and clinics).

As a consensus on how to reform public hospitals into efficient health care providers has yet to be reached, the two documents call for more experimentation and discussion. Some reform proposals emphasise the need to improve the management of public hospitals while some others highlight the need for more competition by allowing social/private capital into the health care sector. While the Guideline states that public medical institutions should be the main medical service providers, it does not deny a larger role for private hospitals in health care provision. Thus both reforms are likely to be carried out simultaneously in different places in China.

Furthermore, both the Guideline and the Action Plan stress the need to rationalise the current over-costly spending structure, which exercises an important influence on both the supply and demand of health care services. The present system is criticised for its implicit inclinations to expensive treatment and over-prescriptions; it is the basic rationale of the New Health Care Reform to emphasise public health provisions and offer inexpensive and equitable services that cater for the most basic and general medical needs of the people, rather than covering exorbitant and costly medical services.

The health care reform will probably be the most important policy reform in the next five years. To oversee the reform, a Health Care System Reform Leading Small Group is formed, led by Vice Premier Li Keqiang, the leading candidate for China’s next Premier after Wen Jiabao. Li has a stake in managing the reform well, which provides an important test to his ability to coordinate the very complicated process of policy-making and implementation. It is a daunting challenging because the health care reform involves many government agencies at both central and local levels and affects such a large population.

**Guideline of the New Health Care Reform**

The Guideline first shortly reviewed the problems in the existing medical system. It identifies the following problems as main causes of concern that initiate the Reform: imbalanced healthcare development, misallocation of medical resources, weaknesses in public health sector and grassroots medical service provision, lack of government investments, rise in medical expense and subsequent heavy financial burden levied on household and individual consumers.

The Guideline states four important principles, that is the Reform must accord with the People-first principles and China’s national characteristics, embody the unity of equity and efficiency and follow an integrated approach that takes into consideration both long-term institutional reform and the prominent problems of the day. While the first two principles are commonly found in all Reform proposals in the Hu-Wen era, the
last two principles are highly relevant to the underlying difficulties of the medical system in China today. The gist of the problem is that local government and medical agencies are often incentivised to pursue self profits-maximisation at the cost of distributive justice and long-term social development, as the government share of total health care expenditure declined from the peak of 38.8% in 1982 to an all-time low of 15.5% in 2000.

The main part of the Guideline concerns the building and perfection of four components of the health care system and several institutional mechanisms that will be essential for the Reform to be carried out successfully. The four components of the new medical system are public health, medical service, medical insurance and the pharmaceutical sector. In the area of public health, the Reform is mainly concerned with improving the technical quality in all its service domains, such as diseases control and prevention, and expanding the range and areas of service provision. The other three systems will be subject to major institutional reforms.

In the reform plan for medical service provision sector, the Guideline explicitly states that public and nonprofit medical institutions should form the backbone of medical service sector, while limited leeway will be given to private and profit institutions to play some complementary role. This marks an important shift away from the reliance on market mechanisms and privatisation inherent in the last round of medical reform.

Another important area of reform in this sector concerns the grassroots. The Guideline attaches great importance to village medical stations and township general clinics and community medical service centres as basic units in the new medical systems that cover every single community and reach out to all the people in China. Following a hierarchical plan, basic medical services shall be provided as priority in thousands of grassroots medical establishment; as level of services and technical requirement rises, patients can seek more advanced treatment at higher level medical establishments located in cities at higher administrative ladders. These medical centres and clinics effectively constitute the cells of a mini-NHS, through which heavily subsidised medical services will be made available to the public in accordance with the basic logic of governance domination.

A national medical insurance system based on pre-existing systems and networks will be expanded with joint efforts of the central government and local governments to ensure universal coverage of basic medical insurance. The three medical insurance schemes, targeted at urban employees, urban non-working residents and rural households respectively, only cover about 30% of urban residences and just 10% of rural residences.

The Guideline demands all three systems, especially the rural medical insurance scheme, to increase their coverage to at least 90% of all urban and rural residences within the next three years, aided by heavy government subsidies to pay for contribution of the least privileged social groups. It is also planned that medical insurance schemes will be made more flexible and transferable across regional and provincial borders, so that migrant workers will retain their insurance contributions when they move to other provinces or back to their rural homeland.

Lastly, in order to set free the pharmaceutical sector which has been attached to and
relied on hospitals and other medical institutions for the sale of their products, the Guideline proposes a separation of the medical and pharmaceutical sectors. This means that drugstores and pharmacies will operate administratively and fiscally outside the control of medical institutions and pharmaceutical firms can rely more on the markets. In the next three years, a new list of basic national medicines will be published with a view to satisfy the basic medical needs of the people. Every drugstore and grassroots medical service centres will be required to provide all medicines on the list at a substantially subsided price.

Apart from building major systemic frameworks in the medical service sector, the Guideline also stresses the importance of institutional mechanisms for the Reform. These institutional mechanisms are meant to address some of the most important and difficult issues in the Reform process. The most prominent issues to be addressed, among others, cover government role, medical price mechanisms, human resource, supervision, information system and legal framework for the sector of medical service.

The Guideline states that the government has to play a leading role in providing basic medical services via public medical systems, through fiscal investments in basic construction, daily operations, personnel deployment, equipment acquisition and R&D expenditures for relevant medical institutions. It is also the government’s responsibility to provide adequate transfer payment in the form of premium contributions to insurance schemes, especially for rural cooperative medical insurance, stunted in terms of its reach and size of coverage due to the lack of regular contributions from low-income rural households. The total amount of expenditure is estimated to be 850 billion RMB in the next three years, with 40% from the central government, up from 27% in the past three years.

The government will assume a more active role in regulating the prices of medicines and medical services. While price discrimination and price differentiation are still allowed, the government will certainly exert tighter control over medical prices at all different levels. Guiding price will be set based on a variety of considerations, with both societal and business interests and long-term policy objectives taken into consideration. Price differentials in pharmaceutical products accrued in the circulation process will be greatly reduced as hospitals and drugstores are left with little room for manoeuvring as they are now under stringent supervision and under a new pricing mechanism.
Human resources and R&D is another important area for deep concern; the low level of education and technical qualifications among medical workers and the underdeveloped R&D capability in medical research have been long awaiting solution. To improve the overall standards of human resource in the medical sector, the Guideline suggests a huge increase in national healthcare expenditure to promote human capital formation through various institutional channels. While expanding the human resource pool to ensure continuous injections of fresh blood to the system, the Ministry of Health will seek to standardise and institutionalise the system of professional qualifications while promoting a proper code of conduct for all medical practitioners.

Towards the end, the Guideline also mentions targets for improving key service areas such as introducing an efficient information system, exercising effective internal supervision and formulating a proper legal framework in the healthcare sector; they are rightly regarded as important institutional frameworks for the system to operate properly. In essence, the Reform will seek to centralise and standardise control of the information, supervision and legal frameworks of the whole medical sector, with heavy reliance on informational technology and the authority of the central government.

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Together with the Guideline, the government released an action plan that laid down the basic steps and procedures to carry out the Reform. In this action plan, the core of the Reform is divided into five areas: (1) establishment of a nationwide Medical Insurance System; (2) institution of the National Basic Medicine System; (3) building and perfecting the grassroots medical service system; (4) equalisation of public health services, and (5) pushing forward public hospital reform via experiments.

**The establishment of a nationwide Medical Insurance System**

In this area of reform, the action plan explicitly states that in the next three years, the pre-existing medical insurance schemes should be extended to include 90% of all urban and rural residents. For those economically disadvantaged social groups, the government shall provide subsidies to fulfill their premium contributions. In particular, the government’s annual subsidy for the rural cooperative medical insurance scheme will be raised to 120 RMB per head; the maximum payable indemnity will be capped at about six times of annual dispensable incomes for both urban and rural residents.
The system will also be made more accountable and flexible for the public. Strict regulations and greater transparency in fund management will generally render the insurance fund safer and more amiable to public interests. For social groups that may not follow easy categorisation due to their greater social mobility, the system will adopt flexible institutional and technical arrangement to take care of their interests. For example, migrant workers will be able to access the system using an “electronic card” at different locations and levels of service units.

The National Basic Medicine System

As stated in the Guideline, the National Basic Medicine System will be centred on the compilation of a new list of basic medications and the set-up of a fully independent pharmaceutical sector. Medications on the list will be subject to national pricing and quality control administered by the central government. All public medical establishments will be asked to make available these medications on the list. They will also have priority in receiving government subsidies and reimbursement. The Ministry of Health issued a list of 307 essential drugs in August 2009 for state-owned grassroots health institutions. A separate, expanded list of essential drugs will be released in 2010 for higher-level health institutions.

A national market of pharmaceutical products will be established, with its independent market outlets and professional personnel, thus freeing the sector from the overriding influence of medical service providers. The implicit surcharge derived from the prescriptions of pharmaceutical products will no longer furnish a lucrative source of income for the hospitals. Prescriptions of all medications by hospitals, especially those outside the list, will be put under close surveillance and supervision.

The grassroots medical service system

In response to the dilapidated state of grassroots medical service system since the onset of the market reform, the Action Plan sets out forcefully to overhaul and rebuild the whole system through massive government investment. In the next three years, the central government plans to build about 2,000 county-level general hospitals, 25,000 township clinics and renovate another 5,000 clinics and other grassroots public medical providers, in an effort to ensure that every county possesses up to three renovated hospitals and every village has at least one medical station. In the urban area, 3,700 community medical centres and 11,000 community medical stations will be built or renovated to meet growing demands for low-cost medical service; the central government is ready to fully fund about 2,400 of these medical establishments in regions facing financial constraints.

To support the rebuilding of grassroots medical systems on such massive scales, the government is also prepared to enlarge the supply of human resources and perfect various institutional mechanisms to maintain and upgrade service standards of the grassroots medical systems. Fully subsidised training of medical workers will be provided on an extensive scale to ensure basic qualifications and technical proficiency of all public medical service providers. Extra government subsidy and mechanisms to facilitate
daily operations and quality of services will be put in place, such as subsidy for payroll of medical practitioners, introduction of strict human management system and policy incentives to encourage hospitals to adopt appropriate techniques, appliance and basic medications while discouraging excess inclinations towards expensive hardware acquisition.

Equalisation of basic public medical service provision

In this area, the government will build on existing achievements to further ensure that every citizen has an equal share in the provision of public health. From 2009, the government will attempt to establish a medical documentary system for each citizen, provide regular medical check-ups for all senior citizens aged above 65, infants aged below three and pregnant women, among other needy social groups; common and contagious disease prevention ability will be further strengthened. National public health projects will be extended to cover a variety of fields ranging from free scanning for prenatal deficiency, free operation for poor cataract patients, renovation of rural water and lavatory facility to the launching of the CCTV Health Channel.

Public hospital reform experiments

The Action Plan re-emphasises the raison d’être of public hospitals as serving public and societal interests with the interests of patients as their central of concern. To that end the plan recognises the need for reforming various institutional mechanisms inside public hospital system, including institutions governing source of income, personnel management, quality control, personnel training, professional assessment and salary determination. Experiments will be carried out in various regions to enforce stricter regulations and impose internal control, on the principle of separation between ownership and management and perfection of the institutions of governance.

The most important area of reform experimentation concerns source of income for public hospitals. As mentioned earlier, surcharges derived from prescription of medications will be abolished as a legitimate source of income for public hospitals, while service charges and fiscal subsidy will remain as the only legitimate sources of income. The government will raise fiscal subsidy in general, with the support of special
service departments such as emergency service, and special hospitals specialising in areas like traditional medicines, contagious diseases, psychiatric diseases, health care for women and children. Meanwhile, public hospitals will be allowed to raise their service charge within a reasonable margin, subject to regular checks and assessments by health authorities. To prevent possible undersupply of medical services, private sources of finance will be encouraged to build non-profit hospitals, with equal access to all favourable policies and subject to similar regulations for public establishments.

**Implementation as a Challenge**

To implement the Guideline and the Action Plan, a Health Care System Reform Leading Small Group has been formed, headed by Vice Premier Li Keqiang. As 16 government agencies have their representatives in the small group, there is little doubt that complex departmental and sectoral interests are at work in shaping the whole policy implementation process.

Among the major participants in the Small Group, National Development and Reform Commission (NDRC) is the neutral body to ensure that agencies are not merely interested in protecting their own interests but in establishing a functioning medical system; the Ministry of Health, with overlapping jurisdiction with most other parties involved, will have clear interests in expanding their jurisdiction and providing supervision of an enlarged public health sector; the Ministry of Human Resource and Social Security will be responsible for public insurance schemes and will seek to contain health care costs; the Ministry of Finance will restrict total state funding due to limited budgets. Other participants include the Ministry of Civil Affairs, the Ministry of Education, the State Population and Family Planning Commission, the Ministry of Supervision, State Food and Drug Administration, the State-owned Assets Supervision and Administration Commission, All-China Federation of Trade Unions, and so on.

China has spent three years formulating a comprehensive plan for overhauling its ailing health care system. It will need more time to establish a functioning health care system that is affordable and accessible to both urban and rural residents. The most daunting challenge is to balance the interest of different agencies, public hospitals, private healthcare providers and various social groups. To a large extent it will depend on whether China can implement the reform in an inclusive and collaborative manner, just as it did in producing the new health care framework.