Executive summary

China is the most populous country in the world. The population of mainland China reached 1.35 billion in 2012, accounting for 19% of the world’s people. China is rapidly ageing, with 8.7% of its population now older than 65. As a result of rapid urbanization, 51.8% of Chinese people are residing in cities. It also has a migrant “floating” population as large as 236 million in 2012. The administrative system is composed of central government (the State Council), and local governments in provinces, cities, counties and townships. China’s economic system was a planned economy from 1949 to 1978, followed by market economic system reform from 1978. Since the reform and opening-up in 1978, China has seen strong economic growth, growing into the world’s second-largest economy in 2010. China’s gross domestic product per capita reached US$ 6093 in 2012, though huge gaps exist among regions as well as between urban and rural areas. The health status of Chinese people has seen considerable improvement, with life expectancy at birth extending from 35 in 1949 to 75 in 2012. The demographic and epidemiological patterns have transitioned from high birth rate, high death rate, and infectious diseases to low birth rate, low death rate, and chronic diseases. In the two decades from 1990 to 2010, the major changes in cause of death were the rising mortalities and proportions of cancers, cerebrovascular diseases and heart disease, along with the dropping proportions of infectious diseases, chronic respiratory tract diseases and digestive system diseases. Chronic diseases have become the major burden of disease in China, contributing to 85% of the approximately 10.3 million deaths of all causes each year, accounting for 70% of the total burden of disease in China.

In China, by end of 2014, there have been 11 health laws and 38 administrative regulations promulgated by the State Council. The major health authorities at the state level in China are the National Health and Family Planning Commission (NHFPC) and the State Administration of Traditional Chinese Medicine overseen by the NHFPC. Based on their functions and responsibilities, other departments of the State Council, such as the National Development of Reform Commission, the Ministry of Civil Affairs, Ministry of Finance, and Ministry of Human Resources
and Social Security, also fulfil their duty in planning, funding, and insurance management in the health system. China’s health system has gone through a series of evolutions since 1949. The establishment and development of this system, in particular its pattern of organization and management, have been intertwined with the reforms of China’s political, economic and administrative systems.

The structure of China’s health administration consists of four levels: National Health and Family Planning Commission, provincial health bureaux, municipal health bureaux, and county health bureaux. In spite of several waves of reform emphasizing streamlined administration and decentralization, the central government is still the leading force in lawmaking and decision-making. Directed by the principles formulated by the central government, local governments at various levels issue and execute plans and decisions within their jurisdiction. Health planning in China is divided into two major sections – health development planning and specific health planning (i.e., human resource planning and disease control planning). China has a long history of multisectoral collaboration in promoting health, represented by the “patriotic health campaign”. Various levels of patriotic health campaign committees function as a deliberative and coordinating agency for related government sectors of the campaign. All main aspects of health service delivery are regulated in China. Governments at various levels are responsible for carrying out the regulatory functions within their jurisdiction.

During the planned economy period, China was a highly centralized country. Local governments had to obtain authorization from the central government to exercise power, following directions and supervised by the central government. Resource allocation was centralized horizontally to each level of government and public sector, and to the central government vertically. Since the beginning of reform and opening-up in 1978, especially since the tax reform in 1994, the main focus of administrative system reform in China has been the decentralization of administrative and fiscal power to governments at lower levels and entities outside governments.

China has a history of multisectoral collaboration in promoting health, the epitome of which is the “patriotic health campaign”. Patriotic health campaign committees function as deliberative and coordinating agencies of governments at various levels, formed by sectors of party, government, military and mass organizations, working through its executive office.
The committee is in charge of leading, arranging and coordinating its health campaign all over the country, while the member agencies of the committee all perform their own duties and work in cooperation. In recent years, the vision of “health in all policies” has drawn attention in China, and is now the guiding principle in the development of healthy cities.

There are four main methods of fundraising in the health financing system in China: tax-based, social health insurance, private insurance and out-of-pocket (OOP) payment. Along with reform and opening, rapid development of the market economy and progress in medical technology, the health system in China entered a stage of rapid development, while health expenditure also rose rapidly. In the 1980s and 1990s, due to the absence of universal health insurance coverage and the low coverage of basic medical insurance, health expenditure was largely in the form of OOP payments. In recent years, China has increased government investment in health and established basic medical insurance in order to reduce OOP health payments and to raise the accessibility and equity of health services. Due to these measures, the proportion of OOP payments in total health expenditure has significantly declined in the last decade. Between 1995 and 2012, China’s total health expenditure showed a 12.9-fold increase, its percentage of GDP growing from 3.5% to 5.4%. The proportion of government health investment in GDP has been rising year by year, while the proportion of OOP payments in total health expenditure, after peaking at 59.0% in 2000, has been continuously decreasing, reaching 34.4% in 2012. Taking 2012 as an example, 30.0% of the total health expenditure was covered by the government budget, 35.6% by social insurance and 34.4% by OOP payments.

China has built up a basic medical insurance system covering both urban and rural residents. Urban Employee Basic Medical Insurance (UEBMI) is mandatory for workers in urban areas, with premiums paid by both employers and employees and covers expenses incurred at outpatient clinics, for inpatient services and at designated pharmacies. Those not covered by UEBMI can join the voluntary Urban Resident Basic Medical Insurance (URBMI), jointly financed by premiums and government. Rural residents enrol voluntarily in the New Rural Cooperative Medical Scheme (NRCMS) as families, financed by premiums and the government. Government subsidies play a dominant role in the financing of URBMI and NRCMS. The three basic medical insurance systems all establish a pooling fund for inpatient expenses in compliance with regulations and some major outpatient diseases, with specific deductibles, co-payment
percentage, and reimbursement cap. Those in poverty who are unable to afford the basic medical insurance premium or the OOP payments of medical insurance are subsidized by an urban and rural medical assistance system, which provides a safety net in the multi-level health insurance systems in China, financed through various channels including government and public donations to ensure the access of poor people to basic health care.

From 2003 to 2006, a disease prevention and control system and a medical care system for public health emergencies covering both urban and rural areas were completed, funded by central and local governments. Basic public health services have been free of charge in China since 2009. Public health service financing, and personnel, development, construction, and business expenditures in specialized public health institutions are all included in government budget. Earmarked government grants are also allocated for public health works carried out by public hospitals.

China has long held to the “fee-for-service” payment model, causing wastage of medical resources and burdening the medical insurance fund. In the Planning and Implementation Plan of Deepening Health System Reform during “the Twelfth Five-year Plan” issued by the State Council in 2012, the reform of medical insurance payments is to be intensified in combination with clinical pathways of diseases, promoting payments based on diagnosis-related groups (DRGs), capitation, and global budget across the country. Currently, China is exploring various types of payment reform.

Health-care facilities in China consist mainly of hospitals, grassroots medical institutions and professional public health institutions. Over the last 60 years, the number of hospitals has been continuously rising, as have the numbers of beds and hospital staff. In 2012, there were 950 000 medical institutions, 5 720 000 hospital beds, and 6 680 000 health workers in China. The number of beds per 1000 people is 6.88 in urban areas, and 3.11 in rural areas; there are 8.54 health care practitioners per 1000 people in urban areas and 3.41 in rural areas. The health workforce in China has been relatively stable with a fairly regulated career development system. However, there is still a long way to go in balancing urban and rural personnel distribution, attracting and retaining grassroots health workers, and improving their professional capacity. China has established a continuous medical education system.
consisting of medical colleges and universities, postgraduate education, and continuing education. Heavy medical equipment is concentrated in secondary and tertiary hospitals, while the equipment in primary medical institutions is upgraded year by year. Rapid progress has been achieved in hospital management information systems, clinical information systems and regional health information technology systems.

A relatively well-developed health service system has been established in China, providing services including infectious disease control, emergency care, outpatient services and inpatient services. NHFPC is in charge of health development planning and administrative management nationwide, while local health and family planning administrations are in charge of local health development and management. Centres of disease prevention and control, health supervision authorities, maternal and child health care institutions, community health service centres (stations), township health centres and village clinics provide public health services in infectious disease prevention and control, prevention and treatment of chronic and endemic diseases, health education, food safety inspection and supervision, workplace health inspection, public health emergency response, and maternal and child health care. As grassroots health facilities (or primary care institutions), community health service centres (stations), township health centres, and village clinics provide primary medical services and some basic public health services for residents within their regions. Secondary and tertiary comprehensive hospitals are mainly responsible for outpatient and inpatient services. Services for mental conditions and stomatological diseases are available in specialized hospitals. Every city and county has at least one independent traditional Chinese medicine (TCM) hospital, and most comprehensive medical institutions and grassroots health facilities have a TCM department. These TCM hospitals/departments provide TCM services such as herbal medicines, acupuncture and moxibustion. Since the outbreak of SARS (severe acute respiratory syndrome) in 2003, the Chinese Government has increased financial input for public health institutions, greatly supporting public health service in aspects of infrastructure, capacity strengthening, and public health service delivery. In the meantime, nongovernmental capital investment in medical service market is encouraged and supported.

In order to solve problems encountered in health development, China has initiated a series of health reforms, which can be divided into the preliminary exploration period from early 1980s and the continuously
deepening reform period from 2003. Despite a backward economy and scarce health resources from 1949 to 1979, China managed to build a basic health system and improve people’s health drastically by strengthening grassroots health development, emphasizing disease prevention, launching large-scale mass public health campaigns, and establishing wide-coverage of low-levels of urban and rural basic medical insurance. China entered a stage of preliminary exploration of health system reform in 1980, and started to adapt the system to the socialist market economy, while further exploring the rules of health development in a stepwise manner. The main reforms at that stage were focused on health financing mechanisms for health institutions and the health insurance system, in which financing of public health providers increasingly relied on user charges and drug price mark-ups. In early 1997, the Central Committee of the Chinese Communist Party (CCP) and the State Council issued the Decision on Health Reform and Development, which required health care institutions to put social benefits in the first place, instead of pursuing economic benefits blindly; proposed to give priority to basic health services; and announced the decision to establish a rural medical security system and deepen the reform of Urban Employee Basic Medical Insurance (UEBMI). During that period, the total amount of health resources expanded dramatically, and the infrastructure, construction and technologies of medical institutions were fundamentally improved, while the motivation of health professionals was boosted. However, problems such as spiralling medical expenditure and “difficulty and expense in seeking medical care” emerged. In March 2009, the CCP Central Committee and the State Council issued *Opinions on Deepening Health System Reform*. The main goal of the document was to establish a basic health system covering both urban and rural residents by 2020, and the basic tasks were to form a developed public health service system, a medical service delivery system, a medical security system, and a relatively well regulated pharmaceutical supply system. In order to achieve these, eight measures and policies have been implemented, including human resource development, health financing reform, and reform of management systems and operating mechanisms of medical and health institutions. This new round of reform has clearly defined the basic health service system as a public good for all, and the principles of “ensuring basic services, strengthening grassroots level health care and building effective mechanisms (bao jiben, qiang jiceng, jian jizhi)” have also been established.