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Health Care System

Quánkē yīxué 全科医学

Political, social, and economic changes since the establishment of the People's Republic of China have created a continued challenge to provide medical care for 1.33 billion people in both urban and rural populations. As reforms made in response to the 2003 SARS epidemic have begun to show their efficacy, the government recognizes the need to rein in costs and address public concerns over quality of health care.

Modern China's health care system has undergone substantial change in conjunction with the country's political, economic, and demographic change. The rapid economic growth since the 1980s and changes in living conditions, nutrition, and health have resulted in decreased infant mortality (estimated at 21.16 deaths per 1,000 births in 2008) and increased life expectancy (estimated at 73.18 years in 2008).

China faces huge health problems, however, including a lack of access to affordable health care, often-inadequate medical insurance coverage, and an inequality in health services between urban and rural areas. As it has in the past when health concerns have caused great discontent among its populace, China's government has proposed reforms to provide safe, effective, convenient, and affordable health care to both urban and rural populations.

Development of Health Care in People's Republic of China

When the Communists established the People's Republic of China in 1949, the country's health and health systems had been weakened both by the civil war and by China's war with Japan. In the period from 1949 to 1965, the government took steps to improve the nation's health, emphasizing preventive measures. A three-tiered health care delivery system was implemented. At the lowest level, rural, village, or urban street clinics provided basic prevention and cure. Township or community health centers provided care for patients who needed additional treatment. Specialized services, unavailable at either of the two lower levels, were provided through a network of government-funded hospitals. The government established basic insurance systems for urban workers. The Government Insurance Scheme, or GIS, covered active and retired government employees, disabled veterans, and university staff and students. The Labor Insurance Scheme, or LIS, was funded by state-owned enterprises for their employees. The commune-based Cooperative Medical System, with village and town clinics, was developed in rural areas. New medical schools were established. Famine during the Great Leap Forward (the period in the late 1950s when farm workers were mobilized to work in factories and crops failed to be harvested) was a disaster in which up to 30 million people starved to death. But improved sanitation, water quality, and nutrition contributed to overall improved health during the period before the Cultural Revolution. For example,

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schistosomiasis, a parasitic disease from infected water, was virtually eradicated.

Many of these health-care-system improvements were lost during the social upheaval of the Cultural Revolution (1966–1976). Medical schools were closed for five years, and their students and faculties were sent to the countryside. Treatment, specifically psychiatric treatment, favored political re-education over drug therapy. In rural areas, where up to 80 percent of the population lived, basic health care was provided by the "barefoot doctors." These peasant youth received three- to six-month training courses that included traditional Chinese medicines and procedures (such as acupuncture) in addition to Western medical practices. The barefoot doctors continued farming work in the fields while providing first aid, immunizations, and health education. In 1986, there were an estimated 1 million barefoot doctors. Chen Zhou, appointed China's Minister of Health in 2007, began his medical career as a barefoot doctor.

Rapid economic growth, decentralization of political and economic power, and a shift to a market economy characterized the thirteen years immediately following the end of the Cultural Revolution. Decentralization of government financial responsibility to provinces resulted in an inequity of health care between rich and poor areas. The percentage of health care services that the government subsidized declined, and financing of health care was increasingly privatized. A government-mandated price cap on some drugs led to increased use of expensive drugs and diagnostic technology (such as MRIs and CAT scans) to increase revenues for privatized large hospitals. The increasing costs had to be borne by consumers on a pay-as-you-go-approach that often forced people to forego treatment. Changes to the rural Cooperative Medical System resulted in fee-for-service treatment by often undertrained village doctors. Gaps appeared in medical insurance coverage. Industrialization resulted in the creation of many urban migrant workers who lacked health coverage, and the increasing numbers of people employed in the private sector were not covered by GIS or LIS plans. A positive step during this period was the undertaking of new public health initiatives that decreased the incidence of infectious diseases and infant mortality.

The period from 1990 to 2002 saw government efforts to rein in health care costs. Resistance by large hospitals and drug companies, plus the inability of poor provinces to implement centralized changes, largely resulted in the failure of these reform efforts. The number of private health care providers increased. GIS and LIS, which covered formal public sector employees, collapsed as insurance became a burden for businesses. A new program for urban uninsured, merging GIS and LIS into the Basic Health Insurance Scheme (BHIS), was implemented. This new plan is employment based: both employers and employees make contributions to a common fund. This period saw an increase in the incidence of sexually transmitted diseases, HIV, hepatitis B, and schistosomiasis.

The SARS epidemic of 2002 and 2003 brought the world's attention to the inequities and infrastructure

A Red Cross kiosk in Harbin, Heilongjiang Province. China has proposed reforms to provide safe, effective, convenient, and affordable health care to both urban and rural populations. PHOTO BY JOAN LEBOLD COHEN.

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weakness in China's health care system. Reforms inspired by this crisis included partial resumption of central management of public health and reallocation of funds. A new rural Cooperative Medical System, operated by county governments and funded by beneficiaries, counties, and the central government, was formed. As of September 2007, around 80 percent of the whole rural population of China had signed up (about 685 million people). One consumer weakness in the Cooperative Medical System is that benefits are provided on a sliding scale: The program pays a lower percentage of fees for treatment in urban areas, with patient responsible for the balance, but patients must often go to urban areas for specialized treatment. The numbers of people with health insurance seems to have increased significantly in 2007. A total of 220.51 million people participated in the urban Basic Health Insurance Scheme; a significant portion of the increase is due to the inclusion of migrant workers coming from the rural areas. The Chinese Center for Disease Control and Prevention was organized; the renewed reduction in infectious diseases since its inception shows its efficacy. Health care response to the Sichuan earthquake of 2008 was another indication of a strengthened system.

Strategies for Reform

Even after reforms that responded to the SARS (severe acute respiratory syndrome) outbreak of 2003, many challenges remain, including soaring medical costs, a lack of access to affordable medical services, antagonism between health-care providers and patients, and low medical insurance coverage. New reforms of the health care system, proposed in late 2008 and passed by the State Council in January 2009, attempt to address these problems. The goal is to provide universal medical services that are safe, effective, convenient, and affordable to both urban and rural populations. The plan promises to spend RMB¥850 billion by 2011 (approximately US $124.4 billion) to provide a universal primary medical service to the country's 1.33 billion people. There are five key strategies in the plan.

The first key proposal is to increase the amount of urban and rural population covered by the urban Basic Health Insurance Scheme or the new rural Cooperative Medical System to at least 90 percent by 2011. Each person covered by the systems would receive an annual subsidy of 120 yuan (approximately US $17.50) beginning in 2010. Currently, farmers and their families and unemployed urban workers must pay for health care. Responding to a concern that the goal should be 100 percent insurance coverage, Li Ling, a professor at the National School of Development at Beijing University who developed the draft of the new plan, said that even developed countries can't achieve 100 percent coverage.

The second key proposal is to build a basic medicine system that includes a catalogue of necessary drugs produced and distributed under government control and supervision starting from this year. All medicine included would be covered by medical insurance, and a special administration for the system with strengthened government control over drug production and distribution would be established. Medications represent more than half of health care costs for consumers, and the high cost is often a point of contention between health-care givers and patients. Opposition to this proposal comes from pharmaceutical companies, who say going back to a planned and controlled economy would result in lower productivity and that lowering drug prices may reduce drug quality.

The plan proposes to implement reforms to improve services in public hospitals. Increased government subsidies would partially offset reduced revenues from drug sales. A pilot program running from 2009 to 2011 would reform public hospitals in terms of their administration, operation, and supervision in order to improve the quality of their services. The government will select public hospitals in several cities to participate in the pilot program. Li Ling said that reform of public hospitals lies at the heart of the new plan.

A fourth strategy is to improve services of grassroots medical institutions, especially hospitals at provincial levels, township clinics or those in remote villages, and community health centers in less developed cities.

The final key proposal addresses inequality in delivery of health services. According to the United Nations, in 2005, 25 percent of public-health resources were devoted to rural residents, even though they made up roughly 60 percent of the population. China would gradually provide equal public health services in both rural and urban areas in the country.

Reforms are designed to address public concerns about the cost and quality of health care. The government describes the reforms as "putting people first," but plan proponents expect additional benefits to China's overall economy. Out-of-pocket health expenditures by individuals are one factor in the increased poverty rate in China (16.2 percent

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A Pediatric Hospital in Beijing. Since the 1980s, changes in living conditions, nutrition, and health have resulted in decreased infant mortality rates and increased life expectancy. PHOTO BY JOAN LEBOLD COHEN.

in 2006). With lowered costs for health care, people would have more money to spend on consumer goods. It is hoped that increased domestic consumption would result in less reliance on exports for economic growth. As was seen with the SARS epidemic, improved public health in China has implications for global health care.

The Editors

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