In the early 2000s, the central and local governments in China undertook a series of reforms and initiatives to improve access to health care among distinct cohorts. To this end, the government established and strengthened three primary insurance schemes: the New Cooperative Medical Scheme (NCMS), a voluntary program that targets rural residents; the Urban Employee Basic Health Insurance Scheme (UEBMI), a mandatory policy for the estimated 300 million urban employees in both private and public sectors; and the Urban Residents Basic Medical Insurance Scheme (URBMI), a voluntary scheme which aims to cover the approximately 200 million children, students, elderly, disabled, and other non-working urban residents (1, 2). As a result of these initiatives, national insurance coverage increased from 23% in 2003 to 87% in 2008, with 72% of urban residents and 93% of rural residents covered in 2008 (2).

The NCMS, initiated in 2003, is financed through support from the central and local governments, which bear 80% of the premium, and contributions from beneficiaries, which together totaled over RMB 230 per person in 2011 (3). This funding has steadily increased since the inception of the program; in 2009, the total cost per person was RMB 100 (2). The NCMS stipulates that all local schemes must adhere to two guidelines: voluntary enrollment and coverage of catastrophic diseases (4). All rural residents are eligible for the program, and administrators are prohibited from refusing any individual on the basis of health status or pre-existing conditions (4). Because enrollment is voluntary, the government has instituted several safeguards against adverse selection (5). For example, the central government matches contributions in poor provinces if 80% of the eligible households participate (4).

While inpatient services are covered in all NCMS programs, the specific height and depth of the package significantly varies by county (5). For example, in 2009, the NCMS in Changle County expanded coverage to include such chronic treatments as cancer chemotherapy and cerebrovascular disease, at a reimbursement rate of 25% (1). Other counties have altered reimbursement policies for chronic disease patients by waiving outpatient reimbursement deductibles, increasing the ceiling, and/or increasing the reimbursement rate for covered chronic disease above that of other diseases (25%) to an average of 40% (1).

The UEBMI and URBMI, which target urban residents, reimburse 70% and 50% of inpatient expenditure, respectively (6). While the UEBMI is financed through a cumulative payroll tax of 8%, the URBMI is financed through annual premiums of RMB 150-300 for adults and RMB 50-100 RMB for children, supplemented by contributions of RMB 40 by central and local governments (6). Similar to the NCMS, the UEBMI benefit package largely differs by geographic location, particularly for outpatient chronic disease care (6).

These three insurance schemes are associated with the China National Registration System. As a result, individuals registered as rural residents are not eligible for the URBMI. This residence
based registration process poses barriers to care for the almost 200 million migrant workers in China (7). Each local government bears the responsibility of how to address the needs of the workers who migrate from their jurisdiction. The policy varies across the country in terms of depth and height of coverage, as different local governments have different financial ability, priorities and managing capacities.

These schemes are supplemented by the Medical Financial Assistance program (MFA), which is financed by the central and local governments. The MFA covers premiums for NCMS and URBMI, medical expenses beyond insurance limits, and temporary financial support for medical expenses for the poor. By 2010, urban and rural MFA programs covered over 93.37 million poor individuals (2).

While these programs have likely improved access to care, the increasing burden of chronic diseases such as cancer pose a threat to the sustainability and success of each initiative. In 2008, chronic diseases accounted for approximately 80% of China’s total mortality, with cancer contributing an estimated 21% of total deaths (8). Recent studies have shown that the NCMS increases access to health services, but does not improve financial protection, potentially due to increasing costs of care (5). Chronic disease patients’ repeated and expensive medications are often not covered under NCMS programs. As a result, according to studies by Yip and Hsiao (2009), chronic disease outpatient expenses impoverished approximately 11.6% of rural poor households in their study sample in 2006 (9).

In order to improve financial protection and access to care and to reduce the number of people impoverished by catastrophic disease, the government released several documents prioritizing health systems strengthening across the country. For example, in 2009, the government released an official document, Opinions of the Communist Party of China Central Committee and the State Council on Deepening the Health Care System Reform (10), setting forth the principle that the new round of health reform must prioritize mass affordability and accessibility of health care (11). Hence, government spending at the central and local levels increased, and community and rural health centers were strengthened (12). In August 2012, six departments in Chinese government, including the National Development and Reform Commission, together with National Health And Family Planning Commission, released a document on Guiding Opinions regarding providing insurance of catastrophic diseases for urban and rural residents (13) The initiative aims to supplement the insurance provided for NCMS and URBMI beneficiaries. According to this document, funds from both of these insurance schemes will be earmarked for catastrophic disease insurance. Local governments will use these funds to purchase health insurance plans to cover such diseases from private health insurance companies. The local government is responsible for regulating the reimbursement rate and the range of the risk pool, as well as soliciting open bids from private insurance companies. Due to the fact that the devolution and management of this policy falls under the responsibility of each local government, the specific details of the insurance policies vary across the country. The general recommendation is that beneficiaries should be reimbursed first through HCMS or URBMI coverage. If the remaining out-of-pocket expenses are deemed significant, the catastrophic insurance policy should reimburse approximately 50% of the costs incurred (13).

In November 2012, the National Health and Family Planning Commission launched several complementary official documents including the Opinions regarding fastening promotion of catastrophic disease medical insurance for rural women from the Minister of Health (14). These
documents require each local government to establish catastrophic diseases insurance for at least the following twenty diseases through the aforementioned catastrophic insurance mechanism before February 2013: childhood leukemia, congenital Heart disease, end stage renal disease, breast cancer, cervical cancer, severe mental Illness, MDR-TB, HIV/AIDS opportunistic infections, hemophilia, chronic lymphoid leukemia, cleft lip and palate, lung cancer, esophageal cancer, type I diabetes, hyperthyroidism, acute myocardial infarction, cerebral infarction, colon cancer and rectal cancer (14).

As these policies were recently developed and promoted, monitoring and evaluation is required to determine the performance of the catastrophic insurance scheme. However, even with these new initiatives, several challenges in financing health services, particularly for chronic conditions, remain. The three main insurance schemes are based on residence and employment, though rural-urban migrants are common (6). Further, because urban and rural schemes are distinct, geographic differentials in access to health services persist (15). Nevertheless, the rapid expansion of the insurance schemes and innovative approaches to improving financial protection against chronic and catastrophic illnesses may serve as a model for other low and middle-income countries.

REFERENCES:


