Progress and challenges of the rural cooperative medical scheme in China
Qingyue Meng & Ke Xu

Introduction
The BRICS countries – Brazil, the Russian Federation, India, China and South Africa – have made remarkable advances in economic growth. To sustain this growth, countries such as China have started to focus more on social development, including health care. However, like many other transitional economies, China faces great challenges in raising public funds. Strengthening the health-care delivery system, and the availability of a monitoring and evaluation system. Further improving the RCMS requires a focus on cost containment, quality improvement and making the scheme portable.

Example
In its first decade, the RCMS made progress through political mobilization, government subsidies, the readiness of the health-care delivery system, and availability of a monitoring and evaluation system. Further improving the RCMS will require a focus on cost containment, quality improvement and making the scheme portable.

Abstracts in العربية, 中文, Français, Русский and Español at the end of each article.

Problem
During China’s transition to a market economy in the 1980s and 1990s, the rural population faced substantial barriers in accessing health care and encountered heavier financial burdens than urban residents in paying for necessary health services.

Approach
In 2003, China started to implement a rural cooperative medical scheme (RCMS), mainly through government subsidies. The scheme operates at the county level and offers a modest benefit package.

Local setting
In spite of rapid economic growth since the early 1980s, income disparities in China have increased, particularly between rural and urban populations. In response, the government has put greater emphasis on social development, including health system development.

Relevant changes
After 10 years of implementation, the RCMS now provides coverage to the entire rural population and has substantially improved access to health care. Yet despite a drop in out-of-pocket payments as a proportion of total health expenditure, paying for necessary services continues to cause financial hardship for many rural residents.

Lessons learnt
In its first decade, the RCMS made progress through political mobilization, government subsidies, the readiness of the health-care delivery system, and the availability of a monitoring and evaluation system. Further improving the RCMS will require a focus on cost containment, quality improvement and making the scheme portable.

Approach
Political commitment
An official document entitled Decisions on the strengthening of the rural health system was issued in 2002 by the Central Committee of the Communist Party of China and the State Council, the country’s highest decision-making authorities. This policy document laid out the principles for the RCMS, including its sources of funding, level of fund pooling, benefit package and fund management. It also defined the responsibilities of each level of government in fund collection, management and service procurement.

Features and implementation
The RCMS was piloted in 2003 and expanded rapidly, with strong administrative and financial support from the government. In China, the distribution of public funds usually follows political decisions. Besides subsidies to the RCMS fund, the government allocates extra budgetary funds to support the operation of the scheme by setting up county RCMS offices. To sustain this growth, countries such as China have started to focus more on social development, including health care. In rural areas, obtaining health services continues to cause financial hardship for many rural residents.

Examples
- The RCMS makes progress through political mobilization, government subsidies, the readiness of the health-care delivery system, and the availability of a monitoring and evaluation system. Further improving the RCMS will require a focus on cost containment, quality improvement, and making the scheme portable.

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- To sustain this growth, countries such as China have started to focus more on social development, including health care. In rural areas, obtaining health services continues to cause financial hardship for many rural residents.
The RCMS benefit package was modest initially; in most cases it covered only inpatient services. Today, some high-expenditure outpatient services are covered by the RCMS, although the fraction of the cost that is coverage depends on the availability of funding. The payment to providers is still dominated by the fee-for-service model, but a growing number of counties have been piloting and implementing alternative payment methods, such as capitation and case-based payment.

After 10 years, the RCMS has established stable institutions. The scheme is mainly supported by government taxes, supplemented by household contributions (Table 1). Funds are pooled at the county level. Although there is no direct risk-equalization mechanism, both central and provincial government subsidies are weighted in favour of poor counties.

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**Table 1. Features and implementation of the rural cooperative medical scheme in its first decade**

<table>
<thead>
<tr>
<th>Elements of the RCMS</th>
<th>Features</th>
<th>Implementation</th>
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<tbody>
<tr>
<td>Eligibility</td>
<td>Entire rural population, including rural migrants in urban areas</td>
<td>Population coverage increased from 10% in 2003 to 98% in 2012.</td>
</tr>
<tr>
<td>Government role</td>
<td>Guiding principles from the central government, overall implementation plan from provincial governments, and concrete implementation plans from county governments</td>
<td>Accountability of each level of government has been more clearly defined.</td>
</tr>
<tr>
<td>Fund collection</td>
<td>About 20% from rural households and 80% from government subsidies</td>
<td>The fund increased tenfold between 2003 and 2012.</td>
</tr>
<tr>
<td>Fund pooling</td>
<td>The fund is pooled at the county level, with an average population of a half million</td>
<td>Discussions about raising level of fund pooling to increase capacity of financial protection are ongoing.</td>
</tr>
<tr>
<td>Fund management</td>
<td>An RCMS management committee led by the county government</td>
<td>RCMS management staff and staff capacity have increased.</td>
</tr>
<tr>
<td>Benefit package</td>
<td>Service package: both outpatient and inpatient Reimbursement: adjusted according to availability of funds and scope of services covered</td>
<td>The service package has been extended and co-payment has been gradually reduced.</td>
</tr>
<tr>
<td>Service procurement</td>
<td>Contracting with health providers Encouraging alternative payment systems to replace fee-for-service payment method</td>
<td>New payment systems, including capitation and case-based payment methods, have been adopted.</td>
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**Progress and challenges**

**Rapid expansion of population coverage**

The initial strategy for the development of the RCMS was to start with a modest benefit package but rapidly expand population coverage. For historical and political reasons the RCMS is, in principle, a voluntary scheme. Initial efforts to avoid low participation rates and adverse selection (i.e. lack of participation by healthy people) made the scheme vulnerable. The central government has taken a series of actions in this respect, including steps to link allocation of its subsidies with population coverage in each of the counties, and the establishment of population coverage targets for local authorities. Local governments have a strong incentive to expand population coverage to increase subsidies from the central government.

In addition to the aforementioned approaches, other policies and measures for expanding population coverage include: continuously increasing government subsidies for the RCMS (Fig. 1 shows increases in RCMS funding per capita – 80% from the government and 20% from individuals – and in population coverage); increasing public awareness of the benefits of the RCMS through the media; changing the individual-based enrolment policy to a family-based one (one of the most effective methods for rapid expansion); simplifying procedures for enrolment and reimbursement; and attracting people to join by expanding the service package.

**Increasing service and cost coverage**

The scope of services covered by the RCMS in its first five years was limited to selected inpatient care in most counties. Coverage of services has gradually been expanded, along with funding. By 2008, the RCMS in most of the counties covered both inpatient and outpatient care. The RCMS drug reimbursement list currently includes about 1138 drugs. Part of the funds of the RCMS are allocated to outpatient medicines for patients with noncommunicable diseases. Since 2012, 15 Chinese yuan per capita per year have been pooled, on average, to cover 70% to 80% of total expenditures for 20 high-cost health conditions.

**Better access, lower expenditure**

Health-care use increased substantially after the implementation of the RCMS. Before 2003, the annual hospitalization rate was steady at around 3%, but by 2011 it had increased to 8.4%. However, excessive and unnecessary use of health-care services resulting from the expansion of health insurance coverage has occurred. One example is the rise in caesarean deliveries in rural areas.

Although RCMS funding has rapidly increased and co-insurance has declined, some rural dwellers still face financial hardship in paying for necessary health services. Between 2003 and 2008, the rate of impoverishment due to medical expenditures declined from 5.5% to 4.6% overall, but it continued to increase for the poor. Compared with the urban employee insurance, the RCMS benefit package is still small. However, now that the RCMS covers most of the rural population, the priority is to expand the benefit package to cover more services and costs.

**Controlled costs, improved quality**

Rapid increases in health-care use and in demand (possibly supplier-induced) have caused an escalation of medical...
expenditures in a way that threatens the sustainability of the scheme. Government and RCMS administrators have been actively exploring solutions. For example, in 2012, the central government issued guidelines for reforming provider payment systems in an effort to replace the fee-for-service payment method with alternative payment systems, such as capitation, case-based payment, and a global budget.16

Quality of care is a central issue in RCMS management. Various indicators are used for paying health providers; they include rational use of drugs, provider compliance with standards and protocols of medical care, and patient satisfaction. Medical expert panels monitor the quality of health care. However, it will take time to improve the quality of care in village clinics and township health centres because of a lack of qualified health workers.

**Portable for rural migrants**

Migration from China’s rural areas to its cities is enormous: 165 million people in 2012.17 About 70% of the rural labourers in urban areas are self-employed or work in private and small enterprises, commonly in high-risk jobs with low pay.18 In most counties, migrant workers seeking medical services are required to pay the full service cost and can only be reimbursed when they return to their hometowns. This is the case even though few counties with intensive outflow of migrants try to make reimbursements and services convenient for these migrants by contracting with health providers in the cities where the migrants are residing. The central government is working on making the RCMS portable by using information technology and by integrating the RCMS with urban health insurance schemes. Both approaches will take time to produce palpable results.

**Lessons learnt**

The RCMS has progressed rapidly in its first decade. High-level political commitment has been a critical factor for its nationwide scale-up. The RCMS is one of the top priorities on China’s social development agenda and the scheme was included in the country’s 11th (2006–2010) and 12th (2011–2015) national five-year development plans.

Transforming political will into actions is the key to the success of China’s RCMS. The central government as well as local governments have allocated substantial budgets to subsidize the enrolment of rural dwellers in the RCMS. In fact, about two thirds of the funding for the RCMS comes from government taxes. The government subsidy to RCMS is one of the most important factors attracting people to join and trust the system.

Box 1 summarizes the main lessons learnt from implementing the RCMS. Incentives for local government are very important. The matching method (in which local government matches the central government’s subsidies and rural households’ contributions) has worked well in this context for mobilizing support from local governments and encouraging rural dwellers to join the RCMS. Furthermore, the progress on the RCMS is one of the performance indicators for assessing local governments.

Another factor that is often overlooked is the service delivery system. Insurance is a demand-side intervention; if the services covered by the insurance do not exist, there is nothing to be insured. China has relatively good three-tier health-care delivery systems in rural areas – one of the preconditions for establishing the RCMS. Increased resources through the RCMS in turn strengthen the capacity of the health-care delivery system in rural China.

Now that the RCMS covers nearly the entire rural population, the next step will be to improve the benefit package. Compared with the urban employee scheme, the RCMS provides a modest benefit package in terms of the range of services covered and the fraction of the cost that is reimbursed. Service coverage and financial protection are the major concerns in connection with the RCMS once its population coverage has reached a high level. While expanding the benefit package, RCMS is putting more emphasis on cost control and quality improvement through different provider payment methods. These are daunting tasks and close monitoring and constant adjustment are required.

**Competing interests:** None declared.
Lessons from the field
China's rural cooperative medical scheme
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Aim
China is a vast country in East Asia with a rapid growth in the last 10 years. The rural cooperative medical scheme (RCMS) is a government-led program that helps the rural population to access healthcare services. The program has been implemented since 2003 and has been successful in covering the entire rural population and improving access to healthcare services. However, despite the increase in healthcare coverage, many rural residents still face financial difficulties due to the cost of healthcare services.

Method
The RCMS is implemented at the county level and provides a modest service package. The program has been successful in improving healthcare access and reducing the financial burden for rural residents.

Results
The RCMS has been successful in improving healthcare access and reducing the financial burden for rural residents. However, the program still faces challenges such as high costs and low quality services. The discussion addresses these challenges and proposes solutions to improve the RCMS.

Discussion
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Résumé
Progrès et défis du plan médical coopératif rural en Chine

Problème
Au cours de la tran...
Resumen

Avances y desafíos del sistema médico cooperativo rural en China

Situción. Durante la transición de China hacia una economía de mercado en las décadas de 1980 y 1990, la población rural se enfrentó a importantes barreras para acceder a la atención sanitaria y tuvo que hacer frente a cargas financieras mayores que los residentes urbanos para pagar los servicios de salud necesarios.

Enfoque. En 2003, China comenzó a poner en práctica un sistema médico cooperativo rural (RMS, en sus siglas en inglés) a través, principalmente, de subsidios del gobierno. El esquema funciona a nivel de condado y ofrece un paquete modesto de beneficios.

Marco regional. A pesar del rápido crecimiento económico desde comienzos de la década de 1980, las disparidades en los ingresos han aumentado en China, en particular entre las poblaciones rurales y urbanas. En respuesta, el gobierno ha puesto un mayor énfasis en el desarrollo social, incluido el desarrollo del sistema de salud. Ejemplos de ello son la priorización de un mejor acceso a los servicios sanitarios y la reducción de la carga de pago por los servicios necesarios.

Cambios importantes. Tras 10 años de implementación, el RMS proporciona en la actualidad cobertura para toda la población rural y ha mejorado sustancialmente el acceso a la atención médica. A pesar de una reducción de los pagos directos del gasto total en salud, el pago por servicios necesarios sigue provocando dificultades financieras para muchos residentes rurales.

Lecciones aprendidas. En su primera década, el RMS ha logrado avances por medio de la movilización política, los subsidios gubernamentales, la buena disposición del sistema de atención sanitaria y la disponibilidad de un sistema de supervisión y evaluación. Con objeto de seguir mejorando el RMS, será necesario centrarse en reducir los costes, mejorar la calidad y lograr un sistema móvil.

References