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Health Care Financing in Rural China:
New Rural Cooperative Medical Scheme

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by

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1. History of the Rural Cooperative Medical Scheme

The Rural Cooperative Medical Scheme (RCMS) dates back to late 1950s, during the time of collective economy in rural China. The schemes were financed at the village and commune level (where the average population per commune was around 10,000 to 20,000 people) and aimed to provide nearly free preventive and curative care to farmers. The RCMS was then mainly supported by commune welfare funds, which were part of the communes’ collective revenue. The services provided by the RCMS were rather basic and relied heavily on traditional Chinese medicine. Barefoot doctors, with limited training, were the main providers. By the mid 1970s, more than 90% of the rural population was covered by the RCMS, when universal coverage of basic health services was achieved. RCMS was a success story in the international community during that time.

In late 1970s, China started its rural economic reform. The collective commune economy started to disappear and the RCMS lost its main source of funding. Coupled with rapidly increasing medical costs and other reasons, the RCMS almost completely collapsed and only around 5% of villages had a scheme by the late 1980s.

Economic reform has resulted in an astonishing GDP growth since 1978. Accordingly, living standards increased and absolute poverty reduced dramatically since the reforms. At the same time, the demographic transition since the 1980s resulted in a greater burden of chronic conditions. The demand for health services in terms of both quantity and quality increased, along with its cost. During the economic transition, health facilities, although publicly owned, were encouraged to cover their costs through user charges and selling drugs. By 2000, the government budget for rural facilities covered less than 15% of total cost on average. Some households had to forgo health care and others faced financial catastrophe as a result of user charges.

2. The New Rural Cooperative Medical Schemes (NCMS).

It was clearly acknowledged that social development was far behind economic development at the beginning of this millennium. Establishing a social security network and improving equity are the key elements for further economic growth. In the early 1990s, the government renewed its interest in the RCMS as health care is one of the focuses of the public and the government. This was also supported by farmers, who wished to have RCMS back. Various pilot schemes were set up under health insurance principles involving contributions of individuals and households. Then in October 2002, the State Council announced that the New Rural Cooperative Medical Schemes (NCMS) would be the main strategy for financing rural health care.
In 2003, large scale pilots of the NCMS were inaugurated. The scheme is voluntary in principle, although farmers are actively encouraged to enrol. Two-third of the NCMS fund is from central and local governments. Population coverage has extended rapidly: by the end of 2008, the NCMS had been introduced in 2729 counties and now covers 91.5% of the rural population and has 830 million members. The official target is to cover the entire rural population by 2010. The NCMS is under the supervision of the Ministry of Health. It is operated at the county level (which typically have a population of around 200,000 to 300,000). The county health bureau is responsible for design, implementation, management and administration of the scheme.

3. Revenue collection for the NCMS.

The origin of NCMS revenues is threefold: it comes from central and local governments and households. In 2003, the minimum contribution per person per year was 30 Yuan (1$=8.4 Yuan), which was evenly split among central, local (provincial, city and county) governments and households. In 2006, the minimum annual contributions by central, local (provincial, city and county) governments and households were 20 Yuan, 20 Yuan and 10 Yuan per person per year respectively (1$=7.97 Yuan). NCMS funds are pooled at the county level. There is no direct cross subsidization between counties. In richer counties, such as those affiliated to Beijing and Shanghai, the city governments contribute more to NCMS and the benefit packages are larger than in the poorer counties. In order to address this, the central government makes higher contributions to some poorer areas, particularly in central and western regions. Provincial governments also vary their contributions to the NCMS according to the income level of different counties within the province.

In 2008, the contribution from central and local government doubled to 80 Yuan and households were required to contribute 20 Yuan. The government contributed on behalf of poor households who could not afford the premium. From 2010, the expected minimum local and central government contribution will be increased further to 120 Yuan, whereas households will contribute about 30 Yuan.

4. Revenue management and benefit package

NCMS revenues are earmarked for paying for health services, including part of the salaries and the operation cost of service providers. Investment using NCMS funds is not allowed. The benefit package is determined by the funds available from government subsidies and household contributions. Counties were encouraged to explore models tailored to their particular contexts during the piloting period. Currently, there are four main models of using NCMS funds: 1) covering both inpatient and outpatient care; 2) covering inpatient and high cost outpatient care; 3) covering inpatient care only; and 4) covering inpatient care with pooled government contributions and covering outpatient care using household contributions as savings accounts. However, the last model has been discouraged as its pooling function is weak.

In general, the NCMS intends to cover high cost services such as inpatient care. Deductibles (minimum payments required from the insured to mitigate against high transaction costs) and ceilings (maximum reimbursement offered to the insured to limit risk) are commonly applied. The reimbursement rate (or the percentage of the expenditure reimbursed by the NCMS) is between 30% and 80% for inpatient services. Services provided at different levels of facilities also have different reimbursement rates,
with a lower rate for higher level facilities. In some counties, approval from the NCMS office is necessary to refer patients to hospitals outside the county. On average, only 38% of the household health expenditure was reimbursed in 2008. For the very poor, the government covers copayments through the Medical Aid Program, which started in 2003 and was financed by government and charitable contributions.

It is also worth noting that in earlier years, there was a large surplus in NCMS funds due to the fear of bankruptcy of the scheme. The carry over of the NCMS fund increased from 1.39 billion Yuan in 2003 to 12.3 billion Yuan in 2008, although it has reduced gradually in the last two years. This was the result of an increased benefit package for outpatient care and chronic illnesses as well as an increased ceiling for reimbursements.

5. **NCMS Performance**

Routine statistics show that the population coverage of the NCMS has grown rapidly, even though the scheme is voluntary in principle - this shows that stewardship is strongly pronounced. In counties with the NCMS, the enrolment rate is normally above 85%. There were concerns in early stages that government subsidies for the premium may mainly go to higher income counties, where local governments could match the subsidies by the central government and where the higher income households could afford the premium. However, adverse selection does not seem to be an issue.

The early evaluation showed that the NCMS improved access. However, financial risk protection was rather limited. Although the NCMS has reduced some households' out-of-pocket payments, catastrophic expenditure still exists because of insufficient funds, incomprehensive benefit packages and the maximum amount which can be reimbursed. As the benefit package expands, continuous political and financial support by both central and local governments will be critical for the financial sustainability of the NCMS, particularly in poor areas.

6. **Challenges and the way forward**

The NCMS has made progress in extending coverage and improving access to care for China’s rural population. However, for the NCMS to achieve its full potential, several challenges need to be addressed. Firstly, whereas the NCMS reduced some of the financial burden of health care costs for households, the degree of risk protection is still quite limited. Enlarging the benefit package to cover outpatient services would be desirable. With the planned increase in government contributions to the NCMS and direct budget to the township health centres for infrastructure and overhead expenditures, this would be feasible in theory. Secondly, using NCMS funds efficiently is a challenge for local governments. Technical and administrative capacities need to be improved. Routine data collection on health care utilization and spending of NCMS funds is very useful for further improving the efficiency and equity.

7. **What can be learned?**

The establishment of the NCMS in rural China is considered as an important step towards universal coverage. The rapid population coverage and the development of institutional structures have built a foundation for further improvements in the scheme. Observing from the early stages of the NCMS, several lessons can be drawn.
(1). **Governance.** The central government has declared that the development of the NCMS is an important part of the overall social protection program. NCMS is under the supervision of the MOH, but has also benefitted from policy consensus and strong support of the State Council, the highest government executive body in China. This has contributed to rapid population expansion and organizational development since 2003.

(2). **Government subsidies.** Government subsidies are essential for development of the NCMS. The largest part of NCMS revenue (about 80%) is from the government, and for the poor, the government makes a full contribution. Furthermore, the government has also increased investment in health facility infrastructure in rural China.

(3). **Membership.** The NCMS is a voluntary scheme and covers more than 90% of the population in the counties where it exists. There is no doubt that heavy subsidies from the government for the contribution have attracted the population to join the scheme.

(4). **Small benefit package with large population coverage vs. comprehensive benefit package with small population coverage.** When starting a new prepayment mechanism, it is always difficult to decide whether to start with a small part of the population and comprehensive coverage or with a large part of the population but with a rather small benefit package. There is no theoretical basis to say which approach is better. Both alternatively need to deal with expansion of population coverage or with expanding the benefit package. In practice, many developing countries took the first option, mainly because it is easy to start with. Very often, the formal sector and better-off populations are the first to benefit from coverage. Chinese policy makers selected the other option based on the country settings. Nonetheless, difficult challenges may lie ahead in order to translate population cover into universal coverage through improved access to services and financial risk protection for rural China.

(5). **Strengthen health service provision.** The NCMS increased health service demand in rural China. However, the increased demand will not automatically be met without new capital investment in the three-tier health service network in rural China, which is a public delivery system that was established in the previous 60 years. In return, the financial strengths of the NCMS may help the performance of the delivery system.