Respected Assistant Director General Dr Carissa F. Etienne,
Respected Secretary P K Pradhan
Respected Dr. Jarvis Barbosa
Ladies and Gentlemen:

Good afternoon! It was inspiring to listen to my colleagues’ presentations on the rural health program in India and the family health program in Brazil. It is also my great pleasure to share with you China’s experience in rural health reform and development.

China is a developing country with 1.37 billion people, over 60% of whom, or 850 million, live in rural areas.
The national condition of a big rural population and the gap between rural and urban areas in China makes it necessary to prioritize rural areas in its health policy. In April 2009, the Chinese government launched the new round of health care reform, making it an imperative to establish and improve the basic medical and health system for rural and urban residents, providing health services as public goods to the entire population, adding new meaning to the rural health reform and development in the new era.

Page 3
Now I would like to update you on the results of this endeavor.

I. Improving Three-Tier Rural Health Service Delivery System

Page 4

The three-tier rural health service delivery system is composed of county-level hospitals, township health
care facilities, and village clinics, providing the rural population with such services as prevention, primary health care, health inspection and health education. This network covers the 2,856 counties across the 31 provinces.

Since the launch of the health care reform, an earmarked 52 billion RMB yuan from the central governmental budget has been allocated to improve the rural health delivery system, including over 2,000 county hospitals and 25,000 village clinics. By the end of 2010, there were 6,400 county hospitals, over 1,500 county maternal and children’s hospitals, nearly 1,700 county CDCs and over 1,500 county health inspection institutions in China. There were also 38,000 township hospitals, i.e. almost every township has one or more hospitals. There were 648,000 village clinics, covering 92.3% of all the villages. From 2006 to 2011, the number of visits to township hospitals and village clinics increased from 2.07 billion to 2.66 billion, an increase of 28.5%.
II. Strengthening Rural Health Workforce

From 2004 to 2011, 2.26 billion RMB yuan was allocated from the central governmental budget to Mid-and-Western areas, providing 4.36 million person-times training among rural health professionals. The program of “ten thousand medical doctors supporting township hospitals” was initiated in 2005, and 1.32 billion RMB yuan was allocated for the project of “medical institutions at and above secondary level supporting township hospitals”. So far the project has covered township hospitals in poverty-stricken areas in 21 provinces in central and western parts of China. 70,000 person-times of technical assistance has been provided there.
Strengthening health workforce with on focus on training general practitioners has been one of several priorities in the past years. 36,000 rural health professionals have been trained to become GPs. Over 10,000 medical students have been enrolled without tuition fee on the condition that they promise to work in rural hospitals after graduation. Above 20,000 licensed physicians have been recruited at township hospitals.

By the end of 2010, there were nearly 1.6 million health workers in county hospitals; 1.2 million in township hospitals, about 1.3 health workers per thousand rural population at township level. Village clinics have 1.2 million health professionals, among whom over 1 million were village doctors and 173,000 were licensed practitioners or assistant licensed practitioners.
III. Consolidating the New Rural Cooperative Medical Scheme (NRCMS).

Page 10

China’s basic health insurance system is composed of four parts: the Urban Employees’ Basic Medical Insurance Scheme, the Urban Resident’s Basic Medical Insurance Scheme, the New Rural Cooperative Medical Scheme and the Medical Financial Assistance Scheme, covering urban employees, non-working urban residents, rural residents and poverty-stricken people respectively.

Page 11

NRCMS, a plan which provides coverage to rural residents, has played an essential role in reducing their financial burden, protecting them from falling into or back into poverty when being struck by catastrophic diseases, and improving their health. In the year 2011,
the coverage has expanded to 832 million people, 97.5% of the rural population. So we can see basically this is universal coverage. The funding per person has increased from 30 RMB yuan in 2003 to 300 RMB yuan per person in 2012. Under the scheme, patients are reimbursed for about 75% of their inpatient expenditures and the annual reimbursement cap is no less than 60,000 RMB Yuan in 2012. The funding pool for the scheme has increased substantially from 4 billion RMB yuan in 2003 to 204.8 RMB Yuan billion in 2011, out of which 77.2 billion RMB yuan are contributed by the central government. NRCMS has become the medical security scheme with the largest coverage in the world.

Page 12

In June 2010, beginning with rural children’s congenital heart disease and acute leukemia, we started a pilot program to improve the insurance level for catastrophic diseases for rural residents. NRCMS reimbursed 70% of the medical expenditures for the
pilot diseases, and Medical Financial Assistance reimbursed another 20% for eligible patients. In 2011, another 6 catastrophic diseases, namely, end-stage renal disease, severe mental disease, breast cancer, cervical cancer, multi-drug resistant tuberculosis, opportunistic infections among HIV/AIDS patients, were included into the pilot program. In 2012, the insurance program for the above 8 diseases will be fully scaled up. Meanwhile, in 1/3 of the NRCMS covered areas, another 12 diseases, including hemophilia, chronic myeloid leukemia(CML), cleft lip and palate, lung cancer, esophagus cancer, gastric cancer, type I diabetes, hyperthyroidism, cerebral infarction, stroke, acute myocardial infarction, colon cancer and rectal cancer, will be included into the pilot program.

Page 13

With NRCMS and improved health service delivery system, healthcare facilities are constructed or upgraded, and service capability of providers is
enhanced in the rural areas and in particular remote areas, which leads to farmers’ easier and more affordable access to medical and healthcare services.

From 2008 to 2011, the proportion of the rural households who had access to healthcare services within 15-minutes walk climbed from 75.6% to 80.8%;

Page 14

the percentage of the out-of-pocket expenditure for rural residents dropped from 73.4% to 49.5% ;

Page 15

the percentage of those who choose not to see a doctor when falling ill dropped from 12.4% to 6.1%;
IV. Providing basic public health services across rural areas.

Page 17

Equitable access to basic public health services, a highlight of China’s health care reform, provides institutional arrangements for its long-standing policy of putting prevention first. Currently, 41 basic public health programs under 10 categories are provided, as the government subsidy for basic public health services per person goes up from 15 RMB Yuan in 2009 to RMB 25 in 2011.

Page 18

As a result, health development gap between rural and urban areas is narrowing and health indicators for rural residents are improving rapidly: for example, rural maternal mortality rate dropped from 36.1 to 26.5 per 100,000, which is exactly at the same level as in the cities;
Page 19

infant mortality rate dropped from 18.4‰ to 14.7‰;

Page 20

In 2011 in rural areas, 62.6% residents had electronic health records; hospital delivery rate reached 96%; 8.84 million pregnant women received government subsidy for hospital delivery; 4 million women received cervical cancer screening; 400,000 women received breast cancer screening and 9.9 million women took free folic acid supplements.

Page 21

Thanks to the strenuous efforts in the past few years, the health care reform has brought more tangible benefits to the people, improving their access to healthcare services and bringing down the out-of-pocket costs. This reflects that the target,
direction and guidelines of the reform are in line with the law of health development, the specific national conditions of China and the aspirations of the people.

The objectives for the reform in the next few years are as follows: by 2015, China will provide more equitable access to basic healthcare services and improve the efficiency and quality of the healthcare services; while properly controlling the growth of total health expenditure, China will gradually enhance the share of government spending on health in the total fiscal expenditure to bring down the out-of-pocket expenditure for individuals to below 30%; the problem of inadequate and unaffordable healthcare services will be eased; average life expectancy will reach 74.5; infant mortality rate will be reduced to below 12‰, and maternal mortality rate below 22 per 100,000.

Page 22

The Chinese government is committed to pushing
forward the health care reform in rural areas through improving NRCMS, health infrastructure and health workforce, so as to achieve the goal of universal access to basic health care service. We will work unswervingly to overcome all difficulties and blaze a path of health development with Chinese characteristics!

I would like to thank WHO and the international community for your support.

Thank you!