A Comparison of International Healthcare Systems: China

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Overview

- Health Insurance Coverage (Fang, 2019)
  - Publicly-funded basic insurance
  - Option for private insurance
  - 95% of population is covered
- Gross Domestic Product (World Bank Group, 2021)
  - 14.28 trillion U.S. dollars (2019)
- World Health Organization Ranking
  - WHO Rank: 144 (Tandon et al., 2000)

Public Health Insurance

- Government covers 95% of population through basic insurance
- Urban Employee Basic Medical Insurance (UEBMI)
  - Mandatory for urban workers
- Urban-Rural Resident Basic Medical Insurance (URRBMI)
  - Voluntary for rural residents, self-employed urban individuals, children, elderly (Fang, 2019)

Private Health Insurance

- No official statistics about % covered
- Mostly for-profit insurers (Ping An Health, Kunlun Health)
- International insurers (Aetna, Cigna, Bupa)
- Employer-based or individual (Fang, 2019)

Health Financing

- UEBMI: employee/employer shared
- URRBMI: annual fixed premiums
- Private Insurance: employee/employer
- Medical financial assistance programs (Fang, 2019)

China Health

Population (2019)	1.4 billion
Elderly Population (2018)	11.2% of total
Per Capita GDP (2017)	$14,306
Current Health Expenditure (% of GDP, 2018)	5.35
Current Health Expenditure Per Capita (2018)	$501
Life Expectancy at Birth (2018)	74.5 years
Hospital Beds (2017)	4.3 per 1,000 inhabitants
Infant Mortality Rates Per 1,000 Live Births (2018)	7.4
Nurses Per 1,000 Inhabitants (2017)	2.7
Doctors Per 1,000 Inhabitants (2017)	2.0

(OECD, 2019; World Bank Group, 2021;World Health Organization, 2019)

Production and Choices

Production

- Central government oversight with local government production and delivery
- Primary Care
  - Village doctors and community health workers (rural clinics)
  - General practitioners or family doctors (rural township and urban community hospitals)
  - Medical professionals- doctors and nurses (secondary and tertiary hospitals)
- Hospital
  - Public or private, non-profit (62%) or for-profit (38%) (Fang, 2019)

Choices

- 95% covered by insurance- coverage not required
- Seek care in village clinics, township, or community hospitals before secondary or tertiary hospitals (lower cost-sharing)
- General practitioners as gatekeepers (Fang, 2019)

Reimbursement

- Public insurance programs only reimburse to ceilings
  - Costs above ceilings are out-of-pocket
  - Annual deductibles must be met before reimbursement
- Patients pay deductibles and copayments at time of service
- Hospitals bill insurers directly for remaining payment
- Paid through out-of-pocket, health insurance reimbursement, government subsidies
- Village doctors earn income through reimbursement for health services
  - Fee-for-service primary type of provider payment (Fang, 2019)

Challenges

- Uninsured:
  - 5% of total population lacks health insurance
  - Less developed/poor areas are in greatest need of coverage but still lack coverage
  - 262 million migrant workers lack health insurance (Finch, 2013)
- Premiums:
  - Increasing total value of private health insurance premiums
  - Grew by 28.9%/yr between 2010-2015
  - Accounted for 5.9% of total health expenditures in 2015
- Medical Finance Assistance Programs
  - Safety net for those unable to afford individual premiums or cannot cover out-of-pocket spending
  - Funded by local governments and special donations
  - Covers primarily catastrophic care expenses (Fang, 2019)

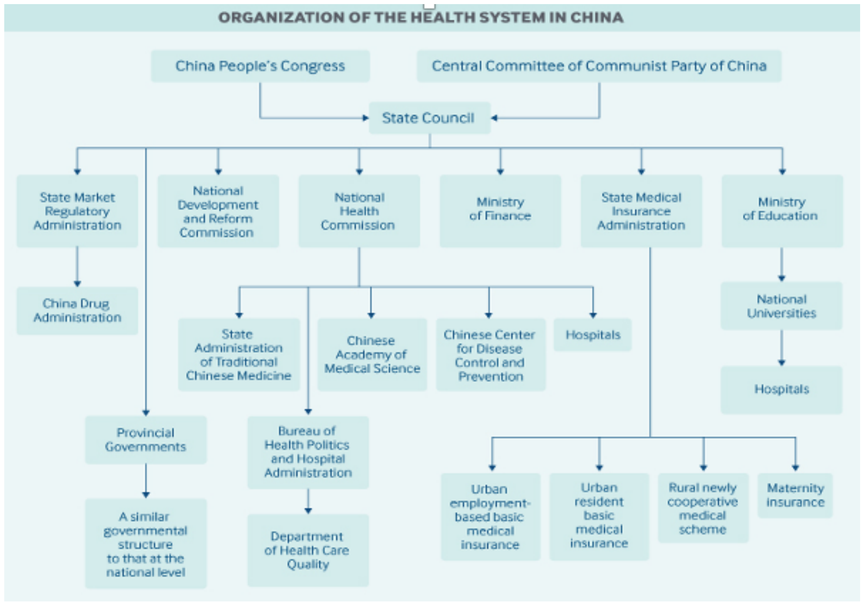

Chart from Fang, 2019

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