Chapter 2

Moving Towards Universal Health Coverage:
Challenges for the Present and Future in China

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ABSTRACT

This study uses a refined version of historical institutionalism to critically examine the complex interplay of forces that shape the health insurance reform trajectory in China since the mid-1980s and identifies problems that impede the government from achieving universal health coverage (UHC). It shows that China's multi-layered social health insurance system has covered more than 95 percent of its population, but failed to provide insured people with access to a range of essential services and make health care affordable. To achieve UHC, the government has to overcome significant hurdles, which include the inherently discriminatory design of the social health insurance system, disorder in the drug distribution system, deficits in the funding of health insurance, and insufficient medical protection for the old people.

INTRODUCTION

Since the mid-1980s, the problem of rising medical costs and the combing forces of population ageing and the burden of non-communicable diseases (NCDs) have driven the Chinese government to establish a multi-layered social health insurance system with an aim of providing affordable and sustainable health care for its population. At present, the social health insurance system has covered more than 95 percent of population (Asia Insurance Review, 2015). However, many insured people still have difficulties in accessing a range of essential services and face high out-of-pocket medical expenses. Meanwhile, the uninsured people lack access to basic and affordable health care. The government still has a long way to go to achieve universal health coverage (UHC), which refers to all people having access to needed health services without suffering financial hardship (World Health Organization, 2013, p. xi).

Health insurance reform in China has been explored and examined in many Western and Chinese studies. But the processes of health insurance reform and forces that shape the reform trajectory have not been completely understood. The relationship between UHC and health insurance reform has not been explored clearly. In order to fill the existing research gaps, this study uses a refined version of historical institutionalism to examine the forces that have shaped the trajectory of health insurance reforms in China since the mid-1980s, the problems that have impeded the government from achieving UHC and solutions adopted by the government to solve such problems.

BACKGROUND

Rapidly ageing population (Hsu et al., 2015), rising medical costs (Augustovski et al., 2011) and the burden of NCDs (Bristol, 2014, p.1) have driven governments worldwide to find ways to achieve UHC. According to the World Health Organization (WHO), there are three dimensions of UHC: (i) the breadth of coverage; (ii) the depth of coverage; and (iii) the height of coverage (World Health Organization, 2008, pp. 25-6). The breadth of coverage refers to 'the proportion of the population that enjoys social health protection' (World Health Organization, 2008, p. 25). The depth of coverage refers to the provision of the range of essential services that can effectively address people's health needs (World Health Organization, 2008, p. 26) while the height of coverage refers to the portion of healthcare costs covered by pooled funding and pre-payment mechanisms (World Health Organization, 2008, p. 26). In recent years, UHC has become a key global health objective advocated by WHO and the World Bank (Cheng, 2015, p.1) and has been adopted by many countries as a national aspiration (Reich et al., 2016, p. 811). It is believed that UHC can improve the health and well-being of people (World Health Organization, 2013, p. xi), and "is necessary for economic growth and development" (Cheng, 2015, p. 2).

However, there is neither a single model nor a single correct path to achieve UHC. Due to resource constraints and differences in political, economic, social and historical contexts, the timetable, the pace, the process and the approach to achieve UHC vary among developed and developing countries. International evidence shows that UHC is achieved gradually and over many decades (Carrin et al., 2008; Savedoff & Smith, 2011). The study of Savedoff and Smith (2011, p. 45) found that Chile and Malaysia achieved UHC at least 20 years later than Sweden and Japan, but they reached comparable levels of population health by spending smaller shares of their income on health services. The study of Reich et al. (2016) categorized 11 countries into four groups based on their pace of attaining UHC. Bangladesh and Ethiopia belonged to Group 1 countries because they were still in the agenda-setting stage of attaining UHC (Reich et al., 2016, p. 812). Indonesia, Vietnam, Ghana and Peru belonged to Group 2 countries, which had initial programmes in place but "coverage gaps remained in access to services and financial protection" (Reich et al., 2016, p. 812). Thailand, Brazil and Turkey belonged to Group 3 countries, which had achieved many UHC policy goals but faced the challenges in sustaining coverage (Reich et al., 2016, pp. 811-2). Japan and France belonged to Group 4 countries, which had achieved UHC but continuously adjusted their national policies to meet changing circumstances and solve the problem of rising costs (Reich et al., 2016, pp. 811-2). The above studies show that achieving UHC is a long term process and an ongoing task with different development stages.

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