

Implementation Plan for the Recent Priorities of the Health Care System Reform (2009-2011)

According to the *Opinions of the CPC Central Committee and the State Council on Deepening the Health Care System Reform* (hereinafter referred to as “the Opinions”), five reform programs should be carried out with emphasis from 2009 to 2011. Firstly, accelerate the establishment of the basic medical security system. Secondly, preliminarily set up the national essential medicines system. Thirdly, improve the grass-roots health care services system. Fourthly, gradually press ahead with the equalization of basic public health services. And fifthly, push forward pilot projects for public hospital reform.

The implementation of the five priority reform programs aims at effectively solving the problem of “difficult and costly access to health care services”, which arouses intense public concerns. In promoting the establishment of basic medical security system, all urban and rural residents will be included into the system to effectively reduce the burden of drug expenses on the individuals. In establishing the national essential medicines system, and improving the grass-roots health care services system, it will be made more convenient for residents to access health care services; the role of the traditional Chinese medicine (TCM) will be brought into full play and the prices of health care services and drugs be reduced. In promoting the gradual equalization of basic public health services, all urban and rural residents should be entitled to basic public health services, for prevention of diseases to the maximum extent. In carrying out pilot projects for public hospital reform, efforts will be made to improve the service quality of public health care institutions and to meet the demand of the people to have “convenient and affordable access to health care services”.

The implementation of the five priority reform programs aims at actualizing the commonweal nature of health care undertakings, and is characterized by the salient phased features of a reform. Making the basic health care system as public goods to the general public and providing everyone with basic health care services, is a major reform from concept to institution in the development of China’s health care sector, which meets the fundamental requirement in implementing the Scientific Outlook on Development. As an arduous and long-term task, the health care system reform shall be promoted with specific emphasis in different phases. Fairness and effectiveness should be appropriately balanced. The fairness issue will be tackled at the early stage to guarantee the basic demands of the people for health care services, which will be followed by a progressively increased benefit level along with the social and economic development. Efforts will be made to gradually address the issue of integration among the urban employees’ basic medical insurance, the urban residents’ basic medical insurance, and the New Rural Cooperative Medical Scheme. Social capital investment in the sector will be encouraged to develop multi-level diversified health care services. Efforts will be made to utilize health care resources of the whole society in an all-round way to improve service effectiveness and quality and meet the various demands for health care services of the people.

The implementation of the five priority reform programs is to enhance the operability of the reform, highlight the priorities, and to push forward the comprehensive reform in the health care system. Establishing the basic health care system is an important institutional innovation, which is a pivotal step in the comprehensive reform of the

health care system. The five priority reform programs involve key links and areas such as building up the medical security system, secured pharmaceutical supply, price formation mechanism of health care services and drugs, construction of health care institutions at grass-roots levels, reform of public health care institutions, mechanism of investment in health care, development of the health care workers' team, health care administration system and etc. The purpose of prioritizing the five reform programs is to fundamentally change the situation of no medical security for some urban and rural residents and the chronic inadequacy of public health care services, reverse the profit-orientated behaviors of public health care institutions and drive them to resume their commonweal nature, effectively tackle the prominent problems in the current health care sector, laying a solid foundation for realizing the long-term objectives of the health care system reform.

I. Accelerating the establishment of the basic medical security system

(i) Expanding the coverage of the basic medical security The urban employees' basic medical insurance (hereinafter abbreviated as UEBMI), the urban residents' basic medical insurance (hereinafter abbreviated as URBMI), and the New Rural Cooperative Medical Scheme (hereinafter abbreviated as NRCMS) will cover all urban and rural residents within three years, each with the coverage rate over 90%. Retirees of closed-down and bankrupted enterprises and employees of enterprises in difficulties will be covered by UEBMI in about two years. Those who cannot be covered by UEBMI should be entitled to URBMI, with the permission of provincial level government. Retirees of closed-down and bankrupted enterprises should be entitled to the benefits of the basic medical insurance regardless of the premiums affordability by these enterprises. To enable insurance participation, appropriate subsidies shall be given by the central government to retirees of closed-down and bankrupted state-owned enterprises in financially constrained regions. The UEBMI system will be implemented universally in 2009, which will also cover all the on-campus college students. Efforts should be made to vigorously promote UEBMI participation by employees of economic entities of non-public ownership, temporary contract workers and migrant rural workers. For those with employment difficulties, the government will subsidize their participation in UEBMI if they are eligible according to the *Employment Promotion Law*. Temporary contract workers should volunteer their participation in either UEBMI or URBMI. Those migrant rural workers with difficulty in participating UEBMI, can opt for URBMI, or NRCMS in their registered permanent residence.

(ii) Improving the basic medical security level Efforts will be made to improve the fund-raising standard and benefit level of URBMI and NRCMS. By 2010, subsidy on URBMI and NRCMS by government budgets at various levels will be increased to 120 Yuan per person per annum, and premium paid by individuals should be appropriately increased, with specific standards set up by provincial governments. The proportion of hospitalization expenses reimbursed by UEBMI, URBMI and NRCMS will be increased step by step within the scope of policy. The scope and proportion of reimbursement for outpatient expenses will be expanded. The maximum amount payable by UEBMI and URBMI shall be increased to about six times of annual average salary of local employees and disposable income of residents respectively. The maximum amount payable by NRCMS shall be increased to over six times of the per-capita net income of local farmers.

(iii) Regulating administration of basic medical security funds In the administration of various basic medical security funds, the principles of “determining expenditure by revenue, balancing expenditure and revenue and pursuing slight surplus” should be followed. Efforts should be made to maintain reasonable control over annual balance and accumulated balance of UEBMI and URBMI accounts, and in localities where there is an over surplus of balance, measures such as raising the benefit level should be adopted to reduce the balance to a reasonable level step by step. For NRCMS, the surplus of the pooling fund of the current year shall be capped within 15%, the accumulated surplus shall not exceed 25% of the current year’s pooling fund. The risk adjustment fund shall be institutionalized for basic medical insurance funds. The fund balance status shall be made public regularly. The fund pooling for basic medical insurance shall be upgraded, and funds for UEBMI and URBMI respectively should be preliminarily pooled at the municipal (prefecture) level by 2011.

(iv) Improving the urban and rural medical aid system Efforts should be made to effectively utilize medical aid funds and streamline procedures for examination, approval and the delivery of such funds. Financial assistance should be provided to members of urban and rural households receiving the minimum living standard allowance and those entitled to “five guarantees” to secure their participation in URBMI and NRCMS. For members of economically strained households, the subsidization standards on out-of-pocket medical expenses will be gradually raised.

(v) Improving service quality and management of basic medical security Local governments should be encouraged to actively explore establishing a negotiation mechanism between medical insurance handling institutions and providers of health care services as well as reforming ways of payment, and to rationally determine the payment criteria for drugs, health care services and medical materials, and to containing the cost. Efforts should be made to improve medical security services, promote the application of the “All-in-One Card” (a multi-purpose card) among insurants, and realize direct settlement between medical insurance handling institutions and designated health care institutions. Farmers participating in NRCMS should be allowed to access designated health care institutions within the pooling area, and referral procedures for accessing health care services beyond the county should be streamlined. An account settlement mechanism will be established for treatment from allopatry, and for relocated retired insurants, methods should be explored to settle account in the same locality where treatment is received. Efforts should be made to formulate methods of transferring and connecting basic medical insurance accounts so that the problems in transferring basic medical security accounts from one region to another, or from one system to another, of those temporary contract workers including migrant workers, can be resolved. Proper connection should be made among UEBMI, URBMI, NRCMS and urban-rural medical aid. Efforts should be made to explore and set up an integrated basic medical security management system for urban and rural areas, and gradually integrate the administrative resources handling and managing basic medical security. On the premises of ensuring safety of the funds and effective supervision, efforts should be made to explore entrusting qualified commercial insurers to provide various medical security management services in the way of government purchasing medical security services.

II. Preliminarily establishing the national essential medicines system

(vi) Establishing the selecting and readjusting management mechanism for the list of national essential medicines Selection and management methods for national essential medicines should be formulated. The list of essential medicines shall be readjusted and updated regularly. The list of national essential medicines should be publicized in early 2009.

(vii) Preliminarily establishing a secured supply system for essential medicines

Efforts should be made to bring into full play the role of market forces in pushing forward merger and restructuring of pharmaceutical manufacturing and distributing enterprises, and to develop unified distribution and achieve operational scale; encourage retail pharmacies to develop chain operation. The professional pharmacist system should be improved and retail pharmacies, as of required, must be staffed with certified pharmacists, who can provide patients with consultation and guidance in purchasing drugs. Essential medicines used in government-run health care institutions, shall be purchased through open tender organized by institutions designated by provincial governments, and unified distribution by distributors selected through the open tender is also required. Manufacturers and distributors bidding for tender should have appropriate qualifications. In purchasing drugs through open tender and selecting distributors, the principles of nationwide unified market, equal participation and fair competition among enterprises of different ownerships and regions should be applied. Both the purchaser and seller should sign the contract according to the result of tender, and strictly implement the contract. Essential medicines required in small amount could be designated to manufacturers through tender. Efforts should be made to improve the national reserve system of essential medicines, strengthen supervisions over drug quality, and conduct sampling inspection on the quality of drugs regularly and make the result open to the public.

The central government determines the guiding retail prices of essential medicines. Based on the result of tender, provincial governments set the unified purchasing prices within the range of the government-guided prices, with the distribution charge included in the purchasing price. Government-run health care institutions at grass-roots levels shall sell drugs with zero mark up. Local governments are encouraged to explore purchasing means of further reducing the prices of essential medicines.

(viii) Establishing priority selection and rational utilization system for essential medicines To meet the demand of patients, all retail pharmacies and health care institutions should store and sell the national essential medicines. The utilization rates of essential medicines in health care institutions at various levels should be regulated by government health departments. Starting from 2009, essential medicines should be stored and used in all government-run health care institutions at grass-roots levels. All other health care institutions must use essential medicines as regulated. Health departments of the government should formulate guidelines and prescription formularies of essential medicines for clinical use so as to strengthen guidance and supervision over medication. Patients are allowed to purchase drugs in retail pharmacies with prescription. All the essential medicines are included in the drug reimbursement list of basic medical security, with the reimbursing rate much higher than that of non-essential medicines.

III. Perfecting the system of health care services at grass-roots levels

(ix) Strengthening construction of grass-roots health care institutions Efforts should be made to improve the three-tier rural health care service network, and give full play to county-level hospitals' leading role. The central government will give full support to the construction of around 2000 county-level hospitals (including TCM hospitals) within three years, and at least one hospital in each county should reach the level of a standard county hospital. Construction standards for township health care centers and community health centers should be improved. In 2009, the construction of 29,000 township health centers supported by the central government planning should be completed, and support will also be given to the renovation and expansion of over 5000 lead township health centers, with one to three centers in each county. Village clinic construction in remote and border areas will be supported, and each administrative village will be equipped with one clinic nationwide in three years. 3700 urban community health centers and 11,000 community health stations will newly built or renovated in three years. The central government will support the construction of 2400 urban community health centers in regions with difficulties. The health care resources should be restructured in areas with excess public hospitals resources, for the purpose of strengthening health care institutions at grass-roots levels. Through ways of service purchasing, the government compensates public health services provided by grass-roots health care institutions run by non-government sponsors. The government will compensate basic health care services provided by non-government institutions through channels such as basic medical security funds and by means including signing designated health care insurance contract. Qualified health care professionals are encouraged to run clinics or establish their individual practice.

(x) Strengthening the team of grass-roots health care workers Efforts will be made to work out and implement the plans of free of training general practitioners and recruitment of certified practitioners for rural areas. The plan is to train 360,000 health care professionals for township health centers, 160,000 for urban community health institutions and 1.37 million for village clinics in three years. The system of counterpart aid between urban and rural hospitals will be improved. Each urban tertiary hospital shall provide long-term counterpart assistance to about three county-level hospitals (including township health centers where conditions allow). Efforts will be made to implement the project of "10,000 doctors providing health care assistance to rural areas", and improve the quality of county-level doctors with further training in large urban hospitals, or with standardized training for resident physicians.

Efforts will be made to effectively implement the policy that doctors in urban hospitals and disease prevention and control centers shall work for at least one year in rural areas before obtaining intermediate or senior professional titles. Graduates from medical universities are encouraged to work in health care institutions at grass-roots levels. Starting from 2009, the government will compensate tuition fees and student loans for those medical graduates who volunteer to work for at least three years in township health centers in mid-western regions.

(xi) Reforming the compensation mechanism for health care institutions at grass-roots levels The operational costs of health care institutions at grass-roots levels shall be compensated through service charges and government subsidies. With regard to government-run township health centers, urban community health centers

and stations, the government is responsible for their basic construction, equipment purchase, staffing costs, and public health service costs, in accordance with state regulations, and the compensation will be delivered through ways such as fixed amount funding for designated items and service purchasing. The salary level of health care workers should be in line with the average salary level of staff of local public institutions. The service charges of grass-roots health care institutions shall be set according to the costs after deduction of government subsidy. As long as drugs are sold at zero price margin, the revenue from drug sale will no longer be compensation sources for funding grass-roots health care institutions, and drug discount shall not be accepted. Efforts will be made to explore separated management of expenditure and revenue of health care institutions at grass-roots levels.

The government provides rational subsidies to rural doctors for providing public health services. The criteria shall be regulated by the local government.

(xii) Transforming the operation mechanism of health care institutions at grass-roots levels Health care institutions at grass-roots levels shall provide low-cost services for urban and rural residents by using appropriate techniques, appropriate equipments as well as essential medicines, and promoting the use of TCM including ethnic minority traditional medicines. Township health centers shall change their way of services, organizing mobile medical teams to rural areas. The urban community health centers and stations shall provide on-the-spot services and household visits for patients whose movement is restricted because of illness. Local governments are encouraged to formulate diagnosis and treatment criteria for health care institutions at different levels, carry out pilot projects of “initial diagnosis at community health centers”, and establish dual referral between grass-roots health care institutions and superior hospitals. Efforts will be made to completely implement staff recruitment system, establish the human resources management system that allows two-way movement of staff flow, improve the income distribution system, and establish the evaluation and incentive system with service quality and quantity as the core, and job responsibility and performance as the basis.

IV. Promoting the gradual equalization of basic public health services

(xiii) Covering both urban and rural residents with basic public health services The items of basic public health services will be defined and the content of services specified. Starting from 2009, residents’ health record will be gradually established with standardized management nationwide. Actions should be taken to conduct regular health checkup for senior citizens over 65, carry out regular growth checkup for infants and children under three, conduct regular prenatal examination and postnatal visit for pregnant and lying-in women, and provide guidance of prevention and control to patients with diseases such as hypertension, diabetes, mental disorders, HIV/AIDs, and tuberculosis. Efforts will be made to disseminate health care knowledge, and establish CCTV health channel in 2009. Both central and local media shall intensify publicity and education on health care knowledge.

(xiv) Increasing major national programs of public health services Efforts will be made to continue implementing major public health programs such as prevention and control of major diseases including tuberculosis and HIV/AIDs, national immunization program, hospitalized delivery for women in rural areas. The following projects will be launched starting from 2009: supplementary vaccination of Hepatitis

B for individuals under 15; eliminating the hazards of toxification by coal-burning fluorosis, supplementary intake of folic acid for rural women at the pre-conception and early pregnant stage for the purpose of preventing birth defects; cataracts cure for economically constrained patients; improving water supply and toilet facilities in rural areas.

(xv) Strengthening capacity building of public health services Priority will be given to improving facilities of specialized public health institutions for mental health care, maternity and child health care, health supervision, family planning, etc. Efforts will be made to enhance the capacity of forecasting and early-warning of and responding to major diseases as well as public health emergencies; proactively promote the application of methods and techniques of disease prevention and care with TCM; implement the compensation policy for staff working on high-risk posts in infectious disease hospitals, plague-control institutions, schistosomiasis-control institutions and other disease prevention and control institutions.

(xvi) Ensuring funding for public health services The government will provide fully from the budget the costs of specialized public health institutions related to staffing, development and construction, general administration expenses and business operation, and the service revenue of these institutions shall be turned over to a special fiscal account or integrated into budget management. Free basic public health services shall be provided to urban and rural residents item by item. Funding standard for basic public health services will be increased. In 2009, the average per capita public health funding shall be no less than 15 Yuan, and no less than 20 Yuan by 2011. The central government will grant subsidies to the regions with financial difficulties through transfer payments.

V. Push forward pilot projects for public hospital reform

(xvii) Reforming the management system, operation and supervision mechanisms of public hospitals All public hospitals shall stick to principles of maintaining the commonweal nature and providing social benefits, and adopt a patient-oriented approach. Local governments are encouraged to actively explore the effective formats of separating government agencies and public institutions, and separating government administration and business operations. The responsibilities and rights of public hospital sponsors and managers should be defined. The corporate governance structure of hospitals should be improved. The reform of the human resource system should be carried out, specifying the criteria for selecting and appointing a hospital president with job description for the post, improving the professional title assessment system for health care workers, and implementing the performance-based salary system. The standardized training system for resident physicians should be established. Local governments are encouraged to explore ways of multiple-site practice of individual certified practitioner. The management of health care service quality should be strengthened. Behaviors of public hospitals in clinical inspections, diagnoses, treatment, medication, and implantation (intervention) of medical appliances should be regulated, prioritizing the use of essential medicines and appropriate techniques and implementing mutual recognition of the testing results among health care institutions of the same level.

Efforts will be made to explore and establish the public hospital quality regulation and assessment system with the joint participation of government health departments,

medical insurance institutions, social assessment institutions, representatives of the public and experts. Strict hospital budget and expenditure and revenue management should be exercised and costing and cost-control strengthened. Hospital information disclosure should be universally implemented for public monitoring.

(xviii) Promoting the reform on the compensation mechanism of public hospitals

Efforts will be made to gradually transform the three compensation channels of public hospitals, namely service charges, revenue from drug price margin and fiscal subsidy, to two channels, i.e. service charges and fiscal subsidy. The government shall support public hospitals for basic construction and large-sized equipment procurement, development of key research subjects, costs for retirees in conformity with state regulations, and compensation for policy-related losses, etc.; grant special subsidies to public health services delivered by public hospitals; ensure funding for public services designated by the government, such as emergency rescue and treatment, foreign aid, assistance to rural and border areas; offer preferential investment policy to TCM hospitals (including ethnic minority hospitals), women and children's hospitals, and hospitals specialized in prevention and treatment of communicable diseases, occupational diseases, mental disorders, etc. The construction scale, standards and loan-taking behaviors of public hospitals should be strictly controlled. The separation of health care services and drug sale should be promoted, gradually rescinding the drug price margin, and banning the acceptance of any drug procurement discount. The revenue reduction and losses incurred from the reform shall be resolved through introducing prescription fees, readjusting the charging criteria for some technical service, increasing government investment, and etc. The prescription fees shall be integrated into the reimbursement scope of the basic medical insurance. Efforts will be made to actively explore various effective means of separating health care services and drug sale, appropriately increase the price for health care technical services, lowering the price of drugs, medical consumables and examination by large-sized equipment, and conduct regular costing of health care services and sound assessment of the efficiency of health care services.

The special-needs services offered by public hospitals shall be no higher than 10% of the total health care services provided. Local governments are encouraged to explore and establish the mechanism for pricing health care services through the consultation of all stakeholders.

(xix) Accelerating the formation of a health care structure featuring multiple hospital sponsors The provincial health department shall specify, in conjunction with the departments concerned and in light of regional health planning, the quantity, layout, number of hospital beds, allocation of large-sized equipment, and major functions of public hospitals within the provincial jurisdiction. Efforts will be made to actively and steadily transform some public hospitals to non-public institutions, formulate the structural reform policy measures for public hospitals, and ensure that the value of state-owned assets be maintained and the legal rights and interests of employees safeguarded.

Non-public investors are encouraged to sponsor non-profit hospitals. Non-public hospitals are entitled to the same treatment with their public-owned counterparts in terms of designation of medical insurance eligible institutions, approval of research projects, professional titles assessment and continued education, and both types of hospitals shall be treated equally in terms of service access and supervision. The

preferential taxation policies for non-profit hospitals shall be implemented, and the taxation policy for for-profit hospitals shall be improved.

The pilot projects for public hospital reform will be launched in 2009, and popularized in 2011.

VI. Safeguarding measures

(xx) Reinforcing organization and leadership The State Council will form a leading group on deepening the health care system reform to organize and coordinate the reform work. The relevant ministries under the State Council should waste no time in formulating relevant supporting documents. Governments at various levels, should strengthen leadership, organization and implementation, and accelerate the progress of the priority reform programs.

(xxi) Intensifying financial support Governments at various levels should conscientiously implement the health investment policies of the *Opinions*, readjust the expenditure structure, transform the investment mechanism, reform the compensation methods, ensure funding for the reform, and increase the benefit of fiscal funds. In order to realize the reform goals, in accordance with preliminary calculations, governments at various levels should increase investment in health care by 850 billion Yuan, including 331.8 billion Yuan from the central government in 2009-2011.

(xxii) Encouraging pilot projects at local levels As the health care system reform involves a wide range, complex situation and strong policy orientation, some major reform programs must undergo piloting before being popularized. Now that conditions vary from place to place, local governments are encouraged to formulate specific implementation plans according to actual local conditions, conduct diversified pilot projects, and make explorations and innovations. The State Council Leading Group for Deepening the Health Care System Reform is in charge of overall coordination and the guidance of the pilot projects in various localities. Adequate attention should be given to summarizing and accumulating experience, and deepening the reforms progressively.

(xxiii) Reinforcing publicity and public opinion guidance Efforts should be made to provide correct public opinion orientation, and formulate the step-by-step and multi-phase publicity programs; adopt popular, comprehensible, attractive approaches to publicize far and wide the goals, tasks and major measures of this *Implementation Plan*, and resolve the concerns of the people; summarize and publicize the experience of the reform in a timely manner and create a sound social and public opinion environment for deepening the health care system reform.