

# IMPROVING HEALTH SYSTEM EFFICIENCY

**CHINA**

## The Zero Mark-up Policy for essential medicines at primary level facilities

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# 1

## INTRODUCTION

China has achieved rapid economic growth and the health status of the Chinese population has achieved considerable improvement, with life expectancy at birth increasing from 35 years in 1949 to 75 years in 2012. The demographic profile of high birth rate, high death rate, communicable diseases epidemics and malnutrition has gradually been transformed into one of lower birth rate, lower death rate, and prevalence of non-communicable chronic diseases. Rapid economic growth has resulted in urbanization and industrialization, large-scale migration, and population ageing. Consequently, risk factors related to lifestyle and environmental pollution have become the major health concerns (Center for National Health Statistics and Information, 2012).

During the period 1995–2012, the total health expenditure (THE) as a proportion of the gross national product (GDP) of China increased from 3.5% to 5.4%. Government health spending as a proportion of GDP decreased during 1980–1995, but almost doubled during 2005–2012. Out-of-pocket (OOP) payments reached their peak in 2000 at 59% and began to drop gradually to 34% in 2012 (China National Health Development Research Center, 2014).

China has established a comprehensive health service provision system capable of delivering infectious disease control, emergency services, outpatient and inpatient medical services, and other specific medical services. Community health centres and their affiliated stations in urban areas, together with township health centres and village clinics in rural areas, provide primary medical care services and essential public health services. By contrast, secondary and tertiary general hospitals offer most outpatient and inpatient services. Health professionals are employed and remunerated by the health facilities.

As for the ownership of hospitals, the majority of tertiary and secondary hospitals are public institutions. The concept of social capital is encouraged by the Government and as a result the number of private hospitals (most of which are primary hospitals and specialized hospitals) operated by social capital is increasing. Both public and private hospitals need to become accredited through health insurance authorities in order to receive reimbursement for services delivered to the insured.

Government subsidy for public hospitals shrank sharply from 60% of hospitals' total revenue in the early 1980s to 24.73% by 2008. To maintain the operation of hospitals, the Government permitted them to capitalize on a 15% markup for western drugs and a 20–25% markup for manufactured traditional Chinese medicines (TCM) between wholesale and retail prices, known as the “markup policy” (China National Health Development Research Center, 2009).

Three basic medical insurance schemes in China – namely, urban employees' basic medical insurance (UEBMI), urban residents' basic medical insurance (URBMI), and the new cooperative medical scheme (NCMS) – have covered over 95% of the population (Chinese Health Statistics Yearbook, 2012). Employees in urban areas are covered by UEBMI, unemployed residents in urban areas are covered by URBMI, and residents in rural areas are covered by NCMS.

In general, pooling funds have been established by the three basic health insurance schemes in the prefecture-level city or county. Eligible expenses for hospital admissions and outpatient services for severe diseases can be reimbursed to insured users from the pooling funds, with certain requirements involving deductible, copayment, and ceiling.

The UEBMI and URBMI share the same drug reimbursement list, with more extensive coverage than that for NCMS. In the latest version of the drug reimbursement list for UEBMI and URBMI, a total of 2151 drugs can be reimbursed, including 1164 chemicals and biologicals and 987 TCMS.

# 2

## OVERALL INEFFICIENCY RELATED TO MEDICINES IN CHINA BEFORE 2009

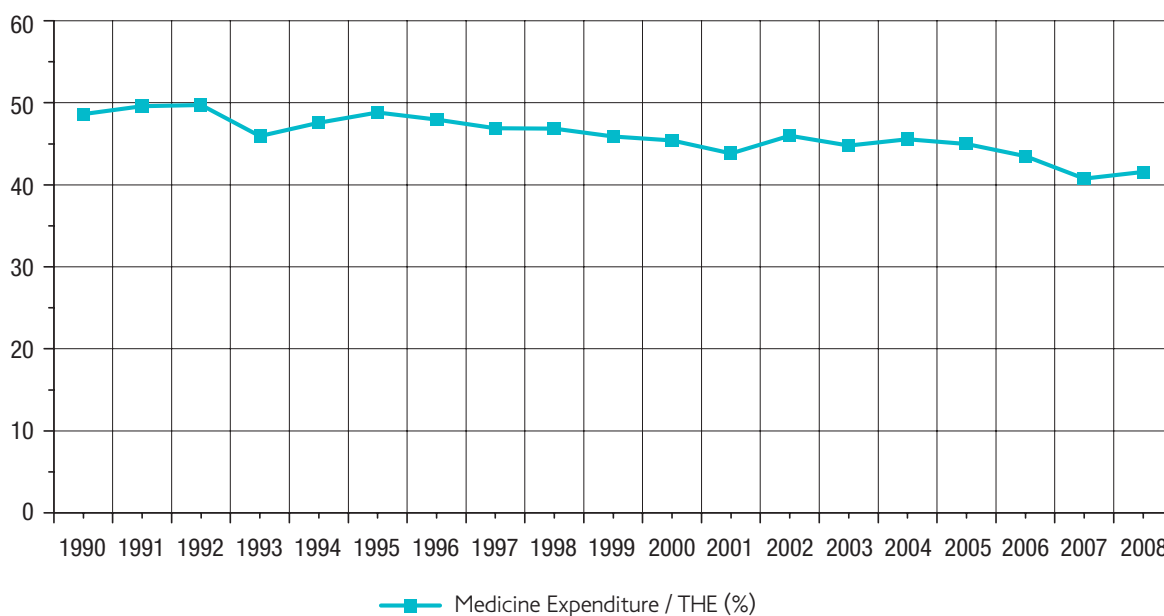
### 2.1 General situation

#### 2.1.1 Share of medicine expenditure relative to THE and GDP

For an extensive period of time, drug sales constituted a major proportion of healthcare providers' revenue in China. Between 1990 and 2008, the proportion of medicine expenditure relative to total health expenditure fell, on average, from 55.97% to 42.67% (Figure 1). This decline reflected the slightly slower growth rate of medicine expenditure in relation to the total health expenditure in the long term.

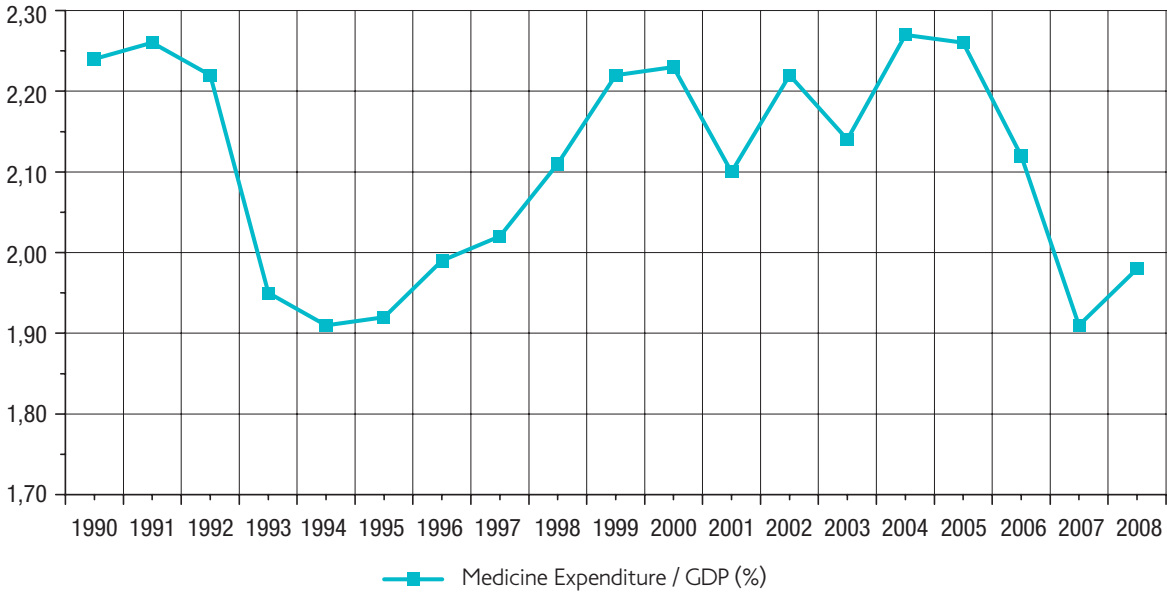
However, the percentage remained at a high level of over 40% and the declining trend was very slow. During the same period, the ratio of medicine expenses to GDP fluctuated by approximately 2% (Figure 2) (Center for National Health Statistics and Information, 2005, 2010, 2012). Hence, one persistent criticism of the (arguably inefficient) health system of China maintains that it is prone to overdependence upon, overemphasis on, and excessively strong influence from drug expenditures (Eggleston et al., 2008).

Figure 1. Share of medicine expenditure relative to total health expenditure



Source: China National Health Development Research Center (2013).

**Figure 2. Share of medicine expenditure relative to gross domestic product (GDP)**

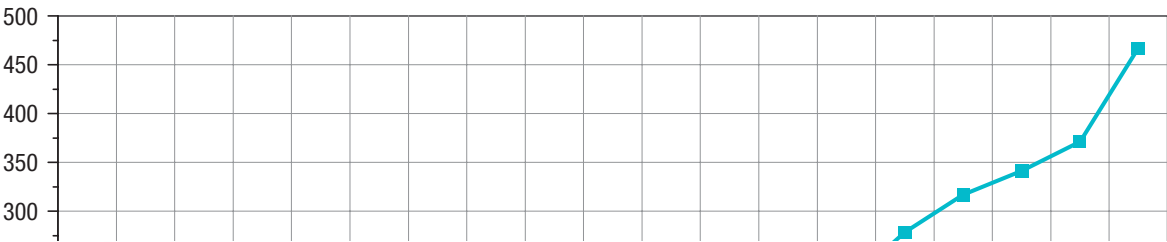


Source: Center for National Health Statistics and Information (2005, 2010)

### 2.1.2 Growth of medicine expenditure per capita

The medicine expenditure per capita grew at an annual rate of 15%, from 36.59 Yuan to 467.04 Yuan, between 1990 and 2008 – higher than the growth rate of GDP during the same period. As shown in Figure 3, the rate of growth accelerated during the several years before 2009 (Center for National Health Statistics and Information, 2005, 2010, 2012).

**Figure 3. Medicine expenditure per capita (RMB)**



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