SOCIAL POLICY BRIEF SERIES

BASIC MEDICAL INSURANCE FOR CHILDREN IN CHINA[1]

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Achieving universal health coverage is a key objective of the Sustainable Development Goals. Medical insurance plays a crucial role in protecting individuals and families against unpredictable and financially disruptive health expenditures. This brief presents the situation and key issues relating to basic medical insurance for children in China, and it proposes potential pathways for reforming the system to improve coverage and benefits for children.

KEY MESSAGES

- China has achieved near-universal social health insurance coverage through the basic medical insurance system, covering more than 96 per cent of the population. However, children still face challenges in fully enjoying the benefits of the system, especially children living in rural areas, migrant children, and children in low-income households.
- The design and implementation of the basic medical insurance system should be further reformed so that every child can be supported by adequate, equitable and improved health insurance:
  - Enrolment policies of the Urban and Rural Residents Basic Medical Insurance should be reformed to support migrant children to enrol in their current place of residence, and a one-stop service model should be established for newborns to streamline key services, including basic medical insurance registration.
  - The medical insurance scheme can be improved to better support low-income families with children, such as adjusting premiums based on household income, expanding the benefits package, improving reimbursement rates, and lowering deductibles for children.
  - The supply of medical services for children can be strengthened by establishing a list of essential medicines for children, improving the supply of pediatric services and medicines covered by basic medical insurance based on children's needs, and improving the quality of these services.
  - A family-based health insurance scheme can be explored, and the two basic insurance schemes could be integrated to increase the coverage and benefits for non-working dependents including children.

I. Context

China has achieved near-universal social health insurance coverage through the basic medical insurance system, with over 1.36 billion people - more than 96.49 per cent of the population - covered in 2021.[2] The basic medical insurance system consists of two parallel and separately funded schemes, the employment-based Urban Employees Basic Medical Insurance (UEBMI)[3] and the non-employment-based Urban and Rural Residents Basic Medical Insurance (URRBMI).[4]

As of 2021, the URRBMI covered over 1 billion people - around 71.40 per cent of the total population- including around 245 million children and students in primary or secondary education.[5] Children can only be enrolled in the URRBMI, which is co-financed by individual contributions and government subsidies shared between the central and local governments. In 2021, the government subsidies represented 67 per cent of the total contributions, with the minimum standard of fiscal subsidies increasing from RMB 200 per person per year in 2011 to RMB 580 per person per year in 2021.[6] Individual contributions represented the remaining 33 per cent, and the minimum contribution increased from RMB 50 per person per year in 2011 to RMB 320 per person per year in 2021.[7] To ensure access to basic medical insurance, the URRBMI premiums for low-income families are partially or fully waived through a medical assistance programme.

In general, most prefectures have set a standard premium for enrollees of the URRBMI. However, some prefectures across China have adopted preferential premium policies for newborns, children and students. For example, in the city of Wuhan, if one parent of a newborn already participates in basic medical insurance, the parents are exempted from paying premiums for the newborn in the first year of life. In the city of Chengdu, the annual premium for children and students in 2022 was set lower than that of adults. Moreover, if the premium is paid within 180 days after birth, the benefits are valid from the date of birth to 31 December of the birth year.

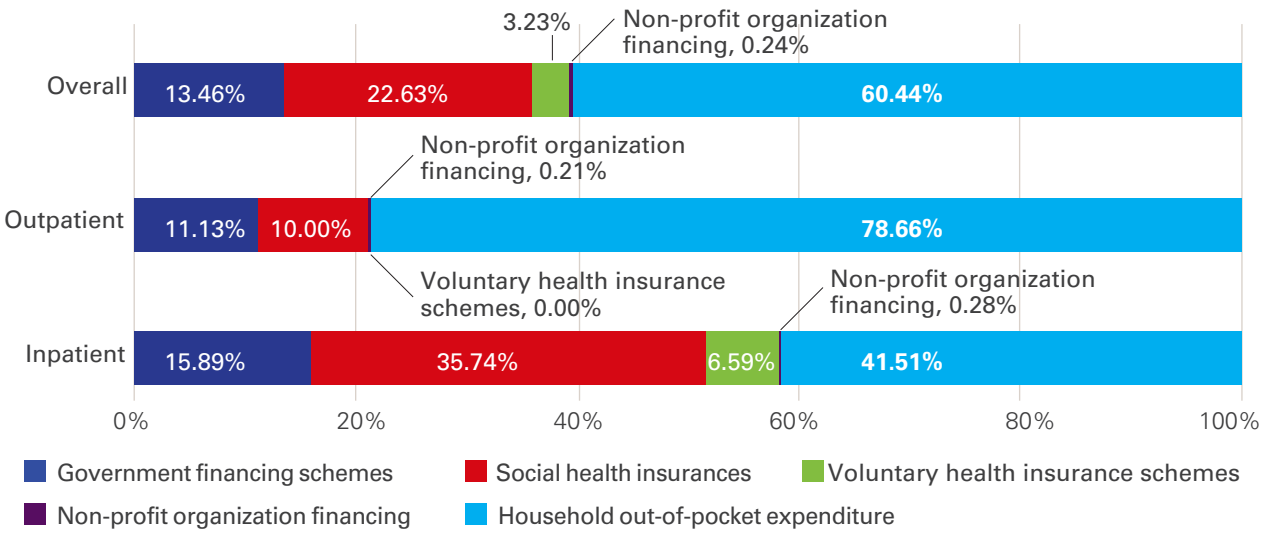
II. Major challenges

The basic medical insurance system for children in China faces five major challenges.

1. High out-of-pocket expenditure

Out-of-pocket (OOP) expenditure remains high for families with children. In 2018, 60.44 per cent of children's medical treatment expenses were borne by their families and 22.63 per cent were covered by the URRBMI (Figure 1). Household OOP expenditure accounted for 78.66 per cent of outpatient expenses for children, and the URRBMI only covered 10 per cent of outpatient care costs. Considerable OOP expenditure on health care can be a substantial financial burden on families, especially the most vulnerable. It can adversely affect families' utilization of health services and the health outcomes of children, and it can reduce households' disposable income available for other vital goods and services like childcare and education.

Figure 1. Financing of medical treatment expenses for children aged 0-17 in China (%), 2018[8]



Note: Government financing schemes refer to fiscal subsidies for service providers (e.g., hospitals, primary health care institutions and preventative health organizations) and for service users (e.g., financial assistance to enrol in insurance, assistance for children with congenital heart diseases).

2. Voluntary and *hukou*-based enrolment create bottlenecks for the enrolment of migrant children

Enrolment in the URRBMI is voluntary. Some families opt their children out of the scheme due to a lack of awareness of the insurance benefits or inability to afford the insurance premiums, which results in an unbalanced risk structure and weakens the risk-sharing function of the health insurance. Enrolment in the URRBMI is also based on *hukou* instead of where the household resides, significantly impacting migrant parents' ability to enrol their children in the insurance scheme due to barriers in registration and claiming of insurance benefits.[9]

3. Lack of portability and inequitable benefits between rural and urban areas

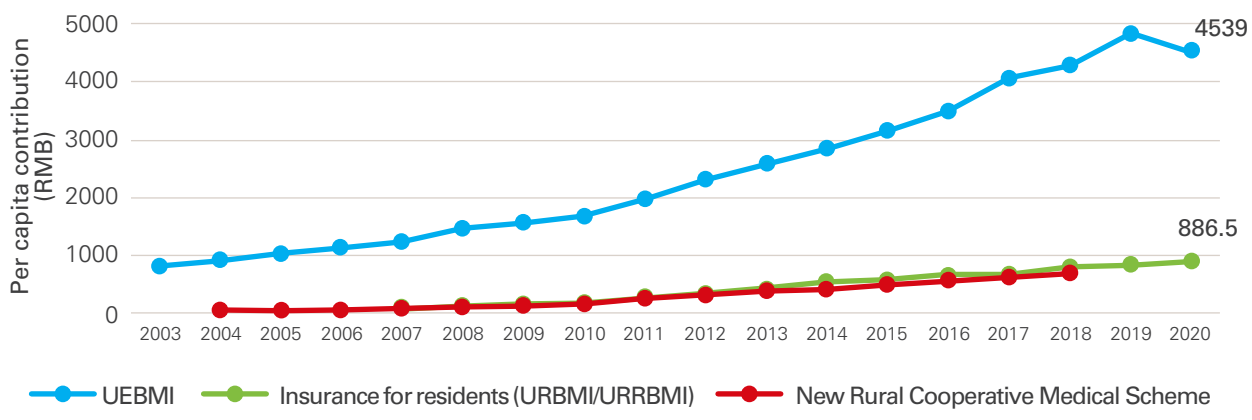
The implementation of the URRBMI is decentralized and generally managed by prefecture-level governments. Based on general principles and minimum standards set by the central government, each prefecture develops its own benefit packages including deductibles, reimbursement rates, annual ceilings and coverage of services and medical supplies. This has greatly restrained portability across localities.

For medical treatments received in a location outside one's *hukou*, outpatient care costs usually cannot be reimbursed, and inpatient care costs receive a much lower reimbursement rate. This can result in higher OOP expenses for migrant families with children. For rural residents, if they seek health services at a hospital in an urban area, their OOP spending will accordingly be higher as well.

4. Insufficient funding pool for URRBMI and unbalanced benefits compared to UEBMI

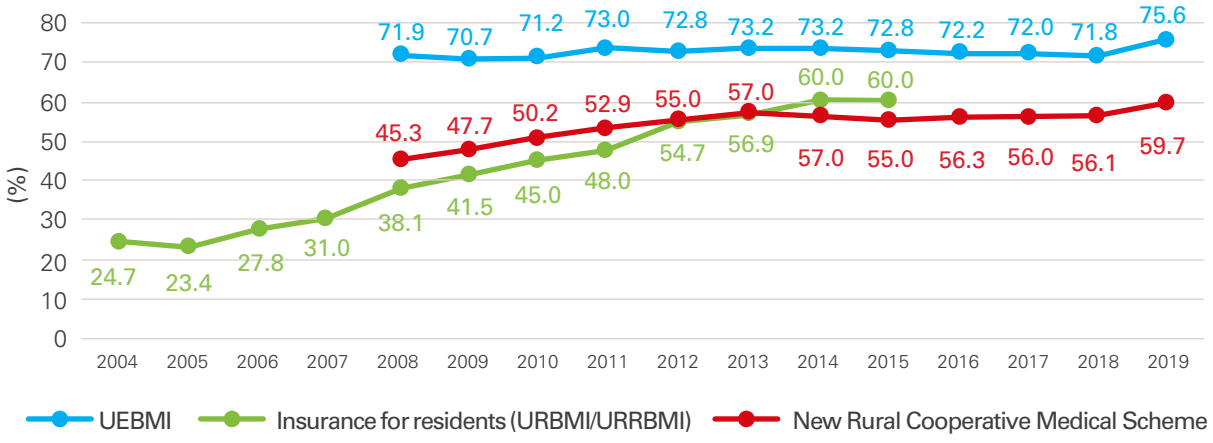
Unlike the UEBMI, where contributions are linked to employees' income and increase as wages grow, the URRBMI institutes a fixed contribution, which is adjusted annually. Taking into account both the government subsidies and individual contributions, the per capita contribution for the URRBMI is much lower than the UEBMI, and the gap has widened over time (Figure 2), leading to a funding disparity between the two schemes.

Figure 2. Per capita contribution for basic medical insurance schemes (RMB), 2003-2020[10]



Limited financing of the URRBMI has contributed to notably lower benefits coverage for its enrollees. The OOP expenditure for URRBMI enrollees was much higher than that of UEBMI enrollees. In 2019, 40.3 per cent of expenditure on inpatient care for URRBMI enrollees was OOP, compared to only 24.4 per cent for UEBMI enrollees (Figure 3).[11]

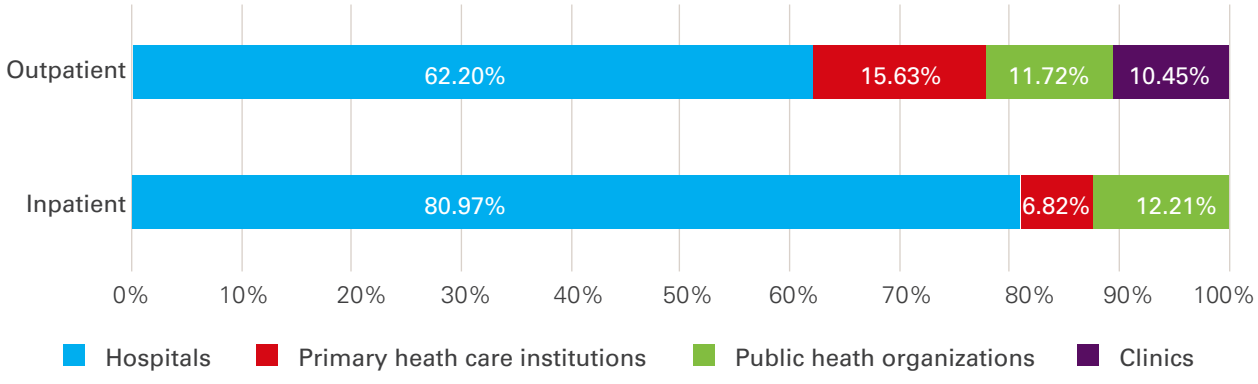
Figure 3. Actual reimbursement rates of basic medical insurance for inpatient care (%), 2004-2019[12]



5. Limited provision of pediatric services and medicines at primary health institutions

Children tend to suffer from common and minor illnesses and injuries that could be handled by primary health organizations. However, due to insufficient capacity and supply of pediatric services and medicines at primary health institutions in China, the health care needs of children are generally satisfied by outpatient and emergency care units at higher level health facilities, such as specialized children's hospitals and pediatric departments of tertiary hospitals. As indicated in Figure 4, medical expenses of children in hospitals represented higher proportions than those in primary health institutions in 2018. Moreover, although the basic medical insurance schemes cover 600 medicines for children, the types of medicines, the dosages and the dosage forms available for children are still limited.[13]

Figure 4. Outpatient and inpatient expenditure for children aged 0-17 years old by health care providers, 2018[14]



The URRBMI sets higher reimbursement rates for inpatient care and lower rates for secondary and tertiary hospitals, which is incongruent with the health needs of children, and results in high OOP expenditure for families with children. As of 2019, 83.5 per cent of overall URRBMI funds were spent on inpatient care, only 10.4 per cent on general outpatient services, and 6.1 per cent on outpatient services for chronic and special diseases.[15]

III. Policy options

The following recommendations can be considered to advance basic medical insurance for children, and in turn improve social protection for children in China.

1. The enrolment policies for the URRBMI should be further reformed so that every child can benefit from the basic medical insurance schemes. The *hukou* restriction on insurance enrolment should be relaxed to meet the needs of migrant populations in their current place of residence. For newborns, one-stop services should be established nationwide, integrating key services during the issuance of birth certificates, including *hukou* registration, basic medical insurance registration and premium payment for medical insurance.

2. The design of the medical insurance scheme can be improved to support low-income families with children. Prioritized actions could include adjusting premiums based on household income to reduce financial burdens associated with insurance participation on low-income families, expanding the benefits package for children, improving the reimbursement rates and ceiling, and lowering the deductibles for children to reduce OOP expenditures for families.

3. The supply of medical services for children can be further strengthened through expanding the coverage of pediatric services and medicines. A list of essential medicines for children should be established. It is also necessary to further improve access to pediatric medicines that are covered by basic medical insurance under the existing management framework based on the needs of children. Moreover, the number of pediatricians and children's hospitals as well as the quality of pediatric services should be enhanced to cope with the pediatrician shortage.

4. A family-based health insurance scheme can be explored. By integrating the two parallel basic medical insurance schemes (UEBMI and URRBMI) and fostering the establishment of a family-based health insurance scheme, a unified funding pool and benefits coverage can be achieved in the long run. This would allow non-working dependents including children to enrol in the mandatory and employment-based scheme, and greatly increase the coverage and benefits of non-working dependents.

ENDNOTES

1 This brief was developed by the social policy team of UNICEF China. It is based on two research reports (both written in Chinese), one written by Dr. GU Xuefei, 'Study on effectively improving medical insurance for children in China', November 2022, and one by Dr. WAN Quan et al., 'Research on the financing mechanism of children's health in China (interim report)', June 2022, commissioned and financially supported by UNICEF China.

2 The National Healthcare Security Administration, '2021 Statistical Bulletin on National Medical Insurance Development', <www.nhsa.gov.cn/art/2022/6/8/art_7_8276.html>.

3 The compulsory UEBMI was introduced in 1998 for urban employees and retirees in formal sectors and co-financed by employers and employees, with 354 million people or 25.08 per cent of the total population covered in 2021.

4 The URRBMI was rolled out in 2016 by integrating the former Urban Residents Basic Medical Insurance (URBMI) and New Rural Cooperative Medical Scheme (NRCMS).

5 The National Healthcare Security Administration, '2021 Statistical Bulletin on National Medical Insurance Development', <www.nhsa.gov.cn/art/2022/6/8/art_7_8276.html>.

6 The National Healthcare Security Administration. 'Reply to No. 9447 Proposal of the Fourth Session of the 13th National People's Congress', <www.nhsa.gov.cn/art/2021/10/25/art_110_7250.html >.

7 Ibid.

8 Estimated by the China National Health Development Research Center based on its National Health Expenditure Database.

9 China's *hukou* system, also known as the household registration system, was introduced in the 1950s to limit rural-to-urban migration. It categorizes Chinese citizens into rural residents (or agricultural *hukou* holders) and urban residents (or non-agricultural *hukou* holders) depending on their place of origin, and the status is inherited. Children are assigned the type of *hukou* their parents hold regardless of their place of birth. *Hukou* has played an important role in creating rural-urban divides in access to social entitlements and public services, such as health care, education, social insurance, and social assistance.

10 Based on 2003-2020 figures included in the China Statistical Yearbook, China Health Statistical Yearbook, China Health and Family Planning Statistical Yearbook, and Statistical Bulletin on National Medical Insurance Development.

11 The National Healthcare Security Administration, '2019 Statistical Bulletin on National Medical Insurance Development', <www.nhsa.gov.cn:800/art/2020/6/24/art_7_3268.html >.

12 Based on figures from the Analysis Reports on Operation of National Medical Maternity Insurance, the Information Statistical Manuals on New Rural Cooperative Medical Scheme, and the Statistical Bulletin on National Medical Insurance Development from various years.

13 The National Health Commission. 'Reply to No. 01046 Proposal (No. 102 Health Sector) of the Fifth Session of the Thirteenth National Committee of the Chinese People's Political Consultative Conference', <www.nhc.gov.cn/wjw/tia/202211/4c65e887ff1a4ea288228b7ff059de41.shtml>.

14 Estimated by the China National Health Development Research Center based on its National Health Expenditure Database.

15 The National Healthcare Security Administration, '2021 China Medical Insurance Statistical Yearbook'. China Statistics Press, 2021.

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