Universal Health Care Coverage in China: Challenges and Opportunities

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Abstract:

China's new round health systems reform aims to achieve universal health care coverage by 2020. Universal health care coverage has three dimensions, breadth (population coverage), depth (service provision), and height (financial protection), according to WHO's analytic framework. This article analyzes situation of universal coverage in China using existing data and raises challenges and opportunities for achieving the aims.

Basic clinical health care is provided under a system of three health insurance schemes in both rural and urban areas. In terms of population coverage, 90% of rural population and 65% of urban residents have been covered by the social health insurance schemes, reaching a relatively high population coverage level. However, due to the low level of premiums, especially in the rural health insurance scheme, scope of services and financial protection are constrained. In 2008, per capita premiums of the urban employee-based health insurance and resident-based health insurance were 14 and 4 times higher than that of the rural health insurance.

Even though provision of public health care is overall good, there exist disparities in service provision between regions, the rural and urban areas, and population groups. Population coverage of maternal health care and chronic disease management need to be improved. For prenatal health care and chronic disease management, population coverage in rural area is about 50% lower than the urban cities. In addition, there is a gap between standard of health care provision and actual practice. For example, only 78.5% and 43.9% of urban and rural pregnant women utilized more than 5 times of prenatal care. Insufficient provision of public health care would affect control of medical cost escalation.

China's government has implemented a number of policies and interventions for the universal health care coverage, including improving the existing health financing system, advancing provision of public health care, and strengthening interventions for priority public health problems. It is important to realize the challenges facing the government, including imbalance in economic and social development, the role of health care in agenda of the local government, low per capita health resource, and balance of different interest groups.
1. Background

In April of 2009, China's government announced its blueprint for health system reform and development for the next decade in an official policy document entitled “Guidelines for Deepening Health Systems Reform.” The aim of the reform is to establish universal coverage (UC) that provides “safe, effective, convenient, and affordable basic health services” to all urban and rural residents.

Between 1950 and 1980 China's health care system provided basic health care to almost all the country's population through public health network and urban and rural health insurance schemes. Despite government promises to implement WHO's primary health care strategies designed to achieve “Health for All by 2000”, the economic reforms of the late 1970s brought significant change to the way the system was run. While the government continued to invest in health, market-oriented financing mechanisms were implemented to fund both curative and preventive care. As a result, health services became unaffordable and inaccessible for disadvantaged populations (Tang et al. 2008).

By the late 1980s, the rural health insurance scheme had collapsed. Urban health insurance schemes were also crippled by the rapid rise of medical costs and the inefficiency of state-owned enterprises—their main financiers (Liu 2002). Since then, the lack of coverage provided by the health insurance system and inadequate government support for essential public health programs have been identified as the main obstacles to universal coverage. Public dissatisfaction with health sector performance along with emerging public health problems, notably SARS in 2003, became driving forces for reform. A number of critical reviews, especially a report by the Development Research Center of the State Council, have also been important in highlighting the need for change.

UC policy in China is the outcome of protracted discussion and debate regarding the main challenges faced by the domestic health system as well as trends in international health care development. Core government policy regarding the establishment of a harmonious society makes the issue of equity in health and healthcare of paramount importance. Improving people's access to basic health care has thus become a guiding principle in development policies, and the needs of vulnerable populations have received particular attention. Policy formulation has also been supported by international health projects such as the World Bank Health VIII Project and DFID Urban Health and Poverty Project.

The new round of health sector reform announced in 2009 is backed by strong political and financial support, notably from a high level committee at the central level which is overseeing implementation. In addition to the regular health budget, 850 billion Chinese Yuan (126 billion US $), has been committed for the funding of reform activities between 2009 and 2011.

To achieve the goal of UC, a series of strategies and measures are proposed, summarized as “four beams and eight pillars” (Si Liang Ba Zhu). The “four beams” comprise: public health care; medical care; health insurance; and essential drugs.

Public health system reform is designed to achieve the equitable provision of basic public health programs to all residents. The reform of the medical system will focus on improving health care quality and efficiency. Health insurance, which includes the new rural cooperative medical scheme (NCMS), the urban employee-based basic medical insurance scheme (UEBMI) and the urban resident-based basic medical insurance scheme (URBMI), will be strengthened by increasing government financial support and improving management. Finally, a system will be established to ensure the provision of essential drugs of a reasonable price and quality. The “four beams” will be supported by eight pillars—concrete strategies and policies, covering areas such as financing, human resources, regulation, and information. With regard to health financing, both supply and demand sides will be supported by public funding. Priority will be given to the subsidizing of primary health providers and public health programs. On the demand side, government subsidies to health insurance schemes, especially the NCMS and URBMI, will be augmented on a continuous basis to benefit all people, but especially the vulnerable. To improve the distribution of qualified health care professionals, policies for training and encouraging health professionals to work in remote areas are to be reformed.
In China, the core issue in UC is to extend coverage to disadvantaged areas and populations. The next section describes the current status of universal coverage to illustrate the main challenges. Section 3 summarizes a number of policies and actions undertaken by the Chinese government with a view to achieving the UC goal.

2. Situation analysis of universal coverage

Coverage can be analyzed in terms of breadth, depth, and height, with breadth indicating coverage in terms of population; depth indicating coverage in terms of service provided; and height indicating coverage in terms of the extent of financial protection. A universal coverage system can be evaluated as effective when the above three dimensions are completely filled. This section uses the above framework in describing the UC situation in China.

2.1. Coverage of health insurance schemes

From the mid-1950s, health insurance schemes were introduced both in urban and rural areas. In cities, the health insurance schemes covered those working in the government sector and enterprises. However, most of the non-salaried people in urban areas were excluded from the schemes. Encouraged by the government, the rural health insurance scheme was operated with support from the collective economy, reaching a high point in coverage in the late 1970s of nearly 90%. Those health insurance schemes encountered difficulties in operation from the early 1980s, because of disorganization in the collective economy in rural areas and the transformation of state-owed-enterprises.

From the late 1990s, the government started to reform urban employee-based medical insurance schemes by increasing the premium level and consolidating the funds of separate organizations. The NCMS was established in 2003 and was mainly subsidized by the government. This was a departure from previous rural health insurance schemes in terms of finance. From 2007, the government decided to establish a health insurance scheme for urban non-salaried residents, especially for children and old people. In addition to the social health insurance schemes, the medical assistance program, supported by the government, was put in place in 2003.

Population coverage

In 2008, 87% of the total Chinese population was covered by various social health insurance schemes with the UEBMI covering 15% of the total population, URBMI 4%, and NCMS 68%.

Statistics on population coverage by urban and rural areas from different sources shows a rapid increase in coverage over the past decade for the rural population (Table 1). In 2008, nearly 90% of the rural population was covered by the NCMS, while 65% of the urban residents were covered by urban health insurance schemes. After the NCMS was set up in 2003, its coverage of the population expanded rapidly, jumping from 8 million of the rural population in 2003-2004, to 179 million in 2005, 815 million in 2008, and 833 million in 2009 (MoH)—representing an expansion from 3% to 90% in five years. The lower coverage rate of urban residents achieved by the URBMI was mainly due to a shorter implementation period and also reflected the greater challenges it faced, notably the enrolment of rural-to-urban migrants.

Table 1  Population coverage of health insurance schemes by urban and rural area

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Urban health insurance schemes (%)</td>
<td>52.5</td>
<td>49.6</td>
<td>64.8</td>
</tr>
<tr>
<td>Rural health insurance scheme (%)</td>
<td>4.7</td>
<td>3.1</td>
<td>89.4</td>
</tr>
</tbody>
</table>

Coverage of health care benefits

UEBMI covers both outpatient and inpatient health services. The NCMS covers both outpatient and inpatient care in about 70% of the NCMS counties, the other 30% offering coverage for inpatient care only. The URBMI in principle covers inpatient care only. All three schemes include reimbursed drug lists. In general, the health care and drug packages covered by the UEBMI are more generous than the other schemes, because of its sound financing base (employer/employee contributions); the NCMS and URBMI schemes rely heavily on government subsidy.

The UEBMI drug and health care package are developed and implemented by the municipal cities which are the unit of fund pooling. The design and implementation of the health care package and drug lists is mainly the responsibility of each of the NCMS counties that are the unit of fund pooling and management. There is a big gap in the number of drugs covered by the different schemes, with an average of 2,000 drugs covered in the urban health insurance schemes, and just 400 in the list covered by the NCMS.

Financial protection of the health insurance schemes

The NCMS has seen a rapid growth in premiums since its inception. On average, 30 CNY per capita (20 CNY from government and 10 CNY from individual premium payment) was collected between 2003 and 2005. This increased to 50 CNY and 100 CNY in 2006 and 2008, respectively. Government subsidy comprises 80% of the premiums (half from central government and half from local government in the western and middle provinces). However, the per capita premium level for the NCMS in most rural areas is around ten times lower than for the UEBMI scheme.

As shown in Table 2, per capita premium in the NCMS was 100 CNY, compared to 1,400 CNY for the UEBMI, in 2008. The premium level for the URBMI was somewhere between the NCMS and UEBMI levels—an average of CNY 350. Figures in Table 2 are averages (premiums vary among many municipal cities and rural counties). Central government allocates more funds to subsidize URBMI and NCMS schemes in low-income provinces located in the west and middle regions.

Reimbursement rates also differ between the three schemes. For example enrollees covered by the UEBMI scheme can claim higher reimbursement, reflecting the higher premiums paid as well as their greater capacity to pay medical expenses.

Table 2 Arrangements of health insurance schemes in 2008

<table>
<thead>
<tr>
<th>Schemes</th>
<th>UEBMI</th>
<th>URBMI</th>
<th>NCMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium per capita (CNY)</td>
<td>1,400</td>
<td>350</td>
<td>100</td>
</tr>
<tr>
<td>Ceiling (CNY)</td>
<td>100,000</td>
<td>80,000</td>
<td>20,000</td>
</tr>
<tr>
<td>Reimbursement rate (%)</td>
<td>72</td>
<td>50</td>
<td>40</td>
</tr>
</tbody>
</table>

Data source: based on reports from the National Health Services Survey in 2008 and from Ministry of Human Resources and Social Security.
The impact of the health insurance schemes on health care utilization is evident, with utilization rates increasing especially among low-income populations. It was also found that unmet health care services (defined as having needs for health care but not using any health services in a defined time period) reduced after the operation of NCMS in rural counties. For example, unmet inpatient care was reduced from 34.7% in 2003 to 27.9% in 2008 (CHSI 2009).

The impact of the NCMS scheme on the financial burden of health care is thus seen to be inconsistent, revealing a complex relationship between changes in financial access, utilization, and medical expenditure. Wagstaff et al (2008) found that the NCMS increased total medical expenditure (for all income quintiles) without reducing catastrophic expenditure (for all but the poorest). A recent study using data from the National Health Services Survey reports that the NCMS reduced by 50% the households suffering catastrophic medical expenditures in 2008 (Zhang YH, 2009). Wu (2009) found that compared with the NCMS, the UEBMI can significantly reduce out-of-pocket payments for old people, based on the data from the national survey.

**Observations**

From the above analysis of the coverage of health insurance schemes, we reach following observations.

- China's health insurance schemes in both rural and urban areas have developed rapidly over the past decade in terms of population coverage, especially in rural areas. This rapid development creates a sound foundation for an equitable financing model designed to provide people with financial protection when they suffer illness.
- Urban and rural health insurance schemes are operated separately and reveal significant differences in premium collection and risk protection. The integration of the urban and rural health insurance schemes will remain a challenge if the difference in the premium levels of the schemes cannot be narrowed.
- As coverage reaches a higher proportion of the population, priorities need to focus on coverage of depth and height. Policy makers and insurance administrators need to identify appropriate ways to select cost-effective health care services for the benefit package.
- Development of health insurance schemes need to be accompanied by improvements in health delivery and human resource systems. Appropriate incentives are required for health providers to ensure cost-effective, quality care.

### 2.2. Coverage of essential public health programs

Increases in life expectancy and the reduction of infant and maternal morbidity in China are largely the result of cost-effective interventions within the public health programs. However, there are still significant disparities in health status between regions, urban and rural areas, and among population groups (Tang et al 2008). These disparities can be attributed in part to differences in the coverage provided by essential public health programs.

In this section, we focus on three types of health program—project immunization, maternal health care (ante-natal and post-natal care), and management of non-communicable diseases (NCDs)—to illustrate coverage differences in public health care.

**Population coverage of selected public health programs**
Table 3 shows immunization coverage for five vaccines (for children) broken down by area. Although the coverage is over 90% for almost all vaccines, coverage in the wealthy region (East coastal provinces) is always higher than in the other two regions. Coverage of vaccinations of DAT, Pertussis, and Tetanus was less than 90% in the poor area (Western provinces) (CHSI 2009). It should be noted that because of the large populations involved, a small difference in the percentage covered can reflect big differences in the number of unimmunized children.

Table 3 Population coverage of immunization programs in 2008 (%)

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Total</th>
<th>East</th>
<th>Middle</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>98.8</td>
<td>99.3</td>
<td>98.7</td>
<td>98.4</td>
</tr>
<tr>
<td>DAT, Pertussis, and Tetanus</td>
<td>90.7</td>
<td>93.2</td>
<td>91.2</td>
<td>88.5</td>
</tr>
<tr>
<td>Polio</td>
<td>92.4</td>
<td>94.5</td>
<td>90.6</td>
<td>92.3</td>
</tr>
<tr>
<td>Measles</td>
<td>92.1</td>
<td>91.5</td>
<td>93.8</td>
<td>91.4</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>93.3</td>
<td>95.6</td>
<td>93.7</td>
<td>91.5</td>
</tr>
</tbody>
</table>

Data source: CHSI 2009.

The coverage of maternal health services has increased rapidly with the introduction of a number of important interventions. The proportion of women receiving no ante-natal care during their pregnancy fell from 25.3% in 2003 to 5.6% in 2008. As shown in Table 4, the coverage of ante-natal health care has reached a high level but there are some differences in coverage between the eastern, middle, and western regions—with poor provinces getting the lowest coverage rates (CHSI 2009). Meanwhile the coverage of post-natal health care was lower than ante-natal care in all regions, with the lowest coverage in the middle provinces.

Table 4 Population coverage of maternal health care in 2008 (%)

<table>
<thead>
<tr>
<th>Health care</th>
<th>Total</th>
<th>East</th>
<th>Middle</th>
<th>West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante-natal</td>
<td>94.4</td>
<td>97.6</td>
<td>94.9</td>
<td>91.5</td>
</tr>
<tr>
<td>Post-natal</td>
<td>56.9</td>
<td>62.7</td>
<td>43.0</td>
<td>61.2</td>
</tr>
</tbody>
</table>

Data source: CHSI 2009.

Chronic non-communicable diseases (NCDs) have become a major public health problem in both urban and rural areas. In 2008, for example, 270 million NCD patients were registered and 80% of deaths were caused by NCDs. Over the past decade, the incidence of hypertension and diabetes has doubled. Table 5 shows management rates (managed cases / total cases within a community) of hypertension and diabetes. NCD case management is usually conducted by primary health providers in China. Less than 50% of hypertension and diabetes cases were managed by health providers in 2008 (CHSI 2009). About 54% of hypertension cases never received blood pressure tests by doctors, 30.2% of hypertension cases were not aware of their condition before diagnosis; only 24.7% of the cases took drugs as advised by physicians, and the effective control rate was only 8.0% of total hypertension cases (CHSI 2009). A recent study revealed that the prevalence of diabetes was higher among urban residents than among rural residents (11.4% vs. 8.2%) (Yang et al 2010).

Table 5 Population coverage of management rates of hypertension and diabetes in 2008 (%)

<table>
<thead>
<tr>
<th>NCDs</th>
<th>Total</th>
<th>Urban</th>
<th>Rural</th>
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</table>
Dosage levels in the public health programs

Of course high population coverage is not the same as high coverage in terms of service provided. For instance, for children under five years old, the recommended dosage of vaccinations for DAT, Pertussis, and Tetanus is five according to the national guidelines. But on average only 3.37 doses per immunized child were actually provided in 2008 (CHSI 2009).

Maternal health care provides another example. According to the requirements of the Ministry of Health, pregnant women should have a minimum of 5 ante-natal examinations. However, as reported, only 78.5% of women in urban areas and 43.9% of women in rural areas who received ante-natal health care received 5 or more antenatal care examinations in 2008.

Moreover, some crucial services procedures were not provided in ante-natal examinations, including weight measurement, blood pressure test, and urine analysis. It is a similar story with post-natal examinations. The minimum number of visits recommended by the Ministry of Health after childbirth is three per childbirth. In reality, only 22.0% of women received this level of post-natal care in 2008 (CHSI 2009).

Financial protection of the public health programs

Public health programs could cut medical costs by reducing and controlling the prevalence and severity of both infectious and non-communicable diseases. Disadvantaged populations benefit most from the improved coverage provided by public health programs because they are most vulnerable to public health problems and least able to pay for treatment. Many studies undertaken over the past two decades have shown the positive impact of essential public health programs (including immunization, maternal health care, and control of NCDs) on medical expenditures for providers and users of health care (Sturm 2002).

Observations

- Public health programs are crucial for improving the health status of populations and have been sustainably operated in China for several decades.
- The population coverage of major public health programs has increased and some of those programs (notably immunization) have reached the level of universal coverage.
- Control of NCDs is low, especially in rural area. NCDs are a major source of health problems and financial burdens.
- Quality of public health delivery needs to be improved in line with increases in population coverage. Public health programs should ensure adequate provision of a high standard of health care; for example post-natal care visits, including the provision of appropriate procedures in each of the visits.
- A number of factors influencing coverage of public health programs, including the quality of health workers, financing policies, cooperation between health providers, and regulations, need to be considered in addressing the challenges of UC.

3. Efforts and actions related to universal coverage

China has enacted several initiatives to develop universal coverage including joint projects with international organizations. This section summarizes selected key actions, policies, or efforts that relate to
health system development. A sub-section is dedicated to outlining contributions from international agencies in promoting the development of China's health policies.

3.1. Government led actions on the financing of clinical services

Besides operating health insurance schemes in both rural and urban areas, the government also supports a medical assistance program (MFA) for the poor. Both the new health insurance schemes (NCMS) and MFA were introduced in 2003 when the central government turned its development strategy from a GDP-centered to people-centered policy. NCMS and MFA are two strategies designed to close the health security gap between rural and urban areas and between the rich and the poor.

NCMS

In introducing the NCMS, the government aims to reduce illness-related financial burdens and increase the affordability of medical care for rural populations. In order to encourage enrollment and sustain the operation of the NCMS, the central government allocates subsidies to different regions according to their level of economic development. Over the past years, an average of 80% of premiums has been subsidized by the government, with 20% coming from individual farmers. In the new health reform plan, the government has promised to increase subsidies to the NCMS on a regular basis to sustain the scheme. Per capita premiums increased from 30 CNY in 2003 to 150 CNY in 2010. Premier Wen Jiabao has promised to increase premiums to the level of 300 CNY per capita in 2012.

NCMS guidelines are issued by the central and provincial governments. Rural counties handle the administration of insurers developing and implementing concrete NCMS plans. In each county, an NCMS management office, staffed with 5-8 administrators, is set up to manage the NCMS operations. A rural county has an average population of half a million people.

Central government guidelines encourage the NCMS to provide mainly inpatient care. However, at present, most NCMS schemes provide both outpatient and inpatient services as a way of encouraging enrollment and also because it helps to stop minor health problems becoming more serious.

Fee-for-service is the major payment system in the NCMS, which could be one of the reasons for the rapid rise of health care costs. In recent years, experiments with alternative payment methods including capitation, DRGs, case-base payment, and fixed charges have been organized in some counties in order to control cost escalation (Meng 2008).

As mentioned before, the NCMS has reached a high level of population coverage. Due to low premium levels, however, NCMS co-payments are high and financial risk protection is thus limited.

Medical Financial Assistance (MFA)

Since its launch in 2003, the MFA has been committed to protecting the poor from the financial risks associated with high-cost diseases. Both rural and urban areas are covered by the MFA. Central and local governments are responsible for allocating funds, and subsidies from central government are concentrated on poor provinces (western and middle provinces).

The MFA targets mainly people living below the poverty line. Target populations are identified by the county (district in urban areas) Department of Civil Affairs in collaboration with community government organizations. The beneficiaries of the MFA can also receive subsidies for their contribution to NCMS and URBMI premiums. They can also claim reimbursement from the MFA if they cannot afford co-payments in the NCMS and URBMI schemes. MFA has been a crucial source of financing for the poor to pay NCMS premiums and co-payments.

Government subsidies to the MFA have continuously increased since it was first started. In 2003, the urban MFA received 210 million CNY from the central government. This was increased to 300 million in
2005 and 420 million in 2006, respectively. Provincial and county (municipal and district) governments allocate matching funds for the MFA and develop their operational plans.

3.2. Delivery and financing of public health services

In general, public health services have been delivered effectively by public health providers over the past six decades. This was especially true prior to the 1980s when those services were publicly funded. Basic preventive care including immunizations, maternal and child health care, health education, and monitoring of infectious diseases were provided by village clinics (and by community health stations in urban cities), township health centers (and by community health centers in cities), and county (district) Centers for Disease Prevention and Control.

User fees were introduced in the mid 1980s and health providers were encouraged to run profitable health care operations. This had a significant effect on the provision of essential public health programs.

The new health sector reform is designed to improve coverage of public health programs through the implementation of two types of public health programs and services. These are defined as an essential public health care package and key health programs for priority health problems.

**Essential public health care package**

Government run health care facilities began to deliver an essential public health package in late 2009. The rationale behind this measure was to gradually achieve equality in the provision of essential public health programs to the whole population. The current package includes nine categories of services, including health information system, health education, immunization, prevention and control of infectious diseases, child health promotion, maternal and geriatric health care, chronic diseases management, and the management of severe cases of mental health problems. These services, selected on the basis of an assessment of current health needs, are being delivered from primary health care facilities, including village and township clinics in rural areas, and community health centres in urban areas.

Because chronic diseases have become a serious public health problem in both rural and urban areas, the essential public health care package includes a new focus on prevention and early-stage interventions for NCDs, including mental health.

The Chinese government also intends to establish a medical records system over time that will enable the exchange of medical information among clinical providers and will also support epidemiological analysis. By the end of 2009 a medical records system was in place, covering 30% of the urban and 5% of the rural population.

In 2009, 15 CNY per capita was allocated to cover the operating costs of the public health care package. This funding is additional to the regular health budget already allocated to cover the salary of health workers. The central government will increase the subsidy to 20 CNY per capita in 2010. The central government also allocates subsidies to economically disadvantaged areas to the extent that those places can ensure provision of the essential public health service package as defined by the central government.

In addition to the nationwide implementation of the essential public health package, China has identified key public health priorities to be addressed through services delivered by specialized providers such as CDCs and general hospitals. A case in point is Hepatitis B. In 2009, the Government began to provide immunizations to all children under 15 years of age. Other priorities include screening for cervical and breast cancer for women aged between 15 and 59, hospital childbirth, and ensuring the intake of folic acid for women during pregnancy. Other services include cataract surgery for poor patients, a cooking stove manufacture initiative to prevent fluorine poisoning, and the construction of sanitary toilets. All the above programs are fully supported with government funding.

4. Challenges and opportunities
China has made a promising start in its efforts to construct a universal healthcare system. However, attempts to achieve universal coverage in such a vast and diversified country are bound to face challenges. How China’s government addresses those challenges can provide useful lessons for other developing nations.

4.1. Challenges

It is not easy to realize UC in a short period because of the big gaps in healthcare coverage between regions, urban and rural areas, and population groups. The following specific challenges need to be taken into consideration:

- China is a big country characterized by varied levels of economic and health development. Determinants of health and health care often lie outside health sector. Efforts to reduce disparities need to be made by all relevant sectors.
- Despite the fact that the central government supports the development of a people-centered ideology in governance, local governments are still focused on economic development. As a result health and health care are not always at the top of the political agenda in many areas of the country. This may lead to proposed health reform policies and actions not being sufficiently and effectively implemented.
- China is still poor in terms of its average per capita resources. UC requires increased investment from both government and individuals. Health care services delivered by the UC system cannot exceed the availability of resources. Thus government is faced with the perennial problem of how to mobilize and sustain resources for the health care system.
- UC in China emphasizes the provision of primary and cost effective health care mainly supported by public funding. This involves a shift in the allocation of health resources from tertiary hospitals to community health systems and from expensive pharmaceuticals to generic drugs. This reallocation may be resisted by strong stakeholders.

4.2. Opportunities

While there are many challenges, there are also reasons for optimism regarding the achievement of the UC system in China.

- The development concept. China's central government has changed its development policy from GDP-centered to a broader coordinated concept which includes non-economic sectors such as health and education. Even if local governments need time to catch up, this new direction represents a welcome change.
- The established health care system. Over the past six decades, China has established a health care system through which basic health care can be provided if current health resources can be adjusted and redistributed. It provides a foundation which, through the strengthening of human resources, governance, and regulation, can offer accessible quality health care.
- The influence of the public's voice. Public complaints have been more important than was previously the case in influencing policy making and changes. The current health sector reform is partially a result of public pressure. Government should do its utmost to achieve its aims and to implement promised policy in order to avoid public dissatisfaction.
- Stable and rapid economic development. China’s economic development is stable and fast, which provides the financial conditions necessary to operate and sustain health programs that move towards a UC system. The government is likely to continue increasing financial support for the health sector if economic development and growth is maintained.
References


