Chinese Healthcare Reform: A Shift toward Social Development

Modern China
38(6) 630–645

DOI: 10.1177/0097700412457913
http://mcx.sagepub.com

Ling Li[1], Qiulin Chen[1], and Dillon Powers[2]

Abstract

This article discusses the Chinese healthcare reforms of the past decade and their relation to broader shifts in Chinese development. It examines the historical context, theoretical framework, and major achievements of the reforms, focusing on the three-year healthcare reform push from 2009 to 2011. During that period, the Chinese government implemented reforms with great efficacy, including expansion of health insurance coverage to 95 percent of the population. In a limited timeframe, the Chinese government restructured the healthcare system, placing an emphasis on primary care. However, as this article argues, the more significant achievements include a redefinition of the government's role in social development and an exploration of more open policy-making procedures among top government officials.

Keywords

China, healthcare reform, social development

Introduction

SARS and an Unhealthy China

In the wake of the 2003 SARS (severe acute respiratory syndrome) epidemic, China's ineffectual healthcare system came under harsh domestic

[1]National School of Development, Peking University, Beijing, China
[2]School of International Studies, Peking University, Beijing, China

Corresponding Author:
Ling Li, National School of Development, China Center for Economic Research, Peking University, Beijing 100871, China
Email: lingli@ccer.edu.cn

and international scrutiny. Staff editorials in the *New York Times* lambasted "Beijing's catastrophic mishandling of the health crisis," likening it to the Soviet fumbling over Chernobyl ("Diagnosing SARS in China," 2003). The authors declared, "China's public health system is in ruins. Sanitation is . . . atrocious, and hospitals [have] failed to practice basic infection control" ("Opinion: The Cost of SARS," 2003). But for Chinese leaders, the moment of reflection revealed far deeper and more troubling flaws in a healthcare system that had deteriorated from a once healthy establishment.

When the People's Republic of China was established in 1949, decades of war, famine, and disease had lowered the average life expectancy to a mere 35 years. The government's limited resources only further compounded the dearth of trained doctors. Yet by implementing a basic public health safety net, promoting healthy living, and organizing a corps of semi-professional "barefoot doctors" 赤脚医生 to administer care in rural areas, the Chinese healthcare system attracted international praise. By 1980, China's average life expectancy had soared to 67 years. The success of the healthcare system, however, would not continue alongside the opening and reform period.

As China pursued more of a free market economy, two trends threatened the government's once stellar healthcare system: dwindling coverage and over-marketization of healthcare providers. Whereas the government once supplied healthcare delivery and health insurance through work units and collective farms, the privatization of industry and agriculture also gutted the both the delivery and insurance systems. By 2002, 45 percent of urban residents and 79 percent of the rural population had no health insurance whatsoever (Center for Health Statistics and Information, 2004). Along with the work units went the once famed barefoot doctors, who were abolished and labeled remnants of a backward society. Furthermore, with the government's retreat from the healthcare sector, public hospitals implemented new pricing structures that drove up costs and reduced quality of care. Hospitals relied heavily on the newly privatized pharmaceutical industry as a source of revenue. The phenomenon of "medicine-subsidized healthcare" 以药补医 saw Chinese doctors overprescribing at rates that far outstripped nations at any stage of economic development. By the time of the outbreak of SARS in 2003, the average life expectancy had yet to reach 72, a paltry five years higher than two decades earlier. China's neighbors along the Pacific Rim fared much better in the same time period (see Table 1). At the start of the new millennium, China's healthcare woes coagulated into a common phrase that summed up the disheartening situation: "Seeing a doctor is hard and expensive" 看病难, 看病贵.

Table 1. Life Expectancy in Selected Economies (1980–2003)

	Life Expectancy (Years)			Increase in Life Expectancy (Years)	
	1960	1980	2003	From 1960 to 1980	From 1980 to 2003
China	43.46	66.99	71.76	23.53	4.77
South Korea	53.00	65.80	77.26	12.80	11.46
Mexico	57.04	66.57	75.00	9.53	8.43
Mauritius	58.75	66.99	72.12	8.24	5.13
Malaysia	59.42	67.40	72.66	7.98	5.26
Sri Lanka	57.86	68.22	73.18	10.36	4.96
Singapore	65.66	71.68	79.04	6.02	7.36
Australia	70.82	72.42	78.63	1.60	6.21
New Zealand	71.24	72.83	79.15	1.59	6.32
Hong Kong	67.00	74.67	81.33	7.67	6.66
Japan	67.67	76.09	81.76	8.42	5.67
OECD members	67.46	72.20	77.69	4.74	5.49

Source. World Development Indicators, World Bank, http://data.worldbank.org/data-catalog/world-development-indicators.

Determining the Approach to Healthcare Reform

Chinese leaders reacted to the SARS crisis by reassessing the major goals of their ongoing economic development. Although statistics like export volumes and annual GDP increases remained of paramount importance, the new wave of healthcare reforms signified a significant shift toward focus on social development. Embracing the concept of *xiao kang* 小康, whose common translation as "modest prosperity" does not reveal its undertones of healthiness, the Chinese government made a monumental shift to a new commitment guaranteeing public goods like education, social security, and healthcare to all Chinese people (Hu, 2007).The debate over how to provide affordable healthcare, however, still hinged on arguments over the degree of its marketization. One camp called for a move toward a privatized system in which government would continue to retreat from its role as a healthcare provider. The other side argued that the nature of healthcare as a foundation of public welfare required a more involved government role in managing the sector. A major breakthrough came on October 23, 2006, when President Hu Jintao advocated the latter approach during a Politburo Group Study Session (Hu, 2006). The principles of increasing government responsibility and

maintaining the nature of healthcare as a public good were again emphasized in the Report to the Seventeenth National Congress of the Communist Party of China (Hu, 2007). In March of the following year, the State Council's Inter-Ministerial Coordination Group for Healthcare Reform (ICGHR) asked six Chinese and international organizations to submit proposals for reforming the healthcare system. Come September 2008, the central government adopted a composite reform framework proposed by the ICGHR, but also created an online mechanism the following month to solicit suggestions from the Chinese public on ways to improve the proposed reforms ("San nian mo yi jian," 2009). Finally, the official decision came in 2009, when two central government documents detailed the new wave of reforms ("Zhonggong zhongyang," 2009; "Guowuyuan guanyu yinfa," 2009).

China's New Wave of Healthcare Reforms

As described in the central policies cited above, the overall goal of the new wave of healthcare reforms in China is to establish a universal basic healthcare system, which will provide secure, efficient, and affordable healthcare services by 2020 ("Zhonggong zhongyang," 2009). The reforms follow multi-tiered implementation: first, a three-year push from 2009 to 2011 to revamp the basic healthcare system; second, reforms accompanying the twelfth five-year plan from 2011 to 2015; and third, comprehensive goals to be attained by 2020. The reforms focus on addressing the problems that came to light following the outbreak of SARS, as well as strengthening the primary care system. At the heart of this renewal stands the three-year plan for reforming basic healthcare. Because of its fundamental significance as the renaissance of government's participation in healthcare, the three-year plan and its five distinct targets for improvement merit detailed inspection and analysis: coverage, primary care, pharmaceutical delivery and regulation, public hospital reform, and the public health system.

Providing basic health insurance for China's massive population had already started before this round of healthcare reform. In 1998, 2002, and 2007 the central government announced three new insurance programs: one for urban workers (Urban Employee Basic Medical Insurance 城镇职工基本医疗保险), one for rural residents (New Rural Cooperative Medical Scheme 新型农村合作医疗), and one for urban residents without formal employment (Urban Resident Basic Medical Insurance 城镇居民基本医疗保险) ("Guowuyuan," 1998; "Zhonggong zhongyang," 2002; "Guowuyuan," 2007). The healthcare reforms outlined in 2009 set the goal of extending those basic coverage plans to the entire Chinese population. Reformers

allocated the bulk of that work—extending coverage to the large majority of the Chinese population—to the three-year reform plan.

In addition to increasing coverage, the reforms also sought to extend healthcare delivery systems to reach a larger number of Chinese citizens. The widened net of healthcare services would come in the form of establishing a primary care system. Building a primary care system would involve investment in infrastructural hardware and facilities as well as training for doctors and other health professionals. New health centers, especially those in rural areas, would harken back to the decentralized approach of the barefoot doctors, albeit staffed with formally trained medical technicians.

To combat ballooning hospital fees and the endemic problem of medicine-subsidized healthcare, the recent wave of healthcare reform sought to alter and regulate the system through which pharmaceutical companies sell and deliver their products to hospitals and healthcare centers. Before the recent push for healthcare reform, hospitals earned a 15 percent markup on prescribed medicines; in addition, doctors would often earn around 30 percent under-the-table kickbacks from pharmaceutical companies for medicines they prescribed. To combat such harmful trends, the leaders of the healthcare reform aimed to reduce the overall cost of medicine by launching a catalog of essential medicines and an auction-based structure for their procurement. Such reforms aimed to remove medicine-subsidized healthcare as an income source for primary care institutions.

Aside from over-prescription, poor pricing schemes plagued China's public hospitals through various manifestations of over-marketization. Profit-driven mechanisms also led to the overuse of various diagnostic tests and procedures. In 2009, Chinese hospitals administered 10.4 billion intravenous drips. That per capita rate of 8 per person far outstrips the world average, which ranges from 2.5 to 3.3 annually ("Xinwen yi jia yi," 2011). As public hospitals accounted for 77 percent of all hospitals beds and 92 percent of all hospital diagnoses in 2010, it is clear that the breadth and depth of the problem rested in the state-sponsored institutions (Ministry of Health, 2010). As such, the recent wave of healthcare reforms established pilot projects for comprehensive public hospital reform and aimed to shift the hospitals' income sources by creating a competitive work environment that incentivizes high performance, not a high volume of prescriptions and tests.

Finally, the healthcare reforms set out to strengthen the public health net that SARS had proven underdeveloped and ineffective. New policies would seek to expand basic free services that would bolster the healthcare infrastructure. The priority given to public health did not emerge solely

as a reaction to the failures during the SARS outbreak. Rather, the reforms supported the goals of creating a healthy population through prevention and education, simultaneously diminishing the cost of healthcare as well as providing healthy workers to support continued economic development.

Reform Outcomes

Coverage

By expanding the three existing government coverage programs, the Chinese government now insures over 1.27 billion people. In 2000, only 15 percent of all Chinese had healthcare insurance; ten years later, that has risen to 95 percent, with plans for complete coverage by 2020 (Chen, 2011). Furthermore, in addition to expanding coverage, the government also increased investment in insurance programs. For the rural and urban residents' insurance programs, the per capita government-paid premium rose from 20 RMB in 2003, to 80 RMB in 2008, to 200 RMB in 2011 (and again to 240 RMB this year), and the percentage of reimbursed hospitalization costs rose from approximately 50 percent to 70 percent (State Council Healthcare Reform Office, 2012).

The move toward nationwide health insurance coverage ranks among one of the most impressive successes of the recent healthcare reforms. With incremental goals already in place, the government is well on track to achieving universal coverage by 2020. However, the reforms have yet to address the confusion that arises from having three different types of insurance schemes, a problem sometimes exacerbated by the increasing frequency with which the Chinese workforce migrates annually from the countryside to urban centers. Some of the 140 million migrant workers in China have already enrolled in the government healthcare insurance program. Approximately 46.41 million are enrolled in the urban workers' insurance program ("Yibao ziyou," 2012); however, that does not allow migrants to receive reimbursements when outside the city of their employment. To combat such problems, some cities have begun to provide special insurance programs catering specifically for migrant workers; others have instituted "nationwide roaming" 全国漫游 and "continual transfer" 转移接续 programs. For migrant workers enrolled in the New Rural Cooperative Medical Scheme, receiving reimbursements at city hospitals and medical centers has proven troublesome. As such, in cities with large migrant populations, certain public hospitals have formed special arrangements to accommodate reimbursements through migrant workers insured under the New Rural Cooperative.

Furthermore, each scheme of coverage may vary according to the needs of different geographic regions, though such needs have yet to be fully determined. Some well-to-do counties have happened upon excess government funds, and as a result have placed operations like organ transplants in standard insurance packages; coverage in other regions has allowed patients to see specialists without first receiving referrals from general practitioners, a luxury no other nation's healthcare system provides (Li and Jiang, 2001). Still, increased investment in the various programs has reaffirmed the government's commitment to provide healthcare as a public good to the Chinese population despite the hurdles of demographic complexity.

Primary Care System

The new wave of healthcare reforms also sought to strengthen China's healthcare delivery systems by refocusing the sector on primary care facilities, such as township hospitals and community healthcare centers.[1] All told, the new healthcare reforms allocated 60 billion RMB to establish over 33,000 new regional healthcare clinics, mostly in underdeveloped rural and western regions of China (State Council Healthcare Reform Office, 2012). Already the shift toward primary care has altered how Chinese people seek medical treatment. From 2008 to 2010, outpatient services rose 22 percent from 2.96 billion to 3.61 billion annually, while discharges rose 10 percent from 359 million to 396 million (Ministry of Health, 2011).

Of all five areas targeted for reform, the successes in the primary care system have signified the most monumental shift in remolding the Chinese healthcare system. Anhui was the first Chinese province to undergo a comprehensive reform of state-run primary care centers. By increasing investment in primary care centers, the provincial government guaranteed steady incomes for healthcare workers, in turn minimizing the harmful effects of medicine-subsidized healthcare. Price controls on essential medicines, such as selling at the buying price 零差率, eliminated pharmaceutical products as a source of revenue. Finally, by reassigning thousands of unqualified healthcare workers and linking salaries to performance evaluations, the government ensured high-quality medical services. Such reforms eliminated medicine-subsidized healthcare and reaffirmed primary care clinics as institutions advancing public welfare.

Pharmaceutical Delivery and Regulation

Reforming China's public hospital system stood as a major tenet of solving the high cost and difficulty of visiting doctors. To alleviate the heavy reliance

on pharmaceutical prescriptions as a source of hospital income, in August 2009 the central government published the National Essential Medicines Catalog 国家基本药物目录 of 307 types of basic medicines supplemented by other medicines according to the needs of certain localities. Those medicines are now available in all state-run health centers at the township and urban community level, and are sold at the buying price 零差率, removing kickbacks and commissions. In addition to providing access to such medicines through health clinics, the reforms have also instituted an auction mechanism for hospitals to purchase medicines. As a result of competitive selling, the costs for basic medications have fallen on average 30 percent at healthcare centers. Such reforms have helped curb the medicine-subsidized healthcare income mechanism in primary care institutions (State Council Healthcare Reform Office, 2012).

However, the new catalog has left many of the pharmaceutical pricing issues yet unsolved. Some products' pricing remains exaggerated due to a sharp rise in listed cost before the catalog was published. In addition, the catalog system does little to regulate the process of manufacturing and delivery. The cost of medicine still occupies approximately half of China's total healthcare expenditures, and remains a major source of revenue for hospitals. To combat rising costs, further regulation of the pharmaceutical industry through additional reforms remains the most viable way to strengthen China's healthcare system and improve the livelihoods of Chinese people.

Public Hospital Reform

To create new incentive mechanisms for doctors and other medical technicians, the healthcare reforms have outlined new personnel standards that aim to incentivize workers competitively. By instituting a performance-based compensation structure, public hospitals might rid themselves of medicine-subsidized healthcare. In seventeen pilot cities, such reforms have already begun to be implemented. Their approaches vary, such as at the Beijing Friendship Hospital 北京友谊医院, where service fees now form the main source of hospital income. In all pilots, however, the focus remains on ridding public hospitals of medicine-subsidized healthcare and meeting the same success as the reforms of the primary care system.

These initial reforms have produced positive results, but their widespread implementation has yet to materialize. As such, public hospital reform remains one of the top priorities for the healthcare reform goals of the twelfth five-year plan. Furthermore, hospitalization and prescription costs have risen sharply even in light of ongoing reforms. Unlike at primary care clinics, where government subsidies have eliminated the practice of medicine-subsidized healthcare, many public hospitals remain reliant on prescription

fees as a major source of revenue. At one county-level public hospital, revenue from hospital residence and prescription fees rose from 4.6 million RMB in 2008 to 25 million RMB in 2010, an annual increase of 134 percent. Average hospitalization bills rose from 741 RMB to 3,068 RMB, and the proportion of revenues from prescriptions rose from 47 percent to 62 percent, evidence that the over-marketization of public hospitals may actually be growing stronger. Clearly, the structural problems of public hospitals identified a decade ago have yet to attain significant improvement.

Public Health

Most relevant to the faltering system under SARS, the public health system received attention as a priority of the three-year healthcare reform plan that began in 2009. As of 2011, the government now invests 25 RMB annually on a per capita basis nationwide, a 67 percent increase from the 15 RMB standard in 2009. Those funds help provide 41 basic public health services at local levels of government (county, township, and village). The new public health system places an emphasis on fields such as prevention, education, immunization, infant and maternal care, and geriatric medicine. Over 16 million pregnant mothers, 81 million infants, and 110 million elderly Chinese have already taken advantage of free health checkups paid for by the new reforms (State Council Healthcare Reform Office, 2012). The increased awareness around disease prevention has also led to a push for consolidating and digitizing medical records, another monumental task that China's public health workers must face in the coming years.

The successes of the new public health services signify more than an effective reaction to a potentially disastrous pandemic. Disease prevention underlines the overarching goals of the healthcare reform policies, including raising the overall health status of the population. Instead of simply giving peace of mind in light of future public health threats, a healthy population is now seen by government leaders as a beneficial and necessary component of sustainable economic growth. That correlation represents more than just a reframing of healthcare reform—it also demonstrates a fundamental shift in the Chinese government's approach to social development.

Moving Forward

Significance of the New Reforms

In the span of just three years, the Chinese government was able to enact broad changes in its national healthcare system. Insurance coverage rates

soared to 95 percent, leaving a miniscule gap that shrinks with every year. The speed and directness of policy implementation has resounded throughout China's rise over the past three decades. Yet the healthcare reforms represent much more than simply another sector in which the government has been able to stimulate great change in a limited timeframe. Rather, the recent wave of healthcare reform represents two major shifts in the nature of Chinese social policy. First, the push for healthcare reform has played a leading role in China's fundamental pivot toward emphasizing social development. Second, the procedural innovation of soliciting various consultants and crowdsourcing feedback demonstrates the creative and open approach of a government that formerly used entirely top-down implementation structures.

The push toward creating a healthy society demonstrates a fundamental change in how the Chinese leadership views the country's development. From the start of the reform period, the emphasis remained on expanding and privatizing the economy. But SARS revealed fundamental flaws in an approach that valued cold statistics over public welfare. In a 2010 article published in the state-run journal *Seeking Truth* 求实, Premier Wen Jiabao described how the SARS crisis challenged the previous model of solely focusing on economic development. He likened the China of 2003 to a person with "one long leg, one short one" 一条腿长, 一条腿短, a metaphor for how strong economic growth needs "social development and bettering of people's livelihoods" 发展社会事业和改善民生 (Wen, 2010). Wen's metaphor grows all too fitting when considering how healthcare reform was the first step in helping rectify the imbalanced gait of Chinese development.

The change in emphasis is also apparent when comparing the rhetoric of top Chinese leaders at the Sixteenth Party Congress, which was held in 2002, less than one year before the SARS outbreak, and the Seventeenth Party Congress in 2007. At the Sixteenth Party Congress, President Jiang Zemin, who was transitioning out of office, did make reference to the long-term goal of establishing *xiao kang* 小康 in Chinese society. However, the focus remained largely on economic development, as Jiang labeled "an increasingly open economic system" 更加开放的经济体系 as a primary goal of establishing modest prosperity. Healthcare and other social programs received brief lip service thereafter (Jiang, 2002). Contrastingly, in his address at the Seventeenth Party Congress in 2007, President Hu Jintao committed an entire section of his speech to the topic "Accelerating Social Development with the Focus on Improving People's Livelihood" 加快推进以改善民生为重点的社会建设. Thereafter, Hu outlined five distinct areas that would serve as the foundation for social development: public education, worker's welfare, public housing, care for the elderly, and universal healthcare (Hu, 2007).

At the forefront of the new push for social development, the recent healthcare reforms have reaffirmed the government's role as a provider of public goods, which are now viewed as a parallel to the development of the overall economy. According to the new mindset of Chinese leaders, a healthy workforce not only reduces overall healthcare costs, it also helps increase overall economic productivity. The concept of healthcare and the economy growing in tandem resonates as well with the long-term goal of establishing modest prosperity and Healthy China by 2020. Healthcare reform has played a leading role in the move toward a Chinese welfare state. Never before had top Chinese leaders championed the government's role in establishing a "basic system" 基本制度 in the realm of social development. Numerous campaigns had previously invoked the term "basic economic system" 基本经济制度, but the "basic healthcare system" 基本医疗制度 advocated in the years following SARS was the first aspect of social development to merit such prioritization in its wording.

Furthermore, the healthcare reforms signified a major shift in the government's role in the delivery of public goods. In 2009, Premier Wen Jiabao promised a prodigious government investment of 850 billion RMB to finance the proposed healthcare reforms, much of which spurred the successes of the three-year push (Li and Chen, 2012).[2] That influx represents a major pivot from what had been over two decades of continued privatization of the healthcare sector. From 2000 to 2010, government investment as a proportion of healthcare expenses rose from 16 percent to 29 percent, while individual expenses fell from 60 percent to 36 percent, reducing the relative cost to individuals and solidifying healthcare as an essential public good with considerable government investment (see Figure 1).

The new push toward social development can be seen as the third major transformation the People's Republic has undertaken, the first being the establishment of a socialist state in the 1950s and the second Deng Xiaoping's move from a command economy to a free market system after 1978. With a new generation of leaders soon to take the nation's helm, social development will likely continue to define the major policy decisions in the coming years.

The recent wave of healthcare reform enacted a second broad shift in policy making by experimenting with procedural innovation. During the healthcare reform debate, two new practices broadened the scope of input as the central government mulled over what approach to take to address the problems in the healthcare sector. The first was the solicitation of reform proposals from a select number of public and private institutions. Especially since the beginning of the reform period in 1978, the Chinese government has continually shown eagerness to learn from experts in various fields and across

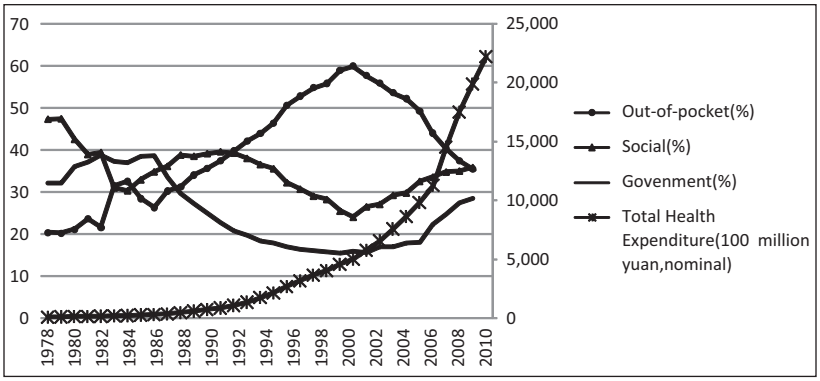

Figure 1. Value and structure of total health expenditures, 1978–2010
Source. Chinese Health Statistics Yearbook (Ministry of Health, 2011).

international borders. Yet the drive for adopting various models had always been an internal process. With the recent wave of healthcare reform, the highest tiers of government asked for policy options from half a dozen organizations, including McKinsey & Company, the World Health Organization, and Peking University.

In addition to its open consideration of various reform frameworks, the Chinese government also constructed an online crowdsourcing system to collect feedback and suggestions from ordinary citizens. This was the first time the Chinese government implemented such a system of dialogue with the greater public. The online commenting is all the more remarkable because it utilized the Internet, a sign of how the Chinese government has adapted to new technologies. In total, the online tool received over 35,000 comments from Chinese citizens ("Xinyigai," 2008). This phenomenon deserves the further attention of political scientists who seek to explore democratic structures evolving in a modern Chinese context.

Challenges and Future Direction

With the three-year plan now at an end, the challenges for the coming stages of healthcare development have begun to capture the attention of top policy makers. Perhaps one of the most pressing concerns is that of resources: overall healthcare costs more than doubled between 2006 and 2010, from 984 billion RMB to almost 2 trillion RMB annually (see Figure 1). Furthermore, with the complexity of China's five-tier federalist structure, providing government incentives to carry out sustainable healthcare reforms

also presents a formidable challenge as the work of extending and consolidating the past three years' work continues. As with any healthcare system, the complexity of issues requires careful regulation among parties with competing interests, something only more daunting given the context of China's size and regional diversity.

More broadly, demographic shifts will almost certainly alter the nature of health problems facing the Chinese people. China is aging quickly, and a large percentage of the population may soon face late-onset diseases common among the elderly. Annual migration patterns, which fuel China's manufacturing, complicate the healthcare delivery systems that serve migrant workers. And with the continued growth in per capita income, disease patterns have already shifted toward more chronic afflictions, those that are more common among prosperous nations.

The future of China's healthcare reforms lies in fitting the nation's needs to the goals set forth by the twelfth five-year plan, the next tier in the reform process. The past three years have seen the government's role in the healthcare sector renewed and reinvigorated, defining the initial stages of what may likely evolve into China's third great national transformation. Now, all that remains to be seen is how exactly China and its government will choose to ensure its populace remains healthy for many decades to come.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Ministry of Education (Key Program 07JJD840182).

Notes

1. The debate continues over what elements of healthcare ought to fall under the primary care sector, though in general, health clinics provide basic services, whereas secondary and tertiary hospitals employ specialists and surgeons.
2. The actual amount totaled approximately 827 billion RMB during the three-year span.

References

Center for Health Statistics and Information, MOH 卫生部统计信息中心 (2004) 第三次国家卫生服务调查分析报告 (An analysis report of the third national health service survey in China). 北京: 中国协和医科大学出版社.

CHEN ZHU 陈竺 (2011) "我国基本医保制度覆盖12.7亿人" (The basic healthcare insurance system has covered 1.27 billion people). 新华网, Aug. 18. http://news.xinhuanet.com/politics/2011-08/18/c_121879138.htm.

"Diagnosing SARS in China" (2003) New York Times, May 19. www.nytimes.com/2003/05/19/opinion/diagnosing-sars-in-china.html.

"Guowuyuan guanyu jianli chengzhen zhigong jiben yiliao baoxian zhidu de jueding" 国务院关于建立城镇职工基本医疗保险制度的决定 [Resolution of the State Council concerning building a system of urban employee basic medical insurance] (1998) www.gov.cn/banshi/2005-08/04/content_20256.htm.

"Guowuyuan guanyu kaizhan chengzhen jumin jiben yiliao baoxian shidian de zhidao yijian" 国务院关于开展城镇居民基本医疗保险试点的指导意见 [Instructions on establishing the urban employee essential medical scheme, State Council, China] (2007) 中国政府网, July 24. www.gov.cn/zwgk/2007-07/24/content_695118.htm.

"Guowuyuan guanyu yinfa yiyao weisheng tizhi gaige jinqi zhongdian shishi fang'an (2009–2011) de tongzhi" 国务院关于印发"医药卫生体制改革近期重点实施方案 (2009–2011)"的通知 [Implementation plan for the recent priorities of the healthcare system reform (2009–2011)] (2009) 中华人民共和国国家发展和改革委员会网站, April 8. www.sdpc.gov.cn/shfz/yywstzgg/ygzc/t20090408_359820.htm.

HU JINTAO 胡锦涛 (2006) "胡锦涛强调建设覆盖城乡居民的基本卫生保健制度" (Hu Jintao emphasizes the basic health insurance system's establishment of coverage for rural residents). 人民网, Oct. 24. http://politics.people.com.cn/GB/1024/4954631.html.

——— (2007) 高举中国特色社会主义伟大旗帜为夺取全面建设小康社会新胜利而奋斗——在中国共产党第十七次全国代表大会上的报告 (Hold high the great banner of socialism with Chinese characteristics and strive for new victories in building a moderately prosperous society in all respects—report to the 17th National Congress of the Communist Party of China). 新华网, Oct. 24. http://news.xinhuanet.com/newscenter/2007-10/24/content_6938568.htm.

JIANG ZEMIN 江泽民 (2002) 全面建设小康社会, 开创中国特色社会主义事业新局面——在中国共产党第十六次全国代表大会上的报告 (Build a well-off society in an all-round way and create a new situation in building socialism with Chinese characteristics—report to the 16th National Congress of the Communist Party of China). November 8. www.ce.cn/ztpd/xwzt/guonei/2003/sljsanzh/szqhbj/t20031009_1763196.shtml.

LI LING 李玲 and CHEN QIULIN 陈秋霖 (2012) "理性评估中国医改三年成效" (Evaluating the Three-Year Healthcare Reform). 卫生经济研究 5.

LI LING 李玲 and JIANG YU 江宇 (2011) 努力突破瓶颈 加快医改攻坚 7 (Speeding up the public hospital reform). Working paper.

Ministry of Health, PRC (2010) 中国卫生统计提要 (China health statistical digest). www.moh.gov.cn/publicfiles//business/htmlfiles/zwgkzt/ptjty/digest2010/index.html.

——— (2011) 中国卫生统计年鉴 (China health statistics yearbook). www.tjcn.org/plus/view.php?aid=21285.

National Bureau of Statistics, PRC 中华人民共和国国家统计局 (2009) "2008年末全国农民工数量为22542万人" (Rural worker population reaches 225.42 million in 2008). Mar. 25. www.stats.gov.cn/tjfx/fxbg/t20090325_402547406.htm.

"Opinion: the cost of SARS" (2003) New York Times, May 1. www.nytimes.com/2003/05/01/opinion/the-cost-of-sars.html.

"San nian mo yi jian: woguo shenhua yiliao weisheng tizhi gaige dashi ji" 三年磨一剑——我国深化医药卫生体制改革大事记 [Sharpening the sword for three years: major events in China's healthcare reforms] (2009) 新华网, April 7. http://news.xinhuanet.com/health/2009-04/07/content_11141029.htm.

State Council Healthcare Reform Office 国务院医改办公室 (2012) 深化医药卫生体制改革三年总结报告 (Summary report on the three-year healthcare and pharmaceutical reform expansion). 新华网, June 25. http://news.xinhuanet.com/politics/2012-06/25/c_112286717.htm.

WEN JIABAO 温家宝 (2010) "关于发展社会事业和改善民生的几个问题" (On problems concerning social development and the betterment of the people's lives). 求实, April 1.

"Xinwen yi jia yi: Shuye weihe fanlan chengzai" 新闻1+1: 输液, 为何泛滥成灾? [One-plus-one news: why the overuse of intravenous treatments?] (2011) 中国网络电视台, Jan. 6. http://news.cntv.cn/society/20110106/114470.shtml.

"Xinyigai fang'an zhengqiu yijian jieshu gong shoudao 3.5 wan yutiao yijian" 新医改方案征求意见结束 共收到3.5万余条意见 [New healthcare reform plan commenting system receives over 35,000 replies] (2008) 人民网, Nov. 17. http://medicine.people.com.cn/GB/8350603.html, accessed June 29, 2012.

"Yibao ziyou qianxi yuzu" 医保自由迁徙遇阻 [The migration of health insurance is blocked] (2012) 财新网, July 6. http://magazine.caixin.com/2012-07-06/100408178.html.

"Zhonggong zhongyang guowuyuan guanyu jinyibu jiaqiang nongcun weisheng gongzuo de jueding" 中共中央国务院关于进一步加强农村卫生工作的决定 [Resolution of the Chinese Communist Party Central Committee and the State Council concerning strengthening rural health work] (2002) 人民网, Oct. 29. www.people.com.cn/GB/shizheng/19/20021029/853848.html.

"Zhonggong zhongyang guowuyuan guanyu shenhua yiliao weisheng tizhigaige de yijian" 中共中央国务院关于深化医药卫生体制改革的意见 [Opinions of the Central Committee of the Central Party Committee and the State Council on deepening the reform of the pharmaceutical and healthcare systems] (2009) 中华人民

共和国国家发展和改革委员会网站, April 7. www.sdpc.gov.cn/shfz/yywstzgg/ygzc/t20090407_359819.htm.

Biographies

Ling Li is a professor of economics in the National School of Development of Peking University and the Vice President of the Chinese Health Economics Association. She received her PhD in economics from the University of Pittsburgh and taught at Towson University and Hong Kong Polytechnic University.

Qiulin Chen is a postdoctoral research fellow in the National School of Development of Peking University and Assistant Research Fellow of the Institute of Population and Labor Economics of the Chinese Academy of Social Sciences. He received his PhD from Peking University and was postdoctoral research fellow at the Shorenstein Asia-Pacific Research Center of Stanford University.

Dillon Powers is a visiting scholar at the School of International Studies of Peking University. He graduated from Harvard University in 2011.