Empowering CSO Networks in an Unequal Multi-Polar World

Development, Achievements and Experiences of China's New Rural Cooperative Medical Scheme

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I. Preface

Health is the common aspiration for all human beings. Every individual in the human world is likely to be posed of the risk of illness. In the unremitting endeavor to fight diseases, each county is exploring solutions for its citizens to enjoy the right to medical care. With strong economic capacity, developed countries have established their medical insurance schemes and made efforts to cover all people through different insurance approaches. Many developing countries are also exploring appropriate medical insurance schemes and operation mechanism in tune with the national economic development, so as to safeguard the health of all people.

As a developing and also an agricultural country, China has a huge population of 1.4 billion people, 70% of which, nearly 0.9 billion in number are farmers. Listed on China's top medical task agenda was the establishment of basic medical insurance scheme, which aimed to alleviate the scarcity of medical resources in the rural areas, and enable its citizens to access to and afford the medical services, thus protecting their health. Since the establishment of new China, the central government has introduced various medical insurance mechanisms to adapt to changes in different period. Regarding the medical insurance development, China has experienced a big success of traditional cooperative medical insurance scheme (CMS) in its peak time, and later a declining stage when the reform and opening-up policy was just started. With the introduction of new cooperative medical scheme (NCMS) in 2002, the period after is the reviving and development stage of China's medical care system.

China's public health system, focusing on protecting health of all citizens, has played a significant role in promoting the socialist modernization. The average life expectancy has increased from 35 years old before liberation to the present 75 years old (2013 Annual Health Statistics), and the mortality rate of pregnant women has dropped from 513 PPM in 2002 to 261 PPM in 2011. The morality rate of newborns and children under 5 years old has also witnessed a progressive decrease, with the former dropping from 29.2‰ in 2002 to 12.1‰ in 2011, and the latter from 34.9‰ to 15.6‰, accomplishing UN's Millennium Development Goals well ahead of the deadline. By 2012, the number of enrollment under the Urban Employees' Basic Medical Insurance (UEBMI) program, the Urban Residents Basic Medical Insurance (URBMI) and NCMS has exceeded 1.3 billion. The basic medical insurance system has coverage over 95% of the urban and rural residents. China has established the largest basic medical insurance network in the world.

Years of achievements and practices have shown, as a mutual assistance medical insurance scheme invented by farmers in China, the cooperative medical approach has played fundamental roles in safeguarding farmers' access to basic medical service and reducing the cases of medical-induced poverty and medical-induced re-poverty. It was a special component of China's overall medical care framework. The CMS, in particular, has become a national and historical success, and was widely considered as the only successful model of solving health care financing problem with collective effort by World Bank and WHO. It has won the fame of "medical revolution" and was defined as one of the three pillars of China's rural health insurance scheme, the others being: the rural three-level prevention and health care network and barefoot doctor

scheme. Its experiences has provided valuable inspirations and influence on the development of Declaration of Alma-Ata by WHO in 1978, which called for the equal access to basic medical service by 2000. Since the 21st century, China has taken the equal access to basic medical service for a well-off society as one of its major medical tasks. By fully considering "three rural issues" and farmer's real needs, the NCMS is organized, led and supported by the government; farmers enroll on voluntary basis; and its operation was co-financed by individuals, collectives and government. After six years of effort on pilot exploration, large-scale magnification and basic coverage, the NCMS was fully established with catastrophic expenditures covered, which further promoted China's medical care system.

Since the establishment of new China over 60 years ago, Chinese government and its people have been exploring best rural medical solutions with Chinese peculiarity. The rural medical scheme, as the most unique one with biggest public concern, has experienced many challenges and changes, and accumulated experiences and lessons as well, which will be of significant impact on China's medical development and health of all citizens. Therefore, this paper analyzes and summaries the development process, achievements, experiences and lessons of China's medical insurance system, and China's real experience will be better delivered to a wider scope.

II. NCMS development and achievements over the past 60 years

Cooperative medical system can be defined as the community-based insurance scheme. In the broader sense, community may include both urban and rural residents, whereas here it refers to the rural residents. Theoretically, led by the principle of "risk sharing and mutual assistance", the CMS as a comprehensive insurance mechanism was built on the community effort, with collective funding to cover the medical treatment, disease prevention and health care of the insured and their families. Starting from the 1950s, driven by the industrialization of economic development, protecting labors in the industrial sector has become a priority in China's public policy. Hence, a medical insurance scheme was established to fit the planned economy. Due to the resource scarcity, this scheme did not cover most farmers, making it impossible for them to access to national medical care system. Challenged by this reality, farmers have turned to mutual assistance to relieve their medical needs, which gave birth to the CMS.

1. Development stages and achievements

Regarding the medical insurance system, China has experienced three development stages: a big success stage of traditional CMS in its peak time, a declining stage after the collapse of planned economy and shift to market economy, and the pilot and development stage of NCMS since the 21st century. The following chart presents major development and achievements in these three stages.

From 1955 to the late 1970s
The rise of CMS

- Driven by the rural cooperative campaigns, farmers have built the non-profit heath care

stations and medical care stations out of collective funding.

- In the 1960s, CMS was widely promoted and a three-level prevention and health care network was built progressively, consisting of village clinics, township health centers, county hospitals.
- In 1976, by following the approach of "rural medical care undertaken by communities", 90% of the administrative villages have adopted the CMS.
- China has become one of the developing countries with better rural medical scheme. The CMS was widely considered as one of the three pillars of China's rural health insurance scheme, the others being: the health care network and barefoot doctor scheme ----WHO.
- The CMS cost only accounted for 20% of the total health care cost in China. Despite this fact, it met the needs of 80% Chinese population in rural area for medical care----World Bank.

From the 1980s to 2001

The Declining of CMS

- The introduction of Household Responsibility System has led to the shrinkage of collective economy system. It became particularly difficult to raise funds for the CMS normal operation, and the town-village CMS collapsed quickly.
- At the time, the medical system was experiencing radical changes with the planned economy shifted to market economy. Public hospitals were privatized and gradually transferred to market operation. The medical stations became private clinics and individuals began to own and operate the rural (town and village) health care network by contract, later monopolizing the rural market. As a result of gradual market shift and lack of appropriate supervision on pharmaceutical system, farmers had difficult access to medical care and could not afford it, either.
- In 1986, administrative villages supporting the scheme fell sharply to 5%, the lowest rate ever. The central government tried to revive the CMS in the 1990s, resulting in an increase of village enrollment rate to 17.7% among all villages. However, the villager enrollment rate only 10%, a huge gap when compared to 90% in the late 1970s.

From 2001 to present

NCMS Pilot and development stage

- In 2002, Resolution of Central Government and State Council on Promoting Rural Medical Work has clearly noted that "to progressively establish NCMS with key coverage on catastrophic illness".
- In 2003, the State Council issued the Suggestions on Establishing New Rural Cooperative Medical Scheme, a formal launch of the scheme. NCMS was piloted in the chosen counties in China by following the principle of multiple channel funding and voluntary enrollments.
- In 2005, NCMS pilot counties reached 671, covering 233 million farmers, which accounted for 26.3% of the total rural population; the NCMS enrollments has risen to 100 million people, accounting for 19.94% of the total rural population with the enrollment rate hitting 75.79%.
- In 2008, 2729 counties have adopted NCMS with the enrolled rural population rising to 815 million and enrollment rate reaching 91.5% respectively.
- In 2012, the NCMS fulfilled its universal coverage of urban and rural residents. The NCMS

enrollment has grown to 832 million people, and the enrolled hit 98.3%. China has established the largest medical insurance network in the world.

2. Basis operation approaches of CMS and NCMS

2. 1 Traditional CMS

- Led by the people's commune committee (township government), the health stations were built with funding from agricultural producers' cooperatives and commune members;
- The funding for health stations included 15-10% of public fund from the producers' cooperatives, 20 cents from each villager and the medicine profit from the health stations;
- Doctors in the health stations are barefoot doctors who were first chosen from villagers and then trained with medical skills. Their remuneration was in the form of work-points and cash;
- CMS focused on disease prevention and medical treatment, with prevention as the first priority. Supporting measures included touring medical service, on-site doctor visit and the doctor responsibility mechanism targeting at their own service areas.
- All commune members enjoy free prevention and medical health care services. In medical treatment, only the medicines are charged, and the registering and treatment are free.

Case example

As for the medical funding, each villager pays 1 RMB as the enrollment fee, and the production team pays 10 cents out of the public welfare fund for each villager. Except for those with chronic or catastrophic diseases, villagers only need to pay 5 cents as the registering fee with free medicines. Regarding the remuneration, only two out of 12 medical staff receive regular salary from the commune health stations, and the rest ten were paid with work-points as same as the village head. Considering their travelling work and high cost, they are also provided with a special subsidy of 3-5 RMB each month.

2. 2 NRCMS

- Source of funding: the policy stipulates that there are two funding channels. The first comes from the government subsidies at different levels. The second is from the NCMS participants. Based on the principle of the "farmer voluntary enrollment and co-financing scheme by collective and government", farmers pay their enrollment fee to the overall funding pool, which will be later transferred to the NCMS special account. Then the county government (city) finance department provides the matching fund for the actual enrollment. Then after receiving the county/city statistics statement, and copy of county funding allocation notice and county NCMS income receipts, the city finance department allocates the city matching fund accordingly. Later the city finance department will report the actual funding status to the provincial finance department, so as to apply for the subsidy from the provincial and central government. In NCMS early stage in 2003, the individual contribution was 10 RMB, and the government subsidy was also the same amount. Since 2008, the government contribution increased sharply, with subsidy amounting to 80 RMB in 2009. By 2012, the individual contribution and

government subsidy reached 60 and 240 RMB respectively. It is expected the government subsidy would rise to 360 RMB in 2014.

- Reimbursement range and standard: the inpatient and outpatient costs of NCMS participants will be reimbursed for a certain rate according to specific regulations. (1) In principle, the reimbursement ceiling is 6000 RMB. Some of the counties have slightly higher standard. (2) In 2011, the reimbursement rate of inpatient cost has risen from 60% to 70%. The reimbursement ceiling has increased from 30,000 RMB to no more than 50,000 RMB. Moreover, more areas included the NCMS out-patient compensation, and the outpatient cost of farmers can be covered at a standard of 30%. The reimbursement of inpatient cost is decided by the level of hospital, with the first-class hospital reimbursing no less than 75%, second-class no less than 55% and third-class no less than 45%. Within the policy framework, the actual compensation reaches 70% with 100,000 RMB as the ceiling.
- NCMS Fund account is established to cover the cost of catastrophic illness. The Fund has three components: risk fund, pooling fund for inpatients, and out-patient household fund (abbreviated as household account). And no other funds are available.
- Due to the regional and economic disparity within China, different regions have developed their specific plans to tailor to local needs, and formed their own their own mechanism with regional peculiarities. For details please refer to the website of the Ministry of Health and governments at different levels, for instance, Suggestions of Implementing 2013 New Rural Cooperative Medical Scheme delivered by Yanqing County, Beijing.
  http://www.bjyq.gov.cn/sy/gsgg/1d2f9aad_887e_4eb2_8850_f15ef47815c3.html

3. Major achievements of medical insurance scheme

China's medical insurance scheme has witnessed huge changes as the planned economy shifted to the market economy. Despite its challenges and the conflict between the public health need and economic development, China's health and medical insurance development has progressively tremendously, thanks to years of effort from the central government and several rounds of medical insurance reforms.

3. 1 Universal coverage of basic medical insurance schemes on urban and rural residents

By 2012, the UEBMI program, the URBMI and the NCMS have covered 1.3 billion people with the farmer enrollment reaching 98.3%. China has built the largest medical insurance network in the world with the coverage reaching its historical high, both in number and in proportion. The funding level and the reimbursement rate have increased gradually, with the average government subsidy growing from 20 RMB from the NCMS early stage to 240 RMB in 2012, and the beneficiaries rising from 122 million people in 2005 to 1.745 billion in 2011. And the reimbursement of inpatient cost has reached 70% with the coverage expanded from the inpatient to the out-patient cost. Now with the introduction of real-time reimbursement for medical expenses, people have easier access to medical treatment and timely reimbursement. Various payment reforms were rolled out, including per capita payment, payment by different types of

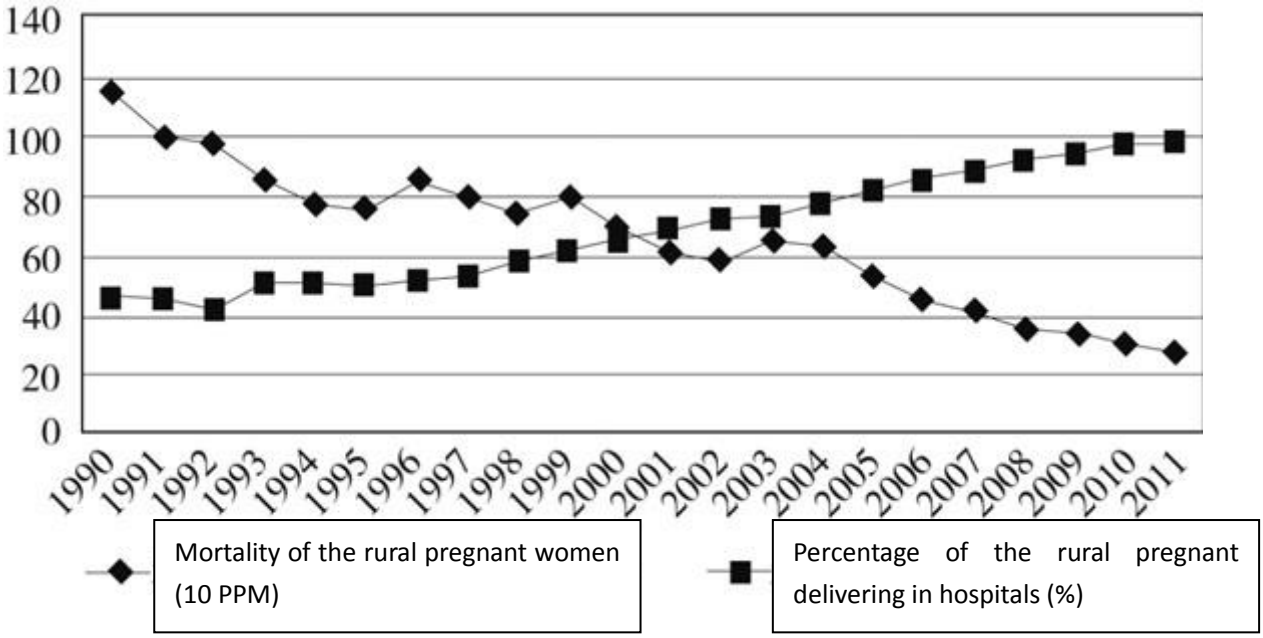
disease, as well as prepayment. This has shown the impact of NCMS to effectively supervise the medical institutions, to control the medical costs and to promote its development. With the introduction of NCMS-catastrophic illness coverage, more than 230,000 patients with congenital heart disease, end-stage renal disease, breast cancer, cervical cancer, multi-drug resistance tuberculosis, child leukemia, etc, have received compensation with the actual compensation reaching about 65% by 2011. In 2012, twelve critical illness including lung cancer, esophagus caner, gastric cancer, were included in the pilot insurance program for critical illness, with the reimbursement reaching as high as 90%. The critical illness insurance for urban and rural residents is operated by purchasing insurance products from commercial insurance agencies, with the specially allocated funding from URBMI and NCMS. This program adopted the critical illness compensation policy to reduce the catastrophic medical expenses of urban and rural households. After the first reimbursement within the basic medical insurance structure, the remaining medical cost, if in line with the policy requirement, will be compensated at the level no less than 50%, a huge relief for the personal medical expenditure. Also, the government has established a medical assistance scheme to assist households in China's *wubao*, and *dibao* program, and the low-income people with critical illness, the severely disabled, and the elderly from the low-income households. The assistance scheme has covered 80.9 million people.

3. 2 Further development of the urban and rural medical care service system

The increased government support has helped to improve the grass-root funding mechanism for local medical care operation. From 2009 to 2011, the central government has invested 47.15 billion RMB to support the development of medical institutions. Various approaches have been taken to build the capacities of medical team, and train the qualified talents for the rural areas and communities with special policies. Also, the general doctor scheme was developed to provide professional training for doctors, and support the grass-root doctors to participate in the job-upgrading training to become general doctors. Special programs were launched to provide medical staff for the mid and west China rural areas by conducting targeted training to medical students. Moreover, a program of 10,000 doctors supporting rural area was introduced. More than 1100 urban class-three hospitals provided technical support to 955 county hospitals. Each year, class-two hospitals in the mid and west China provide similar support to more than 3600 township hospitals. All these measures have proven very effective to enhance the medical skills and management capacities of these county and township hospitals. The grass-root medical services have been reformed with township hospitals undertaking touring medical service in the rural areas, and promoting general doctor scheme and family contracted doctor scheme. With the highlight on disease prevention and treatment, these approaches have met the basic medical needs of the local residents. The common diseases and frequently-occurring diseases can be treated at the local level. With joint effort, the local medical service framework was upgraded, dramatically changing the poor infrastructure and weak service in the rural and remote areas. Local medical staff has shown a positive change regarding its number, education background, as well as structure of knowledge. In 2011, there were 918,000 medical institutions in China, including 26,000 community medical centres, 38,000 township hospitals, 663,000 village medical stations, totaling in 1,234,000 hospital beds.

3. 3 The improvement of equalization of basis medical service

The central government provides free basic medical service package to all its residents in China, covering 41 services of 10 different types, including the resident health record establishment, health education, vaccination, 0-6 year-old child health management, the pregnant health management, the elderly health management, hypertension and type II diabetes patient health management, the severe mental patient management, report and management of epidemic diseases and public health incidents, sanitation supervision and assistance. For special diseases, focus groups and special regions, the government has introduced major public health services. The government intervention covers the following aspects: subsidy for rural women to deliver child in hospital, hepatitis B revaccination for youth under 15 years old, elimination of coal fire-induced fluorosis, folic acid use among rural women in the pre-pregnancy and early pregnancy period, hazard-free sanitary toilet construction, operation for poor cataract sufferers, cervical cancer and breast cancer test for rural age appropriate women, prevention of AIDS MTCT, etc. By 2011, the free vaccination reached 90%, pregnant women delivering in hospitals reached 98.7%, and the rural pregnant delivering in hospitals reached 98.1%. The mortality rate of rural pregnant women was decreasing progressively (**see the following chart: the variation tendency of rural women delivering in hospitals (%) and the mortality rate (10 PPM)**). The use of tap water and sanitary toilets in the rural areas has reached 72.1% and 69.2%. Moreover, in 2009, the government launched the Cataract Operation Program for Millions of Cataract Sufferers to Regain Eyesight. By 2011, more than 1,090,000 cataract sufferers received operation, thanks to the subsidies provided by the government.



Additionally, the basic pharmaceutical system was established and the reform of public hospitals has taken effect. In 2012, the government has fully launched the pilot program of county public hospital reform, which is expected to enhance the overall performance of rural medical care and raise the treatment rate within the county to 90%. Also in this year, the coordination of urban and

rural medical insurance scheme started its pilot program. Its goal is to promote the equal access to basic medical care and reduce the urban-rural disparity, which will improve the poor medical infrastructure and service capacity in the rural and remote area. This program has proven effective to relieve the problems of “difficult access to medical care” and “costly expenditure on medical care”, and reduce the cases of “medical-induced poverty” and “medical-induced re-poverty”.

III. A comparison analysis on CMS and NCMS

The CMS born in the planned economy period and NCMS established with medical reform in market economy period are two main schemes and changes in the developing course of cooperative medical insurance programs in China. In general, a review and analysis of these two schemes shows that NCMS was evolved from CMS with inheritance, reformation and innovation. Though “cooperative” appears both in two terms, it represents totally different meanings. CMS was born in the People’s Commune Period and Cooperative Movement Period, and had the feature of cooperation with the goal of ensuring risk prevention and sharing through voluntary cooperation. As a compulsory medical care system for farmers, it was operated by the collective to deduct the farmer’s enrollment fee from the first product distribution and to redistribute the public fund (surplus product). However, the “cooperative” in NCMS includes not only the contribution from individual farmers, and also the contributing subsidies from governmental at different levels. The government financial subsidies at various levels have shown that national redistribution of social products had enabled the “cooperative” to possess the feature of social mutual assistance, and to reflect the principles of social mutual assistance and social cooperative in the social insurance field.

The historical link decides many common grounds both shared by NCMS and CMs. However, as products born in different periods, two schemes have more disparities than similarities in their institutional framework. The concepts and their properties had dramatic disparity. The following table presents a detailed comparison.

1. Institutional inheritance and consistency

Consistency	Description
1. great background	Both are medical insurance programs with Chinese characteristics, designed for the relatively backward social and economic background under the rural-urban economic and social systems.
2. Insurance targets	Both are targeting at rural residents.
3. Management and supervision mechanism	As the target of insurance, farmers are endowed with appropriate right on management and supervision of the cooperative medical schemes.
4. Medical service provider	Both are based on the county-township-village 3-level prevention and health care network, providing not sophisticated but local and

	community-based basic medical services.
5. Administration	Both are administration authorities. On one hand, on behalf of the farmers, they undertake the tasks of administrative supervision and instruction on the scheme management and operation; on the other hand, on behalf of the nation, they undertake the tasks of supervision and management on the rural medical agencies, and even shares the commission responsibility of both management and administration.

2. A comparative analysis on the two schemes

Differences	**CMS**	**NCMS**
1. Goal	It focuses on minor sickness or injuries, and highlights the disease prevention and traditional health care.	It focuses on the tackling of medical-induced poverty and medical-induced re-poverty through coverage of critical illness cost.
2. The relying and embedded Institutional background	The political and social unity of the People's Commune system. "The Rural Cooperatives and the People's Communes controlling production, distribution and political rights, have the capacity to collect individual funding for CMS operation." Match CMS operation was a triune medical managerial system, one of the three pillars of medical care system, the others being: the county-township-village 3-level prevention and health care network, and the large group of barefoot doctors. The managerial system of political-social unity and medical-social unity has led to the internal and closed operation, as well as community stabilization of medical cost control.	The market economy system. The rural collective economy is independent from government power. The declined collective economy made it difficult to provide financial and organizational support to CMS; The medical service provider is market oriented, and the provider is independent from NCMS regarding the managerial system. The incentive structure of the medical organizations has changed, leading to the appearance of the provider-induced over expenditure; NCMS was operated by specially established government departments, forming a triangle shaped social insurance coordinating relations, including NCMS department, government, the enrolled farmers, and the medical service providers.
3. Institutional change approach	CMS was not included in the regular national medical insurance systems. It was an induced institutional change out of farmer's practice and invention. It was created voluntarily by farmers in Cooperative Movement.	NCMS was the compulsory institutional change driven by government. From 2002, the government issued a series of policies and redefined the government responsibility. It is responsible for the organization and promotion of NCMS pilot programs with its administrative power, and identified the scheme development direction for standardization and legalization.
4. Fund owners and medical	CMS completely relied on the Cooperatives (the People's Commune),	NCMS adopts the pattern of national ownership and governmental operation. The

	system operators	and was part of the collective economy in rural areas. The CMS fund belonged to the collective, which was responsible for the fund management, utilization and distribution.	government is responsible for the policy function including organization, publicity, instruction and support; The government organized NCMS department for the management and operation; the government leads the NCMS pilot programs through compulsory administrative force; NCMS operates on the county basis.
5.	Main contributors	CMS fund consisted of farmer's health care fee and proportion of the Commune public fund. The total medical cost and the reimbursement were all determined upon funding situation, by following the rule of "the collective shoulders the big cost while farmers the small cost". The personal share shall be no more than 50%.	NCMS applies the multiple contribution pattern, co-financed by farmers, the collective, and central-provincial-municipal (county) government funding. The 2012 standard stipulated the contribution share: the government shares the focal funding with its stable resource support; farmers share supporting roles due to the instability of income.
6.	Fundraising approach	CMS was established in the collective economy. The funding was spared by the collective and divided according to year-end work points by villages. It was compulsory to some extent. This funding channel was effective in collecting money easily, which resembles the present basic medical insurance system.	NCMS applies the semi-compulsory funding patter. Funding patter is decided by contributors. Farmers are paying voluntarily and the government applies the compulsory bottom-up financial transferring payment. As for the government funding, the central and above provincial level government jointly shares 50%. As for the below provincial level, the funding division depends on the provincial capacity, usually in the form of 3:3:4 or 4:3:3.
7.	Overall fund management	The CMS fund was managed on the village or township (community) level. Usually it was on village (around 2000 people) basis, and in few cases it was township (20-30 thousand people) basis. The mutual support and the risk resistance capacity were very limited.	The NCMS fund is managed on county level. With its large population base and coverage, NCMS has stronger mutual assistance and risk resistance performance.
8.	Government roles	Organization, management, fundraising, and supervision, etc.	The government takes farmer's health insurance as its own responsibility. Governments at various levels take the role of fundraising, but also its operation
9.	Management system	Farmer-operation and government-support system. Farmers were the main contributors, who voluntarily organized and operated, while the administrative cost was deducted from CMS fund directly,	Government-operation and farmer-participation system. The government is leading in organizing, managing, fundraising, publicizing and supervising; The representatives of enrolled farmers participate in the NCMS management

	obtaining no government financial support. The government operated or subsidized the county-township-village 3-level prevention and health care network, and provided low-cost medical service to enrolled farmers to support CMS operation.	committee and supervision committee; the local farmer self-management associations are involved in the NCMS fundraising, publicizing, and supervising.
10．Selection and management models of medical service providers	CMS was operated in a management system of political- social unity and medical-social unity. The medical service provider was recommended by village or township clinics designated by rural collectives or barefoot doctors. The managerial team and medical service provider of CMS were both under the overall management and supervision of the rural collectives with financial support.	The NCMS medical service providers are identified by government-designated organizations through market mechanism. Abiding the principle of the independence of managerial team and medical service provider, three parties: the operating agencies, the medical service providers, and the enrolled farmers form a triangular restrictive relationship for social insurance.
11. Insurance coverage	CMS covered basic medical treatment and public health care service. With poor medical service conditions, the medical care in rural areas applied local treatments with low cost and wide coverage, usually using some herbs or acupuncture needles. This approach was only effective for minor illness.	NCMS only covers medical treatment(public health care is financially supported by the state separately), and focuses on covering the cost of critical illness, and reimbursing the large expenditure and inpatient cost.
12. Payment approach	CMS functioned with the club style. Members in the club share resources for the short-term institutional welfare. Most traditional CMS provided free treatment and medicines.	NCMS adopts the medical insurance payment. The NCMS special agencies (i.e. the paying party of the medical insurance) cover the medical cost of critical illness of the enrolled farmers on certain rate with three approaches: minimum paying amount, ceiling limit and co-payment; meanwhile, NCMS explores new combination payment approach form with item-based payment integrating with the single type of disease payment.

IV. Four experiences

1. Best use of government's leading role in NCMS development

Government support is the precondition for the normal operation of social insurance system. The roles of government in leading the rural cooperative medical schemes include: political

mobilization (support), policy guidance, economic (financial) subsidies, organization and management, and institutional adaptation. Out of the above roles, political support, financial subsidies as well as organization and management are the most essential ones. In the traditional CMS operation, the collective economic organizations, to some extent, shouldered the role of government in political support and financial subsidies, while the commune-production team management system took the organization and management responsibility. In the NCMS operation, the government directly takes some funding responsibility, by which farmers see the real benefits and become interested in the scheme. As for organization and management, the government not only covers the administrative cost, but also undertakes strict management on fund use and supervision, the reimbursement and compensation, accounts settlement of service agencies, and basic prescription, etc. All these have highlighted the leading role of government, which was also the direct reason for the quick magnification of NCMS pilots.

2. NCMS is promoted with consistent system and classified instructions with bold innovations.

As a huge country with dramatic rural disparities, China's NCMS development shall take full consideration of local economic level, economic system and rural resident's cognition on cooperative medical scheme in different areas, and adopt tailored patterns. However, in the period of People's Commune, CMS was characterized by "single pattern", "single standard", "lack of variations", and "eating from the same big pot", etc. After the economic reform, some places reformed the traditional CMS to tailor to their needs and formed new patterns. At present NCMS has been popularized nationwide, while the specific plans were developed by governments at different levels. Many areas have tried bold innovations in light of their context. For example, some developed areas have considered to reforming the NCMS to integrate urban and rural medical schemes. The tailored pattern by fully taking consideration of local context is the precondition for the healthy development of rural cooperative medical system.

3. The coordinating development and interaction of rural local health service and public prevention and health care system.

From 1950s, China had gradually set up a 3-level rural medical network consisting of village clinic, township health center and county hospital. The cost was totally covered by the state and the collectives. Despite its low operation cost, it provided the most basic medical service for the large population in rural areas. CMS' medical role before reform was related to the government concern on rural medical service system. After reform, the rural medical care system was affected with the public financing cut. The coverage of township health centers had been on decline for a period of time, and most village clinics were transferred to private ones. Meanwhile, the barefoot doctors were incapable to meet the medical needs of the rural residents. In the process of establishing NCMS, the state not only provided subsidies for enrolled farmers, but also increased its investment on the rural medical care system. It further strengthened the supervision on pharmaceutical system and medical service price, which were the important NCMS factors to attract farmers. It is thus clear that the sustainable development of NCMS was built on the continuous support of the rural medical care system. The NCMS and the rural medical care system are of mutually supporting and developing relationship.

4. Good organization and management ensures the NCMS healthy development.

The organization and management of the cooperative medical schemes runs through the process of political mobilization, social publicity, fundraising, plan design and fund management, etc. The precondition to decide the maximum benefit for farmers is whether an effective, fair, and economical management system could be set up and maintained, which is the key for the sustainable development of the cooperative medical schemes. To a great extent, the willingness of farmers to enroll in the schemes depends on its transparency and fairness. Before the Opening-up and Reform, the CMS in many places was not well organized and was financially in a mess, which made farmers lose their trust on the scheme. The whole system was hard to maintain also with its high cost of staff and management. Now NCMS is managed on county level with specialized operating agencies in place for stronger supervision. It promoted the sound management of cooperative medical fund and reduces the average staff cost. This is the key reason to explain why NCMS had encountered any significant issues since its operation, also the precondition for its healthy development.

V. Problems and suggestions

In *Fairness of Health and Health Services*, the initiative WHO and SIDA jointly issued in 1996, health service and health fairness is defined as following: fairness is not equality, meaning the distribution of surviving opportunities shall be based on demands, rather on social privilege. Fairness should be the sharing of social progress, but not the evitable misfortunes and loss of health right. The fairness of health and health services aims to progressively decrease the unfair and unreasonable social gap existed in the health and health service status of social groups, and to enable every member to reach the basic surviving standard. This means every member have the same access to medical services and health, regardless of their social privileges. Also it is reflected in the following aspects: 1. Fair distribution of health resources, not on the absolute equalization but on actual needs; 2. Fair fund raising for medical services, based on actual affording capacities; 3. Fair level of access to health services, not on social privileges but on real needs; 4. Fairness of health, avoiding the absolute poverty and health-deprived status of certain groups. From these four aspects, to realize the fairness of health and health services through medical insurance schemes, China still faces lots of challenges with its insufficient medical resources and high medical cost, and the existence of medical-induced poverty and medical-induced re-poverty. To trace its causes, one was the scheme design and operation issue and the other the side effects of the over-commercialization of medical systems after the collapse of collective economy.

1. From the institutional aspect, though NCMS was the reformed and updated CMS, there is much to be done regarding its benefit, fairness and effectiveness.

   - As far as the fundraising mechanism is concerned, NCMS funding adopts the “funding mechanism of combining individual’s contribution, collective support and state subsidies”, which stipulates the proportion of government funding. However, after the

economic and financial reform, the state finance, especially the local finance, had great difficulties in providing funding. Thus, even though the government has set a clear economic bottom line, the governments at different levels in real practice could only manage for the minimum support and input with huge funding pressure.

- As far as the reimbursement mechanism is concerned, it was originally stipulated that outpatient cost was not covered in the reimbursement. To get reimbursement, many farmers would choose to have transfusion even for a common cold. This may led to such problems as over-treatment, antibiotic abuse, rise of medicine price, etc. What's more, with too many limitations on reimbursement and the minimum payment line, the real reimbursement proportion and actual sum are still unsatisfying.
- As far as the insurance mechanism is concerned, with the fast development of urbanization, about 0.2 billion farmers have moved out of their hometown for migrant work in cities. As stipulated in the scheme, these 0.2 billion migrant workers are not covered in the NCMS. Moreover, NCMS focuses on critical illness to reduce the chances of medical-induced poverty and re-poverty. Still, many farmers are still facing high outpatient cost and low reimbursement rate as also stipulated in the policy.

2. As far as the distribution of medical resources is concerned, the scarcity of resources and its unequal distribution still exist. Quality medical resources and professional medical staff are mainly distributed in large hospitals in cities, whilst rural areas are short of both medical services and medicines. Even when some rural health centers are equipped with advanced equipments, technical staff might not be available to properly use them, affecting both the use of equipments as well as the diagnosing accuracy

3. As for the side effects of commercialization of the medical system, the doctors usually will prescribe high price medicines if the cost can be reimbursed. Usually, it was 30-40% higher than its original price. Meanwhile, driven by the economic benefit from the medicines, medical institutions may engage in over-treatment, unreasonably high price of medical supplies and medicines. The NCMS advantages were offset by these behaviors, thus affecting the enrolling enthusiasm of farmers. Research from WHO (2001) has manifested that, despite its wide use of antibiotics in China, the reasonable use accounted only for about 50%. And every year there were about 200,000 deaths in China due to misdiagnosis and improper use of medicines.

Of course, we cannot list all the problems and challenges here. We believe the key lies in system reform and we have provided some suggestions for discussion.

Suggestions/expectations

With the medical service and health fairness as the incentive, the NCMS structural reform shall be continued with system improvement and governance innovation. The side effects of medical system commercialization shall be addressed to learn from experiences and lessons, to strengthen the rural health care, and to use traditional medical approaches.

I. National policy: institution insurance is the precondition. Note the function shift of various divisions, strengthen the division cooperation and coordination, and promote the consistency and feasibility of policy implementation at the national, local government and different division level. Make full use of government's leading power: first, strengthen the efforts to tackle and coordinate the conflicts of public welfare and private benefit in hospitals; second, Control the overtreatment, promote the medical morality and at the same time reform the hospital managerial system; third, guarantee the basic medicine price and control the fast rise of medical cost. Improve the medical service and efficiency.

II. Medical funding: fundraising is the key to the development of cooperative medical schemes. With the growing funding request, local finance department and individuals face heavier burden. Thus, in-depth research shall be done to develop specific fundraising policies and plans with Chinese peculiarity, which shall fully consider the paying capability of both individuals and local governments and increase the fairness of medical services.

III. Medical care service: The investment in infrastructure and human should be enhanced for township and village health centers, so as to improve the service of local medical institutions and meet the diversified medical needs of farmers. The fairness of medical resource distribution should be noted.

IV. Medical needs: to ensure all citizen's right and realize the fair health for all, many factors shall be considered, including the income level of farmers, enrollment willingness, cognition on risk sharing, social gender factor and the contributing ability of poor people, etc.

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