



Equity for the Elderly: China's New Rural Cooperative Medical Scheme (RCMS)

**Lin Yuan*, Toni Schofield,
Russell Shuttleworth, Rosemary
Cant**

**Faculty of Health Sciences,
University of Sydney, Sydney,
NSW**

Objectives

- To understand the health inequity among the Chinese elderly
- To determine the barriers of the rural Chinese elderly in the new RCMS
- To explore how the health needs of the rural Chinese elderly can be met

Methods

Systematic review on the new RCMS

- Retrieval journal articles on the new RCMS from 2002 to present
- Synthesis the findings on the new RCMS based on the current studies
- Analyse the research findings to illuminate some of the problems of the new RCMS

Background 1: classes of older Chinese people

- Upper class older people who are the retired high-ranking cadres living in urban areas
- Middle class retired older people living in urban areas who can get a comparatively satisfactory reimbursement
 - 70 - 80% of the reimbursement from their public health insurance, “Basic Medical Insurance for Urban Employees”, and private health insurance
- Lower class older people including those
 - who have never been employed and who live in urban areas,
 - in rich rural areas,
 - or poor rural and remote areas

Background 2: History of China's RCMSs

- The first RCMS in China was developed in the 1950s.
 - By 1980, it covered 90 percent of villages
 - The original RCMS has had major problems
- With the demise of the original RCMS, China's rural residents were required to pay for health care out of their own pockets
- New RCMSs began to develop in the 1990s in the wake of the demise of the original scheme

Background 3: What are the new RCMS?

- The new RCMS is different from its predecessor.
 - It is organised, led and supported by the Central Committee of the Communist Party of China.
 - Rural Chinese are encouraged to participate in the Scheme but they, as well as local and central government agencies, must contribute to a medical fund that pays for medical and hospital services

Key observations: Inequities in the new RCMS

- **Inequity among rural older people in terms of rich versus poor districts**
- **Inequity in funding collection**
- **Inequity in reimbursement**
- **Inequity in using healthcare services**
- **Inequity in the distribution of medical resources**
- **Inequity in attitude to public and private hospitals**
- **Inequity in price and quality of drugs**

Inequity in funding collection

- **In the new RCMS, every rural resident decides whether to contribute or not.**
 - **Collecting money this way burdens those poorest families, particularly with older people, who have little income;**
 - **This basis of funding will reduce the participation of poorest families.**
- **Fund raising mechanisms are not finalized and fund collection methods have not taken account of the following.**
 - **Medical costs are increasing fast.**
 - **The number of older people is increasing rapidly.**
- **The RCMS management expenditures are high. Personnel expenditures which includes wages, subsidies for local staff, and so on, is the biggest component**

Inequity among rural older people in terms of rich versus poor districts

Because of the financial differences between each county

- Rural older people could benefit more from the new RCMS if they live in the rich county
- Rural older people could only benefit a little from the new RCMS if they live in the poor county

Inequity in reimbursement

- **Health procedure inequity in reimbursement:**
 - **Reimbursement primarily for serious diseases has created health procedure inequity.**
- **Low reimbursement proportion:**
 - **The designed reimbursement scope for inpatients has excluded diseases, such as mental illness and cancer.**
 - **The proportion of compensation is low**
- **Inequitable reimbursement to the rural older people:**
 - **Seventy percent of older people live in the countryside.**
 - **They become sick much more easily than younger people but their incomes are lower.**
 - **The procedure for applying for reimbursement is complicated so they have a difficulty applying for the reimbursement unless helped by family members**

Inequities evident healthcare services

- The higher a rural patient's income is, the higher the hospitalization rate
- The lower the income is, the higher the rate of chronic disease.
- Village clinics and rural town health centres in rural west China have
 - a limited number of health professionals,
 - and limited and poor quality medical instruments.

Inequity in price and quality of drugs

- Drug fraudsters have a better chance of earning money in low income rural areas because the rural people are kind and naïve, particularly those who are illiterate and older and thus are easily cheated;
- Some village private clinics maintain expired drugs on their shelves;
- Some popular preserved herbal medicines for flu are always out of stock;
- Hormone drugs have been overused by asthma patients;
- Antibiotic tablets are excessively prescribed to patients

Policy implications

- **The out-of-pocket burden for poor rural older people should be reduced**
- **Access to care for the poor rural older people should be increased**
- **Hospital capabilities with local needs should be matched**
- **Regulation of the drug market**

Thank you!

