

CASE STUDY

**Case Study: Comparison of Healthcare Systems in China and Australia**

**Comparative Health Systems**

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**Introduction**

* Introduction of both countries compared in report (Australia, China)
	+ Country wealth profile
	+ Population comparison
* Introduction of points of comparison throughout the paper
	+ History of healthcare system
	+ Structure of healthcare system
		- Suitability to the country
	+ Financing methods
	+ Comparative analysis of health outcomes

**Historical Emergence of Healthcare in Australia**

* Early settlers
	+ Inadequacies and high death toll
	+ Shift of control to privatised model

(Lewis, 2014)

* 1896
	+ First public health (PH) act
		- Gave rise to department of PH
		- Expanded over time
			* Infectious Disease Surveillance Act (1881)
			* Quarantines Act
			* Dairy Supervision Act (1886)
			* Leprosy Act (1890)
			* Pure Food Act (1908)
			* Private Hospitals Act (1908)
		- Milestone with 1929 Public Hospitals Act\ First instance of government control
		- First regulation of quality assurance

(Lewis, 2014)

* + 1973 NSW Health Commission
		- Decentralisation of health
		- NSW Department of Health established under Health Administration Act
	+ 1973 – Universal Healthcare
		- Bill failed to pass the Senate three times
			* Caused dissolution of the Parliament
		- 1974 the bill passed under the new government
			* Provisions reduced under another change of government in 1975
				+ Retired persons meeting stringent means testing requirements only
	+ 1984 – Another change in government
		- Current Medicare system established
			* Universal health care
				+ Free public hospital care
				+ PBS
				+ Coverage for physician services

(Department of Families, Community Services and Indigenous Affairs, 2004)

**Historical Emergence of Healthcare in China**

* Healthcare first nationalised in 1949
	+ Communist party emergence
		- Basic primary care established
			* State run ‘barefoot doctor’ program
				+ Rapid training
				+ Non-extensive
				+ From existing folk healers to farmers
			* Other state funded programs
			* Streamlining of urban regions healthcare systems
* Economic reform 1978
	+ Differentiation in urban and rural healthcare evidenced by health standards and outcomes
	+ Significant privatisation of healthcare sector
	+ Large number of state-run companies were also privatised and employees therefore not covered by existing social securities and health benefits
	+ 1990- Most residents of urban regions paid for their healthcare entirely out-of-pocket
		- Rural based residents couldn’t afford healthcare in urban regions
* 2006 Healthcare Reform
	+ Introduction of a new rural medical care system (NRCMCS)
		- 800m pop. in rural regions were given subsidised medical care

(NHSA, 2020)

**Healthcare System Structure – Australia**

The Australian Healthcare System (AHS) utilises a model of universal health coverage, referred to as Medicare, in combination with an optional complementary private insurance model (Department of Health [DoH], 2022). All Australian citizens and permanent residents are eligible for the Medicare program (Services Australia, 2021). The Medicare program is partially funded through an income tax, the Medicare levy, which is currently two percent of a person’s taxable income. A Medicare levy surcharge is also applicable to high income earners who choose not to purchase private health insurance Conversely, low-income earners are granted an exemption from paying the Medicare levy (DoH, 2022). Medicare’s expenditure exceeds the revenue raised through the levy scheme and the remaining funding is provided through generalised government expenditure (Parliament of Australia, 2020) .

The Medicare program is continually evolving, expanding its access, as evidenced through the introduction of both the Better Access Scheme (BAS) in 2006 and the National Disability Insurance Scheme [NDIS] (multi-step rollout from 2013-2020) (Better Access Initiative, 2022; The National Disability Insurance Scheme: a chronology, 2018). These schemes recognised areas of health which weren’t adequately accounted for in the initial offerings, with the BAS designed to subsidise the cost of mental health treatment and the NDIS funding disability associated costs. Despite the universal coverage of the Medicare program, it is not all-encompassing, approximately 17% of Australia’s health expenditure is funded through out-of-pocket costs for a total cost of $29.8 billion AUD (AIHW, 2018). This ranks Australia as third among the 17 wealthiest OECD nations for reliance on individuals to fund healthcare contributions (Duckett, 2018).

**Healthcare System Structure – China**

* Hybrid healthcare model
	+ Beveridge – Public Hospitals
	+ Bismarck – Coop employer/employee scheme for health insurance
	+ Out -of-pocket model – Some rural regions utilise a tiered subsidy scheme
		- * 30-80% of regular expenses covered, the remainder out of pocket.
			* A large number of standard medical expenses not covered and need to be paid entirely out of pocket

(NHSA, 2022)

Since 2011, China has achieved universal healthcare coverage through three social insurance schemes. The insurances are classified as Urban Resident Based, Rural Cooperative Scheme and Urban Employee-based. The Urban Employee based scheme is funded through tax payer contributions of 2% in conjunction with employer contributions of 6%. Enrolment in the basic medical insurance program is compulsory for those employed in urban regions, however the costs for the other two programs are contributed to by centralised and local government bodies (NHSA, 2020). Complementary private insurance operates alongside the government schemes to provide coverage to gaps in the scheme, with public insurance schemes accounting for only approximately 50% of medical costs. This proportion is even lower for chronic illnesses (UNRISD, 2014). Private insurance is however not accessible for average wage earners, excluded by costs (Chen et al., 2020).

China’s expansive population contributes to problems with regard to access, in recognition of this access problem, medical school tuition is heavily subsidised by the government. Access is further reduced in rural and remote regions of China and to address this discrepancy, there is a reduced entrance requirement and free tuition for those willing to commit to 6 years working in a remote or rural location (Commonwealth Fund: China, 2020). These programs designed to stimulate an increase in trained physicians also serves to address a notable lack in quality of care in the provision of medical services. As it stands Village doctors are commonly sought out for the treatment of patients in the community setting as General Practitioners are predominantly hospital based in the Chinese healthcare system. These Village Doctors undergo a far less rigorous training process and have no tangible oversight on their practice (Hu et al., 2017).

* + Increase in medical insurance for urban region citizens
		- By 2011 >95% of pop. have at least basic health insurance
* Predominantly centralised insurance schemes
* Decentralised insurance offered by privatised companies
	+ VIP status for patients
	+ Access to exclusive private hospitals
	+ Access to VIP wings in public hospitals
* Present – Status
	+ Health infrastructure in major cities has come close to alignment with developed nations
	+ Significantly reduced standards and infrastructure in rural regions, decreased health outcomes.

(Commonwealth Fund, 2020)

**Financing Australia**

* Medicare
	+ Partially funded through the Medicare levy (2%)
	+ Medicare levy surcharge
		- High income earners without private health insurance
	+ Low-income earners are exempt (DoH, 2022).
		- Expenditure exceeds revenue from scheme
			* Remainder funded by general government expenditure

(DoH, 2022)

* Spending on Health
	+ 2016-2017
		- ~$181 billion AUD
			* ~10% GDP
			* Government Outlay
				+ Federal Government 41%
				+ State Governments 27%
				+ Individuals (out of pocket) 17%
				+ Privatised health insurance providers 9%
				+ NGO’s 6%

(DoH, 2022)

* Reimbursement
	+ Activity based funding
		- ICD codes determine diagnoses both 1˚ and 2˚and complications
			* Cumulated in a grouper resulting in a DRG
				+ Broad depiction of a case with expected hospital resource use

**Financing China**

* Recent exponential increase
	+ 2006 – 984 billion RMB
	+ 2011 – 2,4 trillion RMB
	+ 2020 -7.2 trillion RMB (1.5 trillion AUD)

(The World Bank, 2022)

* Past Decade
	+ Tripling of per capita health expenditure
	+ 2% rise in Health expenditure as a percentage of GDP (3.65-5.17%)

(Zhang, 2022)

* Reimbursement
	+ DRGs –
	+ Activity based funding
	+ Direct payments from individuals
		- Co-payments
		- Out of pocket costs
* Costs Breakdown
	+ Private Insurance Providers ~5.9%
	+ Individuals (Out-of-pocket) – ~23%
	+ Social health expenditure (Employee/Employer Scheme) – ~42%
	+ Government – 29%

(Zang et al., 2019)

**Comparative Analysis**

* Breakdown health expenditure as a per capita figure
	+ Outcome analysis
* Why Australia’s healthcare better serves population
	+ Equality under a single system
	+ Regulation of QA in comparison to China
	+ Universal registration authorities for practitioners
	+ Greater expenditure as part of GDP
	+ Single predominant healthcare service (Western EBP vs TCM + EBP)
* Why rural regions are disadvantaged
	+ Providers
	+ Training of practitioners
	+ Expenditure on infrastructure
	+ Government scheme pushes patients to less popular facilities with increased subsidisation tiering
		- Less popular clinics often due to cause not location.

(Commonwealth Fund, 2020)

* Aspects to adopt in Australia from learning about China
	+ Minimal relevance due to huge population discrepancies and a reduction in the division between urban and rural regions
		- Whole provinces considered rural in the interior

**Conclusion**

* Developing nation vs Developed
* Developed regions (Beijing & Shanghai)
	+ Similar health outcomes to Australia

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