

Research on Differences Between Chinese and American Healthcare Systems and Recommendations for Future Development

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Abstract. This study compares China and the United States from a patient-centered lens: what a typical resident pay, how predictable those costs are, and how quickly care can be accessed. Using accessible official reports and policy briefs, the analysis focuses on three parts that shape everyday experience-coverage architecture, drug pricing and reimbursement, and provider payment. China combines broad social insurance with provincial risk pooling, centralized drug procurement, and DRG/DIP payment reforms that compress prices and start shifting demand toward primary care. The U.S. keeps a plural structure that supports choice and innovation, but complex benefits and plan churn can raise out-of-pocket risk; recent steps-Medicare drug price negotiation, marketplace subsidies, and moves toward site-neutral payment-aim to reduce volatility. Based on this comparison, the paper proposes three practical actions that ordinary patients can feel: (1) real-time out-of-pocket estimates at prescribing and check-in; (2) clear monthly caps for common chronic medicines; and (3) stronger team-based primary care as a stable “front door.” These options are incremental, fiscally realistic, and measurable through simple indicators such as waiting time, essential-medicine availability, and the share of households facing large medical bills.

Keywords: China, United States, Health insurance, Drug pricing, Primary care reform.

1. Introduction

This study compares the health systems of China and the United States and offers practical implications for future reforms. The analysis uses clear, accessible language and focuses on how policy rules shape everyday patient experience. A simple organizing lens is adopted: for families, affordability depends not only on average prices but also on volatility-sudden, hard-to-plan out-of-pocket (OOP) charges. A system may still be perceived as fair when monthly costs are stable and easy to understand, even if total spending is not the lowest. Guided by this lens, the discussion addresses three questions: (1) who is covered and what benefits are provided; (2) how medicines are priced and reimbursed; and (3) how providers are paid.

Rather than listing every statute, the paper synthesizes the dominant policy logic and uses brief, illustrative examples-such as a person with diabetes who moves across regions or a worker who changes jobs mid-year-to show how rules translate into bills and waiting time.

Evidence is drawn from open-access sources: the Organisation for Economic Co-operation and Development for cross-country indicators; the U.S. Census Bureau and analyses of national health spending by CMS actuaries for coverage and expenditure [1-3]; China's National Healthcare Security Administration for enrollment, payment reform, and centralized procurement; the World Health Organization's system financing reports [4,5]; and peer-reviewed comparative studies [6]. For China's provider payment and drug coverage, the discussion relies on research on Diagnosis–Intervention Packet (DIP) payment and on national drug price negotiation linked to NRDL updates [7,8]. For U.S. drug pricing, the text also references official CMS materials describing the Medicare negotiation program and the first negotiated drugs [9].

2. Coverage and benefits: what people actually experience

2.1. Coverage architecture

China aims for very broad coverage. Two social insurance schemes make up the core. Urban Employee Basic Medical Insurance (UEBMI) covers people in formal employment. Urban-Rural Resident Basic Medical Insurance (URRBMI) covers students, children, older adults without formal jobs, and other residents. UEBMI relies mainly on payroll contributions; URRBMI relies more on public funds and small premiums [4]. The national government sets the main rules, while provinces and cities adjust details like deductibles and ceilings to match local budgets. In recent years, cross-provincial settlement expanded, which makes it easier to get care and settle bills away from one's home city [4,10].

The United States is deliberately plural. Many people have employer-sponsored insurance. Others buy plans on the Affordable Care Act (ACA) marketplaces with income-based subsidies [11]. Public programs include Medicare for older adults and many people with disabilities and Medicaid for eligible low-income families and children [2,12]. This structure gives choice and room for innovation, but it also creates many different rulebooks. Two neighbors with the same illness can face very different deductibles, premiums, and networks simply because their coverage comes through different channels.

2.2. Eligibility and enrollment

In China, enrollment follows a person's status. Employers enroll workers in UEBMI; local authorities enroll residents in URRBMI. As digital settlement expands across provinces, the paperwork burden falls when people use benefits away from home [4]. For example, a food delivery rider who moves for seasonal work can settle a claim at the hospital instead of mailing paper forms weeks later.

In the U.S., who qualifies depends on age, income, disability status, family size, and employment. The ACA banned denials for pre-existing conditions and created standardized marketplace plans with subsidies. But some states did not expand Medicaid, leaving a coverage gap for adults who earn too much for Medicaid but too little for strong subsidies [12]. A practical difference from China is churn. Chinese residents often stay within the same broad scheme even if jobs change. Americans may switch plans and networks when employers change carriers or when they move to another state. This can break relationships with clinicians and pharmacies. Because chronic diseases like diabetes need steady care, policies that reduce churn-automatic re-enrollment and stable subsidies-help even without adding new clinicians [2].

2.3. Benefit design and patient pathways

Both countries cover inpatient care, outpatient care, and medicines, but the depth of financial protection differs. China focuses on basic protection with deductibles and copays, and the benefit level can vary by city and fund strength. Some residents buy low-cost add-on plans to fill gaps. Many patients prefer large urban hospitals for reassurance, which leads to long lines and higher time costs. To ease crowding and support chronic care, policy promotes tiered diagnosis and treatment and family-doctor contracts that make primary care a trusted front door [4,5].

In the U.S., plan design shapes the path to care. Networks, deductibles, and coinsurance decide where patients go and how much they pay. A person in a generous employer plan may schedule surgery quickly with modest OOP exposure; a person in a high-deductible plan may delay the same procedure because the first part of the bill is theirs. This variety supports innovation but asks patients to make complex financial and clinical choices. A short example: imagine a 45-year-old office worker who develops knee pain. In Beijing, she may choose a tertiary hospital for an MRI because she trusts the specialist, even if a community clinic could start the work-up. In Chicago, a similar worker might check if the imaging center is “in network” and if the deductible has been met this year. The clinical step is similar, but the cost logic and the paperwork logic differ. These differences explain why people in both countries sometimes feel anxious before even seeing the doctor—they are trying to guess the bill and the wait time.

3. Medicines: price policy and the risk of shortages

Medicine policy shows how price tools can lower spending but also create new risks. In China, two tools stand out after approval. The first is volume-based centralized procurement, where public buyers promise large, steady volumes and firms bid down unit prices. The second is annual negotiation for the National Reimbursement Drug List (NRDL), which decides which innovative drugs are covered and at what prices. Together, these tools have brought prices down and widened access [4,8,11]. However, very low prices can push weaker producers out, which risks unstable supply. To reduce this risk, tenders can allow more than one winner in concentrated markets, small buffers can be kept for narrow classes, and early warnings like repeat delivery delays can trigger quick action by regulators. It also helps to keep clinical details in mind. If modified-release or pediatric forms matter, they should be separated when tendering.

From the patient perspective, a person with type-2 diabetes may notice that metformin and other first-line generics are inexpensive and easy to obtain in hospital pharmacies. If a new brand-name drug is added to the NRDL after negotiation, the price drops substantially, and the physician can write a prescription with a smaller OOP share. But if a narrow, older injectable faces only one or two suppliers and the price fell very low last year, the pharmacy might run short for a week. In that case, multiple winners and small buffers make a difference that patients can feel.

The United States sets net prices through many separate negotiations. The Food and Drug Administration checks safety and effectiveness, but prices come from bargaining among manufacturers, pharmacy benefit managers, and insurers. In the past, Medicare could not directly negotiate many prices. The Inflation Reduction Act (IRA) changed that for a limited set of high-spend drugs: the first negotiated “maximum fair prices” take effect on January 1, 2026 [9]. This does not create a single-payer system; it adds a federal tool inside a mixed market. From a patient’s point of view, what matters is the OOP charge at the counter. An insulin user in a good plan may see a clear monthly cap; another person with a high-deductible plan may still face a big early-year bill.

Tools that show the real OOP cost at the time of prescribing—inside the electronic record—help clinicians pick an option that patients can sustain.

4. Paying for care: who holds the risk and how providers respond

Who carries financial risk and how providers are paid—shapes behavior. In China, UEBMI is funded mostly by payroll contributions; URRBMI is funded by public money and small premiums. A major reform is to move from many small city pools to larger provincial pools, which spread risk and allow more even benefits across places [4]. To work well, transfers across cities should follow clear rules that consider age, disease burden, and local input prices. Clear rules build trust and reduce conflict.

On provider payment, Diagnosis-Related Groups (DRG) and the diagnosis–Intervention Packet (DIP) pay by the case rather than by each service. The two systems are cousins: DRG uses diagnosis and procedure groups with case weights; DIP uses intervention “packets” with scores that are sometimes easier to implement in settings with variable coding capacity. Both aim to stop pure fee-for-service inflation and to support pathway-based care. Pilot studies show that when coding is clean and audits are educational, costs can be contained without clear quality harm [7]. Hospitals learn to track complications and length of stay, not just revenue per test. This learning effect is as important as the payment formula.

In the United States, multiple payers are kept on purpose. Employer plans are funded by employers and workers. Medicare is funded by federal taxes and premiums. Medicaid is funded by both state and federal governments. National health spending reached about \$4.9 trillion in 2023, close to 17-18% of GDP [3]. Because payers negotiate separately, prices for the same service can vary widely. One clinic may be owned by a hospital system and charge a facility fee; another clinic down the street may be independent with a lower price for the same visit. Site-neutral payment tries to reduce these gaps by paying similar rates for similar services regardless of location, which can lower sudden bills linked to facility fees [10].

5. What people feel: access, affordability, quality, and equity

5.1. Access

Access is not only about how many doctors a country has. It is also about distance, opening hours, referral rules, and trust. Consider a young parent with a child who has mild asthma. In Chengdu, the parent may choose a tertiary hospital for the first visit but later use a community clinic for refills if the team feels reliable. In Ohio, the parent checks whether the preferred pediatrician is in network. If the employer switches networks in January, the family may need to change doctors. Both families value speed and familiarity; both fears wasting time or facing a surprise bill. Policies that build a stable front door and reduce churn make access feel real.

5.2. Affordability

Families feel affordability as volatility. In China, centralized procurement and NRDL negotiations push down prices for many drugs and make pharmacy bills more predictable [4]. But deductibles and annual caps can still cause big jumps for rare diseases or for patients with many conditions. Adding disease-specific programs and catastrophic protection smooths those spikes. In the U.S., the IRA sets new caps for some Medicare drug spending and begins federal negotiation for a limited list of medicines, but commercial prices still ride on complex rebates that patients cannot see [9].

Point-of-prescribing OOP estimates and steady monthly caps for common chronic medicines can raise adherence even if average spending does not fall quickly.

5.3. Quality

Quality has a measurement side and a craft side. China's payment reforms and accreditation push toward safer, more standard care. Cities begin at different baselines, so building skills in coding, analysis, and audit is essential [7]. The U.S. collects many quality metrics, but lists are not always aligned across payers. This creates paperwork that can crowd out improvement work. A practical step is to publish a short list of public indicators like risk-adjusted readmission rates and timely access to primary care and then pay for improvement on those [1,6]. Quality policy should feel like coaching, not only compliance. When teams see regular feedback that matches what patients care about, they improve faster.

5.4. Equity

Equity gaps track geography and income. China's move to provincial pooling can reduce place-based gaps over time, but provider supply still leans toward big cities [4]. Adding supports-training, telehealth links, and payment add-ons-or clinics in less-developed areas can turn financial pooling into lived equity. In the U.S., gaps follow Medicaid expansion status, job stability, immigration status, and long-standing racial disparities. Making enrollment simple-short forms, wider windows, and proactive outreach-helps people who would otherwise fall through the cracks [2,12].

6. Future development: a practical roadmap

For China, the near-term goal is to deepen what already works while avoiding new problems. Provincial pooling should continue with clear formulas that move funds fairly between cities. These formulas should consider age, disease burden, and local input prices, so poorer counties are not punished by bad luck. DRG and DIP should grow from pilots into daily habits. That means clean clinical coding, friendly audits, and feedback that shows teams where complications arise and how to fix them. Procurement and NRDL negotiations can keep prices low, but supply needs active monitoring. Allow more than one winner where markets are concentrated, keep small buffers for narrow classes, and publish early warnings when bids are too few or deliveries are late [4,8]. Most importantly, build a trustworthy primary-care front door. Family-doctor teams should be able to handle refills, basic risk checks for diabetes and hypertension, and quick online follow-ups. When first-contact care is strong and local, tertiary hospitals can focus on complex cases, and total spending grows more predictably [5].

For the United States, two levers stand out. First, stabilize coverage. Keep ACA subsidies strong and support Medicaid expansion in the remaining states to reduce churn and protect relationships between patients and clinicians. Second, make prices easier to read. The Medicare negotiation program under the IRA should be a clear, evidence-based process that rewards real clinical value and shows patients usable net-price information. At the clinic level, outcomes-based payment for primary care can fund longer visits, team coordination, and community health workers, especially in rural areas. A move toward site-neutral payment can also reduce sudden price spikes tied to where a service happens rather than what the service is [10]. Finally, both countries can do small things with big effects: real-time OOP estimates when a drug is prescribed, simple public dashboards for waiting

times and essential-medicine availability, and plain-language benefit explanations at enrollment. These design choices build trust, which is the quiet currency of any health system.

This is a policy comparison emphasizing patient-facing outcomes rather than exhaustive legal or econometric evaluation. Some reforms—such as provincial pooling details, DRG/DIP scaling, and U.S. Medicare drug negotiation—are still evolving, so measured impacts may change as new data appear. Cross-country indicators can also mask local variation. Future work could track volatility of out-of-pocket spending across income groups, evaluate primary-care access using standardized wait-time dashboards, and assess supply-stability safeguards in centralized procurement and NRDL negotiations.

7. Conclusion

China and the United States are designed differently, but they share a basic challenge: people fear surprise costs more than steady, known costs. Viewing affordability as a volatility problem helps evaluate policies by what families feel. For China, deeper provincial pooling, learning-oriented payment, careful procurement with supply monitoring, and a strong primary-care front door can make daily costs steadier while keeping prices under control. For the United States, steady coverage, clearer prices, and support for team-based primary care can raise continuity and reduce waste without blocking innovation. The proposals in this paper focus on moments that matter: the prescription counter, the clinic doorway, and the monthly budget because that is where health systems become real in people's lives.

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