CHINA’S RURAL HEALTH SYSTEM IN TRANSITION: TOWARDS COHERENT INSTITUTIONAL ARRANGEMENTS?

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INTRODUCTION

China has been in transition to a market economy since the late 1970s. This attempt rapidly to establish a market economy and protect the population against excessive dislocation and suffering is a complex process for which there are few precedents (Nolan 1995; Rawski 1999). The Chinese approach to transition can be understood as a complex and continuing negotiation. It has benefits and costs. The economy has grown rapidly and household incomes have risen substantially. There is a relatively stable environment, within which stakeholders have adapted to change. People have had time to revise their views of how to order social relationships as markets have emerged. China has avoided the kind of institutional collapse that some other transitional economies have experienced (Reddaway and Glinski 2001).

Some argue that that the gradualist approach has resulted in substantial economic losses (Woo 1999a). The absence of a well-defined regulatory framework has encouraged certain kinds of opportunistic behaviour. Interest groups have been able to retard change and individuals and institutions have taken advantage of incentives provided by partially liberalised markets. Inequalities have risen between regions and social groups (Khan and Riskin 2001).

This paper explores the transition from the perspective of rural health. It reviews the development of the health sector before and after the commencement of the transition to a market economy, situates it in the context of transition and explores recent debates about strategies for the reconstruction of a coherent rural health system. It pursues two main arguments. The first is that the health system has to be understood as a complex set of relationships between stakeholders with different interests and positional power. These stakeholders must share expectations about appropriate behavioural norms for it to perform well. This means that health reform has to be situated in the broader context of economic and institutional transition. The second is that transition implies profound changes at a discourse level in how institutional arrangements and relationships are constructed. Transition changes the rules for negotiating behavioural norms, establishing and internalising contracts (implicit and explicit), and understanding accountability. This is a profound challenge, and we can expect to see diverse responses, multiple experiments and considerable turbulence, at least in the short term.

FIFTY YEARS OF RURAL HEALTH DEVELOPMENT

The three-tier rural health system

In thirty years after 1949 China greatly reduced its population’s burden of sickness and premature death. This was largely due a lessening of severe poverty,
improvements to the rural environment and increases in literacy. The health sector contributed by providing preventive programmes and effective and affordable basic medical care (World Bank 1997).

By the mid-1970s China had established a rural health system with the institutional arrangements that analysts believe necessary for it to perform well. These include a network of appropriate facilities and personnel, social financing of a large proportion of health expenditure and mechanisms to co-ordinate service providers and encourage health workers to act in the community’s interest (Chernichovsky 1995). The specific arrangements reflected the prevailing economic and institutional realities (Tang et al 1994).

Most villages had a health station with several part-time health workers. They organised public health campaigns and provided basic health services. Each commune (now called townships) had a health centre, with several doctors and assistant doctors. These facilities co-ordinated and supervised public health programmes and provided medical care. The county health bureau was responsible for the performance of local health services. It prepared plans and allocated the annual government budget. County institutions supervised township and village facilities and provided referral services.

Village personnel were paid a share of collective production. Health centre workers were paid either a share of collective production, or a government salary. Village and township health facilities charged patients a small fee and sold drugs and other consumable items. People paid more at the county hospital. Most communes established local health insurance schemes, which derived revenue from household contributions and collective welfare funds. They provided some services free of charge and reimbursed a proportion of other medical costs.

**Adjustment to the emerging market economy**

During the 1980s and 1990s the rural health system had to adapt to the transition to a market economy. It also had to adjust to demographic and epidemiological changes, urbanisation and industrialisation (Hussein 1999). The institutional arrangements for the rural health system changed a great deal during that period (Bloom and Gu 1997). The dotted lines in figure 1 indicate functional relationships that became weaker. The following paragraphs describe these changes.

**Figure 1, Changes in functional relationships in China’s rural health system since the late 1970s**
Public sector pay increased, reflecting income rises in rapidly growing regions. The government devolved financial management to lower levels (Wong 1995). Governments of poor rural areas experienced growing financial problems. By 1998 township health centres received only 10.5% of their expenditure from government and village clinics received almost no government support (Fu et al 2000).

Health facilities now compete for patients. Supervision and referral has diminished. Government officials no longer influence day-to-day management of health facilities. Many local governments do not have the resources to monitor and regulate the health sector effectively. Health facilities have a great deal of autonomy. There are an increasing number of private providers.

The rural health services increasingly resemble a poorly regulated market. The government has only begun to establish a regulatory framework to replace previous systems for influencing health providers. It retains powers from the past. For example, it controls prices. It has kept charges for consultations and hospital days low, but allowed facilities to earn a surplus from drug sales and test fees. This has encouraged high levels of drug use (Zhan et al 1997; Dong et al 1999).

Health facilities in rich areas provide an increasingly sophisticated mix of services, but at rising cost. Facilities in poor localities provide a smaller range of services than before, partly because they have lost their best personnel (Tang 1999; Gong et al 1997). Preventive programmes have deteriorated in some localities (Shu and Yao 1997). The cost of rural health services has risen more quickly than the income of farmers since the early 1980s (Liu et al 1996; Fu et al 2000). Meanwhile, most local health insurance schemes have collapsed. In 1998, 87% of villagers had no health insurance (Meng and Hu 2000). There is evidence that decisions to consult a doctor, purchase a course of drug therapy or accept admission to hospital are influenced by cost. Some borrow money to pay for treatment. A MoH study claims that a family’s poverty can be attributed to disease or injury in 23% of cases (Meng and Hu 2000).

HEALTH DEVELOPMENT IN THE CONTEXT OF TRANSITION

The rural health system presents a paradox. There is a dense network of health facilities and a large number of health workers (although the most qualified doctors have moved to urban facilities). There are reasonably high levels of health expenditure. Despite this, many rural residents have difficulty gaining access to services. This section situates this poor performance in the context of the changing institutional environment and the need to negotiate new arrangements and behavioural norms.

The institutional environment

The pre-1980s rural health services were embedded in the institutions and behavioural norms of the command economy. This section describes how this environment has changed and continues to change.

Local administration

Townships have been established as the lowest level of government. They are integrated into the system of public administration. Village committees are not part of
government. They manage local affairs, financed by informal levies and profits of local enterprises. The government has instituted elections to village committees. The performance of these local administrative and accountability structures varies a great deal.

Township and village administrations have a great deal of autonomy from central authorities. The latter establish broad development strategies and the legal framework within which localities operate. They also influence promotion of local officials. However, local authorities have substantial control over resources.

Some localities have experienced rapid economic growth and established quite sophisticated welfare systems (Cook 1999). In some cases this includes local health insurance (Carrin et al 1999). So-called “super-villages” have become centres for economic development (Zhe 2000). They organise a wide range of social benefits for their residents. There are a variety of institutional arrangements in these localities. The ownership of enterprises and the relationship between economic and administrative structures differ considerably (Oi and Walder 1999).

Other localities have experienced less economic growth and their public services have deteriorated. It is difficult to assess the relative contribution to these difficulties of economic backwardness, administrative weaknesses and problems with governance. These factors re-enforce each other. Local governments have difficulty retaining skilled staff. They spend 80% or more of their budgets on salaries. They raise additional revenue through informal levies that create burdens for households and local enterprises (Young 1995). Some local authorities use their resources primarily to benefit influential groups. This kind of behaviour fosters distrust in local institutions. These problems, in turn, compromise economic development.

**Labour market**
The shift from a managed labour force with low pay and productivity to a market with growing differences in earnings between regions and between categories of worker has strongly influenced the rural health system. Most village health workers provide care on a fee-for-service basis and also work their land. Township health centres have lost their most experienced personnel and many of their health workers do not have medical qualifications. County health facilities focus largely on revenue-generating activities in order to pay salary bonuses.

When township governments were established, decisions were made about how to treat people who had been performing public tasks for the communes. Village health workers were given access to land but did not become government employees. Workers in township health centres became salaried employees with full pension entitlements. This led to a differentiation between largely private village clinics and the public township facilities. The two levels now compete for patients and for government funding.

The management of public sector pay has reflected the need to adapt to increasing inter-regional differences in earnings whilst maintaining an integrated public service. The government sets a national pay scale. However, localities make their own adjustments. Successful facilities pay substantial bonuses. Facilities in poor areas don’t even pay basic salaries. This was initially experienced as a temporary
phenomenon; some health centres recorded underpayment of salaries as debt. Expectations have altered and a differentiated pay structure has emerged. Employment contracts now include an explicit or implicit understanding that levels of pay will be related to facility’s financial performance.

Facilities in poor areas have been unable to retain their most skilled personnel. Other employees find government salaries and pension entitlements attractive. Township health centres have continued to employ new graduates of local training schools. They also finance pensions for retired employees, some of whom compete for patients as private practitioners. They have had to pay a growing work force from diminishing government grants and a falling number of patients. This has further compromised their ability to retain skilled health workers and provide good services.

System of public finance
There are growing inter-regional differences in levels of public expenditure (Ahmad 1997). The devolution of public finance has given advantages to rapidly growing localities. They have been able to limit the proportion of tax revenues they transfer to higher levels and they have introduced informal levies outside the tax system (Oi 1999). This has allowed them to fund considerable increases in expenditure on social benefits. On the other hand, governments of poor townships often spend more than 80% of their budget on salaries and pensions (Zuo 1997).

During the late 1980s and early 1990s, townships and villages financed an increasing share of expenditure out of informal levies. Fast growing localities derived most of their revenue from enterprises. Other areas depended on household levies. There were protests that some localities imposed a higher burden on farmers than the benefits justified. In 1993 the government limited the levies a locality could collect to 5% of average household income. This reduced opportunities for rent-seeking by local administrations. However, it also lessened the ability of well-run localities to provide additional services. For example, they cannot introduce compulsory local health insurance. This measure was an expression of the limited control government has over the performance of local administrations.

Government-facility relationships
Oi and Walder (1999) describe a variety of relationships between rural enterprises and local government. In some localities collectively owned enterprises predominate. In others, private entities are more important. The authors suggest that it is more useful to look at who has authority over certain key decisions than at the legal status of these entities. Oi (1999) argues that the performance of local administrative bodies strongly influences a locality’s development experience, whatever the formal relationship between enterprises and government.

One finds a variety of relationships between government and health facilities. Half the village health stations are privately owned and most of the rest are leased to health workers. The status of many health centres is ill-defined. Township governments mostly own them and sign contracts with managers. The contracts tend to focus on financial issues. Township governments have a limited capacity to monitor their performance. The manager negotiates an annual government grant based largely on the number of beds and staff. Many facility managers have little control over hiring and firing staff. Some government facilities have developed more explicitly private
characteristics. The author has visited ones where employees have invested in new equipment or where local businessmen were also investors. There are increasing numbers of private providers of health services and producers and suppliers of pharmaceutical products. These private entities operate in a lightly regulated environment.

**The management of change**

A recent paper by Woo (1999b) divides analysts of the post command economy transition into “convergence” and “experimentalist” schools. He interprets their disagreements in terms of their views about the endpoint of transition. He argues that adherents to the convergence school expect a typical market economy to emerge and consequently urge government to create the appropriate regulatory framework as quickly as possible. He suggests that the experimentalists anticipate new forms of relationship between government and enterprises and consequently emphasise local initiatives. Woo’s focus on ultimate institutional arrangements does not adequately capture the issues involved in creating institutional arrangements for a market economy. It does not take sufficient account of the profound discourse changes needed for actors to internalise new rules of behaviour.

An important characteristic of China’s approach to transition has been the devolution of economic power to local government (Shue 1988). The national government establishes broad policies, but local administrations have a lot of leeway in translating them into new practices (Lichtenstein 1993; Oi 1999). This approach permits localities to manage reform locally and test reform options before the national government risks altering the legal framework (Kelliher 1992). The decentralised approach also accentuates inter-locality differences in development experience. Some localities seem to be caught in a vicious circle of poor performance by local institutions, lack of trust on the part of the population and an increasing resort to short-term strategies for solving livelihood problems.

The Deputy Mayor of a prefecture in a poor rural area recently underlined the importance of attitudes and understandings of local stakeholders in the health sector at a meeting to discuss a health reform and development project. He referred to three imbalances in project implementation: (i) progress in rehabilitating infrastructure contrasted with delays in reforming institutions; (ii) different understandings of health reform on the part of officials at various levels of government and (iii) persistence of attitudes relevant to a command economy in the face of the emergence of a market. His analysis is consistent with a language in China that contrasts hardware (meeting quantitative targets) with software (system development). It is argued that insufficient attention has been paid to the latter.

Mackintosh (1999) argues that rules and sanctions have to be complemented by implicit agreements between health stakeholders in low and middle-income countries. She emphasises the influence of shared understandings and expectations on health system performance. She refers to the importance of a service ethic in which health workers act in the interests of patients and receive high social status in exchange. She points out that governments cannot encourage these understandings simply by creating rules and monitoring adherence to them. They also need to foster informal understandings that reinforce ethical and professional behaviour.
The creation of new social arrangements is complicated by the need to reconcile the interests of different localities, age cohorts and employment groups in a situation of rising differences in income. Two recent publications highlight new government thinking about these issues (CASS 1998, 2000). The government is giving high priority to measures to encourage lagging areas to catch up. It is also paying more attention to the reconstruction of the social sector and the social security system. This involves the establishment of rules-based entitlements to resources and a more explicit formulation of strategies to reconcile competing interests.

China’s transition can be understood as a series of local adaptations punctuated by changes to the legal and institutional framework. The government articulates development objectives and establishes a framework within which stakeholders adapt. This framework includes widely accepted limits to opportunistic behaviour. There has been a continuous testing of boundaries and re-negotiation of relationships. Changes to the legal framework have tended to institutionalise forms of relationship that have already been established.

The government treads a fine line in changing the legal framework during a major transition. If it implements reforms that do not reflect local realities people may ignore rules inconsistent with local livelihood strategies and live outside the formal framework. This can erode respect for the rules and weaken constraints to opportunistic behaviour. If government delays the institutionalisation of new relationships for too long, it prolongs a situation of vagueness that encourages stakeholders to pursue strategies for short-term gain. The lack of clear rules creates high transaction costs. It may lead to sub-optimal outcomes because people have little assurance that particular social arrangements will persist. Zhang (2000) argues, for example, that the lack of a clear regulatory and fiscal framework for village-level institutions has become a constraint to the development of local services. Recent experiences with local health insurance lead to similar conclusions (Bloom and Tang 1999).

RECONSTRUCTING RURAL HEALTH SYSTEMS
The Chinese government acknowledges that rural health services have serious problems (Li 2000). Recent policy statements have articulated the following vision of a reconstructed rural health system (State Council 1997a&b). All facilities will provide competent, cost-effective services. Preventive programmes will reach most of the population. There will be good systems of referral and supervision. The use of drugs and diagnostic tests will be rationalised. Government will be an important source of health finance. Local health insurance will protect families against the cost of serious illness. Special measures will ensure the poor have access to essential health services. The government restated this broad direction of rural health development in a 2001 policy statement.

Few disagree with this vision of a future rural health system. However, broad policy statements can mask disagreements about how to achieve the desired goal. Liu and

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2 One example has been the approach taken to the creation of a labour market with increasing differences in pay (Bloom et al 2001). The government permitted institutions and individual health workers to test a variety of strategies for increasing local pay levels. Some of these strategies pushed against the edges of legality. It clearly identified practices that were illegal. Oi (1999) describes a similar approach to the control over the use of extra-budgetary funds.
Bloom (2001) argue that policy statements reflect the state of discussions between national ministries and provincial governments on issues such as permissible tax burdens on peasants, levels of fiscal transfer and the rationalisation of public sector employment. The translation of policy into health system change is largely determined by the actions of local stakeholders.

In order to achieve the government’s vision, the rural health system will have to establish the functional relationships identified in figure 2. These functions could be expressed through a variety of relationships between government, service providers, community structures and local accountability mechanisms as long as they fulfil the following conditions:

- the relevant actors know their roles and have the capacity to play them;
- stakeholders understand the rules of behaviour and mostly can meet their aspirations by conforming to them; and
- it is widely assumed that most people will follow the rules.

**Figure 2, Functional relationships in the China’s future rural health system**

This section focuses on Chinese thinking about how these relationships can be established. It begins with a discussion of the discourses that link health development to transition. It then discusses debates about options for financing rural health and influencing health providers. The discussion draws on presentations made by senior decision-makers, health administrators and policy analysts to a conference on rural health development and reform in Beijing in November 2000 (Shi and Li 2000). The aim is to link discussions of health development and transition management.

**Health and issues of transition management**

Current debates about rural health development pose fundamental questions about the roles of government, collective bodies and private providers (Cai 2000). This subsection reviews the different understandings of how to manage transition to a more appropriate health system.

**Individual versus social sources of finance**

Individuals account for over 85% of total health expenditure in most rural counties. In spite of policy statements affirming the need to reduce the direct financial burden on sick people’s households (State Council 1997a), social sources of finance continue to provide a diminishing share of total health expenditure. One reason is that government does not give high priority to health. It has not included health in the ten
priorities of the Western China Development Programme. This reflects a judgement by political leaders about the relative importance of health. It may also reflect their belief that rural health services are not performing well and that additional funds would not provide substantial benefits. Health systems in poor localities are caught in a vicious circle of low levels of public finance and increasing recourse by health workers to short-term livelihood strategies that reduce public trust and jeopardise their long-term standing.

Planning versus the market
The demographic composition of rural communities and the pattern of disease have changed, transportation has improved and people’s expectations of health care have altered. There is duplication of facilities between levels of government, government departments and public and private sectors. There is a growing mismatch between health needs and available health facilities and services.

There are a number of different discussions about the roles of government and the market in addressing this mismatch. One focuses on reforming the planning system. Government policy statements call on localities to produce regional health plans that take needs into account. These plans would mainly concern the allocation of government investment expenditure, but would comment on other aspects of government action as well. They would resolve competition between facilities owned by different administrative bodies.

Another discussion is about “inappropriate” government interference in health facility management. One area of concern is the pressure to increase staffing levels. Another is the fixing of low charges for basic services, without compensating health facilities for lost revenue. This discussion is linked to a concern about how health workers can be encouraged to respond to community needs. This is understood as a shift from previous attitudes that viewed government facilities as simply implementers of quantitative plans. Analysts point to the way village doctors and private clinics are attracting patients away from township health centres. Health is seen to be lagging behind other sectors in reforming the relationship between local government and enterprise managers and in changing the attitudes of the latter. Present government efforts to clarify the ownership of health facilities can be understood in this context.

There is a strand of thought that points to the limited influence of government plans and policies on health facilities. For example, local governments and health facilities provide most investment funds, themselves. Regional health plans, therefore, have limited influence on capital development. This strand of thought links to concerns amongst some analysts that health providers are losing their ethic of social service as they think more like businessmen. This leads to arguments for government to play a more active role in influencing health facilities.

It is difficult to disentangle these ideas since they reflect a variety of understandings of the relationship between facility managers and government officials and of their likely responses to different initiatives. Almost everyone agrees that government must play an important role in the health sector and that some policies and procedures provide perverse incentives to service providers. However, views differ about the degree to which local governments are likely to use finance and regulatory powers in the public interest.
Vertical versus community approaches

Another set of issues concerns the roles of the government and township and village structures. Zhe (2000) distinguishes between “vertical” and “community” patterns of development of public services. She suggests that vertical structures are rigid and tend to represent the interests of employees. She argues that new relationships will develop out of village and township collective structures. She illustrates with examples from successful super-villages. She suggests that work should focus on strengthening township and village capacities to implement health reforms.

Some localities do not have the capacity or inclination to support health services effectively. Tang and Bloom (2001) illustrate with an example from a county in Guanxi Province, where devolution of health centres to township governments had a deleterious effect on their performance. This raises the more general issue of strategies for health development where local administrations are weak or insufficiently accountable to the population. Should vertical structures play a more active role in these circumstances?

Social sources of finance

Government funding of rural health

The Chinese Government spends very little on rural health by international standards. A study in 7 provinces found that governments of poor counties and townships spent between $0.83 and $2.40 on health per capita in 1996 (Hicks et al 1998). They spent only $0.24 - $0.62 outside county hospitals. Local governments could increase rural health expenditure by re-allocating their budgets. However, poor localities will need larger fiscal transfers to fund basic services adequately.

A government decision to finance rural health services through increased fiscal transfers would raise questions about the channels of flow. Should higher levels of government earmark additional funds for specific purposes, such as health? Should the funds flow to local health departments, or should they go to community structures? It would also raise fundamental questions about how to maintain incentives for local governments to reduce inefficiencies, whilst providing large subsidies. Some administrations may use subsidies mainly to benefit influential social groups. An increase in fiscal transfers would have to be accompanied by measures to make local governments more accountable for their performance. This would involve a major change in the relationship between levels of government.

Community health finance

There has been a great deal of debate about whether local administrations should be allowed to introduce compulsory local health insurance, known as the co-operative medical system (Liu et al 1996; Carrin et al 1999). The health sector has supported this idea (State Council 1997b). Others have opposed it to protect households against financial burdens that do not provide commensurate benefits (Du 2000). Many localities have not been able to convince people to contribute to voluntary schemes, despite the fact that households spend a lot on health. The reasons include the high cost and low quality of services in health centres, lack of trust in the management of funds and the disincentives for the young and healthy to contribute (Bloom and Tang 1999).
The experience of the co-operative medical system highlights the importance of institutional issues. Successful schemes are mostly in localities that have achieved rapid social, economic and institutional development. Their success depends on the ability of local government to generate funds from enterprises and the ability of government and communities to ensure that schemes use money in the interest of their members and are seen to do so.

**Integrating government and community finance**

Rural health services will probably be funded from several sources. A facility may receive a budget from the local health bureau, earmarked allocations for specific preventive programmes, grants from foreign donors and payments by users of services. Users may claim reimbursement from a local insurance scheme or department of civil affairs. This could encourage a fragmented approach to health services and hasten institutional decline. Measures are needed to co-ordinate providers and encourage them to meet priority needs. The following section explores institutional arrangements that might achieve this.

**Encouraging providers to meet priority needs**

Managers of many rural health facilities are caught in a vicious circle. They are under pressure to increase salaries, but they cannot attract enough patients. They face increasing competition. They try to earn money by selling more drugs and providing more clinical tests. But this raises their costs and reduces demand. Users and providers of services lose from this situation. If users do not have confidence in local facilities, they are likely to choose the cheapest provider for minor illnesses and attend hospital for serious problems. It discourages government from increasing funding for basic services. This squeezes out competent local practitioners. The challenge is to construct an institutional environment that enables health workers to meet their aspirations by providing good services. This involves changes to formal rules and implicit contracts between stakeholders.

**Public versus private ownership**

The concepts of public and private ownership are not clearly differentiated in the institutional environment of rural counties. The relationships between local administrations and enterprises are changing. The instruments of direct control are becoming weaker and local governments have complex relationships with enterprises in what Oi (1999) calls “local state corporatism”.

The health sector faces the challenge of simultaneously reducing inappropriate interference by government and political authorities and increasing appropriate constraints to opportunistic behaviour. This involves changes in attitudes and understandings of facility managers and government officials. The former have to think more like managers of private entities by taking responsibility for efficiency and meeting consumer demands, but at the same time, they have to understand their role as professionals and agents for the community. The latter have to learn which forms of interference are no longer acceptable and which are desirable.

Village clinics are mostly private. Government policy focuses on “integrating” them with township health facilities. This mostly means strengthening relationships of supervision and referral between the two levels. Discussions of this matter mostly do not address the question of why village doctors should accept greater government
control over their behaviour. Township governments would have to modify their practice of favouring their own health centres over village clinics in allocating public funds.

The meanings of public and private are complex with regard to township health centres. Some analysts argue that their ability to adapt to the new situation has been limited by the influence of local governments on personnel management and other issues. Others express concern that measures are needed to curb a tendency by health facilities to promote expensive kinds of health care and neglect preventive programmes at the expense of the interests of patients.

A wide variety of forms of private practice have emerged. One response by local administrations has been to “clean up” the local market by putting certain clinics and drug sellers out of business. Another response has been to require village doctors to pass licensing exams. Discussions about how to regulate private providers are just beginning.

**Purchaser provider split**

There are debates about how additional social funding should be channelled to health service providers. Some argue that local health departments give too much weight to the interests of health workers. That is one reason why the government has given control over urban health insurance to the Ministry of Labour and Social Security. Others suggest that arms-length relationships between purchasers and providers make it difficult to establish a collaborative approach to reform management.

Some advocates of an increase in public funding of rural health services call for a similar split in rural areas. Liu (2000) calls on government to allocate additional funds for the provision of specified services, rather than to channel resources through the usual vertical channels. Du (2000) makes a similar point. There are two broad ideas about possible purchasers of rural health services. One possibility is that county and township governments take on this role. The advantage is that the systems are already in place. Problems might arise if these governments were not able and willing to convince health facilities to rationalise their staffing levels. There is also a danger that a level of government would favour its own facilities and employees over private ones or those belonging to other levels of government or government departments.

The alternative is to use community structures. This would involve the establishment of county and/or township health service boards that include representatives of county and township governments, health workers and bodies of democratic supervision. Existing local health insurance schemes can be understood as early stages in the establishment of such boards. The author has visited schemes that have successfully reduced unnecessary costs. The problem with this arrangement is mostly associated with the creation of new institutional structures capable of agreeing health budgets with local governments, negotiating contracts with providers and monitoring the performance of health facilities.

The choice of institutions will differ between localities. The main objective of health system development in very poor counties is to ensure people have access to competent basic preventive and curative services. The best way to achieve this may be by strengthening vertical programmes and subsidising providers of these services.
Where institutions are more highly developed and local capacity for management and
democratic supervision are greater, health boards might be more appropriate.

*Exit and voice for service users*

There are two broad areas of discussion about the role of users in influencing service
provision. One focuses on improving the competency of actors within the health care
market and the other on strengthening institutions of local accountability.

Some discussions focus on individual choice. They highlight the diversity of service
providers and point to the success of village doctors, drug peddlers and a variety
government and private facilities in drawing patients away from township health
centres and county hospitals. There are discussions about the strategies government
health facilities could employ to win back patients.

There is increasing interest in measures to enable people to be more effective
consumers of health services. Some studies point to patients’ role in demanding
sophisticated drugs (Zhan et al 1999). This leads to ideas about informing service
users. For example, schools, clinics and shops that sell drugs could be asked to post
guidelines for the treatment of common complaints on their walls. People would then
know if a health worker or drug seller were offering inappropriate or unnecessarily
expensive products. Also, local government could provide information on the
performance of local health facilities.

Other discussions focus on “democratic supervision”. This is related to the role of
elected village committees and the local People’s Congresses. There have been
developments towards making local decisions about tax and expenditure transparent.
Many villages now publish their annual accounts. There are discussions about how to
improve the voice of local residents in influencing health services. This would involve
provision of relevant information, creation of mechanisms to enable people to voice
complaints and establishment of mechanisms to influence health facility managers.

**CONCLUSIONS**

The adaptation of China’s rural health services to economic and institutional change is
complex. It is easier to imagine the kind of health system that might ultimately be
desirable than to understand the next few steps. Everything seems to be
interconnected. The outcome of one change depends on many other things happening.
This has implications for transition management.

One sign that people give priority to health is the high level of private expenditure on
medical care. There is evidence that people recognise and value competent and ethical
medical practice; one often finds that particular health workers are successful in
attracting patients, whilst others are underemployed. Some localities have well-
regarded health services and people have been willing to contribute to prepayment
schemes. This illustrates that new forms of co-operative relationship can be
established in the health sector.

One major step towards a coherent health system would be for local governments to
end regulations that provide perverse incentives to facility managers. Local
administrations need to find ways to finance pensions for ex-employees without
putting financial burdens on health facilities, to end pressures on managers to hire
staff as a means of preventing open unemployment and to remove price controls that provide perverse incentives to sell more drugs. These measures can all be understood as a withdrawal of inappropriate government interference in facility management.

The health system also requires institutional arrangements that encourage providers to meet community health needs. This involves the creation of new (implicit or explicit) contracts between health stakeholders. It also involves active government involvement in financing and regulating health services. Local government leaders will play a key role in fostering health system development. The outcome will be strongly influenced by their understanding of the problems and their willingness to do something about them.

The creation of coherent health systems is a special challenge in poor localities. If the national government decides to increase fiscal transfers to them, it will have to find ways to link transfers to effective monitoring of the performance of local administrations. It will also have to create incentives for local government officials to use resources and regulatory powers in the interests of the community. This may involve clearer specification of the objectives of rural health finance and of indicators of achievement. It may also involve measures to foster the development of institutions that are accountable to the community. This would imply a change in the balance of influence between higher and lower levels of government, at least with regard to localities that are net recipients of fiscal support.

The development of local health institutions depends on many contextual issues. A variety of organisational arrangements are likely to emerge. They will combine measures that encourage decentralised management of facilities with those that encourage providers to act in the interests of the community. The lesson of the past 20 years is that particular organisation forms are less important than the creation of an environment within which local government officials and local stakeholders have incentives to find constructive solutions to meeting needs.
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