FINANCIAL REFORM AND ITS IMPACT ON HEALTH SERVICE IN POOR RURAL CHINA

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Abstract

China has initiated its economic and financial reform since the early 1980s, tremendous progress has been made in terms of keeping high economic growth rate, increasing revenue and improving people’s living status during the last two decades. The financial sector reforms, mainly instituted in 1993-1994, have tried to rectify the financial sector to solve some of the problems emerged during the reform process such as “too fast and too hot economy growth” in order to maintain a healthy economic development. The financial sector reforms seem successful according to the report by the Ministry of Finance. A stable financial revenue mechanism has been set up; the average annual GDP growth rate was beyond 8% in 1996-2000. The GDP achieved 8,900,000 million yuan and the financial revenue reached 1,338,000 million yuan in 2000, the average growth speed of financial revenue during 1996-2000 was 16.5%, which is the best period in the history.[1]

Paralleled with the economic and financial reform, health sector in China has experienced vast reforms and changes. Large progresses have been made in terms of increasing the numbers of health facilities, hospital beds and personnel, enhancing the availability and accessibility of health services, and upgrading medial service techniques. Major health indicators of the country such as life expectancy, maternal mortality rate (MMR), infant mortality rate (IMR) have been continually improved. However, the health achievement of China is unbalanced with large disparities between rural and urban areas, poor places and non-poor places as well as eastern and western parts of the country. In addition, a number of problems and challenges have occurred during the health reform process. The important problems include the followings: the maldistribution of health resources, 80 % of health resources allocate in urban areas where only 20 % population live, to the contrast, only 20% health resources distribute in rural areas where 80 % population live. Health facilities emphasis on curative services and most health resources concentrate on curative services and expensive high technique medical equipment, while preventive and other basic medical service lack of necessary health resources. Rapidly increasing of medical service fee make the poor unable to afford for medical service, many of them fall into poverty or return to poverty because of serious disease of family member. The proportion of health expenditure provided by government has declined yearly and
government’s financial support to health facilities is almost entirely used on salary and can only cover some percentage of salary, health facilities have to depend on curative services and selling drugs in order to earn their salary. Rural population has to pay for health services by using the money out of their pocket resulting from the collapse of rural collective medical scheme (CMS).

The situation in poor rural areas is even worse than less poor areas. This paper has attempted to look into the impact resulting from the financial reform on the health service in poverty-stricken settings. The first part of the paper reviews the main steps of china’s economic and financial reform. The second part described the major change and development process of china rural health sector reform. The third part that is the bulk of this paper presents the problems and challenges currently facing the health service in poor rural areas obtained from literature review and field visiting in two poor counties separately in Yunnan and Guizhou province. The fourth part tries to analyze and discuss the effect caused by the financial reform on the health service in poor rural areas as well as issues that need further study. Due to the nature of vertical system, most existing data focuses on either financial sector or health sector. Few papers that studied the impact caused by financial reform on health service are available, and it is also rare to find the papers which study the requirements raised by the health sector reform and development for financial reform. Therefore, this paper have made the preliminary attempt to link the reforms happed in two vertical but interrelated systems and to see the impact on health service in poor rural areas.

Reference
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drugs in order to earn their salary. Rural population has to pay for health services by using the money out of their pocket resulting from the collapse of rural collective medical scheme (CMS).

The situation in poor rural areas is even worse than less poor rural areas. This paper has attempted to look into the impact resulting from the financial reform on the health service in poverty-stricken rural settings. The first part of the paper reviews the main steps of China’s economic and financial reform. The second part described the major change and development process of China rural health sector reform. The third part presents the problems and challenges currently facing the health service in poor rural areas. The fourth part tries to analyze and discuss the effect caused by the financial reform on the health service in poor rural areas as well as issues that need further study. Due to the nature of vertical system, most existing data focuses on either financial sector or health sector. Few papers that studied the impact caused by financial reform on health service are available, and it is also rare to find the papers that study the requirements raised by the health sector reform and development for financial reform. Therefore, this paper have made the preliminary attempt to link the reforms happened in two vertical but interrelated systems and to see the impact on health service in poor rural areas.

1. The major reforms and changes of financial sector in China

1.1 The command economy period

In 1950-1979, the financial sector of China adopted a very power-centralized policy called “unify to obtain revenue and unify to allocate budget”, which means the central government was in charge of collecting fund and planning expenditure, local governments had little power to decide financial income and budget. Although some adjustments had been made during this period, the core part of this policy that was to unify arranging revenue and expenditure by central government remained until 1979. Given the highly power-centralized financial management mechanism, large amount of revenues collected from rich areas had been arranged to support the poor places through the national budgeting process. All provinces and municipal cities directly managed by the central government could be roughly divided into 3 categories: large amount financial fund flowing-in provinces, large amount financial fund flowing-out provinces and little financial fund flowing-in or flowing-out provinces. Of which, provinces where fiscal revenue was drawn out mainly locate in the eastern coast areas of China, while the provinces that received financial assistance mostly lie on the western part of China, including Yunnan and Guizhou provinces. For example, the pure flowing-in of financial revenues of Yunnan and Guizhou provinces between 1953-1979 were separately 4701 million yuan and 5939 million yuan, whilst the pure flowing-out financial revenue of Shanghai and Tainjing city during the same period accounted for respectively 85.4% and 71.8% of the total fiscal revenue of the two cities.
1.2 The planned commercial product economy period

In 1980-1987, the central government took a new financial management policy called “eating separately”, which means central government was only responsible for arranging the revenue and expenditure of enterprises and taxes that belong to central government, local governments were in charge of allocating the revenue and expenditure of local enterprises and facilities. For those provinces whose fiscal income was more than expenditure, some percentage of the revenue had to hand in to the central government. For the provinces whose expenditure was more than income, local industrial and commercial tax fee were kept to local government. If the fund was still not enough to fill the gap, central government would allocate fixed subsidies to the local governments. For the poor, remote, border and ethnic minority groups’ residential places, the central government set up a development fund to allocate special fund to support those areas. In 1985-1987, the policy had been rectified, all financial revenue had been divided into three parts: revenue for central government, revenue for local government and revenue shared by both central and local governments. However, the basic component of “eating separately” policy that is fiscal decentralization is kept. In order to encourage local governments to increase their financial revenue, various “eating separately” policies were practiced from 1988-1990.

Due to the practice of “eating separately” fiscal decentralization policy, the fiscal revenue flowed out from the rich regional declined between 1980-1993. For example, the financial revenue flowed out from the rich areas in 1953-1979 was 529919 million yuan with an average 20382 million yuan each year, while in 1981-1993 the financial revenue flowed out from the same rich areas was 201957 million yuan with an average 20196 million yuan each year. It should be noticed that the economic growth between 1981-1991 was much larger than that in 1953-1979. Simultaneously, the percentage of central government’s financial revenue in the national financial revenue decreased and the macro-regulation power of central government over economic and financial work shrank. In 1979, the financial revenue of central government accounted for 46.8% of the national total fiscal revenue (both internal and external debts were excluded), while in 1992 it was only 38.6%.[3]

It’s important to notice that during 1981-1991 the fund flowed into the poor provinces continually increased rather than decreased. For example, the financial revenue flowed into Yunnan province increased from 4701 million Yuan (1953-1979) to 10704 million yuan (1980-1993), while in Guizhou province it increased from 5939 million yuan to 9780 million yuan at the same period. The total financial revenue, which flowed into the poor provinces, was 43823 million-yuan in 1953-1979, and it increased to 164229 million yuan in 1981-1991, the increasing rate was 274.8%.[2]

1.3 The tax reform period

Since 1994 the central government has adopted a new tax-separation financial management policy, the policy clearly separated the financial revenue resources of central and local governments, correspondingly two independent financial tax management systems have been set up. As the implementation of tax-separating policy, all provinces have to hand in tax to central government and the proportion of
central government’s financial revenue in the national total financial revenue increased from 22.02% in 1993 to 55.7% in 1994, then again declined to 48.86% in 1997. At the same time, the financial revenue flowed into poor provinces continued to increase. For instance, the financial revenue flowed into Guizhou Province during 1995-1997 was 15059 million yuan, the financial revenue flowed into Guangxi province (another poor province) during 1981-1991 and 1995-1997 were 11640 and 19932 million yuan respectively.

In March 2000, the central government initiated the pilot rural tax reform in Anhui province and a few counties/cities of other provinces aimed at exploring the establishment of regulatory rural tax system and reduction of farmers’ fee contribution burden from the root causes.\(^4\) rural tax reform has been perceived by policy makers as the third significant rural reform action after the rural land reform and the rural production management mechanism reform (the transition from collective production to individual farmer family production). It’s hoped that based on laws rural tax reform will rectify and regulate the benefits of nation, collective and individual farmer, and bring the allocation of farmers’ revenue into the domain of laws. Rural tax reform is also considered as the effective mean to reduce farmers’ financial burden, to increase their income, to protect rural labor forces, to improve the relationship between farmers and local governmental officers, to keep rural society stable and to promote the continually healthy sustainable development of national economy. The basic contents of rural tax reform is to replace the fee handed by farmers to local village committee and township government by agriculture tax and its appendix, to reasonably decide the farmers’ tax fee and to keep the tax fee level for a long time.

Rural tax reform in Anhui province is summarized as “three cancellations, one gradually cancellations, two adjustments and one reform.” The fee collected from farmers according to their last year pure income by township government has been cancelled. The fee collected from farmers by local government for rural education, administrative matters, government’s foundations and others has been cancelled. The slaughter tax has been cancelled. The province will take 3 years to gradually cancel farmers’ compulsory labor contribution. The collective production and public welfare matters such as building water channel, roads and bridges will take the measure “single matter, single discussion”, will be discussed and decided by village meeting. In the emergency cases such as flooding, it should be approved by county and above government to temporarily use rural labor force. Any departments and institutions are not permitted to use rural labor force without payment. The agriculture tax rate will be adjusted, the upper limitation will be 7%. The agriculture special product tax will be adjusted to avoid duplication with agriculture tax. The fee collected and used by village committee will be replaced by agriculture tax appendix, which can’t beyond 20% of the reformed agriculture tax.

The rural tax reform policy in Anhui Province also states very clearly that after the cancellation of fee collected by township government, the expenditure original covered by the fee for 9 year compulsory education at village and township level, family planning, and training of people’s militia will be arranged by government budget at each level. The rural health service will gradually implement fee-for-service
mechanism, and government will provide some subside. Rural tax reform will decrees the financial revenue of county and township governments, which will be solved by cutting off departments and staff paid by local government, adjustment of expenditure structure and so on. It should be based on the principal: separating government and enterprise, simplification and efficiency to reasonably set up department and institutions of township government and to strictly control staff number. After the tax reform, local government only participates in the investment of public matters such as road, water, electricity, school and agriculture infrastructure and will on longer involve in profit business. The increasing part of agriculture tax after the reform will be kept by local county and township governments, and provincial and city governments are required to increase financial revenue transition for county and township governments in poor areas to ensure the performance of grassroots governments’ responsibilities. However, some county and township governments in Anhui Province have been heavily affected by the reform, the financial revenue of many counties and township governments have declined to the half before reform. Because the fee collected by county and township governments prior to the reform was as high as 3 times of agriculture tax, the actual agriculture tax rate was less than 3%. Facing the financial shortage pressure accentuated by the reform, many township governments have to take measures to cut off staff, matters, expenditure and departments in order to fit the new financial supply capacity. Although there is no data available about the impact of tax reform on health services, it can be estimated that health facilities will be the easiest one to be affected by the cut off. Because the policy of Anhui province clearly stated that health service would gradually practice fee-for-service.

2. The major reforms and changes of China rural health care service

Some scholars divided the process of China rural health care service development into 4 phases: the preliminary establishment phase (1949-1965); the development phase (1965-1979); the reform implementation phase (1979-1990) and the reform deepening phase (1990-present).

2.1 The preliminary establishment of China rural health care system

The focus of this stage was to set up the supply system of rural health care. In 1949, the temporary constitution of P. R. China “ the consensus guideline of Chinese people’s politic consultation conference” clearly stated that: “government will expand health and medical service, actively conduct disease prevention and treatment, and pay attention to protect mother, baby and children’s health.” The statement identified the role the government would play in health care. In 1952, the central government set up 4 strategies for developing health work, the strategies were to serve workers, farmers and soldiers; to emphasis on prevention; to integrate Chinese medicine and western medicine; to combine health work with mass campaign. During 1950s, government founded some health facilities in rural areas, including health care station at county and township level. At that time, health facilities in rural areas embodied clinics and health care stations owned by government, agriculture cooperative units, rural doctor collectives and individual medical practitioners. However, the health care station owned by agriculture cooperative units and the clinics run by rural doctor
collectives took the bulk, the two types of health facilities accounted for 82.4% of the total health institutions in rural areas in 1956. By 1957, all counties established county hospital, county maternal and child health care station (MCH station), and birth delivery post. In 1958, people’s commune were founded, the clinics owned by rural doctor collectives had been restructured to form the commune hospital. By that time, a rural health care service supply system had been preliminary set up. However, farmers had to pay for the services they received, particular curative services. In 1955 the first rural cooperative medicine scheme (CMS) was created in Zhengyan County of Henan province. The CMS used collective fund to provide free of charge basic health care services for members. It was the first time in the history that thousands of Chinese farmers could get free health care services. The National Rural Health Work Conference held in 1959 highly praised CMS, since then CMS had been gradually expanded in the whole country.

However, the rapid transition of clinics from rural doctor collective ownership to people’s commune ownership or government ownership made a huge financial supply requirement to commune and national government while its health budget couldn’t meet the expenditure. Based on investigation and analysis, in 1962 the Ministry of Health issued the document “opinions about the adjustment of rural grassroots health organizations”. The document identified the ownership of health facilities run by collectives was collective ownership (not owned by government). And it also provided the management mechanism of this kind of health facilities: “independent to plan income and expenditure, self-responsible for profit and deficit, protect the original investment, to develop rural grassroots health organizations.”

2.2 The development stage of China rural health care

On June 26 of 1965, Chairman Mao issued the famous instruction: “put the emphasis of health and medical services to rural areas”. Thousands of farmers in the whole country were trained for a short time to become “barefoot doctor” to provide basic health care services for rural people. Meanwhile many medical graduates and urban medical staff as well as equipment had been assigned to rural areas through politic power, health facilities at county and commune level had been largely strengthened. These health facilities undertook a lot of disease prevention and other public health work. At the same time, CMS was replicated to many rural settings. After 1970, almost all commune hospitals were owned by collectives, government provided some subsides for commune hospitals, county health bureau was in charge of the manpower, finance and equipment of commune hospitals. By the end of 1970s, the coverage rate of CMS was beyond 90%.

2.3 The implementation of rural health care reform

Since 1978, China initiated its rural economic reform, people’s commune has been replaced by township and farmers’ production shifted from collective activities to individual family activities. Many village clinics were dismantled or contacted to private practitioners and CMS in many places was stopped due to lacking of financial support from village collective. On January fist of 1979, the Ministry of Health put forward that health facilities should be operated according to economic rules, which imply the initiative of health sector reform. During the same year, many doctors and
health personnel working at county and township level returned to cities, the service provision capacity of township hospital declined to a large extent. Given the situation, in March 1980 the Ministry of Health put forward to concentrate force to adjust and establish the health service system in one third counties of the country within 5 years, government will provide manpower, financial and equipment support. Simultaneously, the Ministry of Health also stated that as the supplemental component of national owned health facilities, private doctors were allowed to open clinics or hospitals. This means that government would no long to take all responsibilities of health services, more space was given to the private and collectives in terms of health service provision.

In 1985, the State Council approved a series of health reform policies made by the Ministry of Health. Followings are some of the policies: to give more freedom to health facilities; to encourage the private to open health facilities; to encourage health staff to take second medical job or to provide medical service using their spare time; to encourage health facilities with different ownership to open in rural areas; to set up the prices of new medical equipment and service items according to the cost; to allow the medical institutions with better condition to raise up their service prices.

Around in 1986, many provinces began to shift the management of township hospital from county health bureau to township government, some township hospitals dismissed or stopped working while CMS declined to less than 5% in the whole country.

In 1987, some places practiced the reform of township hospital contacting management. In January 1989, the State Council approved the document “ opinions on the expansion of health services”. The document pointed out the health system would promote various types of contracting management, allow to conduct fee-for-service during spare time or to get payment for extra work. The income received through conducting fee-for-service by MCH station, anti-epidemic station and drug test institute would be used to improve staff’s working and life conditions after deducting material fee and depreciation of medical equipment. Government wouldn’t reduce subsides to those health facilities.

2.4 The deepening of rural health sector reform

The development and change of rural health care in 1990s presented multi-directions. In the one hand, in order to fulfill the target set up by WHO “ Health for all by the year 2000”, the Ministry of Health made a plan with concrete health care targets and put forward to further strengthen health personnel in rural areas. On the other hand, a number of health sector reform polices continually have been implemented. It seems that the efforts pushed by the WHO goal to strengthen rural health were rapidly overcome by the reform forces. In 1991, health care system practiced separating management, all health facilities were independent to plan their income and expenditure, self-decided how to operation. The government performed target-oriented management mechanism over health facilities. In rural areas, township hospital ownership reform has been explored. Some township hospitals were changed as stock-sharing cooperative ownership, some were rented to individual medical practitioner or even sold to the private. In the middle of 1990s, some provinces and
cities explored the integration management of township and village health facilities, tried to bring village health facilities into the management field of health administrative department. In 1996, the health administrative department at each level began to recover and rebuild rural CMS. However, CMS recovery work faces many constrain, particular financial constrain. The CMS coverage rate had once reached 17.6% in 1997, then dropped again to only 6.5% in 1999.[7]

In 1997, the National Health Conference announced the famous document issued by the Chinese Communist Party Central Committee and the State Council “Decisions on Health reform and development”. The document restated the welfare nature of health care service and identified regional/district health planning, community health care service and rural CMS as the three major strategies of future health reform and development. Up to now, regional health planning has been tested in a number of places and not yet wildly implemented. Community health care service has mainly been conducted in urban areas. The progress in rebuilding Rural CMS is far more from what have been expected.

3. Challenges and problems facing current health work in poor rural China,

Rural health sector reform almost initiated at the same time with rural economic and financial reforms. It’s undoubted that great progress has been made in health field. However, some old problems are getting worse and new challenges emerged during the reform process, particular poor rural areas. Based on literature review and field visit in one poor county in Guizhou province, the major problems have been described as followings.

3.1 Government’s financial input in health care service is serious inadequate and the limited input is not used appropriately

It’s almost a consensus that government’s financial support for health care service is inadequate, particularly in poor rural areas. However, there is no national data about how many funds each level government spent on the health services in poor rural areas and how big the gap still is. Thus, we still lack of a complete picture about government financial support and the shortage in poor rural areas. In this paper, we try to use data from one poor county to illustrate the situation.

Guizhou province locates in the western part of China and is the number two province in China in terms of poor population. The province has been the financial revenue flowing-in place since 1953. Dafang County of Guizhou province is among the list of national poor counties. As showed in table 1, the financial expenditure of Dafang County was far more beyond its financial revenue. Although government’s health budget increased from 1990-1997, the budget for MCH didn’t increase even decrease if considering deflation, implying the increasing part of health budget spent on curative rather than preventive services. And the special allocate fund for both general health and MCH work, which usually come from upper level governments, declined from 1990-1997. That indicated that the financial support from upper level to Poor County for health work decreased
### Table 1: The Major Financial Data of Dafang County in 1990-1997

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<tr>
<td><strong>Per capita pure income of farmers (yuan)</strong></td>
<td>251</td>
<td>290</td>
<td>355</td>
<td>455</td>
<td>576</td>
<td>764</td>
<td>937</td>
<td>1107</td>
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<tr>
<td><strong>Government's financial revenue (10000 yuan)</strong></td>
<td>3225</td>
<td>3574</td>
<td>3626</td>
<td>3851</td>
<td>3453</td>
<td>4513</td>
<td>6036</td>
<td>7782</td>
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<tr>
<td><strong>Government's financial expenditure (10000 yuan)</strong></td>
<td>4763</td>
<td>4856</td>
<td>5568</td>
<td>6142</td>
<td>7596</td>
<td>8808</td>
<td>9384</td>
<td>12951</td>
</tr>
<tr>
<td><strong>Government’s health budget</strong></td>
<td>191</td>
<td>196</td>
<td>216</td>
<td>209</td>
<td>363</td>
<td>296</td>
<td>319</td>
<td>347</td>
</tr>
<tr>
<td><strong>Government’s budget for MCH</strong></td>
<td>21</td>
<td>22</td>
<td>16</td>
<td>16</td>
<td>21</td>
<td>18</td>
<td>23</td>
<td>22</td>
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<tr>
<td><strong>Budget for staff’s medicine</strong></td>
<td>119</td>
<td>136</td>
<td>155</td>
<td>180</td>
<td>207</td>
<td>249</td>
<td>263</td>
<td>379</td>
</tr>
<tr>
<td><strong>Special allocate fund for health</strong></td>
<td>28</td>
<td>22</td>
<td>25</td>
<td>24</td>
<td>26</td>
<td>13</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td><strong>Special allocate fund for MCH</strong></td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>45</td>
<td>4</td>
<td>3</td>
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Prior to 1998, there was 100,000 yuan allocated from Dafang County Government to Health Bureau each year for health work, half of the fund was allocated by the Health Bureau to townships for spending on maternal and child health care and anti-epidemic work. Since 1998, there has been no fund allocated from County Government to County Health Bureau except for the salary of County Health Bureau staff. Instead of, the County Health Bureau has been required to hand in money to County Government since 1996. And the amount of money handed in increased yearly: 50,000 yuan in 1996; 100,000 yuan in 1997; 50,000 yuan in 1998; 50,000 yuan in 1999; 120,000 yuan in 2000; and will be 150,000 yuan in the year 2001. 6% of the handed in money has been returned to the County Health Bureau since 1998. The major income source of County Health Bureau is the issue of certifications for private clinics and drug stores, which could generate income around 160,000 each year. After finishing the financial handing in task, the left money has been used to maintain telephone, car and travel cost. Recent two years, the County
Health Bureau has difficult to fulfill the income task, it has to shift part of its income-generation task to health facilities such as county hospital, county MCH station. Therefore, the County Health Bureau has no fund to allocate for health work since 1998. The World Bank Loan Health project and other health project provide some financial support for the Health Bureau, one staff of the county health bureau said: “we can not even maintain our office telephone operation without these projects.” Prior to 1990, the MCH station of Dafang County had 50,000 yuan each year for its work. The money had been reduced and finally stopped in 1998. There has been no fund at all for MCH work except for the salary of 29 staff since 1998 and the MCH station couldn’t get the salary unless it complete the tasks required by the upper. Therefore, the MCH station has to use some fund generated from its clinic services to support preventive care, monitoring and supervision over low levels as well as the operation of MCH information system. Furthermore, the MCH station has to hand in some money to the County Health Bureau since 1999: it was 8,000 yuan in 1999 and 12,000 in 2000.

The financial shortage at township level of Dafang County was even worse than in county level. Township governments are only responsible for providing 60% of the salaries of township hospital staff and 30 yuan subsides of each village MCH worker. However, the money is usually not allocated in time in many townships. The main reason is the serious financial shortfall. Many townships couldn’t complete the tax task, which would greatly affect salaries of all township staff, including health personnel. Due to the serious financial deficit, even the salaries of county staff have been often delayed. All township hospitals receive 60% of their salary from township governments and this money is often delayed because of financial deficits. There is no money is allocated from township government or from the upper health units to township hospital for its health work. All funds have to be generated from clinic services.

Health work is almost excluded from the working agenda of township government. Township governments don’t plan health work, they even don’t practice effective management over township hospital. For example, Pudi Township is the number one in terms of tax work, family planning work and comprehensive evaluation in Dafang County. However, the township hospital in Pudi almost breaks down. There is no equipment except for some forms and records required by county health bureau, MCH station and anti-epidemic station in the hospital. There were only 27 patients from January 1 to May 11 with average 4.5 patients per week. All doctors open a private clinic outside the township hospital. But the 60% salaries of township hospital staff are guaranteed by the township government. The director of township office asked: “who should provide equipment for township hospital? It’s the hospital itself or the upper level?”

3.2 Health facilities focus on curative activities, preventive care has been replaced by fee-for-service activities, medical expenditure increase rapidly

Due to the serious financial constrain, health facilities in poor counties have to relay on clinic services to earn their salaries, preventive care is largely ignored. As
One township hospital director in Dafang county said: “Each year, the first thing I need to consider is how much money the hospital need to earn, second is how to arrange each staff’s work, third is what things need to be repaired, fourth is how to finish the MCH and Anti-epidemic tasks.” In addition, some health reform polices also encourage health facilities including preventive care institutions such as MCH station and anti-epidemic station to practice fee-for-service activities, which lead to a negative impact on preventive care. As showed in table 2, the coverage rates of prenatal care and postpartum care and hospital delivery rates were very low in poor counties.

Table 2 The utilization of some basic maternal health care services by women in poor counties of four provinces\(^9\)

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<tr>
<td>Prenatal check up rate</td>
<td>44.22</td>
<td>18.7</td>
<td>74.5</td>
<td>84.4</td>
<td>---</td>
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<tr>
<td>Hospital delivery rate</td>
<td>5.14</td>
<td>15.4</td>
<td>12.8</td>
<td>8.9</td>
<td>11.1</td>
</tr>
<tr>
<td>Modern delivery rate</td>
<td>16.88</td>
<td>---</td>
<td>85.8</td>
<td>53.3</td>
<td>---</td>
</tr>
<tr>
<td>Postnatal visit rate</td>
<td>13.76</td>
<td>54.9</td>
<td>45.1</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Postnatal exam rate</td>
<td>3.67</td>
<td>---</td>
<td>29.4</td>
<td>3.3</td>
<td>---</td>
</tr>
</tbody>
</table>

Another result of emphasis on curative services is the rapidly increasing medical expenditure and medical drug abuse. In the middle and late of 1990s, the annual increasing rate of the national total health expenditure was as high as 12%-18%, of which the increasing of drug fee accounted for 60-80%. In rural areas, the fee for each consultation in 1998 increased by 268% than in 1993, while the increasing of per capita pure income during the same period only increased by 215.02%.\(^{10}\) Medicine fee forms a huge economic burden on farmers, especially poor farmers. One survey reveals that in 1985 the average medical expenditure of farmers was 7.65 yuan, while it reached 70.2 yuan in 1999, which increased 8.2 times. At the same time period, the average consuming expenditure of farmers only increased 3.4 times.\(^{11}\) A survey on 696 farmer households conducted in a poor township in Luoping county of Yunnan Province in 1998 shows that the average medicine expenditure of household was 501 yuan, which ranked the second of family expenditure items, just followed the expenditure of buying chemical fertilizer.\(^{12}\)

3.3 Poor farmers are unable to afford for medical services, their utilization of basic health service is very low and many families fall into poverty or return to poverty because of the sickness of family member.

At present 87.4% of the total rural population have no any medical care scheme, they have to pay for almost all health services they used.\(^{17}\) Among them, there are still 34000 thousand poor population whose basic life needs such as eating and clothing haven’t been guaranteed according to the national statistics. Due to lack of money, poor farmers’ utilization of basic health services is extremely inadequate. As showed at table 2, the hospital delivery rates in forth counties of four provinces were
less than 20%, the major reason for this was poor economic condition. The national health service survey undertaken in 1998 reveals that 37.7% of patients didn’t seek care and 63.7% of patient who should receive inpatient care didn’t use the service because of economic constrain. \[7\] the survey on 30 poor counties conducted in 1994 shows that the farmers’ average medicine expenditure accounted for 12 % of their total family expenditure, and the poorer the family was, the higher the medicine expenditure was. There were 15.6% families borrowed money to seek care and 5.5% families had to sell their property in order to see doctor. \[7\] Heavy economic burden caused by seeking medical services made many farmer households fall into poverty or return to poverty. A survey conducted in Xunyi county of Shanxin province in 1994 shows that the farmers whose per capita pure income was less than 302 yuan in 1993 reported an average 413 yuan fee for each inpatient service, which was 137% of their per capita pure income and 57% of their per household pure income. 47% of the poor farmers who had inpatient service had to borrow loan or sell their property such as cow and house to pay for the medical service fee. Among the poor people in one township in Xunyi County, 33% were getting poor because of sickness.\[13\].

3.4 The health indicators of poor rural areas are much worse than the non- poor settings

Most poor population lives in western part of China. The health indicators of the western part of China are obviously worse than the national average level. The fourth national census data shows that the life expectancy of population in Tibetan, Qinghai and Xingjiang provinces were 9 year, 8 year and 6 year lower respectively than the national average level. The infant mortality rate (IMR) in some western counties was 75 per thousand live births. The maternal mortality ratio (MMR) in western part was as high as 200 / one hundred thousand live birth, which was 4 times of the average urban MMR and 2 times of the rural average MMR. In 1998, the incidence rate and mortality rate of communicable disease in rural areas of the whole country were 186.2/ one hundred thousand and 0.33/ one hundred thousand , while the corresponding data in western part were 201.8/ one hundred thousand and 1.03/ one hundred thousand.\[14\] there are 7 provinces in western part whose tuberculosis disease incidences are higher than the national level.

The survey conducted in 30 poor counties in 1993 illustrated that the IMR, MMR, morbidity within the last two weeks priori to the survey et al were much higher than the corresponding indicators of the whole rural China, as presented at table 3.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>30 poor counties</th>
<th>The whole rural China</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR (one thousand live birth)</td>
<td>52.3</td>
<td>21.5</td>
</tr>
<tr>
<td>MMR (one hundred thousand live birth)</td>
<td>216.8</td>
<td>114.9</td>
</tr>
<tr>
<td>Morbidity in two weeks</td>
<td>130.6</td>
<td>128.2</td>
</tr>
</tbody>
</table>

Table 3 the family health investigating results of population health status in 30 poor counties\[10\]
Day with disease per thousand people in two weeks | 720.2 | 989.2 |
| Disable day due to disease per thousand people in two weeks | 449.0 | 327.0 |
| Stay-in-bed day due to disease per thousand people in two weeks | 312.4 | 123.0 |

All above demonstrated that health status of rural poor population was much worse than non-poor people, poor rural people have much bigger needs for health services. The health equity issues should become a major concern of China’s health reform and development.

4. Discussion

The first part of this paper presents a brief description of the major steps and development of financial sector reform in China. The second part describes the major development and change of China rural health reform. The third part summary the important problems and challenges facing poor rural areas. We will try to discuss the impact caused by the financial sector reform on health service in poor rural areas. In fact, the whole China is in a process of changing and development, financial sector reform is part of the changing process, rural health sector is also self-changing and developing. Therefore, it's hard to distinguish the impact caused by financial sector reform from other factors. However, some issues still need to be discussed and even need further studies.

4.1 Fiscal decentralization: decreasing the financial support from central government to poor areas?

Many people believe that fiscal decentralization or “eating separately” financial mechanism weaken the ability of central government to transfer fund from rich places to poor areas, which cause the serious financial shortage in poor areas, thus local governments don’t have financial fund to allocate to health work. However, the data shows that the financial revenue flowed into poor provinces continually increased after the implementation of fiscal decentralization although central government’s financial revenue decreased. For example, in 1959-79 the total financial revenue flowed into poor provinces was 43823 million yuan, while in 1981-1991 the data was 164229 million yuan, the increasing rate is 274.8%. Another example is Guizhou province, in 1953-1979 the financial revenue flowed into Guizhou was 5939 million yuan, in 1981-1991 it was 9780 million yuan and in 1995-1997 it was 15259 million yuan. The data of Dafang county of Guizhou province reveals that the health budget of county government was increasing from 1991-1997, but the MCH budget was decreasing (see table 2). There is no data available about how the funds flowed into poor provinces has been used. However, it can be estimated that the fund hasn’t been used on health care services, especially preventive care activities. It can be concluded that fiscal decentralization didn’t reduce the financial support provided by central government to poor provinces, at least not as seriously as many people thought. To the contrast, it weakened the macro-regulation power of central government over local
governments. When fiscal decentralization has been implementing and a series of policies has been practiced to encourage local governments to increase financial revenue, the regulation for both central and local financial expenditure to protect health care hasn’t been made by the central government. Particularly there is no regulation to ensure social development and social protection including health expenditure. Therefore, the shortage of health fund, particular the shortage of fund for preventive care in poor rural areas not only caused by financial constrains but also affected by lacking of expenditure regulation by central government.

4.2 Tax-separating mechanism: equity or inequity policy?

Tax-separating policy has been implemented since 1994, all provinces no matter poor or rich have to hand in tax to central government. In the one hand, the policy seems fair, all provinces hand in certain types of tax to central government, and then central government will have more financial revenue to transfer to poor areas or to provide national public goods. On the other hand, the policy seems unfair. Because some poor provinces’ economy heavily rely on certain products whose tax belongs to central government, which will cause to draw fund from poor places. For example, the economies of Yunnan and Guizhou provinces largely depend on tobacco grow and its products, while tobacco tax should be handed into national tax system. The data of Dafang County shows a big drop of local government’s health budget in 1995, it seems the effect of tax-separating policy.

4.3 Rural tax reform: bad new for rural health service?

Currently the rural tax reform has been tested in Anhui province and a few counties and cities. It is hoped by policy makers the experiences gained and lessons learned from the experimental sites will be expanded to other rural areas. Although it’s too early to assess the impact of rural tax reform on rural health care, some effects could be expected. Rural tax reform will greatly decrease the financial income of county and township governments, which already happened in some counties. In order to adapt to the new financial supply capacity, county and township government have to practice “down size”, as a marginalized sector with a unclear nature health facilities are easy to be cut off. It’s possible that township government cut all financial support to township hospital and put it into market to entirely become a business unit. The result of this might be the further worse of preventive care and the constant increasing of medical service fee if without good market management and regulation. In addition, rural tax reform will affect the fee collection of CMS. Before rural tax reform, fee for CMS was collected by township or village that manage CMS. After the reform, all fee collection will be stopped except for agriculture tax and its appendix, some local governments already issued document to stop CMS fee collection. Which will further barrier the CMS recovery. If local government could arrange some fund for CMS, it will promote the development of CMS. However, the situation in Anhui province seems not in this case, because the reform policy states very clearly that after the cancellation of fee collected by township government, the expenditure original covered by the fee for 9 year compulsory education at village and township level, family planning, and training of people’s militia will be arranged by government budget at each level. The rural health service will gradually implement fee-for-service
mechanism, and government will provide some subside. In poor rural areas, given the serious finance constrain, county and township governments usually don’t have fiscal capacity to put in CMS. Thus, CMS recovery work will be more difficult after the tax reform, farmers will have to continually buy health services for themselves.

**4.4 Establishing public finance: how big share health care should take?**

It’s very clear that the problems and challenges currently facing the health work in poor rural areas couldn’t be solved by poor area itself, government should fulfill its role to increase health equity by enabling all people access to basic health services. In the whole history of P. R China, the government’s financial support to rural health work has been mainly spent on supply side. given the context of market economy, it’s the time that government should finance people’s basic health service, particular poor people, so as to achieve certain health equity. Many researchers and scholars recommended that government should increase financial support to health work in poor areas or buy services for poor people. However, it’s still unclear which level government should increase financial input? how much should it put? What services should it buy for people? Is it central government or local government to buy services? What finance change and reform are needed in order to practice the recommendation? Establishing public finance is perceived as an approach to achieve this. However, it still needs to study how big share health care should take in public finance of each government? What measures should be taken to ensure the share? particular the finance segment for preventive care.

**5. Conclusion**

Financial sector reforms do have some impact on the health services in poor rural areas. However, the impact is hard to be distinguished from the effect caused by other factors, because health sector itself has been experimenting huge reforms and changes. The problems and challenges of health care in poor rural areas have been caused by many reasons, financial sector reform is one of the major reasons. But, to solve these problems and challenges need the financial sector reform.

**Reference**


conference on China rural health reform and development held by CHEI and IDS in Beijing in Nov. 7-9, 2000


