THE IMPACT OF SOCIO-ECONOMIC REFORM IN RURAL CHINA ON REPRODUCTIVE HEALTH SERVICES

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1. Reproductive health services in rural China

This part of the paper begins with a brief review of the definition of reproductive health (RH) and related services, given by ICPD Program of Action and confirmed by FWCW, followed by a short introduction of reproductive health services in rural China. Focus was placed upon the maternal and child health (MCH) system, the sexually transmitted diseases (STDs) service and a separated family planning system, which enjoys a relatively richer resource. A brief analysis was given to the Increasing but unmet needs in reproductive health, as a result of a global reproductive health promotion campaign.

2. Socio-economic reform in rural China

The socio-economic reform in rural China was reviewed briefly in order to provide with a general background. Decentralization and privatization in health system in rural China were described with examples, in a broader socioeconomic reform context.

3. Reproductive health impact of socio-economic reform in rural China

Reproductive health impact of socio-economic reform in rural China was analyzed focusing on impact on MCH service, STDs system, and impact on
family planning service.

There has been a clear tendency that more and more MCH service expenditure has been shared from the pocket of the rural residents, as a result of introduction of the fee-for-services policy. While the socioeconomic development and health promotion created an increasing market in MCH services, it might lead to a negative influence in MCH services and outcomes. Fortunately, because of the commitment of governments at various levels in decreasing maternal mortality rate (MMR) and infant mortality rate (IMR), a strong administrative fiat has been introduced. The “administrative intervention” is playing a critical role in preventing health institutions from providing less routine preventive health services in favor of more curative care, although a pressure of marketing does exist. Studies show that in most of the rural areas, an essential MCH services are being provided, and a fundamental equity in basic MCH services can be seen. One example is the nearly 90% coverage of the pregnant check-ups even in very poor rural areas. However, inequity could be also identified by further investigation and analysis. For instance, the poorest of the poor pregnant women have less chance to get pregnant check-up within the first three months of pregnancy. Therefore, medical aids are needed to reach the more vulnerable groups including the poorest women and children. In other word, while most of the clients in rural China become more affordable for essential health service, a consideration must be given to the poorest inhabitants.

The last year witnessed a rapid rise in STDs prevalence in many parts of
the rural China, especially in the County Towns. Mainly because of the traditional “culture of silence”, most of the STDs patients are seeking self-treatment or going to the private practitioners. Much of the money from these clients was abused by the un-standardized treatment. Recently, the new policy of HIV/AIDS control and prevention may provide the public STDs institution with an opportunity in service provision and institutional development, although challenges still exist in competing with the private practitioners.

The family planning in China has been enjoying relatively rich resources even facing the socioeconomic reform. However, some significant changes are emerging, including a new self-payment mechanism in both relatively developed areas as a result of informed choices in contraceptives, and in some very poor rural areas using certain contraceptives as the “new technical products”. Meanwhile, an emerging “reproductive and sexual health market” raises dreams for a new business to the industrial enterprises, as well as to the whole family planning system.

4. Conclusions and recommendations

The diverse and changing pictures in rural China is hard to simply summarize because the nation wide significant differences and unbalance, and the rapid variation everywhere. However, the author would like to draw some preliminary conclusions followed by policy recommendations, which may be useful in reducing the negative impact on RH services in rural China.

Conclusion 1: The on-going fiscal and social reform in rural China makes it more
difficult to maintain/rebuild and develop the public RH services.

Recommendations 1: Efforts must be made to ensure the essential RH services, especially the low-cost preventive services, available, acceptable, appropriate, accessible and affordable to the majority of the rural residents.

Conclusion 2: There are obvious and increasing inequities in RH services between the urban and rural inhabitants, the relatively developed and underdeveloped areas, and among the rich and poor households, as a result of the fiscal decentralization and economic reform.

Recommendations 2: Governments at different levels must take a more active role in reallocating the resources, rebuilding and developing the essential RH service.

Conclusion 3: Because of the significant unbalance and inequity in RH services, there are vulnerable groups of people who are in exposure of more risks of reproductive health illness.

Recommendations 3: Governmental sectors must pay specific attention to the vulnerable groups in order to reduce the inequity in RH. Meanwhile, research must be undertaken to better understand the practical way to empower these populations exposed to more risks.

Conclusion 4: In rural China, the poorest residents are suffering more with heavier disease burdens, but have less accessibility to service to protect them
from ill health. Some of them are falling into worse poverty. Medical aid for the poorest people may be cost-effective, if participatory approaches are successfully applied to motivate the communities and the health providers.

Recommendations 4: Governments at different level must take the responsibility of medical aid for the poorest residents, in order to improve equity in RH services. Meanwhile, participatory strategies must be utilized to motivate resources, and to involve the communities as well as health system.

Conclusion 5: Gender inequity has been identified in rural China, and the rapid changes caused by the socioeconomic reform may have a strong negative influence on the gender equity in RH.

Recommendations 5: Governmental RH sectors must be sensitized, in order to reduce the gender inequities in RH, and to respond to women’s unmet needs in RH services.

Conclusion 6: The population migrating from rural to urban area have a less accessibility to RH services, and their needs in RH are often neglected.

Recommendations 6: Migrating population must be empowered to express their RH needs, by means including RH promotion. Meanwhile, governmental sectors need to be sensitized to respond to the RH needs of the migrating population.

Conclusion 7: There is both positive & negative cultural impact on RH services,
caused by socioeconomic reform.

Recommendations 7: The cultural influences of rapid socioeconomic changes and their impact on RH must be examined carefully. While market forces must be carefully taken into account, the study and intervention focusing on culture will be also informative and should be useful. Especially, evidence-based intervention must play a more critical role.

Conclusion 8: The emerging market in sexual and reproductive health in rural China is a chance as well as a challenge for governmental family planning and health sectors.

Recommendations 8: Efforts must to be made to enhance the market monitory and management, and to motivating possible resources to respond to needs of the clients.

Conclusion 9: The MCH Prepay Scheme pilot project showed a possibility to motivate clients to invest in their health.

Recommendations 9: While provision of essential RH service for the poorest residents must continue to be a priority for governmental sectors, strategies of social marketing may be utilized to create a new market of MCH and other RH services for the majority of the rural inhabitants in China.

Conclusion 10: While administrative fiat is less and less reliable to direct local
implementation of health policy as the whole system is increasingly influenced by market mechanisms, evidences are identified that “administrative interventions” can still play a critical role in making health institutions to provide essential and critical routine reproductive health in rural China.

Recommendations 10: Administrative fiat must be utilized until better alternative interventions are identified, in providing the essential reproductive health services in rural China.
The Impact of financial reform in Rural China on Reproductive Health Services
Kaining Zhang

1. Reproductive health and reproductive health services

The 1994 Cairo International Conference on Population and Development (ICPD) marked a turning point for reproductive health. For the first time, reproductive health were internationally recognized by Governments, and contained in international documents:

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and its function and processes. People are able to have a satisfying and safe sex life and they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility, as well as access to health care for safe pregnancy and childbirth."[1]

The nations of the world agreed that special attention should be given to comprehensive reproductive health services to enable couples to achieve their reproductive goals. Sexual and reproductive health services within the primary health care context should seek to include: quality family planning counselling, information, education, communication and services; prenatal, safe delivery and post-natal care, including breast-feeding; prevention and treatment of infertility; prevention and management of complications of unsafe abortion; safe abortion services, where not against the law; Prevention, diagnosis and treatment, wherever possible, of reproductive tract infections, sexually transmitted diseases and other conditions of the reproductive system; Information, education and counselling on human sexuality, sexual and reproduction health, and responsible parenthood, including on effective prevention of sexually transmitted diseases and HIV; and a number of other services.

In resource poor settings like rural China, a broad definition of all possible services which contribute to reproductive health would be unrealistic as neither the equipment nor personnel exist to carry out these activities. Rather, a minimum set of low technology services aimed at screening for common reproductive problems of rural Chinese women are included in our definition of reproductive health services: maternal and child health care(MCH), family planning services and the sexually transmitted diseases (STDs) prevention, treatment and control service[2].

RH service is not totally separated with general health care. Therefore, this paper will first lay a hand on the general health care, and then give a more in-depth analysis on RH service in rural China.

2. Impact of financial reforms on health care in rural China: a brief review

Prior to 1976, when China initiated an ambitious economic reform program and open-door policy, the rural areas was organized into a commune system. The government used surpluses from state enterprises to fund public-sector social services. Beginning in 1978, the Chinese government introduced radical economic policy shifts that moved China away from a centrally planned economy and toward a competitive market system. This change in economic policies was accompanied by a devolution of power to provincial governments. The whole rural areas witnessed a transition from agricultural collectives to the household responsibility system State enterprises were overhauled. Local governments have had to rely on locally collected taxes to finance social services. The poorer areas were most affected by this structural change that has resulted in shifting public-sector financial constraints to the lower levels of government. In the health sector the government has encouraged
programs and facilities to rely on user fees to support their operations, but continues to administer many prices, setting most below cost, and to control staffing in public facilities\textsuperscript{2,3}.

Financial reforms have produced a dramatic effect on health care in rural China. There were three distinctiveness of health care system in rural China: Cooperative Medical System (CMS), three-tiered health care system and the “barefoot doctors”. This presentation will try to touch each of them briefly and correspondingly.

2.1 CMS rebuilding or risk-sharing scheme promotion

China pioneered rural, community-based health financing with the rural cooperative medical system, which operated under the agricultural commune system in the 1960s and 1970s\textsuperscript{3}. By 1975 the rural cooperative medical system had reached about 90 percent of the rural population. Although this coverage was not without major problems, it did provide China’s citizens with some access to cost-effective preventive and curative health services and some sharing of the risks of medically caused financial misfortune. China’s shift from agricultural communes to the rural production contract responsibility system weakened the collective economic foundation supporting the cooperative medical system. It eliminated the communal welfare fund, the main source of financing for the system and the only source of support for the barefoot doctors and for drugs and other health services. By 1983 only 40-45 percent of China’s villages were still covered by the CMS\textsuperscript{3}.

Figure 1 showed the changing coverage of the CMS in rural China during the last decades. It can be seen that the CMS dropped to about 10% in later of 1990s\textsuperscript{4}.

![Figure 1. Change in Cooperative Medical System Coverage](image)

**Sources:** Wu Qunghong (2001)

There has been a long-term debate in rural China: Moving to a market-oriented economy, do we need a planned or market-oriented health system? Many people believe that a critical issue is to rebuild or enhance the health care system with stronger supports of the governments at various levels. A great number of papers published in China investigating the practical ways to achieve this goal. Efforts and successful stories are continually reported. Different cases and evidences showed that the fiscal inequities have led to enormous variation in the provision of public health care services, and this has made significant differences in re-building the CMS. Nevertheless, if the governments provide a strong support under a great commitment, a new CMS will be in the place serving the people\textsuperscript{5}.

On the other hand, there are unambiguous evidences of efforts in privatization of rural health system. All of the 38 of the Township Health Centers have been sold recently in a county in Jiangsu Province is just a typical example\textsuperscript{6}. The debate and discussion will continue, although the majority are hoping the State Council will launch a policy for rural China, like what it had done for health care reform in urban areas.

2.2 Change in the three-tiered health care system, and promotion of township-village integrated health service

Currently farmers and their families normally enter the health system through a visit to one of China’s approximately 1
million village health workers, who work independently, engage in both health care and farming and often earn as much from farming as from medicine. Many of them received rudimentary training as barefoot doctors in the 1960s and 1970s and continue working in the villages of their birth.

In this first tier of the system village doctors diagnose and treat patients, prescribe pharmaceuticals, and refer patients to higher levels of service as warranted. Village doctors generally operate on a fee-for-service basis, but they also depend for income on the markup on drug prescriptions (typically about 15 percent). The village doctor may refer patients needing a higher level of care to the nearby township health center or hospital, the second tier of the rural health care system. There are some 52,000 rural township health centers, operating 730,000 beds, about a quarter of all hospital beds in China.

The fiscal reforms have led to enormous and dramatic impact on the provision of public goods and services. As mentioned above, the three-tiered health care and referring system provided the majority population in rural China with health care. Among these health institutions, the township health centers used to play an important role. There used to be friendly and supportive relationships among the three-tiered health care system. For example, village health workers used to be responsible for PHC, under the close supervision of the township health center. They often referred the patients to the township health centers, and even county institutions whenever necessary.

**EPS**: Anti-epidemic Station
**Source**: Li Changming (2001)

### Table 1. The number of three tiered institutions in rural China (1999)

<table>
<thead>
<tr>
<th>Institutions</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Hospital</td>
<td>2,040</td>
</tr>
<tr>
<td>County EPS*</td>
<td>1,688</td>
</tr>
<tr>
<td>County MCH</td>
<td>1,438</td>
</tr>
<tr>
<td>Town Care</td>
<td>49,694</td>
</tr>
<tr>
<td>89.9% of the Villages have clinics</td>
<td></td>
</tr>
</tbody>
</table>

Table 1 gives number of the major health institutions in rural China in 1999. It shows that a rather complete three-tiered health system still exists in rural China, providing with health services at different level. However, dramatic changes have happened in their relationships and operating mechanism. Financing reforms led to a fee-for-services mechanism, and now nearly every institute or provider is thinking about earning money. Driven by the market force, the village health workers are not willing to refer their patients to upper institutions now. Sometimes they even take the risk to perform certain treatment out of their ability, in order to generate extra incomes. Meanwhile, the financial reforms led to the better road & communication and these made it possible that more of the villagers can seek health care at the county hospital or even higher level. The traditional knowledge and beliefs in health shaped the health-seeking behavior for most of the rural inhabitants. Current studies showed that the majority of the peasants only purchase medicine at the village clinic or a drug store, and have a self-treatment when a minuscule illness occurs. If they did feel ill seriously, they intend to go directly to the county level institutions. As a result, the township health center lost a great part of their market.

One strategy to respond to this change is to combine village clinic with township health centers, by means of a united financing and management system. The staff of township health center often went to the affiliated village clinics working together with the village health personnel. This has been regarded as a part of the strategic health care planning for rural residents in current rural China. To a large extent, it might lead to a significant change in structure of the three tiers health care system in rural China.

2.3 From barefoot doctor to village doctor: health providers at grassroots level in rural China
It is well known that in rural China, there used to be an enormous number of the “Barefoot doctors”. They are the health care personnel in the community and for the community. The financial reforms made the “Barefoot doctors” affordable for “shoes”. In fact, the majority of them were up-graded as the “Village doctors” now, with a much more income than they used to earn.

However, to be up-graded each of them had to pass an examination in knowledge and skills in primary health care (PHC). The exam is the same to female and male “Barefoot doctors”. Nevertheless, a study showed that as there is a heavier burden on the shoulder of the female “Barefoot doctors”, the probability of success for female doctors is really less. Fortunately, because the global movement of women’s health and reproductive health, governments realized that female doctor is a must at each village clinic. This had made a number of female “barefoot doctors” survived, and they made a big difference in providing primary health care in rural China.

3. Reproductive health impact of financial reforms in rural China

Financial reforms have produced an enormous impact on reproductive health service in rural China.

First, the financing reforms have contributed to creation of the increasing needs and marketing in reproductive health service in rural China. The data given in the following parts will show evidences that the reforms did make new opportunities and create marketing for MCH and sexual health care in rural China.

Second, the reforms have led to a dramatic rise in disparity and inequality between reproductive health care resources distribution and service provision in rural and urban China, and disparity and inequality between rich and poor districts within rural areas, rich and poor households within a same district.

It was noted that financial reforms have produced a dramatic rise in disparity between general health care resources distribution in rural and urban China. For instance, Table 2 shows that the urban residents in China, making up of about only 30% of the whole population, are enjoying the 80% of the health resources. In fact, majority of the urban residents are covered by various kind of health insurance programs, while very few rural inhabitants can enjoy health insurance. Obviously, this has led to a strong influence on reproductive health service.

| Table 2. Population and health resource distribute in urban and rural China |
|-----------------------------|-----------------------------|
| Population                 | Urban | Rural |
| 30%                         | 70%   |
| Health Resource            | 80%   | 20%   |

**Resource:** Li Changming (2001)

In terms of reproductive health, evidences are available to illustrate that new disparity, inequality and inequity generated also by the reforms.

The following analysis will focus on impact of financial reforms on MCH service, STDs system, and impact on family planning service correspondingly.

3.1 Impact on MCH service

Table 3 gives several MCH core indicators in rural China in 1949 and 1998. It can be seen that maternal and child health outcomes in rural China looked fine, compared with many countries with similar or even a little higher income. Figure 2 and 3 showed the tendency of maternal mortality rate (MMR) and infant mortality rate (IMR) in the last decade. As illustrated in Figure 2 and 3, the MMR and IMR in rural China has been reduced gradually, during the last decade while the significant reform occurred. The outcomes are results of the interactions of a number of core factors, which are all closely related to
financial reform in rural China.

Table 3. Some Reproductive Health Indicators in rural China

<table>
<thead>
<tr>
<th></th>
<th>1949</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR £/100,000£ ©</td>
<td>200</td>
<td>37.7</td>
</tr>
<tr>
<td>MMR £/100,000£ ©</td>
<td>1,500</td>
<td>74.1</td>
</tr>
<tr>
<td>Life Expectation £/Year £ ©</td>
<td>35</td>
<td>70.0</td>
</tr>
</tbody>
</table>

Resource: Li Changming (2001)[7]

There has been a clear tendency that more and more MCH service expenditure has been shared from the pocket of the rural residents, as a result of financial reforms in rural China, which have led to the introduction of the fee-for-services policy in rural MCH system. The data from State Statistics Bureau showed a clear national trend, while in-depth studies provided detailed community-based evidences. For instance, a Ford Foundation supported three-year study, entitled “A study of the financing, provision and utilization of reproductive health services in rural China”, was undertaken by a team led by scholars from Harvard University School of Public Health, Kunming Medical College and Shanghai Medical University 1994-1997. This study revealed that there had been a decrease in the amount of funds allocated for MCH from the government’s health budget[10].

Figure 2. Decrease of Maternal Mortality Rate (MMR) in China (1990-1998)

Figure 3. Decrease of Infant Mortality Rate (IMR) (1991-1998) in China

Table 4 showed the costs of family planning and MCH services per married woman of reproductive age in the two poorest townships in a poor country in China, as a sample of one study of our team. Clearly, there was enormous inequality in the distribution of money dedicated to family planning and MCH. In addition, our data revealed that from 1985 to 1995 there was an increase in spending on family planning while MCH spending declined from already low levels. When the data were broken down by county and use, the huge decrease in the spending on MCH compared with family planning became obvious. The budget allocation data, corrected for deflation, revealed that there had been a decrease in the amount of funds allocated for MCH from the government’s health budget. This decrease was 6.6 percent in Yimen (where Pubei is located) and 1.2 percent in Shuangbei (where Erjia and Dazhuang are located) from 1990 to 1995. Family planning showed an increase of 1.6 percent in Yimin and 8.9 percent in Shuangbei over the same period[10].

Resource: Li Changming (2001)[7]
Table 4: Family Planning and MCH costs per Married Woman of Reproductive Age in Dazhuang and Erjia Townships, 1985-95 (in 1985 Yuan)

<table>
<thead>
<tr>
<th>Year</th>
<th>Dazhuang FP Costs</th>
<th>Dazhuang MCH Costs</th>
<th>Erjia FP Costs</th>
<th>Erjia MCH Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>13.74</td>
<td>1.74</td>
<td>10.00</td>
<td>1.59</td>
</tr>
<tr>
<td>1987</td>
<td>14.19</td>
<td>1.77</td>
<td>22.30</td>
<td>1.27</td>
</tr>
<tr>
<td>1989</td>
<td>15.09</td>
<td>1.11</td>
<td>12.03</td>
<td>0.84</td>
</tr>
<tr>
<td>1991</td>
<td>26.58</td>
<td>1.48</td>
<td>20.88</td>
<td>1.07</td>
</tr>
<tr>
<td>1993</td>
<td>31.25</td>
<td>1.02</td>
<td>22.25</td>
<td>0.82</td>
</tr>
<tr>
<td>1995</td>
<td>32.28</td>
<td>1.05</td>
<td>22.22</td>
<td>0.66</td>
</tr>
</tbody>
</table>

Resource: Joan Kaufman (1998)[10]

Figure 4 showed that the average annual income per person of the rural residents has been rising greatly and progressively. Meanwhile, as illustrated by Figure 5, health care expenditures of the residents of China have been also increasing gradually[7]. While a significant difference can be seen between the rural and urban residents, it is also clear that in both rural and urban areas, increasing number of people are now more affordable for health social care. As a matter of fact, health care expenditures of the rural inhabitants are increasing gradually.

Resource: Li Changming (2001)[7]

Figure 4. Increase of average annual income per person of the rural residents (Yuan)

Figure 5. Increase of average Health Care Expenditures per person of the Residents (Yuan)

While the socioeconomic development and health promotion created an increasing market in MCH services because that more peasants become richer and are more willing to pay for their health care, an increasing imparity, inequity and disequilibria between districts and households can be clearly identified. The poorest peasants are facing an increasing expenditure in RH care, which is quite often too hard for them to adopt. These poor people are more likely to suffer from ill health, and their health problems often keep them in poverty. Statistics showed that nearly all of the China's absolute poor live in the rural areas. Among the poorest quarter of the rural population, infant mortality is 3.5 times greater than the rate among city dwellers[4]. Therefore, in reproductive health planning and service provision, an attention must be given to the poorest households in rural area. Fortunately, because of the commitment of governments at various levels in decreasing in MMR and IMR, a strong administrative fiat has been introduced, giving a priority to the services to the poorest clients. Quite often the providers first try to collect fees for the essential reproductive health services. If the client is too poor to pay for the essential service, she or him will get a free-of-charge service, because there is a target-oriented management system, which is effective in preventing health institutions from providing less routine preventive health services in favor of more curative care, although a pressure of marketing does exist[11]. For example, when the management system is targeting to the coverage of the pregnant check-ups, nearly 90% coverage rate can be achieved even in very poor rural areas. To ensure to achieve this target, health providers
collect the fees from the majority of the clients who are affordable and willing to pay, but provide the poorest women with free check ups, in order to achieve the fixed target, the coverage. Studies show that this management system is still working fairly effectively [12]. As a result, in many of the rural areas of China, an essential MCH services are being provided, and a fundamental equity in basic MCH services can be seen [13]. Clearly, while administrative fiat is less and less reliable to direct local implementation of health policy as the whole system is increasingly influenced by market mechanisms, evidences are identified that “administrative interventions” can still play a critical role in making health institutions to provide essential and critical routine reproductive health in rural China. Therefore, administrative fiat must be utilized until better alternative interventions are identified, in providing the essential reproductive health services in rural China.

Reproductive health services for the poorest residents became a concern in rural China, as inequity in service utilization had been identified by some investigation and analysis. For instance, the poorest of the poor pregnant women have less chance to get pregnant check-up within the first three months of pregnancy. Therefore, medical aids for RH service are needed to reach the more vulnerable groups including the poorest women and children. In other word, while most of the clients in rural China become more affordable for essential health service, a consideration must be given to the poorest inhabitants. Study showed that medical aids for the poorest is not only useful in decreasing inequity, but also cost-effective in MMR/IMR reducing [14]. Meanwhile, studies showed that participatory approaches are invaluable to involve the communities, providers and to empower the vulnerable clients, the poorest of the poor [15].

Motivation for reproductive health resources is another core issue in rural China. Studies also showed potential and new market in MCH services. For instance, supported by Ford Foundation, a study was undertaken 1999 to 2002, in one of the 128 counties of Yunnan Province, in order to test the possibility of expanding the MCH Prepay Scheme. Participatory rural appraisal (PRA) approaches were employed to better understand women’s needs in safer delivery in poor rural areas, and participatory strategic planning workshops were co-organized by the research team and the County Health Bureau, together with other stake-holders. As a result, it was decided that the new prepay scheme should focus on pregnant check ups, health education and counseling, rather than focus on hospital delivery care. All of them agreed to prepay the Scheme fees 20 Yuan (US$ 2.5) for health care for one of the two births, and the money should be used in:--Developing some easy-to-read booklet with pictures, based on village women’s needs; --Providing the prepaid couples with health counseling and education; --Providing each of the prepaid pregnant women with reasonable pregnant check ups, and information about hospital delivery; --If the pregnant woman is in high risk, the health worker must refer her to higher level hospital. Health worker is required to talk with the husband and persuade them to have a hospital delivery. Moreover, the health worker is required to company the couple to the hospital, either at the township or in the County Town.

The pilot project formally launched in 2 townships on August 1, 1999, and went on smoothly. As shown in Table 5, In two years totally 283 couples enrolled the Scheme. The two-year experiences showed that both clients and providers were happy for the MCH Prepay Scheme, as both felt they win while nobody loses. The scheme was designed for new couples, prepaying for their two births. However, some couples with one child came to complain for “excluding” them! As a result of their insistence, 35 couples enrolled for their health care during pregnancy and birth for the second child. Recently, the MCH Prepay Scheme expanded to the whole county. Meanwhile, as a result of discussion with the representatives of the clients, the prepaid fees increased from 20 Yuan (US$ 2.5) to 80 Yuan (US$ 10), in order to cover all MCH preventive care services.

| Table 5. Number of couples and prepayment for MCH services in Huaning County (1999-2000) |
|-----------------|-----------------|-----------------|-----------------|
|                 | New Couples     |                 | Couples with One Child |                 |
|                 | n               | Prepayment (Yuan) | n               | Prepayment (Yuan) |
| HX*             | 70              | 2 800           | 9               | 180             |
| NZ**            | 178             | 7 120           | 26              | 520             |

15
In the two pilot townships, there were few poorest couples who were not affordable even for the US$ 2.5 of prepayment. They obtained not only free pregnant check ups, but also financial support for hospital delivery if they were identified as in “high risk pregnancy”.

Recently, a noteworthy reform in rural China is being tested and will be expand: shifting from fees collection to a new tax system. The major concern is to reduce the burden on should of the peasants. The village and township administrators are not allowed to collect any fees from the peasant, while the tax bureaucrats will responsible for tax collection. It is believed that each of the peasant households will enjoy a released burden. A considerable challenge is at the village and township level, there will be less funds available in supporting the collective health care. A great number of experts are trying to exam the health impact of the policy of shifting from “fees” to tax in rural China[16]. It might be too soon to reach to a conclusion yet. However, it will be interesting to see for instance what influence on MCH Prepay Scheme.

When investigating impact of financing reforms in rural China on reproductive health services, influence of financial reform on culture change and then culture in turn to services must be recognized.

Female doctors have been playing a critical role in reproductive health service provision and utilization. In rural China, complains from provider and managers were often heard about the little income of the village doctors. It was too often to say that to make the grassroots health care personnel stable, government had to increase their income. This might be true because in the changing society nearly everybody is considering about his or her income from time to time. However, one interesting phenomenon is that even in very poor rural areas, where the income of village doctors is really low, many girls are studying hard in medical schools with a dream to be a village doctor tomorrow. Quite often they are not affordable for the fees of the school. Therefore, they must finish their study with a loan! They declared that because the whole country is facing a marketing-oriented economy, it is fair for them to invest in their education for their future career. This might give some insight that financial reforms did changed people’s value. (In the past, nearly everybody in China believed that education MUST to be FREE!) This change in value or culture may be significant. Obviously there is a hope that new manpower resources for the next generation of health providers at grassroots level in rural China, because the village girls are undoubtedly willing to pay for their training now!

As a result of the rapid socio-cultural change, there is a clear tendency that fewer and fewer clients seek for the traditional medicine services, even in rural areas. This has a strong influence on the reproductive health system in rural China. On the other hand, the new generation of mothers and their partners are now more willing to accept and pay for MCH care, and this certainly leads to a potential market for health providers and planners. Certainly there is both positive & negative cultural impact on RH services, caused by financial reform. The cultural influences of rapid socioeconomic changes and their impact on RH must be examined carefully. While market forces must be carefully taken into account, the study and intervention focusing on culture will be also informative and should be useful. Especially, evidence-based intervention must play a more critical role.

3.2 Impact on STDs service

It was reported that the sexually transmitted diseases(STDs) was eliminated in later of 1950s and early 1960s in China. The department of venereal diseases even disappeared in the hospital, and the new generation of physicians knew nothing about STDs in early 1980s even at the comprehensive hospitals of China, because there was no patient. However, the last year witnessed a rapid rise in STDs prevalence in many parts of the rural China, especially in the County Towns. The rapid growth in economy, the change in culture in terms of sexuality and moral, the increasing migrating from rural to urban China, all made significant contribution to the rising of STDs rates[17]. It is worth noted that there are huge number of low-price sex workers and their clients from migrating male workers, and many of them go back to rural areas after a period of working out. Therefore, a STDs service must be available for the rural residents at a low cost. Ideally, this service had better integrated with
the existing health care in rural China.

Unfortunately, the governmental hospitals and health centers were not ready to respond to this change at all. The doctors were lack of training in diagnosis and treatment of the STDs. Say nothing in counseling and confidential & private services.

The huge number of consumers and the potential profit in STDs diagnosis & treatment have led to launching of a great number of private STDs clinics, in urban as well as in the county towns.

Studies showed that mainly because of the traditional “culture of silence”, most of the STDs patients are more willing to seek self-treatment or going to the private practitioners. The majority of the STDs patients in China adopted a mixed health care seeking pattern: First they purchase medicine and perform a self-treatment. If it not cured, many of them go to see the healers, or visit the private clinics, because of the privacy and confidential environment. Much of the money from these clients was abused by the un-standardized treatment. The patients only come to the public hospital when a perception of severe outcomes obtained, or self-treatment / private practitioners failed in curing their infections[17].

In the past HIV/ AIDS used to be regarded as some “diseased from outside” with stigma. The governmental sectors used to be silent, because they did not wish not mention the negative side of the Open-the-Door policy and development. Fortunately, the emerging storm of HIV/ AIDS in China has changed the perceptions and policies. Governmental sectors began to talk openly the STDs/ HIV/ AIDS. The STDs control and treatment networking is now being rebuilt. Even in the rural areas, the training in STDs diagnosis, treatment, counseling and confidential & private of the services are going smoothly. Hopefully, the new policy of control and prevention for STDs / HIV/ AIDS may provide the public STDs institutions and rural health care system with an opportunity in service provision and institutional development, although challenges still exist in competing with the private practitioners.

3.3 Impact on family planning service

The family planning system in China has been enjoying relatively rich resources even when the whole China is facing financial reforms. The great number of population and the rapid population growth continue to be a major concern of the policy-makers, and family planning service continue to be a national priority. From central to grassroots level, financial reform led to a significant change in structure of the governmental sectors. However, the separated family planning system continues to exist. The recently issued National Regulation on Family Planning Services gave a further evidence that family planning will continue to be a long-term priority of the whole country. Although it is true that the fiscal decentralization has led to significant disparity in resources available for local governments at different districts, the policy of “the core score” in evaluating the achievement of governments at any level and the “number one person responsible for family planning” at any district ensure that the governments at various level try their best to mobilize the possible resources to achieve the demographic goal. As mentioned earlier, in all of the counties selected as study sites for our three-year research on financing of reproductive health services in rural China, the government budget for family planning was growing, although MCH budget decreased significantly.

A factual transformation began in 1995 as a Ford Foundation supported pilot program on QoC in FP. Several outstanding policy-makers and managers began to try “a new mechanism of FP facing a marketing-oriented economy”. Rights of the clients are now emphasized at the pilot areas. Meanwhile, a silent test of fee-for-services started in one of the pilot areas of QoC in FP Program. To summarize, some significant changes in family planning service are emerging, including a new self-payment mechanism in relatively developed area as a result of informed choices in contraceptives[18].

On July 7, 2001 the State Council issued a national regulation on family planning services. For the first time, it is confirmed by law that the clients have the rights in obtaining informed family planning services. The Chinese family planning service institutions and network is now recognized by laws, and for the first time appeared in the documents of the central government. Meanwhile, it is a great challenge for family planning system, because they are required to provide free-of-charge services, because they are enjoying more resources than health system. The whole family planning service system will have trainings at different levels, from the central to grassroots levels. The Family Planning Regulation will be formally implemented since October 1 this year. It is expected that a substantial impact will be identified later.
Meanwhile, an emerging “reproductive and sexual health market” raises dreams for a new business to the industrial enterprises, as well as to the whole family planning system. There are evidences that in both rural and urban areas, there are emerging needs for “sexual health services”. Huge number of consumers stated their needs in information and other service in sexuality, in order to enjoy “a better life”. This has been revealed and reconfirmed by several pilot programs of needs assessment[19].

Industrial and enterprise units recognized the potential market and the emerging needs. The up-and-coming sex shops become a new things to see even in county towns.

The family planning system also appreciates the increasing needs in sexual and reproductive health. A number of papers exposed this sign by discuss the “emerging business in reproductive health”[20]. Moreover, the Scientific Research Division of the State Family Planning Committee (SFPC) organized a number of meetings and conferences investigating the new tendency. In June 2001, the SFPC has launched the “three comprehensive FP project in China for the 21st century”, focusing on “Healthy babies”, “RTIs” and “QoC in FP”. In July 2001, a quite comprehensive International Exhibitions on “RH Products” was organized in Beijing, in order to promote the “emerging business in reproductive health”.

One enormous challenge is how to protect the rights of the clients while motivate the potential resources for the future.

4. Conclusions and recommendations

The diverse and changing pictures in rural China is hard to simply summarize because the nation wide significant differences and unbalance, and the rapid variation everywhere. However, the author would like to draw some preliminary conclusions followed by policy recommendations, which may be useful in reducing the negative impact on RH services in rural China.

Conclusion 1: The financial reforms in China have led to enormous impact on the provision of health care services in rural areas. The on-going fiscal and social reforms in rural China make it more difficult to maintain/ rebuild and develop the public RH services.

Recommendations 1: Efforts must be made to ensure the essential RH services, especially the low-cost preventive services, available, acceptable, appropriate, accessible and affordable to the majority of the rural residents.

Conclusion 2: There are an obvious and increasing inequities in RH services between the urban and rural inhabitants, the relatively developed and underdeveloped areas, and among the rich and poor households, as a result of the fiscal decentralization and economic reform.

Recommendations 2: Governments at different level must take a more active role in reallocating the resources, rebuilding and developing the essential RH service.

Conclusion 3: Because of the significant unbalance and inequity in RH services, there are vulnerable groups of people who are in exposure of more risks of reproductive health illness.

Recommendations 3: Governmental sectors must pay specific attention to the vulnerable groups in order to reduce the inequity in RH. Meanwhile, research must be undertaken to better understand the practical way to empowerment these population exposed to more risks.

Conclusion 4: In rural China, the poorest residents are suffering more with heavier diseases burdens, but have less accessibility to service to protect them from ill health. Some of them are falling into worse poverty. Medical aid for the poorest people may be cost-effective, if participatory approaches are successfully applied to motivate the communities and the health providers.

Recommendations 4: Governments at different level must take the responsibility of medical aid for the poorest residents, in order to improve equity in RH services. Meanwhile, participatory strategies must be utilized to motivate resources, and to
involve the communities as well as health system.

Conclusion 5: Gender inequity has been identified in rural China, and the rapid changes caused by the financial reform may have a strong negative influence on the gender equity in RH.
Recommendations 5: Governmental RH sectors must be sensitized, in order to reduce the gender inequities in RH, and to respond to women’s unmet needs in RH services.

Conclusion 6: The population migrating from rural to urban area have a less accessibility to RH services, and their needs in RH are often neglected.
Recommendations 6: Migrating population must be empowered to express their RH needs, by means including RH promotion. Meanwhile, governmental sectors need to be sensitized to respond to the RH needs of the migrating population.

Conclusion 7: There is both positive & negative cultural impact on RH services, caused by financial reform.
Recommendations 7: The cultural influences of rapid socioeconomic changes and their impact on RH must be examined carefully. While market forces must be carefully taken into account, the study and intervention focusing on culture will be also informative and should be useful. Especially, evidence-based intervention must play a more critical role.

Conclusion 8: The emerging market in sexual and reproductive health in rural China is a chance as well as a challenge for governmental family planning and health sectors.
Recommendations 8: Efforts must to be made to enhance the market monitory and management, and to motivating possible resources to respond to needs of the clients.

Conclusion 9: The MCH Prepay Scheme pilot project showed a possibility to motivate clients to invest in their health.
Recommendations 9: While provision of essential RH service for the poorest residents must continue to be a priority for governmental sectors, strategies of social marketing may be utilized to create a new market of MCH and other RH services for the majority of the rural inhabitants in China.

Conclusion 10: While administrative fiat is less and less reliable to direct local implementation of health policy as the whole system is increasingly influenced by market mechanisms, evidences are identified that “administrative interventions” can still play a critical role in making health institutions to provide essential and critical routine reproductive health in rural China.
Recommendations 10: Administrative fiat must be utilized until better alternative interventions are identified, in providing the essential reproductive health services in rural China.

References