8-2004

China's Public Health Sector in Transition: Assessing Market Reform Impacts

Bo Li
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To the Graduate Council:

I am submitting herewith a thesis written by Bo Li entitled "China's Public Health Sector in Transition: Assessing Market Reform Impacts." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Political Science.

Yang Zhong, Major Professor

We have read this thesis and recommend its acceptance:

Robert B. Cunningham, David L. Feldman

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

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China's Public Health Sector in Transition:

Assessing Market Reform Impacts

A Thesis

Presented for the

Master of Arts Degree

The University of Tennessee

Bo Li

August, 2004

ABSTRACT

Many studies have been done to evaluate China's transitional economy and its impacts on the public health sector. It is a widely accepted proposition that the market reform initiated in the late 1980s significantly changed the public health sector. While some scholars argue that the Chinese people's overall health status has improved compared to that of the pre-reform era, others identify declining health expenditures and widening regional gaps, indicating quite a dim health situation. In this thesis, I argue that market reforms have not improved the people's access to health services. In the reform era, the overall civil health status had been declining due to insufficient public and governmental lack of financial support for the public health sector. The collapse of the Rural Cooperative Health System (RCHS) reduced rural residents' access to healthcare and thus greatly diminished their health benefits. Similarly, the downsizing work unit in urban areas also reduced urban residents' social welfare, including healthcare benefits. I assessed market reform impacts on China's health sector. The newly-established market mechanisms and empirical consequences of market reforms, from the perspective of both inside and outside of the public health sector, related to the public health sector are thus evaluated.

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CHAPTER I

INTRODUCTION

Why should I assess market reform impacts in the public health sector? Before I move on to the discussion of market impacts, there is a need to interpret the academic importance of studying the public health sector. A World Bank report indicates several developing challenges that China need to address (World Bank 2003). One of these challenges is unequal access to health care. Paradoxically, China has been evolving from a socialist state to a profit-maximizing and commercial-oriented state in only 20 years. The public health sector is one of the major areas that experienced radical commercialization, characterized with decreased political control and increased autonomy of health facilities (Bloom 1997). In the commercialization process, the previously publicly financed health sector was now being restructured to be a self-supported, sustainable, and independent industry. The market reform aimed to motivate local governments and public sectors to be self-supporting and self-managing. According to the State Council, the market reform was a great effort on releasing constraints for some economic departments which expected to be more activated.

In addition to rampant reforms outside the health sector, the market reform is also performing in the public health sector domain. The market reform influences in the health sector are called internal impacts, whereas those outside of the health sector are called

external impacts. By internally, I refer to those market mechanisms introduced in the health sector. These mechanisms included the increasing independency of hospitals on the respective governments for separation of drug selling with medical care providers, price reforms relating to health services and medicine, market-oriented hospital management reforms, and newly established patient-hospital relations in the absence of governmental intervention. By externally, I refer to market reforms happening outside the health sector. These reforms are seen within the big picture of China's economic transitions. These reforms, widely discussed by scholars, include: 1) rural Household Responsibility Reform; 2) urban enterprise reform; 3) nationwide price and merchandise reforms; 4) profound fiscal and revenue reforms; and 5) local-central relation adjustment in terms of economic responsibility and development.

It came to my attention that both external and internal market reforms have had some impact on the public health sector. In order to assess the market reform impacts, I will evaluate both these impacts.

The research question I address in this paper includes three subsets. First, in what perspectives has the health sector been changed by market reform? It is widely accepted that the Chinese health sector has changed due to market reforms. However, it is not clear in the extant literature whether the health sector was better or worse compared to the pre-reform era. In this study, I try to find out how significant these changes are for China's health sector transition.

Second, did market reforms change the Chinese health sector internally or externally? In transforming the Chinese health sector, is the market reform inside the health sector or outside the sector the most important factor? This question attracted my attention because the market mechanism was always flexible compared with governmental regulations (Byrd 1991). I want to clarify that market reform outside the health sector is much stronger than inside the health sector. This question will help us understand that China's public sector, including the health care sector, was still less commercialized compared to other economic sectors. However, this does claim commercialization in public sectors is good. Conversely, experience with western developed countries, especially the U.S., showed that commercialization has had some negative impact on public sectors.

Third, how do we assess market reform impacts on the Chinese health sector? Are these positive or negative impacts? This question involves market reform impacts assessment on the three major players: individuals, governments, and the health care sector. I want to discuss the different impacts that market reforms have had on these related players.

All in all, these research questions address the study of the Chinese transitional public health care sector. This study will help us understand how the public health sector is managed under China's transition from a centrally-planned economy to a market-based economy. The extant literature mostly focused on the transition happening inside the health sector. There was not much light shed on the external market reform impact on

health sector transition. This study tries to evaluate the significant role the Chinese government in the health sector which is different from traditional studies, the relationship between the government and health sector transition, and market reform impacts on the Chinese health care system.

Many scholars believe that the Chinese health sector is being transformed to a market-based system (Bloom 1999; Coyne 2002; Gail 1995). Some studies have evaluated the impact that the market mechanism has had on the health sector (Ho 1995). In the post-reform era, out-of-pocket medical costs in China have expanded due to various factors such as high inflation rates, low percent of GDP spent on healthcare, and declining insurance coverage (Coyne 2002). In this study, I argue that the Chinese health care system has been greatly changed because of market mechanisms introduced in the past ten years. People's access to health services has become unequal due to the government's inadequate recession from the public health sector and the *laissez-faire*. Today's health care sector has been reshaped as a profit-seeking market-based system which is thus unfriendly to many people in need of health services. In other words, the present health sector is inadequate for the Chinese society due to the downsizing role played by the government and the increasing reliance on the market mechanism in the post-reform era.

Yanrui Wu suggests that health spending increased due to the improvement in living standards and changing health care system (Wu 1997). Another study indicates that

medical cost escalation was partly due to bad health management; for instance, adoption of high-tech medicine and abusive expensive drugs usage (Liu 1995a). A market mechanism has not improved the Chinese people's overall health status (Liu 1999). Rural residents suffer from health care system reforms because of decreased governmental financial aid (Carrin 1999). Not surprisingly, Chinese people are suffering from increasing medical costs and declining public financial support. Therefore, I argue that the Chinese people's overall health status quo has not been improved in the reform era. On the contrary, unequal access to health services among the different social groups and diminishing coverage of health insurance indicates that the overall market reform impact is not all that positive on the Chinese society. Since many people are losing their health insurance program and benefits, they have come to doubt market reform and thus hinder ongoing reforms. If, in the near future, the government cannot provide adequate health services for those worse-off social groups, market reforms will make the Chinese society a disaster rather than properties.

The primary goal of this study is to find out and then evaluate market reform impacts on the health sector and its political and social consequences. As I mentioned earlier, my core argument is that market reform introduced by the Chinese government reduced the people's health benefits and thus the reform strategies should be adjusted to meet future challenges.

Figure 1.1 explains the analysis frame that I will conduct in this study. The analysis of the market reform impact focuses on the interaction among four players: the government, market, health care sector, and the individual. Obviously, the relationship between market and government and those between market and health sector are the most crucial of this article. As indicated in figure 1.1, arrows representing the market impact on government and the health sector are emphasized. Another important relationship evaluated in this article, as figure 1.1 shows, is the market impact on individuals, emphasized by an amplified dark arrow. To measure transformation of the health sector, the individual's health status is also investigated.

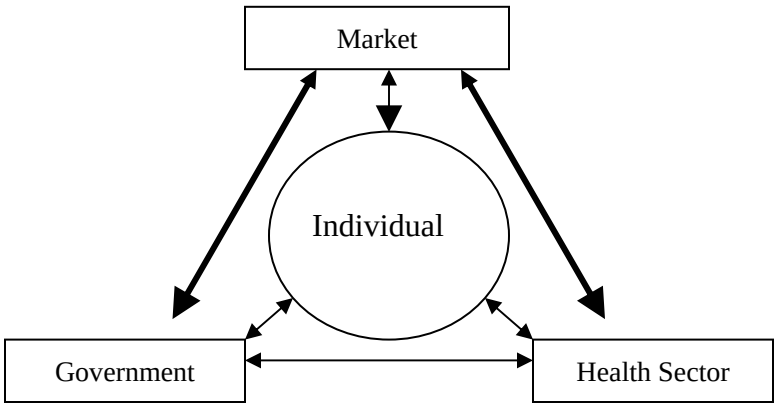

Figure 1.1 Analyzing the Market Impact in the Context of Interaction

Instead of the government, I will put much more emphasis on evaluating the role the market played in translating the public health sector. However, this is not to say that the market has replaced the government in managing the public health sector. My analysis goal is to find the improper impact of market reforms and the possible causation between reform and sustainable development. In order to explain increased market impact, the declining role of government in providing health services is also measured. The individual health status is measured to find the significance of the health sector transition. I will compare the people's access to healthcare and their status quo in the post-reform era to those in the pre-reform era.

To undertake this study, I used data from three sources: one is the World Development Indicators (WDI) provided by the World Bank. This dataset offered current overviews of timeseries data from 1990 to 2001. Various economic indicators were included in this data. Second, detailed health expenditures and the Chinese people's health status came from the Ministry of Health (MoH) statistics. This dataset provided information about public health expenditures, medical personnel (including physicians and nurses), and health facilities from 1980 to 2002. Third, The *World Health Report* provided by the World Health Organization (WHO) and *Key Indicators of Developing Asian and Pacific Countries* provided by Asian Development Bank were used as supplements for the previous two datasets.

Chapter II

THE LITERATURE REVIEW

The Impact of Market Reforms

China's market economic reforms have been the subject of research interest since the 1980s. The development of market mechanisms emerging in the 1990s is only a part of China's great economic transition. However, as William Byrd pointed out, the market reform is a crucial part of China's rapid economic growth and modernization (Byrd 1991). According to the extant literature, economists do not have a unified definition of the market mechanism. Byrd widely discussed various theories and their criticisms of market mechanism (Byrd 1991; 1989). Schumpeter and Clark viewed the market as a much more dynamic and procedural mechanism (Schumpeter 1976; Clark 1961), a principle Byrd emphasized in explaining China's incomplete market institutions, is also followed in this article.

Market reforms have had profound impacts on contemporary China's social and economic transitions. Accompanying China's economic development, market reforms impact has attracted many scholars' attention (Goldstein 1995; Grogan 1995; Nolan 1993; 1994; Rawski 1994a; b; Walder 1995b; Nee 1991). It comes as no surprise that market reforms are deemed to have both negative (Jha 2002; Renard 2002) and positive impacts

on China's transitional society and economy. The majority of the literature on China's market reforms focuses on the positive role played by markets in transforming its centrally planned economic system to a market-oriented economy. Some research on this approach goes even further to uncover the impacts of the newly-established market mechanism on various socioeconomic subjects, such as the reform of state-owned enterprises (Duckett 1998), changing state-society relations (Walder 1995b; Sicular 1995), forging of the civil culture and market norms (Nee 1991), evolution of labor forces (Walder 1991; White 1987; Chen 2003), and the achievement of non-state economic sectors (Goldstein 1995).

Economic Implications

Using economic indicators, herein the market mechanism, to assess China's social and political issues became popularly accepted among researchers. This economic approach wave reached its peak in the late 1980s. The frequently targeted questions comprise three major fields. One comparison is between China's significant economic achievements and the stagnation witnessed in the former Soviet Unions and East European Communist Countries (Jha 2002). Second, some assess the implication of economic reforms on the Leninist-Stalinist political institutions (Walder 1995b). Third, many studies estimate the social and cultural consequences of the ongoing radical and

asymmetrical economic reforms (Perry 1985).

The economic approach, which focuses exclusively on economic indicators, is relatively insufficient in predicting market reform institutional consequences. In the early 1990s, however, the economic approach was gradually replaced by the new institutional approach, which treated the market economy as a substantial institution and assesseed its social and political implications by various scales. It has been noted by some scholars that, after the initial market reforms, a new social structure tangibly changed the party-state, central-local, and public-private relationships in China (Zhang 2000; Sullivan 1990; Byrd 1991). The new institutional approach treats market reforms as the onset of China's social and economic changes since the late 1970s. Researchers in this approach take the market as an exogenous variable and measure its significant impact on China's transition (Putterman 1995; Holton 1991; Wu 2003).

Political Implications

Political implications of market reforms are also discussed in various studies. Since almost miraculous economic achievements have been witnessed in the post-reform era, researchers interested in institutional subsequences of market reforms try to search for alternative interpretations for the path to China's reform. Some studies focus on the distinctions between a market economy and a command economy in distributing

resources and adopting strategies to satisfy individual or institutional needs (Nee 1989; Wu 2003; Nolan 1994; Holton 1991). The comparative advantage of the market economy is well addressed by researchers. However, the risk is also obvious. For instance, Andrew Walder suggested that China's market reforms "postponed the difficult tasks of final price and ownership reform" (Walder 1995a). This argument is reinforced by Perry Jha's findings. In his book *The Perilous Road to the Market*, Jha devotes an entire chapter on analyzing the sustainability of China's transitions and growth and finds that "China had reached a watershed in its economic transition…. political and economic imperatives were in direct conflict with each other in the reforms that lay ahead" (Jha 2002: 69). According to his analyses, Walder suggested that, in the long run, China should release government agencies' incentives. Jha points out that a complete market reform is badly needed in facilitating China's sustainable transformation.

Another trend puts more emphasis on local incentives. Chinese local governments ignored social welfare provisions, including health services, when they set economic development as their top goal. Not surprisingly, local leaderships encouraged market reform at the cost of social welfare. In this perspective, the role of local governments is negative on the health sector. There are numerous studies on China's local governmental economic involvements. One noted study done by Jean Oi suggests that local governmental economic involvements contributed to China's robust development (Oi 1995). Using research on Tianjin city, Jane Duckett argues that Chinese individual

departments and officers, encouraged by both economic profits and political stimuli, are enthusiastically involved in the market economy. Both Oi's and Duckett's studies indicate the Chinese state's adaptation to the market economy. They emphasize the economic role played by the local governments in China's transformation. The difference, however, is that Oi highlights the local government's crucial role in propelling market reforms, while Duckett emphasizes the economic motives of individual government officers. However, one unnoticed change is that the engagement of the local government in commercial issues has had a rather negative impact on the health care sector, in terms of financial support, health personnel provisions, and health facility management.

A third trend is a much more microeconomic view of assessing market reform impacts which is found in the enterprise reform literature. The reform of ownership and property rights in state-owned enterprises (SOEs), rather than anything else, are subject to academic debates in the context of market reform (Putterman 1995; Guo 2003; Steinfeld 1998; Banks 2003). The key issue in this trend is that the Chinese market economy is plausible because of the absence of privatization. The debates about ownership or property rights of SOEs are not whether a market economy or a command economy is dominant but rather to what degree that property rights are held by private individuals (Stiglitz 1994; Steinfeld 1998). According to neoclassic assumptions, the market mechanism would not work properly had market participants seized property rights. That is, the Chinese market is incomplete due to sluggish privatization of SOE property rights.

The fourth trend extends studies of market reforms to the public service sectors. Public goods, including health care, environmental protection, and social security, are influenced by market reform (Ho 1995; Lo 2001; Leung 2003). This group of scholars assesses the market reform impact on social welfare. Their arguments focus upon whether the market mechanism is sufficient to deliver social welfare in terms of equality, efficiency, and sustainability. China's health care sector is well-discussed in this approach (Coyne 2002; Gail 1995; Gerald 1997; Gu 1995; Ho 1995; Hu 1999). Since Chinese reform was initiated in the economic sectors rather than social or political sectors, commercial gains or economic profits are the reformers' major interests. The governmental officers, encouraged by party leaders, became commercial predators. Duckett suggests that China is actually evolving into an "entrepreneurial state." Instead of seeking benefit from rent, Chinese governmental officers are profit-seeking and, to some extent, they are new business elites (Duckett 1998). As a result, the social welfare cause is subordinate to economic development in most Chinese policies. Public health care, a burden on governmental finances, is facing stiff fiscal and facility shortages.

I have briefly discussed the literature on China's market reforms, in which the political implications of market reforms are classified into four broad categories. The political approach is mainly dealing with governmental choice over policies. Since the social development is always entangled with objective conflicts among different social groups, it is crucial for political scientists to describe and discuss the government's role in

the decision-making process. The market reform received intense study in the market-government interaction context. In the policy analysts' view, government plays a significant role in policy making (DiNitto 2000). Policies are the consequences, or sometimes combinations, of civil interests, national goals, and bureaucratic influences (Chen 1996).

My research focus is China's transitional health care sector under the influence of market reforms. In order to assess the impacts, I will discuss two important market reform perspectives. One is that the government relies on the market mechanism to achieve its goals. The second is that the market reform changes the government's behaviors or strategies in obtaining its goals. It is not surprising that market reforms have had profound impacts on Chinese society. Some social relationships, such as those between state and society, or public and individuals, have been subject to market reforms. I chose, however, the public health sector to deeply investigate how much the market reform has influenced this sector.

Public Health Care in Transition

A World Bank report in 2002 discussed the concept of public health in detail. The report points out that public health is actually the responsibility for both individuals and collective organizations (World Bank 2002). The purpose of public health is to ensure

that every citizen in the community enjoys a standard level of healthcare and thus a sustainable development of the society becomes possible. The mission of public health involves at least three players: the government, individuals, and public service agencies. However, it is not clear which one should take the chief responsibility in the public health system. The understanding is extremely blurred in China, where the communist ideology is collapsed in association with the wide-range market reform. A survey on the Chinese perspective toward social welfare indicates that a majority of the Chinese people generally agrees that the state should take a larger share of welfare responsibility. A large group (73.1%) of respondents does not want to be responsible for medical expenses (Wong 2001). Since the survey was done in Shanghai, China's biggest city and most advanced area, the nationwide reliance on the state could be even stronger.

China's gradualist reforms and economic strategies leave many political and institutional problems untouched. This reform approach might be efficient in upgrading China's large economy in a relatively short period. However, the achievement in economy is, to a great extent, at the sacrifice of social and political developments (Zhang 2000; Jha 2002; Wong 2001). In the process of economic transition, where the Chinese economy is forced to dance with a market mechanism, the Chinese government has not been transferred to be in line with the market system. In this view, China's market reform is incomplete (Byrd 1991). Therefore, the disharmony of China's political institutions and the newly established market system attracts many scholars' attention (Nolan 1993).

Because in China most health related services are still provided or maintained by the government, many studies have been done to investigate the role of the Chinese government in public health (Coyne 2002; DiNitto 2000; Gu 1995; Guan 2000). These investigations are extremely interesting because of the finding that the role played by the government has been changed by the newly established market system. Discussions about waning governmental regulation in the reform era are subjects of intense interests (Walder 1995b). These discussions are extremely prevalent among scholars who are interested in explaining China's unique economic transition and its political implications.

For others, it is not interesting to deal with boring official documents and organizational procedures. Instead, they focus their study on health care financing issues associated with market reform. They believe that the funding and financing of public health are core issues (Gu 1995; Liu 1996; Liu 2002a; Hu 1981; Liu 1995b). Some researchers focus on the health care insurance system and find that China's health care sector is shifting from a heavily public subsidized system to a market-based system (Hu 1999; Cheung 2001; Ho 1995). Since financing and health insurance are crucial parameters in assessing a state's health care system, it is not surprising that the majority of China's health care literature is found in this approach. The impacts of market reforms and economic transitions are widely discussed in various articles.

Another trend in China's health care literature, however, turns to inquiring about the Chinese people's health status quo in the reform era. Through comparing health facilities,

insurance coverage, medical costs, and patterns of searching for medical services in the post-reform era with those of the pre-reform era, some scholars find that the Chinese people's health status quo has been changed significantly (Wu 1997; Liu 1995a; Grogan 1995). Some studies evaluate the equitability of different social groups in receiving health services in the post-reform era (Akin 2004; Henderson 1995; Liu 1999). The health situations of some social groups such as females, children, and the aged are also investigated (Li 2001).

Obviously, the relationship between market reforms and health sector transitions received intense attention. It is widely accepted that investigations on China's health sector cannot remove market reform impact. Whether negative or positive, market reforms have had profound impacts on China's transitional health sectors. Although some researchers argue that people's health status has had a significant impact on the state's economic growth (Bloom 2004), the causal-effect direction of this article is clearly going through economic reforms on the people's health status quo. This is, however, not going to claim that economic reform caused fluctuation in the people's health status is the only possible causality. It is the prediction power of social science that prescribes a measurement of causality should be done in this way.

CHAPTER III

AN OVERVIEW OF THE TRANSITIONAL PUBLIC HEALTH CARE SECTOR

China's health care institutions are organized into a vertical structure (Fu 2003). The health care institution comprises three substantial components. First, within the Chinese bureaucracy, healthcare agencies are set up at different administrative levels. At the national level, there are the Ministry of Health (MoH) and the Ministry of Labor (MoL) who are responsible for health service administration (Wu 1997). The structure and responsibilities at the central government level are duplicated at the local administrative level. At the national level, there are health bureaus at regional, city, and county levels responsible for health service administration in respective districts.

Second, the Epidemic Prevention Service (EPS) system is a supplement for the formal healthcare institution. EPS operates preventive stations for disease control at provincial, regional, and county levels (Fu 2003). The academy of Preventive Medicine is responsible for research in preventive medicine and technical support. Some disease-prevention stations are established at local levels, making them responsible for disease control. There are about 3600 anti-epidemic stations and 1800 specialized independent institutions responsible for disease control at the county level (Liu 2002a).

Third, health services are provided by general or specialized hospitals. Enterprises in China, Different from other countries, play an important role in providing medical services. Traditionally, Chinese enterprises are owned and run by the state. Most of these state-run enterprises are required to finance and run a health clinic for their employees. Some hospitals are even run by the Chinese army. There are 300 army-run hospitals, mainly in urban areas (Wu 1997).

The Three-Tier Health Service System

Actually, there are three tiers of health service systems that exist separately in rural and urban areas. In rural areas, the three tiers constructed rural health services before the market reforms initiated in the 1980s (Shi 1993). They are village-located health stations, township health centers, and county hospitals (Figure 3.1).

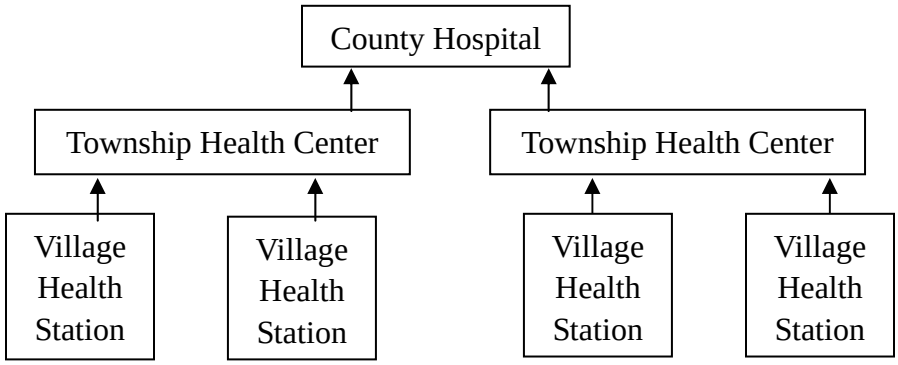

Figure 3.1 Rural Three-Tier Medical Care Network

The characters of the three-tier health service system are well-documented (Fu 2003). At the township and village level, there are 50,000 health centers located in townships and almost 800,000 health stations located in villages. Barefoot doctors, who worked in village health stations, were trained only three month before being licensed to provide medical services in rural areas. Before the 1980s, they were almost the only medical staffs available for the rural population.

Health centers at township levels provide more professional medical services with their well-trained personnel and high-quality facilities. However, a complicated illness is always treated at a county hospital. Patients are recommended to county hospitals when their diseases could not be well-treated at the village health stations or commune health centers. The costs of medical treatment are proportionally or entirely covered by RCMSs. In some areas, cash payments by patients could be reimbursed by collective funds (Feng 1995).

In urban areas, the health service structure is very similar to rural areas. The three tiers include street health stations, community health centers, and district hospitals (Figure 3.2). Most health service providers were state-run hospitals or clinics managed and financed by the Ministry of Health (MoH) or its local branches. Some clinics were funded through public employee insurance. Urban health service was based on widespread state ownership and the principle of full employment, and was provided primarily through state workplaces.

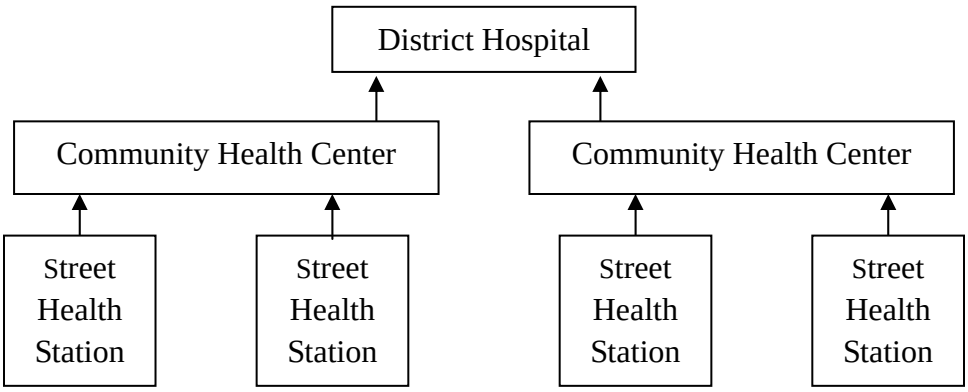

Figure 3.2 Urban Three-Tier Health Service Network

The Public Health Insurance System

China introduced two independent insurance systems in the early 1950s. One was the Government Employee Health Insurance System (GIS) which offered health insurance programs for virtually all government employees, college students and the staff, and employees in non-profit organizations. The other one was the Labor Health Insurance System (LIS) which covered all workers in the public economic sector. Both insurance systems covered only urban residents. They were financed by general revenue and usually provided full payment for the insurant's medical costs.

In rural areas, the Rural Cooperative Medical System (RCMS) was responsible for the rural residents' health insurance programs and, to some extent, provided rural

population with basic health services for free, or at very low cost in some districts. The RCMS was established in almost every village during the 1960s and 1970s because of full governmental support. It was reported that more than 90% of China's villages had established a RCMS by the mid-1970s (Carrin 1999). However, the RCMS collapsed due to market reforms in the 1980s (Ho 1995; Shi 1993). The percentage of rural people covered by RCMSs dropped to only 6.6% in 1998 (see table 3.1). More than 87.3% of the rural population has to pay out of pocket for medical care. A World Bank report points out that China's rural financial system still needs to be improved (World Bank 2003). Although the government claims that basic health services are provided to the poor, China still lacks a comprehensive nationwide risk-sharing health insurance system for rural health expenditures.

Table 3.1 Medical Secure System in 1998(%)

	Total	*Urban*	*Rural*
Government	4.9	16.0	1.2
Labor Insurance	6.2	22.9	0.5
Partial Labor Insurance	1.6	5.8	0.2
Medical Insurance	1.9	3.3	1.4
Socialized Fund	0.4	1.4	0.0
Cooperative Insurance	5.6	2.7	6.6
Self Payment	76.4	44.1	87.3
Others	3.0	3.7	2.8

Source: National Survey on Health Service in 1998.

The health insurance coverage is much better in urban areas. Before the 1980s, virtually all urban residents were covered by GISs or LISs. However, this percentage also dropped to less than 40% in 1998 (see table 3.1). Urban residents could receive health services completely free of charge compared to the rural population. Similar to other welfares earned by urban residents, both GIS and LIS delivered medical care services through a person's employer. Members covered by GISs and LISs could receive many free outpatient and inpatient medical services. Before economic reforms were introduced in urban areas, a work unit was responsible for its members' welfare from cradle to grave. In some big state enterprises, a worker's dependents were also included in the enterprise-funded health care programs. In addition to income, medical services became a crucial part of numerous welfare benefits enjoyed by urban residents. According to the rule of the Chinese government, each enterprise should set aside a fixed percentage of its total payroll for its LIS fund (Hu 1981). Enterprises with more than 200 employees could set up and manage their own clinics, providing some basic medical services to employees. Nevertheless, complicated medical services were mainly provided by public hospitals. There were cooperative relations between the enterprise-based clinics and public hospitals. Illnesses that were not urgent or complex were always treated in clinics. Seriously ill patients were always recommended to well-equipped public hospitals.

Both GIS and LIS were not national insurance systems. Their insurance benefits were employment-based. Some areas began to eliminate the welfare differences between

urban residents, in the early 1990s, pooling the risks of financial burdens caused by medical expenditures. The latest policy of the Chinese government is to establish a national health care insurance system which will pool financial risks for urban residents (Liu 2002b). Prior to the reform, urban residents relied heavily on their work units for medical services. Workers are tied to their employers by a range of policy constraints. Under the command economic system, the employees get benefits while the employers bear the costs. In 1988, the State Council set up a group to work out a health care reform program. Risk pooling was introduced in 1992 for urban health care reforms (see figure 3.3). Risk pooling increased the level of socialization and reduced welfare differences among urban residents. In addition, individual medical accounts were created for every insured urban resident. This is called the social insurance program (*shebao jihua*).

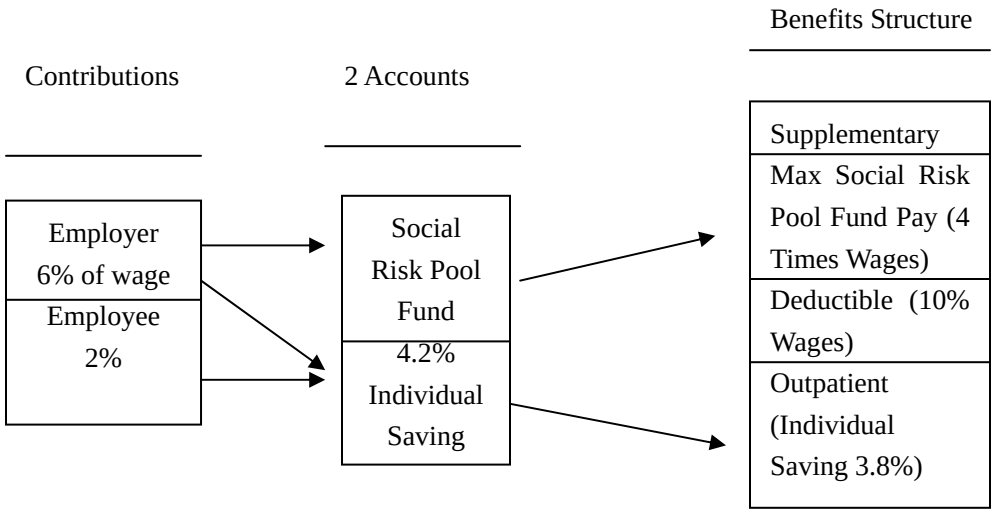

Figure 3.3 Funding and Benefit Structure of the Social Insurance Program (Liu 2002b)

CHAPTER IV

THE DOWNSIZING GOVERNMENT'S ROLE

China has been transforming from a centrally-planned economy to a market economy since the early 1980s. The gross national product has grown an average of 9.5% a year (WDI 2001). However, the governmental budgetary revenue fell, as a share of GDP, from 31.6% to only 11.1% in the period 1978-96 (WDI 2001). The great economic transition has altered the relationship between government and its service units, including health facilities. With the economy moving toward a free market system, the health sector in China has been undergoing marketization. The fiscal system has been decentralized and health care has increasingly become local matter.

The government's financial burden on health care had been reduced because the market reform mobilized resources from private payers and individual health units. However, these achievements were gained at a high social cost and the policy failures were more likely higher than the successes. The most common strategy health facilities employ to augment revenue was to increase the amount of drugs and services they provided per patient. Therefore, the revenue-oriented behavior of health service providers led to the provision of unnecessary services for those who can pay, and the under-provision of necessary services for those who can not (Liu and Mills 2002)

Fiscal Reform

Market reforms initiated a fundamental realignment of central-local relations in China. The most noted reform was the restructuring fiscal administrative system aims at resolving the revenue decline faced by the central government (Wong 1991). It was reported in *Chinese Financial Statistics* that the central government's budget expenditures shrank from 40% of the total revenue in the 1970s to only 25% in 1988. Nearly 70% of the public budget in 2002 went to sub-national administrations. Among them, about 55% took place at the sub-provincial levels (World Bank 2003). The Chinese health sector was experiencing financial difficulties because costs had risen more rapidly than tax revenues. As in other transitional economies, the Chinese government has shifted responsibility for financing services to lower levels of government (Bird et al. 1995).

The immediate consequence of the fiscal decentralization was the increasing local governmental participation in commercial issues (Duckett 1998; Oi 1992, 1995). The local-state corporatism (LSC) approach argued that China's tremendous growth in collective economy was to a great extent due to local government's economic incentives. The argument suggests that China's system of fiscal contracting, by granting local governments the right to collect and keep tax revenues, motivated these local governments to promote business (Oi 1992). In other words, market reforms reassigned

fiscal power, in terms of local-central relations, downward to local government.

Local governments achieved much higher autonomy in economic issues compared to the pre-reform era. The autonomy of local governments and the individual bureau within them has thus increased. Local governments enjoyed control and fiscal rights over local assets. Officers had a strong incentive to seek long-term expansion of those local businesses. In the LSC view, the local administration served as a sort of company headquarters, coordinating the various firms and actually became a business corporation (Oi 1992). Not surprisingly, local governments were encouraged by the central government to be responsible for economic issues rather than social welfare due to fiscal constraints and profit incentives. In the reform era, local governments invested most of their personnel and funds into commercial sectors. Some social functions, including health care, education, and environment protection, were thus greatly ignored by the government.

In the post-reform era, each level of government funded its own health care sector. This meant that townships funded township health centers and counties funded county hospitals. However, governmental contribution to the total budget of health sectors can be as low as 10% in the late 1980s (Bloom and Tang 1999). The fiscal support of the Chinese government in health facilities was lower than most other developing countries, where government provides 80% of the healthcare expenditure.

Price Reform

China's fiscal reforms were followed by enterprise reforms which are closely connected with price reforms. Both enterprise and price reforms were crucial parts of moving toward the commodity economy or thereafter the market economy. Before market reform changed the Chinese economic system, all prices were set by administrative decision. For instance, industrial good prices were determined by the industrial bureau. State commerce bureau set wholesale and retail prices (Guo 1992). Political rather than economic considerations determined pricing policy before the market economic reform.

Price reforms were an important way of giving market players more autonomy and encouraging them to be fully responsible for their business decisions. Before the market reform, China aimed to promote social equality by providing people with basic health services at very low prices. Prices of most health services had been kept low. Prices for official visits and surgical operations were far below real cost (Hsiao 1995). Price reforms introduced supply and demand and customer-service relationship into China's command economic system. For instance, hospitals were allowed to mark up their drugs by 15-20% over the wholesale price. Some service prices are very flexible, hospitals can make profits by increasing the use of new equipments (Liu et al 1996).

First, price reforms had raised consumer prices for urban residents. Under the market-based price system, urban residents had to pay much higher prices for commodities. Second, price reforms had also redefined the government's role in the market economy. While the market pricing system constrained the government's intervention in the economy, it also created conflicts between the government and health sector. Price reforms shifted the pricing mechanism from the government to health sector. Once the health sector achieved the pricing autonomy, the government was thus driven out of the health service. Those who were worse off were thus suffering from increased medical prices. A study undertaken by Wong and Lee showed that 70 percent people agreed that the government should not enhance economic development at the cost of the social welfare provision (Wong and Lee 2001). Third, price reforms, in the long term, shifted the price setting functions from government to market. However, the evolution from a plan-dominated to a market-based price setting system in China's economy had been inextricably linked with the multiple channel phenomenon. The multiple pricing, including market-based flexible prices at one extreme and government-oriented regulatory prices at the other, were termed the two-tier plan/market systems (Byrd 1991: 197).

Price reforms meant an institutional arrangement transformation and a redistribution of costs and benefits from one group to another. One significant impact of the multiple pricing system was that farm produces were virtually undervalued. Peasants are thus put

at a relatively disadvantaged position compared to the urban population. According to a World Bank report, falling grain prices and the domestic slowdown since the mid-1990s have contributed to the poverty of the rural population (World Bank 2003). Figure 4.1 shows the floating price index in the period 1977-1994. The general price index of 1994 is more than 3 times than that of 1977.

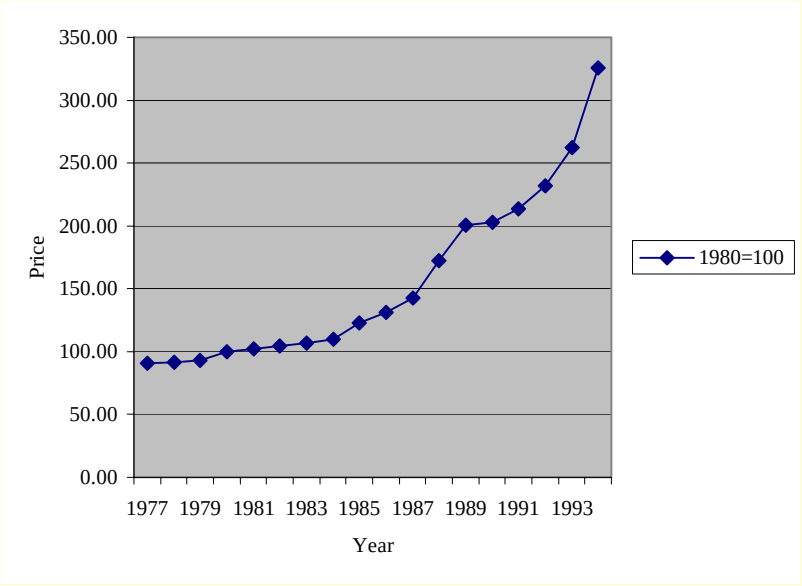

Figure 4.1 Price Index (1977-1994)

Source: Asian Development Bank. 1995. *Key Indicators of Developing Asian and Pacific Countries.* Oxford: Oxford University Press.

The Laissez-Faire Policy

The Chinese government has adopted a *laissez-faire* policy toward the health sector transition. Before the market reform launched in the 1980s, a large part of preventive health programs was funded and managed by the government. The government invested extensively in providing high quality drugs, hospital beds, and health manpower training. However, financial support from virtually every level administration was cut and thus recurrent costs of hospitals and clinics were severely reduced. Figure 4.2 indicates that the public expenditure on health had been declining since 1990.

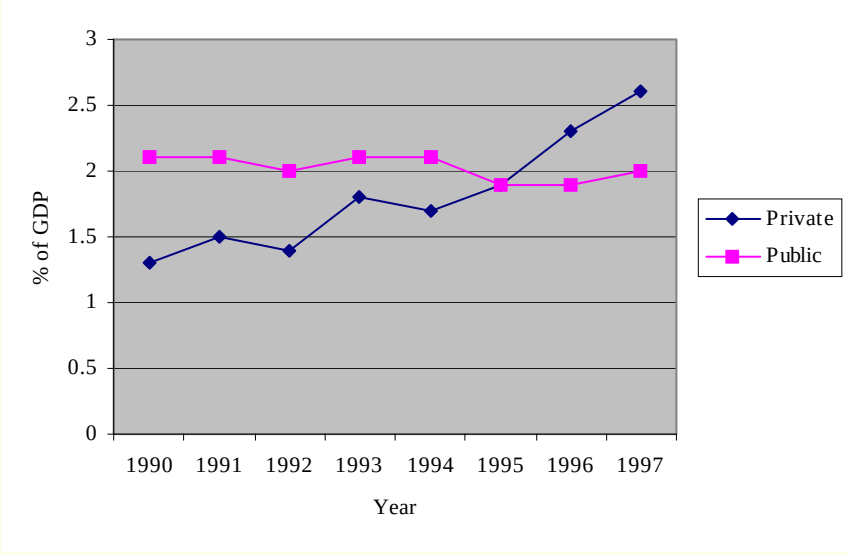

Figure 4.2 Public and Private Expenditure on Health Sector (1990-1997)

Source: World Bank. *World Development Indicators 2001* (WDI): China.

The government invested 2.1% of the total GDP in 1990 in the health sector. Instead of increasing financial support from the government to meet citizens' medical needs, we have seen declining investments from the government. The government only allocated 2.0% of the GDP in 1997 to the health sector while the people's demands for health care have been increasing since the 1980s. Figure 4.3 shows the increasing household spending on health care in the post-reform era. Figure 4.4 shows the respective shares of the health expenditure from the governmental and private sources in the period 1997-2001. The share of government expenditure dropped from 40% in 1997 to 37.2 percent in 2001.

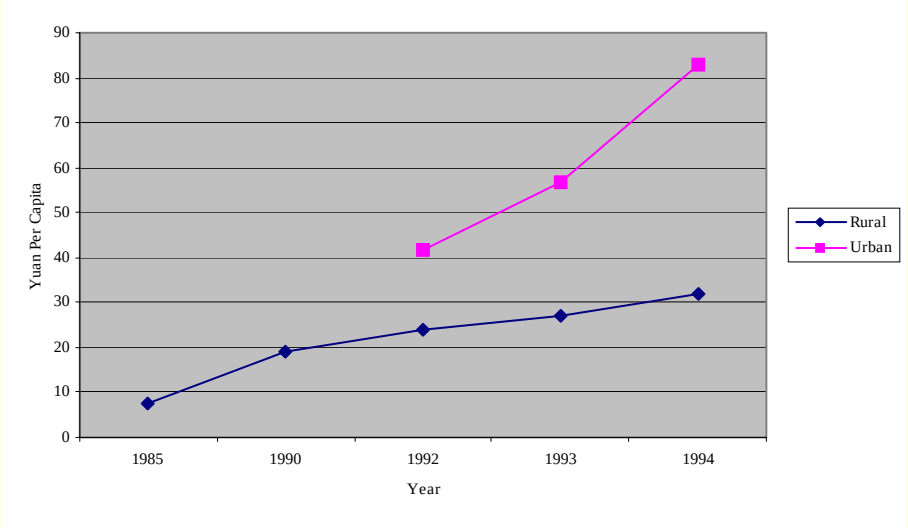

Figure 4.3 Household Spending on Health Care in China (Yuan per capita)

Source: State Statistical Bureau, *Statistical Yearbook of China*. various issues. Statistical Publishing House of China, Beijing. Also see in Wu 1997.

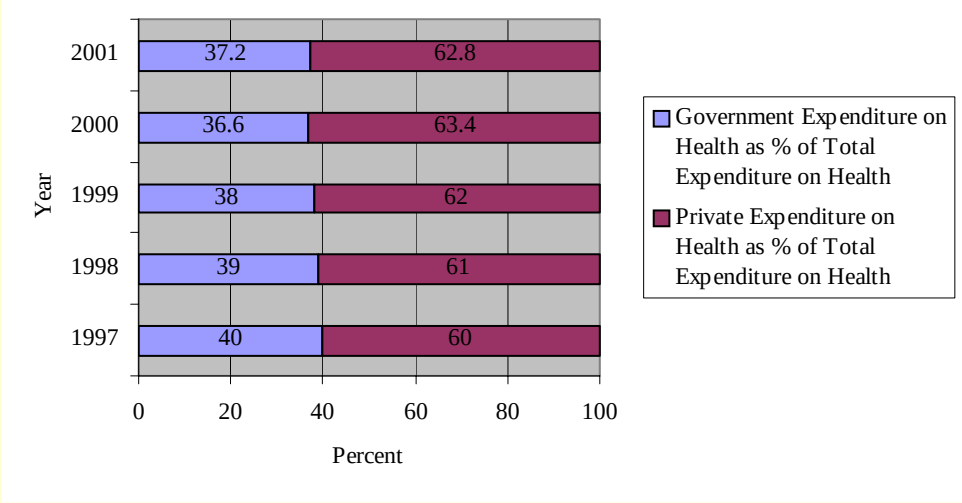

Figure 4.4 Government and Private Expenditure on Health (1997-2001)

Source: WHO *Selected National Health Accounts Indicators: Measured Levels of Expenditure on Health,* 1997-2001.

Hospital Autonomy

Western models of organization and management were also introduced in the health sector. Market reforms propelled the government to adopt market mechanisms in health facilities management. In contrast to planning disciplines, market mechanisms were more likely to encourage competition, autonomy, and reliance on flexible policy tools rather than regulatory methods. Prior to the market reforms, managers of health facilities

reported directly to respective governmental and political authorities (Yung, 1991). The health sector was a vertical hierarchical system before market forces were introduced. Political leaders, rather than hospital managers, established health sector targets. Health service bureaucrats then prepared technical guidelines for service development and forced the bureaucratic system to meet the targets. Central planning and rigid bureaucratic control limited the quality and efficiency of health services (Liu, Rao and Fei, 1998). When market reforms were introduced in the health sector, hospital managers had more autonomy from governmental and political structures (Bloom and Gu, 1997). Hospital managers were entitled to manage and bear the costs of running the hospital.

The hospital autonomy was also associated with the sideline production of the health institution (Liu et al. 1996). Driven by the economic incentive, Chinese hospitals engaged in some businesses other than health services. Hospitals sponsored or owned businesses, including opening shops, running restaurants, selling drugs, providing private medical services, and operating factories. Hospitals tried to undertake sideline production activities and encouraged health staffs to engage in the profit-seeking business. Hospital management was thus pulled in the wrong direction. Providing adequate health services for the public, the major goal of the hospital, was therefore substituted for the hidden goal—generating extra revenue and maximizing the hospital income. On this account, hospitals are no longer taking “serve the people” as their ultimate objective. Instead, they treat patient as their customers.

The Decentralized Health Sector

China's health sector has been decentralized due to surging market-oriented health service programs. For instance, for a long period the Epidemic Prevention Service (EPS) system was the backbone of public health programs in China. One of the important factors that contributed to China's health sector improvement was the strengthening of EPS (Xu 1995). The EPS system mobilized the whole society to develop and participate in the health movement in which people were organized to maintain a healthy environment. Before the market reforms, EPS employed more than 250 thousand workers and extended disease control programs throughout China. It is well known that EPS was fully funded by the respective government. Since the fiscal decentralization and market reforms in the health sector in the 1980s, EPS has been weakened due to rising input costs and decreasing public financial support. Public financing of EPS, as a share of GDP, has dropped dramatically from 0.11% in 1978 to only 0.04% in 1993 (Liu et al. 1998). In the post-reform era, EPS has had to rely heavily on user fees. Total income from user charges increased from 20% to about 60%. A study in five counties in Beijing found that the public expenditure for preventive services in real terms had increased slightly, but as a percentage of the government expenditure, it had decreased from 0.53% in 1981 to 0.29 in 1990 (Zhang and Li 1995).

Rural and township health sectors have also been decentralized. Most of the rural and township hospitals were financed and managed directly by the County Health Bureau before 1983. However, they were decentralized in 1984 from county to township governments (Zheng and Hillier 1995). The township government then had the responsibility of managing and financing rural and township hospitals. Decentralization was reported to have promoted the autonomy and efficiency of the rural and township hospital (Luo 1985). However, in practice, many problems were found. First, township governments did not have the knowledge and experience to manage the health institutions. In some poor areas, the township leadership recruited their non-professional relatives rather than qualified professionals. Second, in some poor townships, the limited budget on health care was used for other purposes by the township governments. The decentralization in the poor area is rather a disadvantage for the health sector and the citizens.

CHAPTER V

THE HEALTH SECTOR TRANSITION UNDER THE MARKET REFORM

In Mao's era, China had a legacy of well organized health care system, with emphasis on prevention. The principles of the Chinese health sector had been to "serve the people", focus on preventive medicines and unite traditional Chinese and Western medical services (Hillier and Jewell 1983). China had developed a comprehensive health care system by the late 1970s. Health services were provided to virtually all urban residents free of charges. The rural population could receive basic health service at low cost through the Rural Cooperative Medical System (RCMS).

However, a major break in the development of the RCMS occurred in the early 1980s, a consequence of widespread market reforms. The rural people had to pay out-of-pocket for medical costs. Health situations in urban areas also decreased due to reforms in economic enterprises and the social welfare system. For instance, health insurance, which used to provide more than 80% medical treatment cost for urban residents, dropped to a total of only 4.7% in 1998 (MoH 1999). Health spending increased in both rural and urban households due to various factors, such as the improvement in the living standard and the changes in the health care system.

The Collapse of Rural Cooperative Medical Systems (RCMSs)

It is well known that the RCMS played an important role in the consolidation of rural health services. However, the RCMS collapsed in the early 1980s as a consequence of widespread rural market economic reforms. These reforms basically involved a shift from communal to household production systems. The adoption of the "household production responsibility system" has thus changed the delivery and financing of rural health services. Most of the RCMSs collapsed due to dramatic market reforms in rural areas (Table 5.1). The majority of rural populations have to pay for health care out-of-pocket again. The collapse of the RCMS has been attributed to combinations of political, financial, and management problems (Feng et al. 1995; Carrin et al. 1999).

Table 5.1 The Percentage of Villages with RCMS (Selected Year1979-1989)

Year	*% of Villages with RCMS*
1979	90.0
1981	58.2
1985	11.0
1987	5.4
1989	4.8

Source: 1958-1979 figures were estimated by Anhui Medical University, 1986.
1981-1989 data are provided by the Ministry of Health.

Prior to rural economic reform, the rural health sector was funded by the respective government, commune, and user charges (Table 5.2). Financial resources of the rural health services could be divided into two major categories. One category was public expenditures: including government subsides and collective contributions, another category was fees for services, including medical service fees and profits associated with the drug selling.

A study shows that the governmental budget in the rural health sector sharply fell by 10% during the 1980-1989 period (Zheng and Hillier 1995). Township health centers and county hospitals had to pay a major portion of salaries and many of them operated at a deficit. Most village health workers, who were paid by the former communes or villages, now had to generate their own income (Liu and Mills 2002).

Table 5.2 China's Health Budget and Subsidies to Rural Health Care (1978-1988)

Year	*Health Budget**	*% of Total Budget on Health*	*Subsidies to RCMS!*
1978	2.2	2.0	39
1980	3.0	2.4	26
1982	3.7	3.2	29
1984	4.8	3.1	29
1986	6.4	2.7	28
1988	7.1	2.6	22

*Billion yuan
!Million yuan
Source: Du L. et al. *Strategic Studies of the Chinese Health Care Financing*, 1982

Rural health facilities increasingly rely on out-of-pocket payments by medical service users. The shrinking governmental financial support incurred increasing service fees for township and county medical care providers. In 1989, 20.54 billion yuan of health sector income came directly from patients while only 11.46 billion yuan came from government budgetary allocations (Ho 1995). In some poor counties, user charges accounted for over 75% of the county hospitals' total revenue (Bloom and Gu 1997). The government grants finance as low as 50% of the budgets for preventive institutes and no more than 25% of the expenditures for hospitals and health center (Bloom and Gu 1997). The financial burden was significantly shifted to individual households who now have to pay for medical services out-of-pocket. Many rural people who cannot afford service fees are then simply denied hospital care.

The rural three-tier medical network was thus weakened or even disappeared due to the widespread market reforms. Many "barefoot doctors" who delivered basic health services left their positions because of relatively low payments. Since the cooperative welfare fund did not exist any more, the RCMS could no longer afford salaries for medical professionals working in township health centers. Medical care staffs in county hospitals were urged to negotiate contracts with their hospitals for payment schemes. According to the Ministry of Health (MoH), the total number of barefoot doctors working in the countryside decreased from 1.8 million to 1.3 million between 1978 and 1985 (MoH 1987).

The three-tier medical network was terminated when rural people changed their patterns for seeking medical services. Before rural market reforms, the three-tier medical system worked very well in providing adequate medical services in the rural sector. The rural people accessed medical services in their own communities through village health stations and township health centers. Figure 5.1 shows the old pattern of seeking rural medical service before market reforms.

Old Pattern

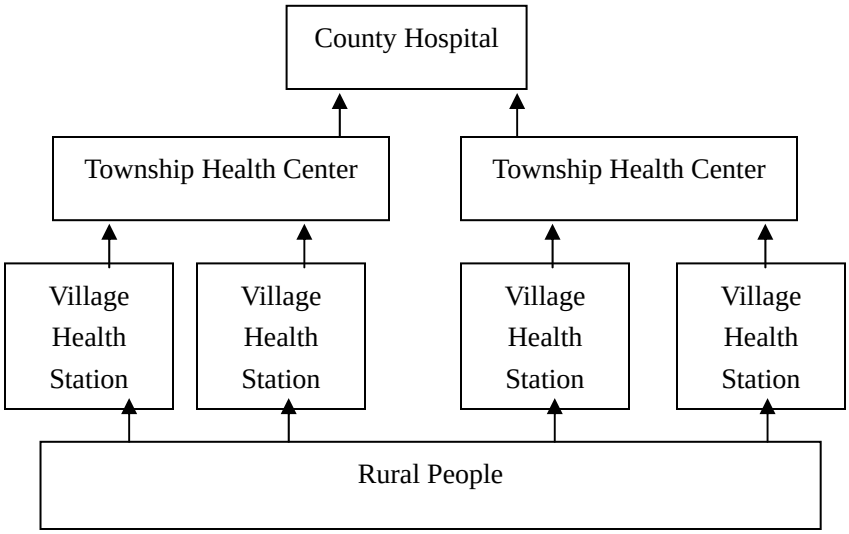

Figure 5.1 Pattern of Seeking Medical Services: Old Pattern

However, as showed in figure 5.2, this pattern was changed when rural people became wealthier and the RCMSs collapsed. Rural people thus went directly to county or regional hospitals which provided better services than township health centers. As a consequence of decreasing patient income, village health stations and township health centers were weakened. On the contrary, the county and regional hospitals were crowded with patients. According to a MoH report, regional hospitals have an occupancy rate of 90% compared with 80% in county hospitals and 45% occupancy rate in township health centers (MoH 1990).

New Pattern

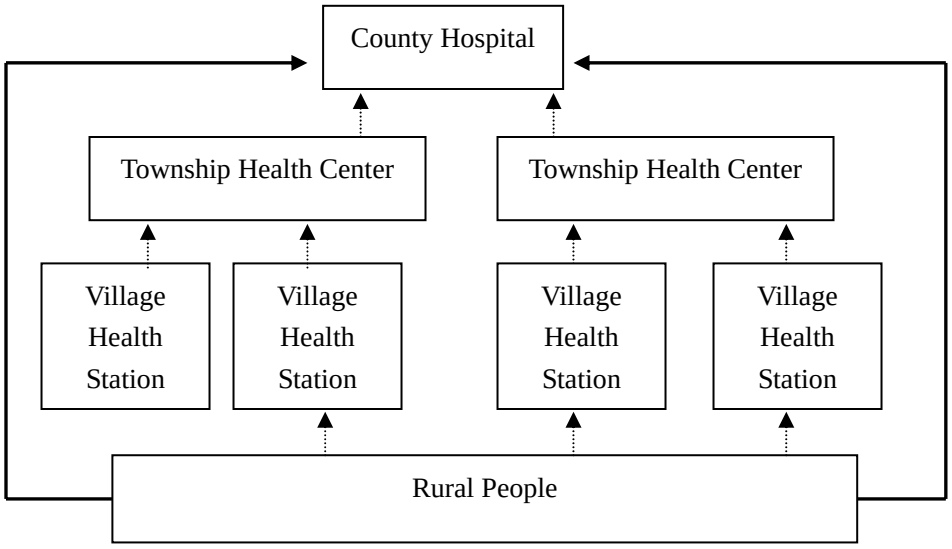

Figure 5.2 Pattern of Seeking Medical Services: New Pattern

The Restructuring of Urban Economy

Urban market reforms, a little later in time than rural reforms, focused on state-run enterprises which are the highest concern in China. Urban reforms were introduced to achieve three basic goals. First, every enterprise is required to negotiate a contract with its respective government to set up an adequate profit and taxation level. Second, enterprises are urged to undertake overall reforms. Life-long employment, fixed salaries, and inadequate welfare were going to be gradually abandoned. Third, enterprises were forced to sell their products in a competitive market and most of them were exempted from government subsidies. For instance, the World Bank conducted a study on China's taxation system reforms and found that more than 80% of the enterprises had contracts with their respective governments (World Bank 1990).

Enterprise reforms led to the disconnection of individuals with their work units. Worker compensation is a policy welcomed by SOEs. This new policy allows the managers to fire workers at a mutually agreed compensation. It is estimated that nearly 26 million (or one five workers) in SOEs were laid off from 1998 to mid-2002 (World Bank 2003). Market economy requires that workers' wages should reflect productivity. The "iron rice bowl" policy of lifetime job security and cradle-to-grave welfare guarantees were thus replaced by a contractual employment system. Enterprise reforms also introduced labor market elements. First, the managers' power in collective and

state-owned enterprises increased significantly compared to the pre-reform era. They could hire, discipline and dismiss workers. Secondly, in 1983, the newly-introduced contractual employment system allowed SOEs to treat the new entrant workers differently from the permanent workers. New entrants received neither lifetime employment nor the same level of welfare benefits.

Bureaucrats were replaced by professional entrepreneurs. In urban reform, local governments achieved power to shape the fiscal system to meet their own objectives (World Bank 1990). Local government appointed the professional entrepreneurs to manage enterprises in their districts (Duckett 1998). Some SOEs were very successful in the market-oriented economy while others earned no profit and approximately one-third had net losses (Hsiao 1995). Therefore, these loss-making enterprises could not pay the required health insurance for their employees (Sun et al. 2002). The LIS in many urban enterprises has thus collapsed by the early 1980s.

Institutional changes were introduced in the Leninist system accompanied by market reform and decentralization of the economic decision-making system. In urban areas, the work unit is subject to reconstruction. As required by reformers, SOEs should be adapted to risk-sharing and profit-seeking enterprises who are eligible players in a competitive market economic system. In most SOEs, employees are now less constrained by the enterprise for whom they are working. The tight nexus between SOEs and their employees is no longer a substantial relationship guaranteed by the state. Instead, a

contractual relationship prescribing all the responsibilities and rights of the two sides, enterprises and employees, terminates the lifelong working position of virtually every employee. Various welfares previously provided by SOEs are now rescinded or transferred into cash payments (Hu et al. 1999). As a result, the coverage of LIS has been declining seriously since the late 1980s in urban areas.

Urban Health Care Reforms

Some reforms were introduced in the 1980s to improve efficiency in health care services. There were two main changes in particular. One of them was characterized by the self-management principle. It decentralized the management of medical care funds from governmental or health administrative branches to health care users (work units) or providers (hospitals) (Ho 1995). This reform aimed to motivate users and providers to face financial constraints. The second change was to decentralize financial risks by pooling health insurance funds which were then managed by the labor offices at the municipal and county level and used by all covered insurants. A third party managing institution was introduced to take care of the pooled funds. Individual accounts, under the new contractual employment system, could be used to cover the insurant's health care expenditures and inherited by his or her families.

Obviously, urban health care reform has focused mostly on financial problems that

the GIS and LIS were facing. The financial burden was no longer a big problem of the government after introducing reforms. Public medical care (gongfei yiliao) expenditures dropped sharply from over 30% in 1987 to only 9.8% in 1990 in the Shanghai Luwan district (Zhou 1992:159).

From Constraining Demands to Constraining Supplies

In the health care sector, the market mechanism exerts crucial influences in decentralizing urban health care systems. It is reported that the national health care expenditures increased from 270 million yuan in 1952 to 22,440 million yuan in 1989 with an accelerating speed (Liu and Hsiao 1995). The increasing health expenditures became a large state burden. Several factors contributed to this significant cost escalation. First, increasing enrollment incurred cost escalation. Second, increases in drug prices and medical facilities lead to big medical bills. Third, aging enrollees were a crucial factor that drove costs up (Liu and Hsiao 1995). Another explanation is that the rampant waste of drugs due to free availability contributed to the escalation of China's medical cost. The waste is partly due to medical providers' income motives because health institutions would generate more income through over prescribing (Wu 1997).

As a result, China implemented two reforms in the urban health insurance system to control cost escalation. First, the government required that every urban resident insured

by GIS or LIS share part of the medical costs when they received medical services. At the first stage, an individual is responsible for 10-20% of the total inpatient or outpatient fees. Second, the government further required that medical providers should be responsible for healthcare expenses. According to this requirement, certain kinds of drugs could not be prescribed to an insured patient unless they were paid out of the patient's own pocket.

Pooling Risks

Prior to urban health care reform, urban residents' health cares were differentiated because of their places of employment. People working in different working units (*gongzuo danwei*) were entitled to different welfare as well as different medical service. The major goal of urban health care reform is to replace the work unit based schemes with municipal schemes (Liu 2002). This reform aims to eliminate welfare differences between urban residents and pool the financial burden risk caused by medical care expenditures.

In 1998, the Chinese government introduced a major reform to establish a social insurance program for urban workers (The State Council 1998). The new program was expected to replace the existing LIS and GIS in urban areas. The new insurance system expanded coverage to private enterprises and smaller public enterprises. Self-employed and rural industry workers were also encouraged to buy into the program.

In the new insurance scheme, insurants were expected to pay all of their outpatient medical costs out of an individual saving account (see figure 3.3) until funds have been depleted. Funds unspent in individual saving accounts are carried over to the next year. Expenses exceeding individual savings are paid out-of-pocket. The new insurance system pooled the risk of medical costs.

The Increasing Inefficiency and Inequality of the Health Sector

The total cost of health insurance has risen rapidly since its market oriented economic reform in the early 1980s. The rate of increase has accelerated since 1980. The government first used demand strategies by introducing co-payment to constrain cost escalation. Then the government altered the strategy on hospital financing and pricing policies for new technology and drugs. There are four factors contributing to cost escalation: increase those covered; the inflation factor which included input price escalation and increasing fee schedules; aging of the covered population; and residual factors (e.g., increasing medical service demands, new equipments use, and increased consumption of expensive drugs) (Liu and Hsiao 1995).

The price of medical services and drugs became unaffordable for many people, especially those worse off in the reform era. Costs of health care have been rising accelerating much more quickly than the income growth rate. Urban income per capita

rose 18% per year during 1989-97, while the outpatient care cost increased 26% per year and 24% per year per admission (CHSI 1999). On average, 20% of urban and 23% of rural populations, respectively, forego inpatient hospital services recommended by health professionals because they cannot afford the medical costs (CHSI 1999).

Medical cost escalation was due to rising in health worker pay and growth in drug expenditures. Between 1981 and 1992, the average wage of employees in health care rose by 84% relative to the rise in retail prices (State Statistical Bureau 1993). Spending for medical services and drugs became a major cause of poverty. Studies showed that 25% of households living in low-income areas who had any health services in a given year had to borrow money to pay for their medical expenses (Liu et al. 1996). 18% of households using health services incurred health expenditures that exceeded their total household income in 1993 (Liu et al. 1996). To the poor, the most basic way of getting medical financial assistance was to ask relatives and friends for help (Sun et al. 2002). In rural areas, 28% farmers do not seek health care when seriously ill (Liu et al. 1996).

Health service inefficiency is associated with the current fee-for-service health care system. China's medical pricing policy is inadequate and provides incentives for inefficiency and waste. Before the market reform, costs for services were largely funded by the RCMS in rural areas and LIS or GIS in urban areas. Most health services and drugs were priced substantially below cost. Conversely, health services and drugs were often priced well above cost during the 1980s when hospitals were allowed to mark up

their prescribed drugs by 15-20% (Liu et al. 1996).

Users often misued the free services. For instance, with the introduction of higher charges for drugs and health services, a person who was covered for GIS or LIS would frequently obtain medicines for his family members. Hospitals did not prevent these abuses because they were mainly interested in selling the drugs.

CHAPTER VI

CONCLUSION

The market economic reform initiated in the early 1980s had a substantial impact on the health sector. As some scholars argued, economic reform and growth do not necessarily improve health status for all (World Bank 1996). China's experience shows that economic growth or relying on market mechanisms alone is not a sufficient condition for improvements in health status, especially for those worse off in market reforms. The poorly-managed health facilities combined with a predatory market economy resulted in inefficiency and reduced access to health services for most people who are vulnerable. It is widely discussed by scholars that the market only works well with appropriate regulations and planning. Relying too much on the free market to finance or manage health care inevitably led to inequal access to health service between social groups, uneven developed regions, and the like. Those worse off are more likely to suffer escalating medical costs and diminished insurance coverage. Health services and medical resources are more likely to be ill-managed or over-provided to the insurants or better-offs due to the health facilities' incentives of self-interests.

The health sector's transition requires a balanced government role and the free market mechanism. In China's case, the government should play a major and active role in the regulation and financing of the health care system. A laissez-faire policy and free

market mechanism cannot resolve the current problems faced by the health sector. The government support is the only reliable force for the health sector to control cost escalation, health service inefficiency, and inequality.

Economic incentive has had a significant influence on reconstructed hospitals and practitioners. The profit-seeking goal encourages Chinese hospitals to introduce expensive equipment and drugs which thus increased medical costs for patients. Chinese practitioners maximized their own interest through increasing drug prescription, adopting expensive equipment and high-quality tests. They relied on new drugs and tests to treat patients which inevitably increased patients' health costs. Hospitals also increased the inpatient stay in hospitals to compensate for their administrative inefficiencies. These behaviors indicated that the pricing system of the health sector played an important role. The health providers misused their autonomy to induce demand which then increased their interest at the expense of patients. The Chinese government should realize the market failures and implement regulatory policies on the transitional health sector.

The roles of the central and local governments in the transitional health sector need to be reexamined. The central government needs to take more financial responsibility to help establish a more stable health care system. The risk pooling of medical costs is a good start to eliminate social injustice on health. The central government should emphasize its role in the improvement of health insurance coverage and reduce unequal access to health services among social groups and uneven developed regions. The central

government has a key role in ensuring that health facilities provide an adequate service at a reasonable cost. Some regulations that distort decision-making by health facilities managers should be removed. Some mechanisms that help diminish opportunistic behaviour of health facilities need to be created and implemented.

In this study, I do not find any evidence showing that the government has taken any official strategies to improve health services for its citizens. The market reform gives the government a good excuse to cut the financial supply to the health sector. Most governmental investment goes to commercial sectors. Social services, including health care, higher education, and environmental protection, are then left unattended. It is widely accepted that the governmental authority has been withdrawing from the health sector which then encourages hospital managers' manipulation over health facilities. In this sense, both China's health sectors and citizens are suffering from ill-managed and inefficient health facilities.

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