A Strategy for Health Sector Reform in Poor Rural China

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1 Introduction

Since the late 1970s, China's rural health facilities have adapted to the consequences of the emergence of a market economy and of the increase in inequalities between regions and between households within a locality. The previous articles describe how this adaptation has led to serious problems in the health services in poor rural areas. This article outlines the major components of a strategy for health sector reform to address these problems. This strategy is outlined in the box.

The behaviour of health service providers is strongly influenced by how they are financed and by the regulatory and administrative environment within which they operate. In a weakly regulated market they tend to over-provide costly services for those who can afford to pay and to neglect the needs of the rest of the population (Hsiao 1994; Preker and Feacham 1994). That is why the government has to manage the adaptation of the health sector to a market economy differently than other sectors. China needs to define new relationships between health facilities, local governments, and other collective bodies to ensure that rural residents have access to effective and affordable health services.

2 The Definition of a Package of Essential Health Services

The Chinese government needs to identify the health services that should be provided as a priority in poor areas (World Bank 1993). The basic package of services should include preventive programmes, outpatient care, and basic inpatient treatment. The advantage of defining a package of priority services is that it makes it easier to set clear objectives for reform and to monitor whether they are achieved.

The roles of village, township and county level facilities in providing essential services should be specified. It may be necessary to change some ideas about how different facilities should function. Once these roles have been clarified it will be possible to determine each level's requirements for facilities, equipment and staff. It will also be possible to estimate the necessary levels of spending on drugs and consumable inputs, and to estimate the cost per person of providing essential health ser-

Box 1 A strategy for health sector reform

Problems that reform is intended to address

- inadequate coverage by preventive programmes and lack of access to curative care
- financial problems of health facilities
- increases in the cost of medical care
- risk to households of impoverishment due to high cost of serious illness

Components of a reform strategy

- define a basic package of essential services and estimate its cost
- establish a secure financial basis for essential health services
- take measures to improve the effectiveness and efficiency of health service providers
- strengthen government support for rural health services
- establish mechanisms to make the services accountable to the population

vices. This can only be a rough estimate because it depends on the probable level of demand for services, on the behaviour of health service providers, and on how the line is drawn between essential and non-essential services.[1]

Many people will not only use essential services. They may purchase drugs not classified as essential (for example tonics and herbs) or pay for extra diagnostic tests. They may also seek costly treatments for severe illnesses that cannot be included in a package of essential services. The purpose of the essential package is to ensure that everyone has access to effective treatment for common health problems.

Government has to decide whether health facilities that receive financial support should be permitted to provide non-essential services. If they are not allowed to provide these services, they may lose patients and an important source of supplementary revenue. Furthermore, some facilities may serve people covered by work-related insurance schemes that entitle members to services not included in the essential package. On the other hand, if facilities are permitted to provide non-essential services, there is a danger that they will neglect essential ones. Mechanisms need to be established to prevent this from happening.

3 Funding of Basic Health Services

The system of health finance needs to be reformed so it no longer rewards facilities for neglecting prevention and providing a costly form of medical care. The system should encourage people to use cost-effective preventive and curative services and it should diminish the financial barriers to access to health services, particularly for the seriously ill.

Health facilities should be allowed either to charge prices that reflect real costs or to recover the cost of the service from another source. For example, if they are expected to provide preventive services free of charge, their government grant should fund these services fully. The present arrangement, whereby village and township health facilities are expected to subsidise preventive services out of profits they earn from selling drugs, has had serious negative effects.

There are a number of reasons why people should not have to pay the full cost of some services (or should be able to claim reimbursement for a portion of the cost). First, rural households need protection against having to sell productive assets or borrow excessively to pay for care of a seriously ill family member. Second, there are strong grounds for keeping charges for certain services low, or charging nothing at all, to encourage people to use

[1] Hsiao (1995) has estimated that it would have cost approximately ¥30 per person to provide a mix of preventive and curative services in poor rural counties in 1993. This is a crude estimate because it is based on existing staffing levels and patterns of drug use. It also makes assumptions about how current levels would rise if users were reimbursed between 60 per cent and 80 per cent of their costs. He estimates that the cost will be higher in richer areas, because demand for services will be higher.

them. These services include preventive programmes, treatment of illnesses that are public health hazards (sexually transmitted diseases, tuberculosis and so forth), consultation with a primary care health worker, and early treatment of common problems to avoid long-term and costly complications. Third, the very poor need access to essential services even if they cannot afford to pay. Where users do not pay the full cost of a service in cash, alternative sources of finance, known as third party payers, need to pay instead. Potentially, the most important third party payers are government health departments, community health care funds, and social relief.

3.1 Government health budgets

Government grants are an important source of income for rural health facilities, but in recent years they have accounted for a diminishing share of their expenditure. These grants should be increased to cover development expenditure, the costs of preventive programmes, and the training and supervisory functions of health facilities. Health facilities in poor areas also need financial support so that they can pay competitive salaries to trained health workers. The issue of government funding of staff salaries must be addressed as part of a broader reform of personnel management to prevent the use of government grants simply to raise the income of large numbers of unproductive staff (see Section 4.1).

3.2 Community health care funds

Government is encouraging localities to establish community health care funds which derive income from household contributions, and grants from county and township governments and village administrations. Approximately 10 per cent of villages already have established such schemes. Community health care funds in the richer areas provide more finance to the health sector than government health budgets. In these areas, it is possible to finance a full package of essential health services out of a combination of government grants, community health care funds, and cash payments by users of services (Carrin *et al.* 1997).

In poor counties government health budgets are small, households have a limited amount of money to spend, and township governments and village administrations collect very little off-budget revenue from enterprises (Zuo 1997). It may not be possible to finance even basic health services out of local resources in these areas. Higher levels of government will have to provide financial support.[2] This support could take the form of increased fiscal transfers so that local governments are able to finance basic services, or, it could take the form of grants to health facilities or community health care funds from higher levels of government or from poverty alleviation funds.

Community health funds should experiment with different ways of paying for health services, including:

- direct payments to health facilities for providing preventive services free of charge and to village and township-level facilities for providing free consultations;
- reimbursement to members of a portion of the cost of curative services (reimbursement rates could be varied to encourage patients to use the referral system, to treat diseases that pose a public health risk, or to seek treatment for vulnerable people such as young children or pregnant women); and
- establishment of a small risk fund to be used at the discretion of the fund management to protect members from borrowing excessively to pay for particularly expensive medical care (this facility could complement medical relief).[3]

Community health funds will not retain popular support for very long if they are not well run. Also, government will not be able to channel money through them. That is why a considerable effort needs to be made to establish funds that collect contributions efficiently, prepare high quality audited accounts, and are answerable to the community for how they spend their money. It will be particularly difficult to

[2] A recent study has concluded that households in poor areas are unlikely to contribute more than two per cent of their income to a health fund. In areas with large numbers of poor households, it might be realistic to expect to collect little more than ¥5 per capita. Local governments may provide grants equivalent to another ¥2-3. Townships and villages in poor areas have little revenue from enterprises. This suggests that there will be a substantial shortfall, even if individuals are expected to pay 50 per cent of the cost of care in cash.

[3] Kaifeng county in Henan province includes this facility in the scheme that it introduced in 1994.

establish funds where there is a shortage of people with financial management skills and where systems of political accountability are weak. In some areas it may not be possible to establish a scheme, and government should consider funding basic services by providing larger grants to health facilities.

3.3 Medical relief

Measures need to be taken to ensure that poor households do not have to sell assets or go too deeply into debt in order to pay for medical care. This can be achieved by establishing a right to medical relief. In the richer areas, village administrations and township governments will be able to pay a substantial share of the cost of medical relief. This is unlikely to be the case in poor areas, where the money will have to come from poverty relief funds or from higher levels of government.[4]

The following steps need to be taken to translate a general commitment to address the needs of the poor into specific measures:

- define criteria for identifying households entitled to subsidised health care;
- define the support to be provided to poor households (payment of contributions to the community health fund, and assistance to poor households in making out-of-pocket payments for essential medical care);
- define sources of money for the fund; and
- establish a system of fund management.

In localities where there are large numbers of poor households it may be more efficient for government simply to subsidise a core package of services for everyone and to create a risk fund to protect those with severe illness.

3.4 Conclusion

The proposed strategy for financing rural health services is complex because health facilities derive funds from direct charges to users and from several third party payers. It could easily lead to increases in costs that ultimately will result in the failure of the financing strategy. It must be part of an overall reform that includes measures to ensure that the money is used to finance an appropriate mix of services at a reasonable cost.

4 Improving the Performance of Providers of Health Services

Several articles in this Bulletin describe the effects on health services in poor rural areas of years of disinvestment. Many health facilities are run down, poorly equipped and staffed by personnel whose skills have deteriorated because of lack of supervision and in-service training. The health services need to be rehabilitated to increase their effectiveness. A rehabilitation programme should include upgrading of buildings, purchase of new equipment, and re-training of personnel. The management of health facilities also needs to be strengthened.

4.1 Improved management of inputs

Human resources. Many rural facilities have too many unskilled personnel and too few well-trained health workers (Gong and Wilkes 1997). A large proportion of their 'doctors' and 'assistant doctors' have not had the requisite pre-service training. In consequence, they provide a narrower range of services than previously, at a higher cost (Tang 1997).

Government should define the number of core staff each kind of facility needs to provide the package of essential health services. It should support a programme of retraining to ensure that personnel are competent to provide these services. This competence should be recognised in some form of re-certification.

The government grant should fund appropriate salaries for the core staff. The practice of sharing bonuses between health workers, whether productive or not, should be ended. Everyone should receive a basic salary that reflects their education and experience. But, the size of their annual bonus should be directly related to the kinds of services they perform. Health facilities should not have to employ additional personnel, but if they have to do so, they should not have to pay high salaries to unproductive staff.

[4] This would not necessarily be the case if China carried out a tax reform that ensured that poor counties and townships received fiscal transfers large enough to finance a basic package of social services and benefits.

Drugs. Drug use needs to be rationalised as a means of improving service quality and decreasing costs. In-service training and the development of case management protocols can help to improve prescribing practices. However, government will also have to regulate the supply of drugs. The right to prescribe regulated drugs should depend on the expertise of the health worker. Rural doctors should be allowed to prescribe only a limited list of essential drugs, health centres should provide more products and county hospitals even more. Health facilities could be permitted to sell unregulated drugs as a means of generating revenue.

The present system, whereby health workers can increase their income by selling more drugs, needs to be changed. However, until reliable alternative sources of income can be established, the health sector will have to retain the right to earn profits from selling drugs. One way of generating revenue, while diminishing the incentive for doctors to over-prescribe, is to pay profits from drug sales directly into community health funds. Another is to replace the percentage mark-up on drug prices with a fixed charge per prescription.

4.2 Integration of health services

Health facilities compete strongly for patients. This has given much more choice to people who can afford to pay. It has also led to decreased cooperation between providers and has contributed to decreased quality control and increased cost. Measures need to be taken to reconstruct a coherent health system.

Integration between levels. Several articles in this issue describe how the disruption of the collaborative relationships between health service providers has weakened the referral system, interrupted the flow of information on health and health services, decreased monitoring and supervision, and virtually ended in-service training. The change from cooperation to competition has undermined the rationale behind the policy of using partly skilled health workers as the major providers of basic health services. It has become quite difficult to ensure full coverage by preventive programmes or to regulate the quality of grassroots services.[5]

Measures need to be taken to re-establish the links between county, township and village levels. In order for this to succeed all levels must benefit. For example, village health workers should be assured a reasonable income in exchange for accepting supervision from higher levels, and health centres need to be paid for performing a supervisory role. One option would be for health centres to sign contracts with village health workers that describe the roles of the two levels and define the financial relationship between them.

Integration between programmes. A second problem regarding integration arises from the organisation of health services into vertically managed programmes. This approach has made it possible to ensure that a defined set of services is provided. However, it has led to a fragmented service and to the inefficient use of resources. For example, a number of specialised personnel, often in different facilities, provide different reproductive health services. None of these services are adequately funded by government grants and facilities often compete for patients. No-one is responsible for the overall quality of these services or their cost. The high maternal mortality rate and the high prevalence of untreated reproductive tract infections indicate that the present system could be improved. Measures need to be taken to preserve the advantages of clearly defined lines of authority and well-established management guidelines for preventive programmes, while making an integrated package of services available to users and making better use of trained personnel.

4.3 Performance monitoring

Prior to the 1980s, the health sector was controlled jointly by the MoH and the Communist Party through a tightly organised hierarchy. Health facilities had little scope for opportunistic behaviour. These controls have been eased considerably and health facilities have a great deal of autonomy. They are subject to less technical supervision than previously and they are under less political scrutiny. They are still answerable to local government for their use of grants, but these grants account for a diminishing share of their budgets.

Managers of health facilities in poor areas are under strong pressure to increase health workers' salaries.

[5] The papers by Deng *et al.* and Shu and Yao show how the preventive services in one county were much more effective than in other study counties, largely because of better cooperation between levels.

They are under much less pressure to provide good quality services or to control costs. Mechanisms need to be established to shift the balance of influence in favour of the users of services. Many facility managers sign contracts with local governments, as do managers of other enterprises. However, their performance is largely assessed on their ability to meet financial targets. In future, contracts should clearly specify the facility's duty with regard to the package of essential services. Its level of funding and ability to pay bonuses should be linked to its achievement of performance targets. This will be particularly important when community health care funds are established.

5 The Need to Strengthen the Role of County Health Bureaux

County governments should ensure effective basic health services are provided at a reasonable cost. They can achieve this by allocating a higher share of their budgets to health and by playing a more active supervisory and regulatory role. Higher levels of government can encourage them to do so by strongly indicating that health services are important. For example, they should include the achievement of targets relating to the provision of health services among the criteria they use to assess the performance of local government officials.

The county health bureaux need to redefine their roles, now that they do not have direct administrative control over grassroots health facilities. They should establish a capacity to undertake the following:

- prepare development plans that include investment and measures to improve services,
- set targets for preventive programmes and monitor their achievement,
- monitor the quality of medical care and provide further training to health workers,
- regulate drug use and the licensing of health workers,
- provide technical support to community health care funds and township governments, and
- collect and disseminate health-related information.

The health bureaux have to decide who should perform each of the above functions. They have a limited capacity to supervise rural health services themselves, because most of the skilled personnel at county level work for a hospital or a preventive institute. It is unrealistic to expect these institutions to subsidise regulatory tasks out of profits from revenue generation. Mechanisms need to be established to fund this kind of work and to ensure that those responsible for regulation act in the interests of the population. One option would be to establish a core group of county health officers with secure part-time or full-time employment, who are directly answerable to the county government.

6 Making Health Services More Accountable to the Population

People must feel confident that their contributions to a community health care fund will be used for the designated purpose and that all members of the fund have equal access to benefits. Higher levels of government also require this kind of assurance if they are to channel substantial amounts of money through them.[6]

Community health care funds must be given a legal mandate that clearly defines their role. The boards of the funds need to include representatives of major stakeholders such as users from different parts of the township and providers of grassroots services. Higher levels of government should be given the power to audit the performance of the fund and they should establish the capacity to carry out this regulatory function. They should also provide information on the performance of the health services in different localities to make it easier for community health care boards to compare local facilities with others in the county.

Community health care funds should establish village and township management structures. Village health care committees should oversee the use of funds specifically allocated to their village. They should monitor the performance of the village health workers and should have a say about how much they are paid. The township committee

[6] Hsiao (1995) argues that one reason why it is realistic for government to encourage localities to establish community health care funds is that many communities already have structures that ensure a degree of accountability. In societies where community structures are weak, it will be very difficult to establish these schemes.

should have overall responsibility for managing the community health care fund. Its functions should include the collection and management of money, the preparation of regular financial accounts, and the negotiation and monitoring of contracts with health care providers.

The county health bureaux will have to provide technical support to community health care funds so that they can obtain value for money from the providers of health services. This will involve experts from county level helping township institutions to function as effective purchasers of services from township and village health facilities.

Each county government should establish a rural health commission on which all the community health care funds are represented. This would provide an opportunity for fund managers to discuss how to improve local health services. It would also make it possible for them to put pressure on the county hospital and the preventive institutions to pay more attention to the needs of the rural population. The commission will be able to exercise considerable leverage over county level institutions since the latter will derive a substantial share of their revenue from government grants and payments by community health care funds. The rural health commission should have the right to participate in the negotiation and monitoring of contracts with these facilities.

The major lesson of the years since the early 1980s is that the health services function as a system. The performance of the health services can be adversely affected if the reform of this system is not managed effectively. The behaviour of health service providers is influenced by their training, financial incentives, the system of technical monitoring and supervision, the degree to which their work is monitored by the community, and the prevailing ethos of health workers. The overall objective of a reform programme should be to establish a coherent system that encourages health facilities to provide the services that meet the major needs of the population at a reasonable cost. This will involve measures to alter many of the above influences. The design of a successful reform must be based on a good understanding of the structure of the health sector and of the economic and institutional environment in which it functions. It also requires a long-term commitment to change by leaders of all levels of government.

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