

## 1 Background

In the last decade, major changes have occurred in the financing of health services in rural China. Simultaneously, major changes have occurred in the organisation and delivery of maternal and child health and family planning services. The effect of these two sets of changes on reproductive health service utilisation and outcomes has neither been fully described nor evaluated.

In the years since 1978 when China's rural economic reforms were introduced, the rural economy has undergone a transformation from large rural collectives to an individual family farming system. The commune system has been dismantled and with it the collective health insurance system, the cooperative medical schemes (see article by Carrin *et al.*). They have been replaced in most localities by a fee-for-service financing mechanism.

One consequence of the move to a fee-for-service system has been that preventive services have decreased relative to curative care, especially in poor regions. Rural doctors earn their incomes from a combination of fees and the sale of drugs in addition to modest subsidies offered by governments at different levels. Critical management services such as supervision and monitoring are supported inconsistently by higher levels. Consequently, quality of services at lower levels varies widely, depending on the availability of funds from higher levels to pay for management and administration costs. Providers at all levels are more concerned with generating salary support through fees for curative care than with providing poorly subsidised preventive services.

Paralleling these financing changes have been changes in the organisation and delivery of reproductive health services. Prior to the early 1980s all reproductive health services, including family planning, were the responsibility of the Ministry of Health and its network of health bureaux and institutions at the provincial, county, township and village levels. Since the early 1980s, family planning clinical services have been provided more and more by new institutions, family planning service stations, under the direction of the national Family Planning Commission and its network of offices and institutions at the provincial, county, township and village levels. Because family planning is a gov-

# Reproductive Health Financing, Service Availability and Needs in Rural China

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ernment-subsidised national programme, resources for service provision are guaranteed from higher levels. The withdrawal of most family planning funds from the health system has removed a guaranteed funding stream which helped subsidise related services such as gynecological care and follow-up for contraceptive side effects and problems. The separation of family planning from maternal and child health and other women's health services has to a great extent fragmented the care that rural women receive.

Preliminary reports suggest that these changes in financing and delivery of services have had an impact on access to and utilisation of reproductive health services such as prenatal care and attended deliveries, diagnosis and treatment of gynecological problems, follow-up for contraceptive side effects and complications of pregnancy and delivery. Specifically, the demise of the cooperative medical schemes and the move to a fee-for-service financing mechanism may have negatively affected the availability of preventive reproductive health services, the quality of those services available in poorer areas, and the ability and willingness of rural women to pay for care. The separation of family planning from MCH and general OB/Gyn services appears to have reduced funding for the latter two critical health services for women.

In response to these changes, some areas have instituted experimental insurance schemes to finance reproductive health preventive services such as prenatal and postnatal care and safe delivery. In such schemes, voluntary prepaid contributions entitle women to a set of services over a specified period of time. Some schemes cover all prenatal and postnatal care and delivery including referral and care of high risk pregnancies and health education, but others cover only prenatal care and postpartum visits. In the best schemes, women are granted a cash reimbursement if they experience an adverse birth outcome. The cost of the scheme varies but is generally low and the services covered also vary and frequently depend on the wealth of the community and the risk of adverse birth or pediatric outcomes. In general, these insurance schemes cover neither curative reproductive health services such as routine gynecological examinations, nor diagnosis and treatment of gynecological problems in other than pregnant women.

Reproductive health services are often confused with maternal and child health services. In fact, they encompass a much broader range of preventive and curative activities than just prenatal and postnatal care. In resource-poor settings like rural China, a broad definition of all possible services which contribute to reproductive health would be unrealistic as there are neither the equipment nor personnel to carry out these activities. Rather, a minimum set of low technology services aimed at screening for common reproductive problems of rural Chinese women are included in our definition of reproductive health services: the provision of contraceptive services, follow-up for contraceptive side effects, diagnosis and treatment of common reproductive tract infections (candida, trichomonas, bacterial vaginosis) and gynecological problems (prolapsed uterus and urinary fistulas), prenatal and postnatal care and delivery, and health education related to family planning, pregnancy and gynecological health.

It is difficult to disaggregate reproductive health services utilisation and financing from overall health services utilisation and financing. Practically, health consumers may not differentiate their service utilisation into neat categories such as reproductive health, nor will funding streams for services be so neatly divided. Nevertheless, attempting to separate these services may be useful. Considerable evidence exists that in places where women's status is low, women's needs are treated with low priority in the household's use of limited resources. This suggests that when critical reproductive health services must be paid for, they may be under-utilised. Other studies, such as those in Matlab, Bangladesh, have shown that in resource-poor settings, integrated reproductive health services tend to be better utilised by women and result in better outcomes.

In an attempt to better understand rural Chinese women's need for, and utilisation of, basic reproductive health services, the Kunming Medical College, in collaboration with Abt Associates and the Shanghai Medical University and in consultation with the IDS Health Unit, conducted a study in four rural counties. The study gathered information on the organisation, funding for and utilisation of reproductive health services in rural areas of Yunnan province, China. This article reports some preliminary findings from that survey.

## 2 Yunnan Province

Yunnan province, where the study was conducted, is located in southwest China bordering on Burma, Laos, and Vietnam. It is a relatively poor province, with a large percentage (34 per cent) of its population of nearly 37 million comprised of national minorities. The province is quite mountainous, complicating the extension of health services to the rural poor.

By the end of 1995, 126 out of 127 counties in Yunnan had established family planning service stations, and 843 (54 per cent of all townships) township-level family planning service stations have been set up under these county-level institutions. Where township-level stations exist, family planning and health services are separated to a great extent in varying degrees.

By the end of 1991, 71 per cent of counties in Yunnan had moved to a total fee-for-service financing mechanism, while 28 per cent maintained a combined system in which some services are free and other services are provided for a fee. An MCH insurance scheme has been instituted in 16 counties, districts and cities, seven of them 'demonstration' areas supported by a large UNICEF project. The nine non-demonstration counties, districts, and cities have had varying rates of participation and success.

## 3 Methodology

The study used a variety of methods including household surveys of reproductive age women, interviews with providers, the collection of routine financial data and service statistics and qualitative interviews to investigate resource flows for reproductive health services in rural China, service needs and availability and user and provider constraints to optimal utilisation of the services that exist. We collected information on user needs and utilisation; pregnancy and delivery; current contraceptive use, gynecological problems and checkups; perceived needs for services; expenditures for reproductive health and other services, attitudes towards fee-for-service financing mechanisms and willingness to pay for comprehensive service packages.

We also conducted qualitative interviews with women and local service providers, including in-depth interviews and participatory rural appraisal

techniques to gather information on reproductive health beliefs and behaviours and perceived barriers to service utilisation.

## 4 Women's Needs for Reproductive Health Services

One of the major objectives of the study was to interview women about their reproductive morbidities in order to learn whether the services available to them were appropriate to their needs. Our findings suggest that there are gaps in services. We asked women about specific symptoms associated with common problems during pregnancy, delivery, and the postpartum period, about problems related to contraceptive use and gynecological infections. We found that reports of symptoms were high, especially in poorer areas. For example in the poorest township, Ejia, between 55-60 per cent of women reported at least one symptom during the pregnancy, delivery or postpartum periods, 80 per cent reported at least one gynecological symptom within the last six months, and 90-95 per cent of women reported a contraceptive problem. But service seeking for these problems was minimal. Only 26 per cent of women sought care for self-reported symptoms during pregnancy, delivery or the postpartum period, 17.5 per cent for gynecological symptoms, and only 25-31 per cent for problems following IUD insertion or abortion. While not all these self-reported symptoms were likely to be serious, it is nevertheless significant that no medical advice was sought.

We investigated constraints to service utilisation and found several important factors impeding use. Traditional attitudes about the need for prenatal care and attended delivery impeded use of MCH services, especially for second births. Women believe that second births will be easy and should take place at home. Many of them believe they only need to see a doctor twice during pregnancy: once to confirm the pregnancy and the second time to determine the position of the baby prior to delivery. Some believe they do not need to see a doctor at all for the second birth. For gynecological problems, there is a serious lack of knowledge by women of the potential consequences of untreated infections, and women are embarrassed to visit health services largely staffed by male doctors. Our study suggests that one of the most important constraints to repro-

ductive health service utilisation in many of the poor rural areas of China is the lack of female rural doctors (Zhang and Xing 1996) and the inability of local areas to retain those that do exist. In many of these poor rural areas, there is no routine screening for infections and in most areas local health workers are not properly trained to diagnose and treat common reproductive tract infections. For problems related to contraceptive use, some women were reluctant to use the local family planning station for follow-up services.

## 5 Functioning of MCH Insurance Schemes

We also investigated whether the newly created MCH insurance schemes improved utilisation of prenatal care and attended delivery. Our findings suggest that the MCH schemes in Yunnan province do not function as intended and do little to improve utilisation in poor counties. A detailed look at the scheme in Yimen county revealed that many women who contribute to the pre-pay scheme when they register for marriage, do not know that they are entitled to prenatal services, often because they are unaware that their husbands have paid for it. Moreover, in some cases the scheme requires women to utilise services at county facilities, which often requires substantial travel for rural women. In those cases, the scheme has become a mechanism to support provider salaries at the county MCH hospital which has lost guaranteed funding from the county government under the economic reforms and with the separation of health and family planning services. But salary support for these county-level providers has been obtained at the expense of locating services conveniently for the rural poor, even though these women are willing to pre-pay for the MCH services. But where the pre-pay scheme is located conveniently at the township level, township MCH providers whose salaries are paid by the MCH prepaid schemes more actively provide prenatal and postnatal care in their communities in order to meet provincial MCH targets.

Another major drawback of the Yimen scheme is that it does not provide coverage for delivery: the event most associated with adverse outcomes of pregnancy. Families must pay for deliveries and frequently choose to deliver at home, especially for second births which are thought to be easier. In Pubei town-

ship, quite close to the county town in Yimen, only 43 per cent of women delivered in hospital; and in Ejia, the poorest township studied, only five per cent did. Strong cultural beliefs interact with convenience and economic factors to impede optimal utilisation of safe delivery services.

## 6 Shortcomings in Preventive Services

One big consequence of the move to a fee-for-service system of health care in rural China has been that preventive care has declined relative to curative care, for which fees can more easily be collected. In the case of reproductive health, this is particularly unfortunate, as health education and screening are major components of the needed service package. These include, for example, health education about the important effects of adequate prenatal care to minimise adverse birth outcomes, screening for non-symptomatic reproductive tract infections (RTIs) in order to treat them before they lead to more serious health consequences, and health education about HIV preventive behaviours, especially important in Yunnan where the China AIDS epidemic is most severe. Women's poor health knowledge and the persistence of traditional beliefs combined with the lack of health education services for reproductive health in rural Yunnan has contributed to very low utilisation of prenatal services and to virtually no service seeking for screening and treating RTIs.

Investigations in Yunnan province have confirmed that common reproductive tract infections are a serious problem for rural Chinese women. Results from a recent prevalence survey (Kaufman *et al.* 1996) revealed that 70 per cent of over 2,000 randomly diagnosed women currently have at least one RTI (trichomonas 16.2 per cent, candida 38.9 per cent or bacterial vaginosis 14.7 per cent). Moreover, 58 per cent of these women currently have varying degrees of cervicitis, of unknown cause. These infections may increase the risk of HIV infection in exposed women, carry the risk of more serious health problems, and potentially cause adverse birth outcomes for pregnant women.

Currently, the rural health system is not able to properly diagnose and treat the common reproductive tract infections in women. Local level (township and village) doctors do not have the training to

make a differential diagnosis of the specific disease, nor do they have knowledge of proper drugs to treat them. Moreover, many infections might be prevented by ensuring asepsis of instruments in local level health stations.

## 7 Conclusion

The changes in the rural health financing system have had a detrimental effect on the provision and utilisation of reproductive health services for poor rural women. The major reproductive health problems facing women in rural China centre around childbirth, use of contraception and chronic reproductive tract infections. The increasing emphasis on curative care to earn income, the lack of funds and provider incentives for health education activities,

and the shortage of female doctors contribute to very poor utilisation by women for services that do exist. Moreover, service availability does not adequately match need. Child delivery is not covered by pre-payment schemes and family planning services are too oriented towards the promotion of contraceptive use and they do not pay enough attention to the follow-up of problems from use in many of the poor rural areas of China. Screening and treatment for RTIs is almost non-existent. Our study suggests that increased attention is needed to the actual morbidities of reproductive age women and their needs for services so that market forces alone do not shape what services are available to them, and cost does not impede the ability of poor women to pay for services universally recognised as effective and necessary for adequate reproductive health.

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