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China's rural health system in a changing institutional context [1]

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Summary

China's rural health services are experiencing problems associated with the transition to a market economy. The cost of care has risen rapidly and arrangements for local health insurance have collapsed. Government health budgets have lagged behind the rise in costs. Major illness has become an important precursor of household poverty. Policy-makers acknowledge that something has to be done to improve access to effective services at an affordable cost. Government policy statements have articulated a vision of a future health system. Few disagree with this vision but people do disagree about how to attain it. Chinese health policy analysts have begun to ask fundamental questions about the role of government, forms of facility ownership and alternative health financing mechanisms. This paper argues that the health sector's problems are best understood in the context of China's attempt to create institutional arrangements appropriate to a market economy. It suggests that the performance of rural health services will be strongly influenced by the degree to which rules-based local administrative and regulatory systems and local accountability mechanisms become established.

Keywords: China, rural health, transition, governance, health finance

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1 Introduction

China has been in transition to a market economy since the late 1970s. This attempt rapidly to establish a market economy and protect the population against excessive dislocation and suffering is a complex process for which there are few precedents (Nolan 1995; Rawski 1999). The Chinese approach to transition can be understood as a continuing negotiation. It has benefits and costs. The economy has grown rapidly and household incomes have risen substantially. There is a relatively stable environment, within which stakeholders have adapted to change. People have had time to revise their views of how to order social relationships as markets have emerged. China has avoided the kind of institutional collapse that other transitional economies have experienced (Reddaway and Glinski 2001).

Some argue that that the gradual adaptation of institutions to a market economy has resulted in substantial economic losses (Woo 1999). They suggest that the government could have created a legal framework appropriate to a market economy at an early stage of the transition. The absence of a well-defined regulatory framework, they argue, has encouraged certain kinds of opportunistic behaviour. Interest groups have been able to retard change and individuals and institutions have taken advantage of incentives provided by partially liberalised markets. Inequalities have risen between regions and social groups (Khan and Riskin 2001).

This paper explores the management of transition in the health sector. It reviews the health sector's development before and after the commencement of the transition to a market economy, situates it in the context of transition and explores recent debates about strategies for reconstructing a coherent rural health system. It pursues two main arguments. The first is that the health system has to be understood as a complex set of relationships between stakeholders with different interests and positional power. These stakeholders must share expectations about appropriate behavioural norms for it to perform well. This means that health reform has to be situated in the broader context of economic and institutional transition. The second is that transition implies profound changes at a discourse level in how institutional arrangements and relationships are constructed. Transition changes the rules for negotiating behavioural norms, establishing and internalising contracts (implicit and explicit), and understanding accountability.

2 Fifty years of rural health development

2.1 The three-tier rural health system

In the 30 years after 1949 China greatly reduced its population's burden of sickness and premature death. This was largely due a lessening of severe poverty, improvements to the rural environment and increases in literacy. The health sector contributed by providing preventive programmes and effective and affordable basic medical care (World Bank 1997).

By the mid-1970s China had established a rural health system with the institutional arrangements that analysts believe necessary for it to perform well. These include a network of appropriate facilities and personnel, social financing of a large proportion of health expenditure and mechanisms to coordinate

service providers and encourage health workers to act in the community's interest (Chernichovsky 1995). The specific arrangements reflected the prevailing economic and institutional realities (Tang *et al.* 1994).

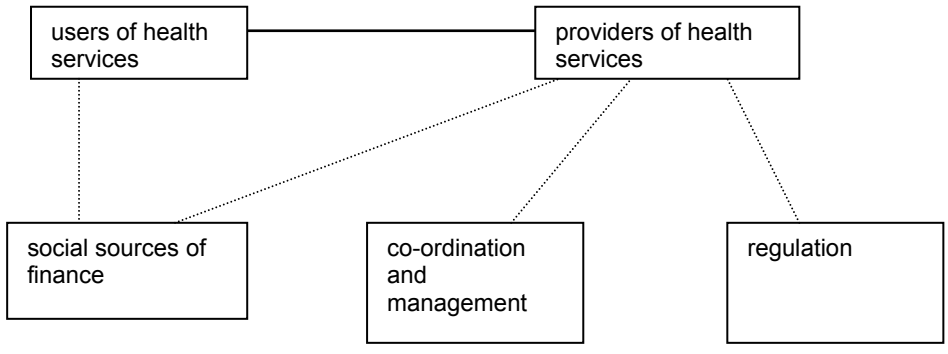
Most villages had a health station with several part-time health workers. They organised public health campaigns and provided basic health services. Each commune (now called townships) had a health centre, with several doctors and assistant doctors. These facilities coordinated and supervised public health programmes and provided medical care. The county health bureau was responsible for the performance of local health services. It prepared plans and allocated the annual government budget. County institutions supervised township and village facilities and provided referral services.

Village personnel were paid a share of collective production. Health centre workers were paid either a share of collective production, or a government salary. County-level workers remained government employees. Village and township health facilities charged patients a small fee and sold drugs and other consumable items. People paid more at the county hospital. Most communes established local health insurance schemes, which derived revenue from household contributions and collective welfare funds. They provided some services free of charge and reimbursed a proportion of other medical costs.

2.2 Adjustment to the emerging market economy

During the 1980s and 1990s the rural health system had to adapt to the transition to a market economy. It also had to adjust to demographic and epidemiological changes, urbanisation and industrialisation (Hussein 1999). The institutional arrangements for the rural health system changed a great deal during that period (Bloom and Gu 1997). The dotted lines in Figure 2.1 indicate functional relationships that became weaker. The following paragraphs describe these changes.

Figure 2.1 Changes in functional relationships in China's rural health system since the late 1970s



Public sector pay increased, reflecting income rises in rapidly growing regions. The government devolved financial management to lower levels (Wong *et al.* 1995). Governments of poor rural areas experienced growing financial problems. By 1998 township health centres received only 10.5 per cent of their expenditure from government and village clinics received almost no government support (Fu *et al.* 2000).

County hospitals also depend largely on user charges, although a significant number of their patients are beneficiaries of the health insurance scheme for government employees.

Health facilities now compete for patients. Supervision and referral has diminished. Government officials no longer influence day-to-day management of health facilities. Also, they are much more concerned with economic growth than the performance of health services. Many local governments do not have the resources to monitor and regulate the health sector effectively. Health facilities have a great deal of autonomy. There are an increasing number of private providers.

The rural health services increasingly resemble a poorly regulated market. The government has only begun to establish a regulatory framework to replace previous systems for influencing health providers. It retains powers from the past. For example, it controls prices. It has kept charges for consultations and hospital days low, but allowed facilities to earn a surplus from drug sales and test fees. This has encouraged high levels of drug use (Zhan *et al.* 1997; Dong *et al.* 1999).

Health facilities in rich areas provide an increasingly sophisticated mix of services, but at rising cost. Facilities in poor localities provide a smaller range of services than before, partly because they have lost their best personnel (Tang 1999; Gong *et al.* 1997). Preventive programmes have deteriorated in some localities (Shu and Yao 1997). The cost of rural health services has risen quickly. For example, the cost of an outpatient visit and an inpatient day increased two to three-fold in county hospitals and township health centres between 1993 and 1998 compared to a 60 per cent increase in the overall consumer price index and a 41 per cent increase in the rural consumer price index (Table 2.1).

Table 2.1 Percentage increase in cost of service in county hospitals and township health centres, 1993–8

	County hospitals	**Township health centres**
Business Revenue	170%	121%
Total outpatient visits	-14%	-15%
Total inpatient admissions	-6%	-7%
Cost per outpatient visit	232%	141%
Cost per inpatient day	208%	157%
Consumer price index	60%	
Rural consumer price index	41%	

Source: World Bank (2002: Table 7.14)

Most local health insurance schemes collapsed so that 87 per cent of villagers had no health insurance in 1998 (Meng and Hu 2000). There is evidence that decisions to consult a doctor, purchase a course of drug therapy or accept admission to hospital are influenced by cost. Some borrow money to pay for treatment. A MoH study claims that a family's poverty can be attributed to disease or injury in 23 per cent of cases (Meng and Hu 2000).

3 Health development in the context of transition

The rural health system presents a paradox. There is a dense network of health facilities and many health workers (although the best qualified have moved to urban facilities). There are reasonably high levels of health expenditure and no drug shortages. Despite this, many rural residents find it difficult to gain access to services and there is growing concern about the impact of major illness on household poverty. This section situates this poor performance in the context of the changing institutional environment and the need to negotiate new arrangements and behavioural norms.

3.1 The institutional environment

The pre-1980s rural health services were embedded in the institutions and behavioural norms of the command economy. This section describes how this environment has changed and has continued to change.

3.1.1 The party-state [2]

The close inter-relationship between the Communist Party and the government has led people to describe China's governance system as a "party-state". The relationship between party and state and between the party-state and other social actors has changed a lot during the reforms. There is a considerable divergence between formal organisational structures and actual decision-making processes (Lieberthal and Oksenberg 1988; Saitch 2001). It is useful to understand how both have changed.

Table 3.1 Levels and governing structure of current Chinese government

Administrative levels	**Communist Party of China**	**State administration**	**People's Congress**	**Legal system and discipline Inspection Committee of the Communist Party**
National	Central Committee	State Council and the ministries, commissions and institutions under its leadership	National People's Congress	National legal and discipline structures
Provincial	Provincial Committee	Provincial government and its commissions and bureaux	Provincial People's Congress	Provincial structures
Prefecture/ District	The prefecture does not constitute a level of political power, but has administrative agencies set up by the province			
County	County Committee	County government and its bureaux	County People's Congress	County structures
Town/ Township	Township Committee	Township government and its departments	Township People's Congress	Township structures

Source: Fang (2002b).

[2] This section draws heavily on Saitch (2001) and Baum and Shevchenko (1999).

The major institutions of the party-state include the Communist Party, the State Administration, the People's Congress and the legal system and Discipline Inspection Committee of the Communist Party (Table 3.1). This structure is replicated at each administrative level.

The Constitution assigns to the Communist Party a leading role in all aspects of development. The party's 63 million members are organised in a pyramidal structure on the principle of democratic centralism. The pyramid's peak is the five-yearly National Party Congress (NPC). The 16th Congress took place in late 2002. The NPC elects a Central Committee. The Central Committee elects the Politburo and the Politburo's Standing Committee, which lie at the centre of decision-making. There are similar structures at each administrative level. The base of the pyramid is made up of 3.5 million primary party organisations in work-units, neighbourhoods and villages.

Between the 1950s and 1970s the party underwent a series of political campaigns aimed at maintaining its revolutionary spirit and ideology. It did not institutionalise a rules-based administrative system or a permanent bureaucracy (Lu 2000). Since the late 1970s, national policy has focused on economic growth. The party has given high priority to improving the technical competence of cadres and creating rules to govern their behaviour within the party and in government (Deng 1984; Lee 1991). The report by Jiang Zemin (2002) to the 16th Party Congress restates the importance of establishing rules-based administrative and legal systems. Analysts disagree about the degree to which this objective has been achieved.

The role of party cadres has changed. They have a diminished capacity to interfere directly in the day to day management of government or enterprises. On the other hand, many have become involved in economic enterprises (Baum and Shevchenko 1999). For example, village party secretaries are often key players in local enterprises. These enterprises provide essential revenue for development activities and services; they also provide income to managers and/or owners. This pattern is repeated at higher administrative levels. It raises questions about how cadres balance their own interests, local interests and party policy.

The government is organised in four tiers and an intermediate administrative level (the prefecture). The highest body of the state is the National People's Congress (NPC). It is elected for five-year terms and meets annually. The highest organ of state administration is the State Council, the executive organ of the NPC. The work of the State Council is presided over by an executive board composed of the premier, vice-premiers, state councillors and the secretary general. Under the State Council are the various ministries, commissions, committees, bureaux and *ad hoc* organisations. Other administrative levels are organised similarly into people's congresses and state administrations.

Government and party decision-making is organised in a complex matrix with vertical channels (*tiao tiao*) stretching from national ministries all the way to affiliated institutions at the lowest government levels and horizontal territorial governing bodies (*kuai kuai*). In the health sector, for example, the Ministry of Health (MoH) formulates plans, guidelines and norms for local health departments and individual health facilities, but each level of government decides its own priorities. The relative influence of the two principles is difficult to define clearly and changes over time. Lieberthal and Oksenberg (1988)

characterise this matrix as a negotiated system in which fragmentation is overcome by negotiation and bargaining. They suggest that informal mechanisms and personal relationships play an important organising role.

One characteristic of the reform period is the increasing influence of local administrations. County and township governments have a great deal of autonomy from central authorities. The latter establish broad development strategies and the legal framework within which localities operate, but local authorities have substantial control over resources. Oi (1999) argues that the ability to retain a large proportion of tax revenue for local purposes has encouraged local government leaders actively to promote enterprise development. This, in turn, has increased their financial autonomy.

Huang (1995) argues that the centre has compensated for the devolution of administrative and financial control by strengthening its capacity to oversee aspects of the party-state. It has improved systems for the collection and analysis of data and established a number of policy analysis units to provide an overview of development. It has also established the cadre responsibility system, whereby higher levels in the party hierarchy appoint local party and government leaders. These cadres sign annual contracts, which establish performance targets for the achievement of which they are assessed. The outcome of an annual evaluation strongly influences a leader's remuneration and promotion prospects.

Localities have followed quite different development trajectories. Some have experienced rapid economic growth and established sophisticated welfare systems, including local health insurance (Cook 1999; Carrin *et al.* 1999; Zhu 2001). So-called "super-villages" have become centres for economic development (Zhe 2000). Other localities have experienced less economic growth and their public services have deteriorated. Their governments have had difficulty retaining skilled staff. They impose informal levies that put financial burdens on households and local enterprises (Young 1995).

A number of analysts have commented on the blurred boundaries between state and society. Lubman (1999) points to the hazy legal definition of property rights. Wank (2002) documents clientelist relationships between enterprise managers and government officials in Xiamen City. Oi and Walder (1999) describe a variety of relationships between rural enterprises and local government. In some localities enterprises are mostly collectively owned and in others they are mostly private. Oi (1999) argues that the behaviour of local administrative bodies strongly influences the performance of local enterprises, whatever their ownership structure or their formal relationship with government.

Baum and Shevchenko (1999) present a typology of four types of party-state involvement in local economic activity in China. Entrepreneurial administrations actively seek economic opportunities and work closely with economic actors to foster development. Developmental ones encourage economic development but do not form ties with preferred enterprises and clients. Clientelist governments link with local entrepreneurs, using bureaucratic connections to support local clients. And predatory ones are geared to the maximum appropriation of existing, extractable surplus. All four types involve a close inter-penetration between the party, government and economic actors. The authors do not explain why local governments choose to play such different roles.

3.1.2 Labour market

The shift from a managed labour force with low pay and productivity to a market with growing differences in earnings between regions and between categories of worker has been a major feature of the transition (Tomba 2002). This section focuses on how this has taken place in the public sector.

When township governments were established, decisions were made about how to treat people who had been performing public tasks for the communes. Village health workers were given access to land but did not become government employees. Most village health workers now provide care on a fee-for-service basis and also work their land. Workers in township health centres became salaried employees with full pension entitlements. This led to a differentiation between largely *private* village clinics and *public* township facilities. County personnel remained in the public sector.

A number of measures have been taken to improve the quality of cadres and civil servants. They are now recruited on the basis of a competitive examination and the Ministry of Personnel manages their careers. Most public sector employees are neither civil servants nor cadres. They now work in a system that combines aspects of planning and of market relations. The Ministry of Personnel oversees the employment of skilled workers with university or college qualifications and the Ministry of Labour and Social Security oversees the working conditions of semiskilled and unskilled workers. Both Ministries have ceased assigning workers to posts. It is difficult to say exactly how employment decisions are made. Many local governments influence personnel management directly by requiring facilities to hire more people. Employees can change jobs, but facility managers have little power to fire people. The number of staff has tended to increase and their workload to diminish.

The determination of public sector pay has reflected the need to adapt to growing inter-regional differences in earnings whilst maintaining an integrated public service. The government sets a national pay scale for its employees. However, many local governments do not provide enough money to pay these salaries.[3] Work units use their revenue to supplement salaries. Successful health facilities pay substantial bonuses above the basic salary. Facilities in poor areas don't even pay basic salaries. The shortfall below the national salary was initially experienced as a temporary phenomenon; some health centres recorded underpayment of salaries as debt. Expectations have altered and a differentiated pay structure has emerged. Employment contracts now embody an explicit or implicit understanding that levels of pay will be related to a facility's financial performance.

Facilities in poor areas cannot pay enough to retain skilled personnel. Nonetheless, government salaries and pension entitlements are high relative to average rural incomes in these localities (World Bank 2002). Local governments have forced health facilities to employ more staff over the years, although this has changed recently. They also finance pensions for retired employees. The retirement age is low and many pensioners go into private practice. The pressure to share limited public resources with a growing workforce and increasing numbers of pensioners has compromised the ability of health facilities to pay

[3] A recent study in Gansu Province suggested that some poor townships make no budgetary inputs to the health sector at all (World Bank 2002: 119)

good salaries to skilled personnel or pay for other inputs necessary for good quality services. Health workers frequently supplement their salaries with informal payments by patients (Bloom *et al.* 2001). Some also work privately on a part-time basis.

The government has two strategies to deal with overstaffing. Central and provincial governments have implemented downsizing exercises. These focused mainly on career civil servants and there is little evidence of the impact on provincial hospitals. The expectation is that county and township governments will implement similar exercises, but it is difficult to assess when they will do so. The other approach is to permit uncompetitive work units to shrink, as has happened with state owned enterprises. This approach has been tempered by the government's desire to prevent rapid increases in open unemployment. Also, local officials sometimes create jobs for people as a form of patronage. Although there has been talk of the privatisation of health facilities, this has not happened on a large scale.

3.1.3 Public finance

There are large inter-regional differences in public expenditure (Ahmad 1997) According to a recent study by the World Bank (2002), inter-provincial variation in *per capita* expenditure grew substantially in the 1990s. The same study demonstrated considerable inter-county variation. During the late 1980s and early 1990s, townships and villages financed an increasing share of expenditure from informal levies that usually fell outside of auditing scrutiny by higher levels.

The devolution of public finance has given advantages to rapidly growing localities. They have been able to limit the proportion of tax revenues they transfer to higher levels. They derive much of their revenue from informal levies on enterprises. Governments of poor townships, on the other hand, have experienced increasing difficulties. They frequently spend more than 80 per cent of their budget on salaries and pensions (Zuo 1997). They depend on informal levies on households to meet these costs. These levies are often referred to as the *three arbitraries*: arbitrary taxation, arbitrary fines and arbitrary expropriation (Wedeman 2000). These levies are illegal and against the government policy of limiting the financial burdens on rural households to 5 per cent of average income.

There have been numerous protests in localities that have imposed a higher burden on farmers than the benefits justified (Bernstein and Lu 2000). The government has made several attempts to reduce these burdens. In 1993 it responded to a major protest by abolishing a number of fees and fundraising programmes as a means of limiting the financial burdens on households. Despite these measures, many localities have continued to collect more than the 5 per cent limit from households. The government is introducing reforms aimed at integrating fees into the tax system. These changes will reduce opportunities for rent-seeking by local administrations. However, they will also lessen the ability of well-run localities to provide additional services. For example, local administrations cannot introduce compulsory local health insurance. This highlights the problem the centre faces in trying to meet the needs of the rural population in the context of a highly devolved system of public administration over which it has little control.

3.1.4 Social organisations

There is a limited, but growing role for "social organisations" that operate outside direct government control (Saitch 2000). According to official registration statistics there were 1,845 nation-wide social organisations and 186,666 local organisations in 1996. Saitch (2000) argues that the best way to understand the changing relationship between the party-state and social organisations is as an ongoing negotiation.

In 1998 the State Council issued "Regulations on the Registration and Management of Social Organisations" to incorporate social organisations more closely within existing party-state structures. These regulations require a social organisation to find a sponsoring unit to support an application to the Ministry of Civil Affairs for registration. The sponsor is responsible for ensuring that the organisation meets a need and that its activities are within the law.

The experience of the All China Women's Federation (ACWF) illustrates the evolving relationship between the party-state and social organisations. The ACWF was established by the Communist Party to mobilise women to participate in the implementation of the policies of the party-state (Howell 1995; Zhang 1994). It has become increasingly involved in efforts to enable local women to develop productive enterprises. It also has made efforts to create local representative structures, with variable success (Jacka 1997). However, control by government officials of the budget and appointment of senior staff has constrained the autonomy of local branches. The limited role of the ACLW is demonstrated by an opinion poll that showed that most women would not seek its support when faced by a serious problem (Howell 1996).

A wide variety of organisations have been established without a formal relationship with the state. Saitch (2000) estimates there were around a million in 1996. Zhang (1994) describes informal women's organisations that have emerged in rural areas. Zhou (1996) mentions the rise of guilds, mutual aid societies and other forms of organisation for mutual economic benefit. These organisations tend to be local and to focus on specific problems and issues.

Saitch (2000) identifies several factors that are likely to reduce government's capacity to control social organisations. These include the decision to downsize government and the role of social organisations as sources of employment for laid-off bureaucrats, the pressure on these organisations to identify alternatives to public funding, and the limited regulatory capacity of government departments. Many organisations simply do not register and remain informal groups. He concludes that the state has retained a great deal of influence over social organisations but that some social space has been opened up.

3.1.5 Rural institutions of local accountability

The government has established new mechanisms to enable rural people to express their grievances and influence local power holders. These include elected village committees, public petitioning of higher level officials about corrupt behaviour by local cadres and the introduction of rule by law and access by citizens to courts (Zweig 2000).

The Ministry of Civil Affairs is responsible for the introduction and oversight of village elections. The process began with the enactment of the provisional law on village committees in 1987; all provinces

had their own regulations by 1994 and the government enacted a definitive law in 1998 (Louie 2001). A village committee consists of a chairman, vice-chairman and other members (a total of three to seven members). They are elected for three-year terms by secret ballot of those aged 18 and above. The village committee answers to an assembly of village residents. Financial matters must be made public at least six-monthly. Village committees are not part of the state bureaucracy. According to the 1998 law, the Communist Party should assume a 'core leading function', which implies that the elected committee is subordinated to the party. The actual relationship between the party and the committee varies from place to place (Kelliher 1997).

There are different opinions about the impact of these measures. Some suggest that elected village leaders are more likely to challenge township officials who act outside the law (O'Brien and Li 1996). O'Brien and Li (1995) state that the number of letters of complaint about local government increased during the early 1990s. They argue that this reflected both the magnitude of problems with local governance and the opportunities for influence that village elections and the appraisal of the performance of government leaders (cadre responsibility system) created. They suggest that this form of protest is most successful where it exposes violations of government policy and where higher government officials are interested in improving the performance of local leaders. Li (2001) presents the results of a survey that shows that residents of localities where local elections were seen to be free and fair were more likely to say they would ask village leaders for help when problems arise.

Edin (2000) emphasises the importance of the cadre responsibility system and the high priority given by the political leadership to social stability in creating opportunities for protest letters and the views of elected village leaders to have an influence. Louie (2001) cautions that many villages have not implemented the law fully either because they have not yet held elections or because local party structures strongly influence the outcome. This has limited the impact of this initiative.

The report of the Central Commission of Discipline Inspection to the 16th Congress (CPC 2002b) emphasises the importance of so-called democratic supervision in stating that 'the practice of ordinary people appraising the services of every sector has been adopted as a general rule' (p125). It also proposes 'developing democracy, improving the legal system and putting the exercise of power under effective supervision and restraint' (p146). These statements suggest that the government will continue to rely on a combination of supervision from above and strengthening of local accountability mechanisms to make local governments more responsive to the population.

A number of authors emphasise the influence of informal networks on individuals and institutions (Gold *et al.* 2002; Yan 1996). They use the term "*guanxi*" to denote a set of inter-personal relationships based on mutual obligations. An important characteristic of *guanxi* is that people exchange gifts as a way to establish long-standing obligations. *Guanxi* is often associated with human feelings and shared ethical norms (Kipnis 2002; Yan 1996).

It is widely agreed that *guanxi* networks became particularly important during the social disruption associated with the Cultural Revolution and its aftermath. There is less agreement on how these networks have adapted to the transition to a socialist market economy. Some argue that *guanxi* is becoming less

important as national rules-based systems are consolidated. Others argue that greater mobility, improved communications and increased economic opportunities have encouraged people to extend their networks beyond their village or work unit (Yan 1996; Zhou 1996; Lin 2002). Yan (1996) cites examples where villagers used *guanxi* networks to force officials to correct wrong behaviour and to bypass bureaucratic obstructions. Several people have documented the importance of networks of mutual obligation in urban areas (Gold *et al.* 2002; Wank 2002). Some argue that as networks have become extended, the exchange of gifts is more instrumental and less associated with long-term relationships and concomitant behavioural norms.

3.2 The management of change

The government strategy for managing reform has been to define certain fixed and non-negotiable rules and permit a wide variety of behaviours concerning most other matters. The fixed points include the primacy of the Communist Party, the maintenance of social stability and national unity and the prohibition against certain criminal activities. The party-state enforces the non-negotiable rules with repressive force and severe punishment for transgressors. This section concerns the management of change outside these boundaries. It does not consider the debates within the political leadership about where these boundaries should be drawn (Fewsmith 1999)

China's leaders describe the management of reform as crossing a stream whilst feeling for the stones. This is a graphic metaphor for the tentative nature of decision-making in China (Lieberthal and Oksenberg 1988). The usual process involves the gradual construction of consensus at national and provincial levels in favour of a new policy. The initial government proclamations often state general principles, rather than specific and enforceable regulations. These general statements may evolve into specific rules, or they may be altered or disregarded.

The evolution of a policy statement into a change in the rules of behaviour for local governments and economic actors is lengthy and complex. Local governments translate national policies into local regulations. Some localities may ignore a policy or implement it unenthusiastically. While the evolution is taking place there is a great deal of ambiguity about what constitutes acceptable behaviour.

Individuals and local institutions play an active role in developing new forms of relationship and norms of behaviour. Zhou (1996) argues that many changes have been driven by a myriad of local adaptations by individual farmers in response to new opportunities. A variety of social organisations and networks have emerged during the reforms. Potter (2002) suggests that these networks provide a framework for stable relationships between members, despite the lack of confidence in the performance of relatively new rules-based systems. He suggests that formal systems and informal networks are likely to co-exist for a considerable amount of time. Potter focuses on the positive aspects of networks. Others point out that they promote the interests of members at the expense of non-members, to the detriment of the consolidation of universal rules. This is particularly important during a period when new forms of social segmentation are emerging and becoming institutionalised.

China's transition can be understood as a series of local adaptations punctuated by changes to legal and institutional arrangements. The national government articulates broad development objectives and establishes a framework within which stakeholders adapt (Liu and Bloom 2002). Local leaders have a lot of leeway in translating policies into new practices (Lichtenstein 1993; Oi 1999; Shue 1988). Local stakeholders (enterprises, workers, farmers and so forth) test boundaries and re-negotiate relationships within the policy framework. This approach permits small-scale experiments with reform before the government alters the legal framework (Kelliher 1992). Government adapts policies to take into account successful innovations.

Whiting (2000) illustrates how this has worked with regard to the relationship between enterprises and local governments. She shows how different historical legacies led the governments of three eastern counties to evolve different relationships with enterprises. She also shows how growing decentralisation and the increased autonomy of enterprises contributed to a fall in tax flows to higher levels of government. National authorities responded to this fall in the mid-1990s by reforming tax and rules for enterprise ownership to reduce opportunities for this form of game playing. She points out that these reforms altered the rules of engagement between local government and enterprise and should lead to further evolution. She concludes that we need to develop a greater understanding of the politics of transition management.

Bloom *et al.* (2001) make a similar point about health worker pay. They describe how health facilities and individual workers have tried a variety of strategies for increasing earnings. Some strategies push against the boundaries of accepted practice. These include selling unregulated goods and services and soliciting informal payments from patients, drug companies and suppliers of medical services. The government identifies illegal practices and punishes transgressors harshly. It imposes less serious penalties for unethical practices, such as the acceptance of informal payments. It alters the legal framework, from time to time, to institutionalise practices that have become established. This process has enabled health worker pay to adapt to growing inequalities between localities and between categories of worker, without explicitly breaking with the concept of a national public service and associated understandings about appropriate norms of behaviour. It has allowed new behavioural norms to emerge. Some argue that the growth in inter-regional inequality will eventually make it impossible to maintain a national pay scale (World Bank 2002). It will then be particularly important that other principles have been accepted for establishing appropriate levels of pay and establishing ethical and legal rules of behaviour.

There is a language in China, which contrasts hardware (buildings, trained personnel and so forth) with software (systems). The latter includes the attitudes and understandings of local stakeholders. The Deputy Mayor of a poor rural prefecture stressed the importance of software at a recent meeting about a health reform and development project. He referred to three imbalances in implementation: (i) progress in rehabilitating infrastructure contrasted with delays in reforming institutions; (ii) different understandings by officials at various levels of government of the meaning of reform and (iii) persistence amongst service providers of attitudes relevant to a command economy.

The government treads a fine line in changing the legal framework during a major transition. If it enacts laws that do not reflect local realities people will ignore them and live outside the formal framework. This can erode respect for rules and weaken constraints to opportunistic behaviour. If government delays institutionalising new relationships for too long, it prolongs a vagueness that encourages stakeholders to pursue strategies for short-term gain. The lack of clear rules creates high transaction costs. It may lead to sub-optimal outcomes because people have little assurance that particular social arrangements will persist. Zhang (2000) argues, for example, that the lack of a clear regulatory and fiscal framework for village institutions has become a constraint to the development of local services. Bloom and Tang (1999) argue similarly with regard to local health insurance.

The creation of new social arrangements is complicated by the need to reconcile the interests of different localities, age cohorts and employment groups in a situation of rapidly increasing inequality. White (1996) suggests that popular discontent about corruption is largely fuelled by a widely held view that certain groups have benefited unfairly from the reforms. Zweig (2000) argues that trusted mechanisms to mediate conflicts of interest have become an important element of a strategy for managing change whilst preserving social stability. Two recent publications highlight new thinking in China about these issues (CASS 1998, 2000). They implicitly acknowledge the political aspects of transition. Li Peilin (2002) argues that '*it is essential for future sustainable development in China to bring about a reasonable order of social stratification with the aid of the legal system*' (p45).

3.3 Creation of rules based administrative and legal systems

Since the late 1970s China's political leaders have repeatedly said they wanted to create rules-based administrative and legal systems. Several commentators view this as a necessary response to the emergence of a market economy (Nee 1989; Huang 1995). The demand for complex arrangements to meet social needs has made it particularly important that government develop a regulatory capacity. This involves defining clear boundaries between individual, local and national interests, establishing competent implementing agencies at all tiers of government and altering the understandings and expectations of key actors.[4] It also involves convincing government officials to act in the public interest.

There is a tension between the wish to establish a clearly defined legal framework and China's strategy for transition management. This strategy has involved encouraging individuals, work units and local governments to push against existing boundaries and explore new working arrangements. It has resulted in a variety of networks of relationships operating under fuzzy rules of behaviour that differ between localities. In some localities this has been widely beneficial and in others it has not.

One source of difficulty in establishing rules-based systems is that institutional and economic arrangements are changing more quickly that the ability of political leaders or the population to

[4] A recent article by Hu Angang (2002) identifies the five aspects of building honest politics and administration as: reform of Communist Party, strengthen monitoring by people's congress, strengthen independent judicial system, strengthen financial audits, and establish a standardised civil service with strong sanctions against corruption.

understand them. Tomba (2002) illustrates in a study of the emergence of a labour market. He describes three phases: decentralisation (giving more independence to economic actors), informalisation (market-driven experiments) and institutionalisation (transformation of successful experiments into policies). He shows how systematic descriptions lagged behind the changing reality. Tomba's chronology neglects the considerable investment in effort and time required to translate policies into effective changes in the behaviour of the party-state. This involves repeated iterations between policy discussions and creation of new institutions.

Lubman (1999) highlights the important influence of the attitudes of government officials and the population on the performance of rules based systems. The former have to understand and accept their role as public servants and the latter need to have stable expectations of how the system will perform and/or ought to perform. Lubman focuses on the development of a rights consciousness and a willingness to use the courts. Lin (2002) alludes to the more general need to achieve social agreement on moral norms to replace the egalitarian emphasis on the social good under the command economy. The highly emotional protests against certain forms of corruption suggest that there is a consensus that certain forms of behaviour are bad. However, there is a great deal of ambiguity about where to draw the line in mediating individual, local (work units, geographic, *guanxi* networks) and social interests.

Some analysts of local networks emphasise their role in establishing local moral norms. Yan (1996) suggests there is a continuum of *guanxi* relationships that extends from exchanges of gifts linked to strongly felt ethical norms amongst long-term members of networks to a variety of instrumental exchanges of gifts in exchange for a specific favour. He provides a fascinating insight into the nuanced moral judgements people make in discussing how villagers view the payment of gifts to officials for different purposes. They thought it was appropriate to give gifts to facilitate purchase of scarce materials but frowned on the use of gifts to secure a place in college for a family member.

We need to understand transition as a long process of creation of a framework of institutions and behavioural norms appropriate to a market economy. This process is neither a top-down imposition of a new framework of enforceable rules, nor a bottom-up construction of new beliefs and institutional realities. Rather, it can be viewed as an interaction between a powerful party-state that is actively codifying rules and establishing institutions to enforce them and locally constructed relationships between individuals, institutions and governments. The following sub-sections illustrate how this interaction works. The first illustrates how government has implemented a new set of rules to control pollution through a combination of strategic leadership from above and organised pressure from below. The second looks at the complex interaction between government rule-setting and individual and local actions in the attempt to create mechanisms to define and deter corrupt behaviour.

3.3.1 Creation of regulations: the case of pollution control

The measures to control pollution illustrate some issues involved in the establishment of a regulatory capacity. Wang (2000) outlines how they were introduced. The centre began by issuing broad regulations. During the early 1980s it became clear that local governments and enterprises did not take these

regulations seriously. Environmental regulators formulated a strategy to change this. The State Council issued regulations in 1982 that required firms to pay a fine if their discharges did not meet standards. By 1996 all cities and counties had adopted them.

The system works as follows. Local environmental protection bureaux collect fines from polluters and use the revenue to finance their activities and support environmental projects (including pollution control by enterprises). A firm can request a remission of up to 80 per cent of its levy to subsidise investment in pollution reduction. A study by Wang and Wheeler (1996) suggests that these measures have been quite effective.

Several studies have explored the role of community pressure in pushing local governments to take pollution seriously. Local environment control bureaux receive hundreds of thousands of complaints each year. Studies purport to show that these complaints have resulted in more inspections (Wang *et al.* 2002), higher pollution charges (Wang and Wheeler 1999) and less air pollution (Dasgupta *et al.* 1996). Wang (2000) cites cases where government decided to act against an offending enterprise in response to pressure by citizen groups and written complaints from the public.

The example of pollution control illustrates how government can establish a regulatory capacity when there is a consensus in favour at national level and when a national body plays an active leadership role. Three factors contributed to the relative success of the pollution discharge levy. First, the regulatory body is independent of the entities it is regulating and has no institutional links with them. Second, local regulators have an incentive to implement the discharge levies, which provide funding for their activities. Third, communities have actively pushed for enforcement.

The regulation of pollution varies between localities. Some local governments have colluded with enterprises to weaken implementation and reduce the size of the levy. Pollution standards vary between localities and there is virtually no regulation in remote rural areas. This illustrates the limited power of vertical structures and the importance of local government (Wang 2002). The studies did not assess the degree to which officials of environment protection bureaux have used pollution levies to further their personal interest or the specific interests of the regulatory agency.

3.3.2 Reducing opportunistic behaviour and inappropriate use of power

Both the general public and the political leadership have repeatedly voiced concern about the need to establish clean government and combat corruption. The government's approach follows the international consensus understanding of corruption as a principal-agent problem (Goudie and Stasavage 1997). This refers to the need to ensure that individuals and institutions use regulatory powers on behalf of society, as represented by the government. The report by the Central Commission for Discipline Inspection to the 16th Party Congress stresses the need to define clear rules of behaviour, create systems to identify and punish transgressors and, where possible, reduce opportunities for rent-seeking by replacing administrative mechanisms with the market (CPC 2002b).

Several analysts argue that the form of opportunistic behaviour in China can be traced to the inter-penetration of the party-state and the economy during the period of the command economy prior to the

late 1970s (Lu 2000; Gold *et al.* 2002). At that time political leaders were opposed to fixed and formal bureaucratic rules so that individuals and work units tended to rely on informal (non-market) arrangements. The government mobilised the population in periodic anti-corruption campaigns. The boundary between acceptable and unacceptable economic behaviour varied over time. But, there were limited opportunities for personal enrichment.

Since that time the distinction between acceptable and unacceptable behaviour have become fuzzier and there are many more opportunities for economic gain. The government ended its ideological opposition to market-oriented activities and carried out intensive propaganda during the early 1980s to convince people that this change was permanent (Nee 1989). It did not clearly define the line between appropriate and inappropriate money-making strategies (Lin 2002). On the contrary, it encouraged individuals, work units and local governments to develop innovative forms of relationship to foster economic growth. This further blurred the boundaries between state and non-state concerns, property and interests (Lubman 1999).

Public attitudes seem not to distinguish clearly between acceptable and unacceptable activities. Lu (2000) mentions a commonly held view that the volume of exchanges and gifts to secure *guanxi* has increased greatly. Several analysts suggest that an increasing number of such transactions are instrumental, without an associated emotional and ethical dimension. Schramm and Taube (2003) draw a parallel between the roles of *guanxi* networks in China and social networks in other countries in ensuring security of interpersonal agreements in the context of a weak legal system. They argue that these forms of reciprocal relationships have been important to the success of the reforms. White (1996) concurs, but points out that the important development question is whether this kind of informal arrangement will continue to be economically productive in the long term. He points out that one person's lubricant to economic activity is another person's unfair use of personal connections.

White (1996) describes a continuum of opportunistic activities. At one extreme are practices that are 'clearly illegal in formal terms and involve a personal or group infringement of institutional rules for purely private purposes'. In the middle are activities by institutions to use their powers and special knowledge for their own interests. At the other end are the inter-personal networks of reciprocity and *guanxi*. There is a clear consensus that the first type of activity is illegitimate and should be punished harshly. This consensus is revealed in a number of surveys and public protests. There is less agreement about where to draw boundaries between appropriate and inappropriate behaviours in other trade-offs between personal, institutional and social interests. These boundaries are constantly being negotiated in public attitudes and in government policies. For example, work units often maintain separate sets of books for government and internal use. Individuals are encouraged to generate income on behalf of their employer, but they also develop personal livelihood strategies. Local governments act to minimise taxes remitted to higher levels of government and increase their own revenue (Lichtenstein 1993).

In the late 1970s the political leadership ended its reliance on mass mobilisation to control opportunistic behaviour and said it intended to establish rules-based systems. The party-state has created control and supervisory systems and encouraged the population to complain about those who break the

rules. These systems include the Discipline Inspection Committee of the Communist Party, government auditors and the legal apparatus. It has issued a number of rules and regulations. Since 1994 many local governments have carried out annual evaluations of civil servants to identify incompetence or dishonesty. The measures to create elected village committees and encourage people to submit written complaints about the misbehaviour of officials have contributed to the anti-corruption effort.

There are indications that opportunistic behaviour persists, despite high profile cases in which corrupt individuals were harshly punished. Li (2001b) reports a survey of rural residents that found little confidence in present measures to control corruption. The reports to the 16th Party Congress reveal concern at the highest level (Jiang 2002; CPC 2002b). The persistence of blurred boundaries between individual, local and social interests and of doubt in the capacity of the state to control opportunistic behaviour is a major constraint to the establishment of rules based systems. It is likely that formal systems will coexist with informal local networks for a long time. The tension between individual, local and national interests will continue to be an important factor in future institutional development.

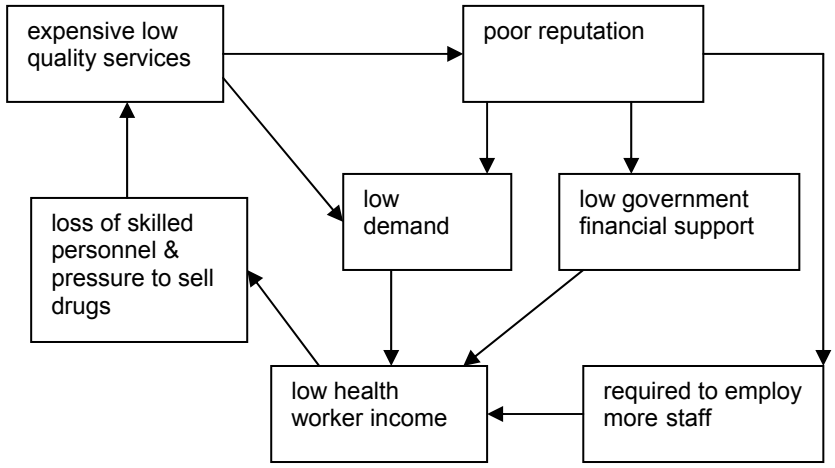
4 Reconstructing rural health systems

The government acknowledges that rural health services have serious problems (Li 2002). It has articulated the following vision of a reconstructed system (State Council 1997a/b): all facilities provide competent services, preventive programmes reach most of the population, there are functioning referral and supervision systems, drugs and diagnostic tests are used rationally, government is an important source of health finance, local health insurance protects families against the cost of serious illness and special measures ensure access to essential health services for the poor. A major policy statement in 2002 confirms this vision (CPC 2002a).

This section argues that health systems perform well only within an appropriate institutional framework. As the institutional arrangements and the social attitudes associated with the pre-reform period changed, the health system became increasingly decentralised and informalised. The reconstruction of an effective health system depends on the establishment of effective management systems, appropriate regulation and new behavioural norms. The performance of the health system can be viewed as an indicator of the functioning of the regulatory state.

This section draws on Mackintosh's (1999) argument that rules and sanctions are complemented in most health systems by implicit agreements between stakeholders. She emphasises the influence of shared understandings and expectations on health system performance. She refers to the importance of a service ethic in which health workers act in the interests of patients and receive high social status in exchange. She points out that governments cannot create these understandings through legislation, alone. They also need to foster informal understandings that reinforce ethical and professional behaviour. Lindelow and Wagstaff (2003) make a similar point in discussing the multiplicity of factors that influence health provider performance.

Figure 4.1 The vicious circle in rural health services in poor localities



Many health facilities in rural China are caught in a vicious circle of rising costs and falling quality (Figure 4.1). They are under pressure to increase salaries. They cannot attract enough patients. They compensate by selling more drugs and providing more clinical tests. This raises their costs and reduces demand. Users and providers of services lose from this situation. If users do not trust local facilities, they are likely to choose the cheapest provider for minor illnesses and attend hospital for serious problems. Government is reluctant to increase funding for service providers it does not trust. Competent local practitioners find it difficult to earn a good living. The best seek employment in urban hospitals.

Older health workers tend to have attitudes formed before the reforms. Younger workers are less likely to be influenced by the previous ethic of public service. If that is so, the constraints to opportunistic behaviour could diminish and the vicious circle could worsen. The challenge for policy-makers and local managers is to construct an institutional environment and set of expectations that transforms the vicious circle into a virtuous one, whereby health workers meet their economic and social aspirations by providing good quality services that people need. This involves changes to formal rules and implicit contracts between stakeholders.

In order to overcome the tendency towards a vicious circle, the rural health system has to re-establish the functional relationships in Figure 2.1. However, they need to be embodied in institutional arrangements appropriate to the new reality (Bloom 2001). These arrangements are likely to differ between localities, which also have quite different patterns of enterprise ownership and government-enterprise relationships. Whatever form they take, they need to fulfil the following conditions:

- relevant actors know their roles and have the capacity to play them;
- stakeholders understand the rules of behaviour and mostly can meet their aspirations by conforming to them; and
- it is widely assumed that most people will follow the rules.

4.1 Actors in the rural health system

This section describes the principal actors in the rural health sector, drawing on the previous analysis of China's evolving institutional structure.

4.1.1 The party-state

The Communist Party, People's Congress and State Administration for township, county, prefecture and provincial levels play roles in the rural health system. Most have not given health much priority. However, the proposal that health be included amongst the targets for judging the performance of cadres and government officials may encourage them to support the health sector more actively (CPC 2002a).

The rural health system is organised along vertical and horizontal lines. Each administrative level controls its own institutions. The provincial level controls a number of referral hospitals as well as institutions responsible for planning, monitoring and supervising province-wide programmes. The provincial hospitals provide services to provincial government employees, residents of the provincial capital and others who can pay. The Provincial Health Department can influence institutions belonging to lower levels, but through indirect means. The pattern is replicated at lower levels.

The recent history of the township health centres illustrates the fluctuating balance between the vertical and horizontal principles. During the 1980s the government devolved control of these facilities to township governments. These governments provided funding, controlled personnel and supervised performance. The county health bureaux retained responsibility for technical supervision but without direct powers over facility managers. A number of problems emerged related to weak management capacity and poor governance of township administrations (Tang and Bloom 2001). The most recent government rural health policy recommends that control of health centres revert to county health bureaux (CPC 2002a).

Many commissions and ministries have health-related mandates for planning, service provision, finance, regulation and accountability (Table 4.1). The State Development Planning Commission oversees the formulation and implementation of the five-year plan and special public sector investment programmes and the Ministry of Finance is responsible for annual budgets and monitoring of financial management.

The Ministry of Health is responsible for government health facilities, several other ministries "own" health facilities or oversee enterprises that do so and the State Family Planning Commission has a network of service delivery institutions. The Ministry of Health provides annual grants to government health institutes and facilities and it manages a health insurance scheme for government employees. The Ministry of Labour and Social Security is responsible for urban health insurance and the Ministry of Civil Affairs funds safety nets for the poor. The Ministry of Agriculture is responsible for limiting the financial burden on farmers.

The Ministry of Health, oversees the performance of its facilities and regulates private providers. The State Drug Management and Monitoring Bureau is responsible for ensuring that drugs are effective and safe. The Ministry of Personnel manages civil servants and also skilled workers in public employment. The

Ministry of Labour and Social Security plays a similar role regarding semi-skilled and unskilled workers. The Price Bureau, under the State Development Planning Commission, sets prices for health services and health-related commodities. The Ministry of Civil Affairs oversees the elected village committees and social organisations. The auditing administration establishes rules for financial audit.

Table 4.1 Government organisations with an influence on health

Ministry of Commission	Principal health-related functions
Planning	
State Development Planning Commission	Responsible for five-year plan and also special public sector investment programmes
Ministry of Finance	- Annual budget
Service Provision	
Ministry of Health	- Responsible for the performance of health institutions
State Family Planning Commission	- Implementation of family planning policy
Ministry of National Defence, Ministry of Railways and other sector ministries	- Health facilities that serve sector employees or are owned by work units under the sector
Finance	
Ministry of Health	- Partial subsidies of public health facilities - Health insurance for government employees
Ministry of Labour and Social Security	- Urban health insurance
Ministry of Civil Affairs	- Safety net for the poor
Ministry of Agriculture	- Represents interests of farmers in preventing excessive financial burdens
Regulation and accountability	
Ministry of Health	- Enforce health-related regulations
Ministry of Personnel	- Management of civil servants and cadres - Oversight of public sector employment of skilled workers
Ministry of Labour and Social Security	- Oversight of public sector employment of semi-skilled and unskilled workers
Price Bureau of State Development Planning Commission	- Sets prices of services and health-related commodities
State Drug Management and Monitoring Bureau	- Enforce regulation of pharmaceutical sector - Oversee government pharmaceutical companies and distribution systems
Ministry of Civil Affairs	- Oversight of elected village committees and of social organisations
Auditing Administration	- Financial Audit

Only a few types of social organisations are involved in rural health activities. One type represents providers, including the Association of Health Centre Managers and associations representing different categories of health worker. Another type represents users of services. For example, the ACWF has a mandated role in rural health according to the 'two guidelines and one law' (Chinese women development

guidelines, Chinese children development guideline and the law on protecting women's rights and interests). Some local informal organisations have become involved in health. For example, Zhang (1994) describes an organisation in Hubei Province, which collected money from its members for a free annual check-up.

Local accountability structures have mostly paid little attention to health. The recent government policy on rural health may change this by ensuring that health is included in the indicators for assessing the performance of local leaders (CPC 2002a). If the argument of O'Brien and Li (1995) is correct, and actions by village leaders and organised communities have been most effective when in support of government priorities, local structures may become more interested in health issues. The SARS epidemic is likely to heighten local interest in health.

Little is known about the influence of informal networks on the behaviour of providers and users of health services. It is likely that the frequently observed preference for village-based doctors and midwives over the township health centres reflects the high levels of trust in local residents. However, we know little about the attitudes of different categories of health worker or of rural residents about what constitutes ethical behaviour and how it is enforced.

4.2 The relationship between local government and health facilities

Local governments have changed their relationship with health facilities following similar changes in their relationship with productive enterprises. Half the village health stations are privately owned and many others are leased by health workers from the village. Directors of county and township facilities sign management contracts with the local government, which specify basic performance targets. They largely control the use of financial surpluses and the organisation of services (Chen *et al.* 1997). These forms of ownership and management resemble township and village enterprises and county government owned enterprises.

Health has lagged behind other sectors in reducing direct government controls. The government still provides budget support, sets prices and strongly influences personnel management. Wu (2002) refers to a semi-market economy in which facility managers seek economic advantage in an environment with many aspects of the command economy.

One feature of the health sector is the persistence of price control. There is little systematic information on how prices are set. The Price Bureau has kept charges for consultations and inpatient days low and has compensated providers by permitting them to earn profits from selling drugs and by setting quite high prices for the use of sophisticated equipment. A number of studies have shown that this arrangement encourages health facilities to provide a costly form of care (Liu 1999). Despite this evidence, local governments have not fundamentally changed the system of payment for services. One reason may be that some stakeholders benefit from the present system.

Drug suppliers and the State Drug Management and Monitoring Bureau benefit from the high volume of drug consumption (Dong *et al.* 1999). It would appear that wholesale prices have been kept high. One indicator of this is that drug suppliers often give discounts to health facilities and sometimes

pay kickbacks to individual employees (Bloom *et al.* 2001). Wu (2002) suggests that hospital managers and health workers have substantial opportunities for rent-seeking. The report to the 16th Party Congress of the Central Committee for Discipline Inspection proposes the use of competitive tender for drugs to reduce these opportunities (CPC 2002b: 125). It also mentions regulation of drug production and licensing of drug sellers. It does not mention measures to reduce over-prescription of drugs.

A second feature of the health sector is the continuing involvement of government in human resource management. Health facility managers cannot fire employees. Local governments put pressure on them to employ personnel. The government's strategy for tackling the problem of overstaffing is to rationalise public sector employment. Central and provincial levels have reduced their staff, but there is little evidence that counties and townships are doing the same.

The government is exploring options to reform facility ownership and give them more autonomy from direct government control (Li Changming 2002). The recent rural health policy favours a competitive system for the appointment of health facility managers (CPC 2002a). The policy does not define clearly the implications of such reforms for an increased need for government regulation. The following section describes some measures being taken to make health facilities more responsive to the needs of the community.

4.3 Increasing government involvement

The new policy advocates increased government involvement in financing and regulating rural health services and in making them more accountable to the population.

4.3.1 Financing health services

The government funds rural health services through health budgets and as part of poverty alleviation and social protection programmes (Table 4.2). Government health budgets are low. A study of 28 poor counties in 7 provinces in 1996 found that their governments spent between 6.8 and 20.2 rmb[5] *per capita* on health services (Hicks *et al.* 1998). This money financed public health services and health insurance for employees of the county government. The same study found that four counties in Qinghai Province spent 29 per cent of their health budgets on government health insurance, which covered a small proportion of the counties' population.

Township health centres and county hospitals receive between 5–25 per cent of their budgets from government grants.[6] Some township facilities have also received money from the three-items construction programme to pay a share of the cost of construction and equipment. Local governments and the facilities, themselves, finance the balance of these investments (Liu and Bloom 2002).

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5 This is equivalent to between $0.82 and $2.45 per capita.

6 The World Bank (2002) refers to a township in Gansu that did not provide any funding to the local health centre.

The Ministry of Civil Affairs funds social relief for the very poor, but only a tiny proportion of this money is for health care. The large government poverty alleviation programmes provide some funding for health through their support for public sector investment and their provision of soft loans for small-scale private investments.

Table 4.2 Social sources of rural hospital finance

Government budgets	
Ministry of Health	Government budgetary allocation may account for between 10–25% of total hospital expenditure Government health insurance reimburses a share of the cost of health care for government employees
Ministry of Civil Affairs	- Minimal payment of medical expenses of the poor - The new government policy favours the creation of a medical financial scheme for the rural poor
State Development Planning Commission	- Three-items construction programme provided investment funds for township health centres
Poverty Alleviation Programme	- Support for construction of health facilities as part of poverty reduction programme
Other collective arrangements	
Labour Insurance	- Enterprise employees may be covered by a health insurance scheme
Cooperative Medical Schemes	Local schemes that derive revenue from government, enterprises and voluntary household contributions. Schemes reimburse a proportion of the cost of medical care. The new policy commits central government to provide 10 yuan per capita to counties in the Western part of the country, which establish schemes.

Each level of government provides its employees with health insurance, managed by its health department. Most schemes pay on a fee-for-service basis, with beneficiaries making co-payments. County government employees mostly attend county-level facilities. State owned enterprises finance a health benefit for their employees. These schemes also reimburse a proportion of expenditure at designated facilities. Members of such schemes are likely to attend county level facilities, as well. Consequently, a significant number of patients at county hospitals are covered by health insurance.

During the period of the command economy most communes established cooperative medical schemes, which reimbursed a proportion of the cost of health care (Feng *et al.* 1997). Most of these schemes collapsed after the introduction of the household responsibility system. Some localities maintained their schemes and others established new ones. They are funded through a combination of voluntary contributions and modest grants from local government. The successful schemes are mostly in localities that have achieved rapid social, economic and institutional development. Their success depends on the ability of local government to generate funds from enterprises and the ability of government and communities to ensure that schemes use money in the interest of their members and are seen to do so.

A number of poor localities have tried to establish schemes. People have been reluctant to join them, despite spending a lot of money on health care. The reasons include the high cost and low quality of services in health centres, poor management of funds and the disincentives for the young and healthy to contribute (Bloom and Tang 1999). Ye *et al.* (2001) and Wang *et al.* (2001) interviewed local government officials and Communist Party cadres in counties with experimental schemes. They concluded that one factor that jeopardised the sustainability of these schemes was a lack of trust between the community, local government and health facilities.

There has been a lot of debate about whether local administrations should be allowed to introduce compulsory local health insurance (Liu *et al.* 1996; Carrin *et al.* 1999). The health sector has supported this idea as a way to increase demand and share risk (State Council 1997b). Others have opposed it on the grounds that poorly designed and managed schemes would impose unnecessary financial burdens on rural households (Du 2000). The most recent government policy supports the establishment of schemes but only if contributions are voluntary (CPC 2002a).

The 2002 rural health policy makes several proposals for increasing government funding of rural health services. They include larger local government health budgets, special transfers of resources from higher levels of government to support health services in poor localities, a health safety net and transfers of central government money earmarked for CMS schemes in Western China. Local governments will have to address a number of issues in attempting to translate this policy into changes in rural health services.

One major difficulty is the present system of public sector financial management. Wang (2002) illustrates with the example of three poor counties in Gansu. They spent a large proportion of their budgets on salaries. They allocated their limited resources preferentially for this purpose, on the basis of numbers of personnel. A few people in the finance department decided on the allocation of non-salary expenditure, with little consultation with sector managers. They often did not know how much money was available until late in the year, because higher levels of government did not finalise the amount they transferred to lower levels until they were certain about their own financial position. This form of financial management makes it difficult to ensure that additional resources would be specifically allocated for improving health services. Also, health facility managers have considerable autonomy in deciding how to allocate resources between salaries and other items.

The new policy encourages local governments to establish CMS schemes and promises that central government will contribute 10 yuan per capita to schemes in poor counties. This will provide a financial incentive for people to join CMS. The policy also identifies the need to protect the rural poor against the financial burden of major illness. The Ministry of Civil Affairs is likely to increase funding for some form of health safety net. The challenge will be to design management and monitoring systems to ensure that additional funding for these two schemes is used mostly to improve access to appropriate services. There is a danger that providers will increase prices and/or encourage higher sales of drugs to increase their incomes.

There are debates about how additional social funding should be channelled to health service providers. Some argue that local health departments give too much weight to the interests of health workers. That is one reason why the government gave control over urban health insurance to the Ministry of Labour and Social Security. Some advocates of an increase in public funding of rural health services call for a similar split in rural areas (Liu 2000; Du 2000). For example, the Ministry of Finance seems to favour purchasing of services from township and village level providers. It is not clear who would do this purchasing and what measures could be taken to ensure that they were competent and acting in the interests of users.

4.3.2 Regulation

This section outlines how government is developing a regulatory role in the health sector. It is not a comprehensive description of all government measures.

The State Planning and Development Commission is shifting from its previous emphasis on the attainment of quantitative targets for buildings, equipment and personnel to a needs-based approach. It issued guidelines for regional health planning in 1999. A few localities have implemented these guidelines to rationalise the distribution of specialist services between facilities and reduce duplication of expensive equipment. One problem is that government has limited influence over health facilities. Hospitals finance their own investment and they are mostly free to make their own decisions about how to use these resources. Another problem is the lack of coordination between ministries involved in health. This highlights the need for government to define more clearly the regulatory responsibilities and powers of each government actor.

A second regulatory issue concerns the need for reliable and timely information about risks to public health. This involves the establishment of a flow of information about outbreaks of certain communicable diseases from facilities through the different government levels. The SARS epidemic revealed weaknesses in this reporting system.

A third issue concerns the definition of the boundary between appropriate and inappropriate economic behaviour. Wu (2002) refers to the strong influence of economic incentives on hospital behaviour, and suggests that limits to opportunistic behaviour are unclear. Bloom *et al.* (2001) draw similar conclusions about health worker livelihood strategies. They find that government has defined illegal behaviour, but has left a large grey area in which actors have a lot of discretion. One topic of particular importance is financial audit. Health facilities often keep separate sets of books for negotiating with government and for internal use. The lack of clear rules of financial probity and a means to enforce them is an important constraint to the establishment of effective health systems.

A fourth issue concerns licensing of health workers. During the 1980s there were no clear rules about who was qualified to produce which services. One of the authors recalls a conversation with a County Health Bureau Director, who said that his health providers faced competition from veterinarians for the supply of drugs. It is now government policy that village doctors should pass a licensing examination to retain the right to practice. County health bureaux "clean the medical market" periodically to put

unlicensed providers out of business. It is also government policy that doctors and assistant doctors will eventually be licensed. This will reduce the opportunities for unskilled providers to offer services. It may also create problems for poor localities, which may find it difficult to retain enough licensed health workers. This raises questions about the phasing-in of national regulatory systems in a country with large inter-regional differences in level of development.

A fifth focus is on dangerous practices. Dong *et al.* (1999a) describe how a series of scandals about counterfeit drugs led to the enactment of laws to regulate drug manufacturers during the 1980s. The documents to the 16th Congress call on local governments to close down illegal drug markets to further reduce the risk of supply of counterfeit products. On the other hand, there is little regulation of the sale of drugs and all products except narcotics and major tranquillisers are available everywhere. Poorly qualified health workers routinely prescribe steroids and sophisticated antibiotics for minor illnesses (Liu *et al.* 2002).

The experience with the regulation of health activities has similarities with that of pollution control. Tang (1999) argues that regulations are much more vigorously enforced when the regulator has a financial incentive to do so. He shows that counties ensure that food handlers have the statutory annual health check, because they earn money from the fees for this check. They enforce regulations concerning maternal and child health care less rigorously.[7] This emphasises the need to pay attention to the incentives that regulators face.

The experience of the pharmaceutical sector, where the government has implemented regulation of drug quality and licensing of drug sellers, but does not regulate the sale of drugs, illustrates another lesson from pollution control. The pharmaceutical sector has strong incentives to implement measures to limit the entrance of unregulated producers into the market. The health sector has similar incentives for preventing unqualified providers from selling drugs, in competition to its own health facilities. However, both benefit from high volumes of drug sales. This points to the need for an independent regulator.

Public pressure has influenced the implementation of regulation. There have been periodic scandals concerning the quality of drugs and more recently the safety of blood products. These scandals have spurred efforts to establish a regulatory system. On the other hand, the greatly expanded use of advertisements by pharmaceutical companies has generated demand for their products. There has been little publicity to counter this view.

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[7] There is a blurring of the boundaries between incentives for necessary regulations and the imposition of arbitrary fees and fines. Two examples of the latter in the health sector are the imposition of a charge for ante-natal care as part of the marriage license in a county in Yunnan Province for care at a county-level facility and the introduction of compulsory annual medical examinations for drivers in another province. In both cases the financial interests of the regulatory institutions would appear to have been more important that health-related objectives.

4.3.3 Increasing local accountability

There are two broad areas of discussion about how users can influence service providers. One focuses on improving the ability of consumers to choose health services well and the other on strengthening local accountability.

Some discussions focus on the need to strengthen people's skills as consumers of health services. Some studies have documented the role of patients in demanding sophisticated drugs (Zhan *et al.* 1997). This has led to ideas about telling service users more about the choice of these products. For example, clinics and shops could be required to post guidelines for the treatment of common complaints on their walls. People would then know if a health worker or drug seller were offering inappropriate or unnecessarily expensive products. There are also discussions about the need to establish clearly differentiated categories of licensed practitioners to enable people to make informed choices about whom to consult.

Local governments have taken some measures to make service providers more accountable to the population. For example, many health facilities post pictures of staff at the entrance and encourage the public to complain. Some medical financial assistance schemes have established telephone complaint lines. However, the low political priority given to health may have minimised the impact of these and other measures to make facilities more accountable. The most common response of people to badly performing health facilities is to avoid them. This may change if health is given a higher priority and local leaders take the performance of the health sector more seriously.

Little is known about the operation of informal networks in the health sector or of social organisations of providers and users. This also applies to the factors that influence health workers (traditional Chinese medicine and western) at village and higher levels.

One important element for effective regulation and democratic supervision of health services is the production and distribution of reliable information. There are widely acknowledged problems with the existing information system. One problem is the strategic use of information.[8] Financial reports may not provide full information on sources of revenue. Reports on health outcomes may be used strategically. For example, some counties report different infant mortality rates in bids for funds from a donor-supported project than in progress reports to the Ministry of Health. A second problem is that almost all health-related information comes from government facilities. Village health stations and private clinics provide very little information. A third problem concerns the flow of information. Reports are mostly used by higher levels of government to monitor performance. Local accountability structures and the general public receive little routine information on the performance of providers or the health system as a whole.

[8] This is summed up in the expression: 'the cadre makes the information and the information makes the cadre'.

5 Conclusions

China's recent experience demonstrates the importance of coherent institutions and shared beliefs and behavioural norms to health system performance. The health sector's problems are a reflection of the difficulties China is experiencing in constructing institutional arrangements appropriate to a mature market economy. Recent government policy statements suggest that the highest political leadership is now giving priority to improving the performance of health and other services. In order to achieve this, it will have to tackle some of the most difficult issues with regard to the establishment of rules-based local administrative and regulatory systems and local accountability mechanisms.

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