A CHINA ENVIRONMENTAL HEALTH PROJECT RESEARCH BRIEF

This research brief was produced as part of the China Environment Forum's partnership with Western Kentucky University on the USAID-supported China Environmental Health Project

January 2008

A Village Perspective of Rural Healthcare in China

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Aunt Li was only 57 when she died of a heart attack in April 2006. However sad, the news did not come to me as a surprise. Aunt Li had been my neighbor during 15 months spent living in a village in Langzhong municipality, northeast Sichuan (2004-2005) and doing anthropological fieldwork on health and healthcare for rural Chinese. She and her husband were very enterprising farmers, who in 2004 raised 6 pigs and over 30 ducks. I had become close to her through trading dietary tips on how to deal with poor digestion, and information on which doctors were both reliable and inexpensive—local knowledge that is crucial given the limited health care access for Chinese villagers like Aunt Li. Aunt Li had long suffered with shortness of breath and tachycardia, but had been unwilling to make a trip to the city's hospital, a 15-minute journey by motorbike, for check-ups and treatment. She was scared the doctors might con her and prescribe expensive treatment simply to increase their own revenue—a perception that remains widespread among China's rural villagers.

When she heard I had acquired some good friends in the city's People's Hospital, Aunt Li asked me to accompany her to a trustworthy practitioner to have a CT scan. The doctor strongly advised her to undergo inpatient treatment for two weeks, for a total of 2,000 Yuan. He explained that this would considerably improve what he saw as a very serious heart condition, although, he admitted, it would not cure her completely. She resolved to take some medicine, which one of the hospital's doctors bought for her through his own health insurance scheme. The doctor told her she would only live a few more months if she did not rest and take medications regularly. Aunt Li shrugged her shoulders: "hospital treatment is too expensive, and if I rest who is going to farm my land? My husband can't do it alone, he's not well either. If I have to die, I will just die."[2] She took medications for a month following her check-up but refused to buy any more, claiming it was not working. She was adamant that she would not undergo in-patient treatment and that she would rather save the money for her two grandsons, who lived with her and received little financial contributions from their parents. Nine months later, after a long day of work transplanting rice, her family informed me that Aunt Li "came home, lay on the bed saying she was unwell, and she just died."[3]

Under what circumstances did Aunt Li become convinced not only that practitioners are unreliable but also that treatment is unaffordable and not worth the investment? With the onset of China's social and economic reforms since the early 1980s, the "iron rice bowl" system of health finance established during the Mao period underwent a radical shift towards the commodification of healthcare, making it expensive for many rural poor.[4] There are at present three main types of health insurance in the China, which mainly benefit the country's urbanites:

(1) Workers' insurance for enterprise workers (*laodong baoxian*), which consists of individually variable benefits attached to a basic salary, such as refunds for a fixed share of healthcare expenses;
(2) Public insurance for government workers (*gongfei yiliao*); and,
(3) Collective welfare for village residents (*hezuo yiliao*).

Despite the variety of health insurance plans and central government prioritization of health care reforms, provincial differences in the distribution of medical insurance are notable, and rural and poor people are less likely to be insured. Income inequalities produced by the reforms have contributed to unequal access to care, which increasingly relies on an individual's ability to pay. Rural Chinese are particularly vulnerable to the limited access to health care, for besides the

spread of infectious diseases such as HIV/AIDS, illnesses linked to growing pollution problems in the countryside are also creating serious health problems among vulnerable farming populations. To improve access, the central government is experimenting with some new rural healthcare schemes, which notably are often viewed with suspicion by rural citizens who are doubtful of local officials' willingness and capacity to implement these schemes.

INCREASING GAP IN ACCESS

A large number of articles have been published recently in journals such as *Social Science and Medicine, Health Policy and Planning,* and in the *IDS Bulletin,* regarding the state of healthcare provision in China.[5] These works highlight that the transition to a market economy affected health services in a variety of ways. The available healthcare options have multiplied; yet prices have risen rapidly, insurance coverage has declined, and user fees have been introduced or increased without an adequate exemption system for the very poor. Less funding has been devoted to the lower levels of healthcare (such as village and township clinics), which are the kinds of services more accessible to rural Chinese because they are cheaper and geographically closer. Yet, no feasible alternatives exist for the rural community to access higher-end medical care at hospitals, which tend to rely on sophisticated medical technologies and expensive drugs for revenue and as a consequence are extremely expensive.

The growth of inequality in household incomes has had a considerable impact on access to hospitals, and especially to the notoriously expensive inpatient care, with its direct costs (e.g., medical care, tests, food, and loss of earnings) and informal costs (e.g., under-the-table payments to hospital staff). Indeed, exemption and discount systems meant to provide inexpensive access to China's poorest citizens are "vague and not enforced,"[6] worsening the economic burden on patients and posing a significant barrier to inpatient care for the poorer strata of society. The booming informal sector provides an alternative, especially in the case of over-the-counter medicines, but has not been adequately regulated, posing problems of inappropriate drug consumption as well as the sale of fake drugs.

Predictably, vulnerable groups of the population, such as the poor, the elderly, women, children and migrants suffer the most from the lack of access to healthcare. Indeed, illness can reduce even economically stable households to poverty by loss of assets, loss of labor power, and indebtedness. As a consequence, the families of ill people are often forced to choose between the value of caring for its dependents and the will to advance the family's status and thus invest in its healthy members—painful choices such as the one highlighted in the opening paragraphs that I often witnessed during long-term research in rural northeast Sichuan.

THE NEW RURAL COOPERATIVE MEDICAL SYSTEM

The Chinese government's latest five-year plan (2006-10) stresses the importance of building a "new socialist countryside," by increasing rural investment and improving social services. Among its aims is the resolution of the problem of healthcare provision through the implementation of a new rural cooperative medical system (RCMS) which is scheduled to cover all of China's vast countryside by the end of 2008.[7] Under this new medical system, the central government allocates at least 10 Yuan each year for participating residents, while local governments, according to their financial status, have to contribute at least 10 Yuan per person each year; and each person who takes part also has to pay 10 Yuan annually.

The success of RCMS however, both locally and nationwide, has been mixed. China rural development research points to some of the problems of implementing RCMS. In poorer areas there are few local resources to finance these schemes, and in sparsely populated or remote areas, the time invested and costs incurred by travel, accommodation and food while accessing healthcare may discourage people from seeking it. Until now, RCMS only covers inpatient care, offering no help for preventive care or for those with chronic conditions treated at home (for instance, high blood pressure or diabetes), which also require high expenditure. A further problem is that RCMS only covers 40 percent of the cost of hospitalisation and do not pay healthcare providers upfront, which means the patient's family must pay first pay and wait to be reimbursed. This requirement to pay first also applies in emergency situations, therefore

reinforcing farmers' widespread perceptions that healthcare is only for the wealthy. Despite these shortcomings, the system is slowly gaining support.

INSIGHTS FROM SICHUAN ON THE RCMS

During anthropological research (2004-2005) in a Sichuan village on practices of health and healing, I found many villagers were keen to stress the high costs of heathcare, and to discuss both local corruption and the absence of a welfare system for farmers more widely. The first new rural cooperative medical system (RCMS) was introduced in the area in December 2005. The government contributed 30 Yuan per person in 2006 and 40 Yuan per person in 2007.[8]

During my initial research on RCMS in July 2006, the first year it was running in the area, locals were predominantly convinced that the schemes were a con (*pian ren de*) and fake (*jia de*). This attitude abated to a large extent by the following fieldtrip I took in March 2007, giving way to increased trust in the schemes. One reason for this growth of faith may be that, to date, locals have had positive experiences using RCMS. The ability to use payments to the new RCMS as credit to purchase medicine from the village doctor has contributed to convince locals that these schemes are beneficial (*bu de chi kui*). The fact that those who had treatment as inpatients appear to have received the amount promised as reimbursement has also been instrumental in establishing trust in the health care schemes among locals.

Roughly one third of villagers interviewed in depth stressed that one of the most positive aspects of the new RCMS is that whereas the Maoist rural cooperative medical system was a "village matter" (that is, administered in the village, based on village funds and mostly only offering village care) the new schemes offer assistance for hospital treatment.[9] Moreover, the new RCMS schemes are mostly funded by the central government and are not controlled by local governments, which means local officials have little opportunity to squeeze money out of the schemes for themselves. The partial disassociation of RCMS schemes from local officials therefore contributes to their efficacy. The same interviewees also added that unwillingness of some villagers to join the schemes is most likely attributed to a lack of understanding of precisely this aspect. These attitudes may be understood within the context of wider perceptions of the local government as corrupt vis-a-vis the central government as benevolent.

THE ROLE OF LOCAL GOVERNMENT IN RURAL HEALTH CARE REFORMS

Mistrust and resentment of rural citizens towards local officials grew during the reform era. Overall, local government corruption, lack of capacity and prioritization of economic growth meant weak enforcement of environmental and social welfare policies mandated by the center. The central government introduced a law to lift agricultural taxes on farmers as of 2003, yet some farmers in Langzhong continued to be taxed until 2005. Although part of the amounts required was allegedly tax overdue from previous years, it fueled perceptions that local officials were pocketing the money. During my research in 2006, locals were still not convinced that taxes had actually been lifted. By my following research visit in April 2007, with most people not having paid any tax in the past year, locals seemed increasingly convinced that central government policies were being implemented. Yet discontent is still fierce, since compensation for the reforestation project has not been offered to local farmers. The village secretary claims he uses these funds to cover the water tax and costs of building local roads. But farmers complain they are given no transparent account of how much money is invested in these activities. This is but one example of a culture of mistrust rural citizens have towards local officials, which contributes to scepticism towards RCMS, especially when they are seen to be the village government's responsibility.

Many villagers in Langzhong municipality joined the RCMS even though they believed it probably offered little advantage (*bu qi shazi zuoyong*). The main advantage was that RCMS was inexpensive to join and the money contributed could be used as credit to buy medicine from the village clinic. Nevertheless, those who opted to join are not satisfied with the reimbursement amount, and complain that the health-care scheme is limited to inpatient services and does not include crucial out-patient or preventative healthcare treatments. As a 23-year old villager put it,

> "…even 60 percent [the current rate of reimbursement for township hospital treatment] is not enough. Surgery for cancer costs 6,000 Yuan, it still leaves thousands for the family to pay, farmers still cannot afford it. And it excludes the cost of medication at home. Doctors are corrupt, they prescribe the most expensive medicine, and inflate prices. If the government could control this and keep the prices low, they would not need to invest in RCMS."[10]

This quote begins to highlight how the fierce scepticism towards hospital treatment is a major obstacle to RCMS functioning and benefiting farmers. Even those who have joined do not feel the scheme has raised their entitlement or access to hospital care significantly. A 60-year-old woman, for instance, claimed that one could only be reimbursed through RCMS if he or she had contacts (*shuren*) in the hospital. Another, in her early 70s, refused to have surgery for glaucoma because she felt that the cost would escalate uncontrollably. She added "one eye is enough, I'm old and there is no point spending so much money on me."[11] Both had joined RCMS. Farmers' perception of hospital treatment remains that they "cheat/extort your money" (*pian ni de qian*) and many interviewees stated that one goes there only when he or she absolutely has to: "if you can walk and eat, you don't go to hospital."

Finally, staff shortages in the township and village government have produced some clear strucural challenges to implementing the new RCMS. As the village secretary explained: "I have to do it all alone. At the higher levels, they have separate departments for water, health, reforestation... Here it's only me. And I'm caught between pressure from above and locals who do not understand."[12] Together with the village head and the village doctor, he was responsible for informing locals about how RCMS worked, and is accountable for local joining rates. Yet, the village school, from which new policies were broadcast through the village public loudspeaker system until 2005, was closed and sold to a private company in 2006, leaving the village secretary with no means to introduce RCMS and urge locals to join. His only option was visiting villagers at home, but most are out during the day (either in the fields or commuting to the city for construction and other menial work), which according to him hinders his chances of implementing RCMS and other policies.

Indeed, joining rates are higher amongst residents of village units closer to the houses of the village secretary, village head, and village doctor, who also share the same surnames. I would suggest that joining rates are higher both because of better access to villagers by local officials and because of higher levels of trust fostered by kinship relations.

To conclude, the abolition of agricultural tax in the countryside has succeeded in appeasing farmers and increasing trust in the central government, and in RCMS by extension, but it has caused a decrease in local government resources which undermines the capacity of local officials to implement the RCMS. If better healthcare is to be achieved, less reliance on the market and more centralised coordination of resource allocation as well as control of drug pricing are needed. Higher levels of trust in local officials is fundamental to improving policy implementation. But to achieve this, more centralised funding is needed to bolster weakened local resources. In a similar fashion, less suspicion towards medical practitioners and the medical establishment as a whole is fundamental to ensuring that when illness strikes, sufferers do not deny themselves treatment, as Aunt Li did. This can only be fostered by creating a perception of medical institutions and its practitioners as not only market-driven, but also available to those with less means. The RCMS is beginning to meet this challenge, but it would produce better results if they could be extended beyond in-patient treatment (the service which is least likely to be employed by farmers) to other expensive medications for chronic problems treated at home. This was the type of treatment that those like Aunt Li would be more inclined to resort to. The road to more accessible and equitable healthcare clearly is still long and winding in rural China.

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[1] This research would not have been possibile without the assistance of the Arts and Humanities Research Council, The Leverhulme Trust, the Universities' China Committee in London, and the Contemporary China Study Programme (Oxford University).
[2] Informal conversation with Aunt Li, Langzhong municipality, northeast Sichuan Province, July 10, 2005.
[3] Informal phone conversation with Aunt Li's neighbour, ibid., April 28, 2006.
[4] For an insightful account of healthcare financing see Duckett, J. (2007). "Local Governance, Health Financing, and Changing Patterns of Inequality in Access to Healthcare." In Shue, V. and Wong C. Eds. *Paying for Progress: Public Finance, Human Welfare and Changing Patterns of Inequality*. London: Routledge.
[5] Two volumes offering comprehensive development and policy studies on healthcare in China are: Anson, O. and Sun, S. 2005 *Healthcare in rural China: Lessons from Hebei Province*. London: Ashgate; and Bloom, G. and Tang S. 2004 *Health Care Transition in Urban China*. London: Ashgate.
[6] Meng, Q., Sun, Q., Hearst N., 2002 'Hospital Charge Exemptions for the Poor in Shandong, China', in *Health and Policy Planning* 17: 56
[7] See the official website for RCMS, http://ccms.org.cn
[8] Interview with Langzhong municipal Health Bureau official, April 4, 2007.
[9] Interviews with villagers, Langzhong municipality, March 2007.
[10] Interviews with villager, ibid., March 23, 2007.
[11] Interview with villager, ibid., March 16, 2007.
[12] Interview with village secretary, ibid., April 1, 2007.