

# Health sector reform and reproductive health services in poor rural China

FANG JING

*Institute for Health Sciences, Kunming Medical College, Yunnan Province, P.R. China*

This paper describes and analyses the major reforms and changes that have occurred in the rural health sector of China. Key findings from a number of empirical studies on reproductive health service provision and utilization are summarized in order to assess the implications for reproductive health services of the ongoing health reform. The focus of this paper is what has actually been happening at the ground level, rather than what should have been happening as stated by rural health sector reform policies. It is argued that reproductive health is a missing component of the current health sector reform agenda. It is also argued that the rural health sector reform in China is really a passive response to the changed rural socio-economic conditions rather than an active action aimed at improving the health status of the rural population. The ongoing rural health reform has produced both negative and positive implications for reproductive health services and there is a need for both the state, and for women, to play a much stronger role in this reform. Further studies and actions are required, however, to identify the specific type of roles and activities that the state and women need to undertake so as to fulfil the reproductive health goals and objectives set forth by the 1994 International Conference on Population and Development.

**Key words:** health sector reform, reproductive health, rural, China

## Introduction

The 1994 International Conference on Population and Development (ICPD) formally put reproductive health onto the international population and development agenda. The majority of countries in the world, including China, agreed to the reproductive health goals and objectives stated at ICPD by endorsing the Programme of Action. The provision of universal access to reproductive health services, including family planning and sexual health services, was one of these reproductive health objectives, which all countries were called upon to make. However, the reproductive health goals were put forward in a constantly changing and unstable environment; many factors have affected the fulfilment of the goals. One factor is the change in attitude of the United States' Bush administration towards the reproductive health goals agreed on by 179 countries at ICPD. Another factor that cannot be ignored is general health sector reform; many countries have been developing their health systems, which may have unavoidable implications for reproductive health services.

Pushed by the enormous socio-economic reforms which commenced at the end of 1970s, the health sector in China has experienced many changes. The divided socio-economic conditions in China have resulted in two different health sub-sectors: urban and rural. As a consequence, the health sector reform in China has presented two different trends. During the 1980s, while the urban health sector reform was focused on the medical care of governmental employees and workers of state-owned enterprises, the rural health sector was experiencing the collapse of a Cooperative Medical Scheme (CMS). The CMS was a collective-based medical care scheme that covered the basic preventive and curative care of most of the rural population during the 1960s–70s.

Since 1990, a number of policies on health sector reform have been issued by the central Government. These policies include 'The Decision on Health Reform and Development by the Chinese Communist Party Central Committee and the State Council', issued in 1997; 'The Guideline Opinions on Rural Health Reform and Development', issued in 2001 by five national Ministries and Commissions; 'The Decision on Strengthening Rural Health Care Work by the Chinese Communist Party Central Committee and the State Council', issued in 2002; and the latest policy is 'The Opinions on the Establishment of the New Rural Cooperative Medicine System', issued in January 2003. However, except for the issue of maternal and child health (MCH), these policies responded little to the call of ICPD on reproductive health despite being promulgated after 1994.

Simultaneously, empirical studies have revealed an extremely low utilization of basic reproductive health services, such as prenatal care and institution-based deliveries, in poor rural China (Fang et al. 1997; Kaufman et al. 1997; He et al. 2000; Ma et al. 2000; Yan et al. 2000; Kaufman et al. 2002). Considerable evidence indicates a much higher maternal mortality ratio (MMR) and infant mortality rate (IMR) in poor rural areas compared with non-poor rural settings (Gu et al. 1994; Hou et al. 1994; Chen 2000). In fact, the disaggregated health indicators in China uncover the huge disparities between rural and urban areas and between the rich and the poor. For instance, the MMR in west China was as high as 200 per 100 000 live births, which was four times the average urban MMR and two times the rural average MMR. In 1998, the incidence rate and mortality rate of communicable diseases for all rural areas were 186.2 per 100 000 and 0.33 per 100 000, respectively, while the corresponding data in west China were 201.8 per 100 000 and 1.03 per 100 000 (Chen 2000).

Given that 70% of the population in China lives in rural areas and 30 million are reported to be poor farmers whose basic living needs are not being met (*People's Daily* online, 2003), a critical review of the relationship between rural health sector reform and reproductive health services in poor areas is needed in order to fulfil China's commitment to the reproductive health goals and objectives set forth by ICPD.

## Data and methods

Data used in this paper come mainly from two sources. The first is literature review and analysis which includes published papers, an unpublished research report, conference proceedings and governmental policy documents; more than half of this data was written in Chinese. The second source is first-hand interview data collected by the author during her PhD fieldwork; data were both note-based and record-based, and then analyzed by hand.

## Findings

### The rural health sector reform: an unfinished business

The rural administrative levels of China consist of county, township and village. The rural health sector includes health service facilities that belong at the county, township and village levels. The Government Health Administrative Department is responsible for the management of these health facilities.

Affected by the tremendous rural socio-economic reform initiated in 1978, huge changes emerged in the rural health sector. While more than two decades have passed, the dynamic reform is still ongoing and has far from ended. Due to the diversity of the social, economic, cultural and geographic conditions in different settings of rural China and the huge disparities that have emerged since the reform, described by Hu as 'One China, four worlds' (Hu 2001), the reforms and changes that have occurred in various rural areas present somewhat different characteristics. This paper emphasizes the most major and common reforms that have occurred in rural China.

#### *Change in the financial arrangements and management of rural health facilities: from decentralization to re-centralization*

Following the financial decentralization, or so-called 'eating in a separate oven', which started at the end of the 1970s, local governments of China have been assigned the responsibility of financing local public health institutions. In rural areas, county and township governments have separately taken charge of allocating their budget funds to support county and township public health institutions. Thus the power and responsibility of financing health care is given largely to local governments.

Since the middle of the 1980s, the managerial and supervisory responsibility of local health facilities has also shifted from central to local governments (Fu et al. 2000). Although the central government still decides upon health related

policies, its power to supervise and control local health matters has been weakened; such power is now in the hands of local governments.

In 2001, a new policy titled 'The Guidelines on Rural Health Sector Reform and Development', promulgated by the central government (State Council 2001), emphasized that each township should have one health centre owned and run by local government. The policy called for the management of such health centres to be handed over from township government to county government. County government has the responsibility of financing and managing the township health centre. This implies that the financing and management of the township health centre has shifted from decentralization to re-centralization. The plan is that by 2005 all township health centres owned by government will be financed and managed by county government (*Health News* 2002). Since 2001, many counties have occupied themselves with the handover of the township health centre. However, the progress made so far is not very encouraging, due to the severe financial deficits of many county governments; many of the county and township governments in the middle and western parts of China are in debt (Wang and Chen 2004).

In one poor county in western China, the County Party Secretary, who is the key decision maker at county level, does not want to finance all township health centres. Instead he only wishes to finance township health centres that are poorly equipped and poorly staffed and have little chance of surviving on their own even though they provide curative services. He hopes that once these health centres are funded they can also undertake preventive health work, including disease control and MCH work. The party secretary wants to stop financing all other township health centres that are better equipped, adequately staffed and relatively strong in providing curative services; he believes these township health centres can make money on their own from the medical market.

The reason behind this plan is the severe financial deficit of the county government. In 2002 the county had a financial deficit of 8 280 000 RMB yuan, with a total population of 951 581 (Wu 2003); the average debt of each person in this county, therefore, from the newborn to the very old, was 8.7 RMB yuan. However, the health administrative department of the county government, the County Health Bureau, maintains that all township health centres can be financed by the county's budget. Those in leadership of the county are not in agreement on this issue. Thus the hand-over of township health centres from township government to county government has not yet been completed, despite the county reporting to the upper level government that this has already been done. In practice, if the county government has indeed financed all township health centres, it can only provide funds to cover a proportion of the salaries of health workers. All the other funds needed to run the health centres still need to be generated by the health centres themselves. The implications therefore of the re-centralization of township health centres appear to be more of a managerial issue rather than a significant change in the financial running of township health centres.

*Change in the financing of health care: from a decrease in government funds on the supply side to an investment of government funds on the demand side*

Before the rural economic and social reforms, all state-owned public health facilities in rural areas were fully funded by the state. Since 1980 local governments could only pay the salaries of health care workers working in public health institutions. The proportion of the local governments' health budget in the total expenditure on health decreased, although the absolute amount of local government's investment in health care was increased. In both urban and rural areas, governments only allocated the budget to fund a proportion of staff salaries, usually 40–60%. All other expenditures, including the remainder of salaries and costs needed to maintain the health facilities, have to be generated by the health institutions themselves. Although preventive health facilities such as MCH and centres for disease control (CDC, the former anti-epidemic station) can obtain full salaries from local government, they get little government funding for actual MCH and disease control work.

As shown in Table 1, the total health budget of Dafang County Government (a poor county in Guizhou Province) increased from 1990 to 1997, but the funds allocated for MCH work did not change if inflation was taken into account (Yan et al. 2000). A similar situation was observed in other poor counties (Kaufman 2002). These health institutions have to generate their own income so as to supply preventive and curative health care. A study in three poor Chinese counties found that government grants funded less than a quarter of the budgets of hospitals and health centres (Bloom et al. 1995). Despite this there is not a national policy which defines public health institutions as profit making enterprises, yet they have been perceived explicitly or implicitly by local officials as businesses that can be sustained through their own services.

In poor rural areas, financial constraints make it difficult for local government to allocate even the 40–60% salary to health facilities; salary payments are often delayed for several months. In spite of persistent call for more funds to be invested into rural health care by the central government, this is far from materializing in reality. Accompanying the decrease in funds allocated to health facilities by the government is the increase in autonomy given to hospitals; a

great deal of freedom to pursue their own interests has been granted to hospital management (Bloom 1997).

In October 2002, a new central policy titled 'The Decision on further Strengthening Rural Health Work by the Chinese Communist Party Central Committee and the State Council' stated that the central government would allocate 10 RMB yuan per person to farmers in the middle and western provinces of rural China to help them build a new cooperative medical scheme (CMS) (State Council 2003). The policy did not explain why farmers in eastern China could not get the 10 RMB yuan subsidy, but it stipulated that provincial, municipal and county governments should arrange funds from their budgets to support CMS and provide medical aid funds for the poor. The policy implies that local governments in the eastern part of China have the financial capacity to provide funds for their farmer's CMS. The policy also stated that the central government would allocate funds through fiscal transfer to provide medical aid to the poor. For the 10 RMB yuan allocated to each farmer in middle and western China, the policy requires local governments (province, district and county) to match this with 10 RMB yuan per farmer and then for each farmer to contribute 10 RMB yuan. The total of 30 RMB yuan was specifically decided upon for the new CMS.

This is considered to be the first time in history that the Central Chinese Government has allocated money to support the medical insurance of the rural population. This also signals the shift in investment in rural health care by the central government from supply side to demand side. In January 2003, the Ministry of Health, the Ministry of Finance and the Ministry of Agriculture jointly issued a document titled 'Opinions on the Establishing of a New Collective Medicine System'. This document announced that from 2003 each province should select 2–3 counties to test the new CMS and then gradually the new CMS would be expanded to other counties. By 2010 it is planned that the new CMS will provide coverage for all farmers in China.

*Privatization of health services provision*

In the context of China the term privatization does not mean the large-scale selling of government-owned health facilities to the private sector. At present the boundary between the public and private health facilities is blurred in rural areas.

**Table 1.** The major financial data of Dafang County, 1990–97

	1990	1991	1992	1993	1994	1995	1996	1997
Per capita pure income of farmers (RMB yuan)	251	290	355	455	576	764	937	1 107
Government's financial revenue (10 000 RMB yuan)	3 225	3 574	3 626	3 851	3 453	4 513	6 036	7 782
Government's financial expenditure (10 000 RMB yuan)	4 763	4 856	5 568	6 142	7 596	8 808	9 384	12 951
Government's health budget (10 000 RMB yuan)	191	196	216	209	363	296	319	347
Government's budget for MCH (10 000 RMB yuan)	21	22	16	16	21	18	23	22
Budget for staff medicine (10 000 RMB yuan)	119	136	155	180	207	249	263	379
Special allocation fund for health (10 000 RMB yuan)	28	22	25	24	26	13	9	15
Special allocation fund for MCH (10 000 RMB yuan)	12	12	12	45	4	3	2	2

Source: Yan et al. (2000).

Many former barefoot doctors have already become private practitioners due to the collapse of the cooperative medical scheme (Hillier 1991), which once covered 90% of the population but now covers less than 10% (World Bank 1996; Bloom 1997; Cai 2000). Retired doctors and newly graduated medical school students who are unable to find a job within public health institutions commonly open their own clinics. Township health centres that only receive a proportion of their salaries from local government operate as private health facilities in order to generate resources through the provision of medical services. Many health workers run their own private clinics while dividing their time with work at township health centres; this was permitted and even encouraged by a number of policies issued in the 1980s by the Ministry of Health (Fu et al. 2000), which aimed at solving the problem of the lack of doctors and medicine in rural areas.

During the 1980s–90s, some township health centres were contracted or rented, or even sold to the private sector (Fu et al. 2000). National statistics reveal that in 2001, there were 136 561 private clinics which accounted for 55.1% of the total number of clinics in China and 41.34% of the total number of health institutions in China (Wang and Chen 2004). In addition, huge numbers of drug stores and shops have emerged in rural areas, even in poor areas, due to the rapid growth of the pharmaceutical industry. Many of the drug stores are privately owned, and also provide medical advice to clients.

#### *Introduction and reinforcement of a fee-for-service mechanism*

According to official statistics, the CMS coverage rate in rural China was over 90% by the end of the 1970s. By 1999, however, coverage had decreased to only 6.5%, despite the state actively advocating the rehabilitation of rural CMS (Cai 2000). Although in recent years there has been increasing debate on the real medical protection provided by the CMS for the rural population, there is little doubt that before the 1980s the most basic medical services and preventive care, such as prenatal check ups and children's immunization programmes, had been provided free of charge, or at a very low cost for the rural population. Since the rural economic reform, the CMS was dismissed in most rural areas due to the lack of financial support from collective funds, which stemmed from the shift in the type of farming from collective production to individual family production commencing at the end of the 1970s. Farmers began to pay for health services out of their own pockets and a fee-for-service mechanism was gradually introduced. This mechanism was further reinforced by the policy issued by the Ministry of Health in 1979, which stated, 'the health sector should operate according to economic rules' (Fu et al. 2000). There is little question that the majority of Chinese farmers have paid for all their own curative services since the demise of the CMS. Fees for services have been implemented even for preventive care. Towards the end of the 1980s, a MCH prepay scheme was introduced and promoted by the Ministry of Health. This scheme collected fees from farmers in advance for prenatal and postnatal care (Zhang et al. 1997).

Since the 1990s, a fee-for-service system has been introduced into immunization programmes as well. Although the five compulsory vaccines (diphtheria/whooping cough/tetanus, polio, measles, TB and hepatitis B) are provided free of charge by the state, farmers have to pay for syringes and for services provided by health workers, to cover items such as the injection fee and the storage and transportation of the vaccines. Within family planning services, contraceptives such as IUD insertion and female and male sterilization are still free of charge if they are provided by the local family planning service station. The compulsory and regular check-ups needed once the IUD has been inserted, as well for pregnancy and gynaecological diseases (required four times per year), are charged at a small fee in some settings. If a pregnancy is identified in these check-ups and an abortion is needed, this has to be paid for by the pregnant woman.

A number of new rural health reform and development policies issued by the Central Government after 2000 addressed almost every aspect of the rural health sector, including the role and responsibility of county, township and village health institutions, the qualification requirements of staff working in those health institutions and the plan to meet those requirements. Little was said about who would pay for these services. Although the new CMS has been perceived as one sort of medical insurance for the rural population, it is aimed at covering serious diseases and it therefore will take time to build up. An instant user fee is and will be an unspoken reality for a long time in rural China.

#### **The provision of reproductive health services in poor rural China**

There are two major systems in China that provide reproductive health services: a family planning system and the general health system. After ICPD, the Chinese family planning system, which was previously target-driven and centred on birth control, changed its emphasis to a quality of care approach in its service provision. Among other things, informed choice in contraceptive use is an important element of the quality of care approach (He 1999). By 2003 the family planning system had been exploring the new quality of care approach in around 1000 pilot schemes throughout the whole of China. A people-focused and client-centred approach has been gradually adopted by the system. Client's needs, particularly women's reproductive health needs, have drawn increasing attention from the family planning system. The provision of comprehensive reproductive health services, including reproductive tract infection (RTI) services, has become a target of many family planning service stations. Compared with the family planning system, the response of the health sector to ICPD has been feeble.

#### *Ignoring the ICPD and confining services to MCH*

It is interesting that almost all policies and documents on health reform and development enacted by the Ministry of Health or the State Council rarely mention ICPD and reproductive health, though MCH is still a top priority of the health system. It seems that reproductive health is left to the business of the Family Planning Commission while MCH is

the natural task of the Ministry of Health. Ignorance of ICPD and reproductive health by health policy makers at the national level ensures that the health sector fails to develop a health reform policy that pays attention to the holistic reproductive health needs of people. The health sector fails to provide integrated reproductive health services; it still confines its services to MCH and largely ignores the wider reproductive health needs of adolescents and men. Affected by a lack of understanding of the reproductive health goals, the health sector in poor rural China faces many problems and challenges in providing reproductive health services.

*Lack of resources in public health institutions to provide reproductive health services*

As depicted above, after the financial devolution reform 'eating in separate ovens', county and township health institutions should receive financial support from county and township governments. However, health institutions in poor rural settings can only receive very limited funds and the funds they do receive are used entirely to pay a proportion of the wages of the staff. There is little funding available from the government for health service provision, including reproductive health service provision. The funds needed for supplying and maintaining equipment, training, monitoring and supervision have to be generated from medical services. Lack of financial resources has led to the following consequences.

- *Difficulty in expanding the scope of services*  
Reproductive health does not just include MCH; it embodies a wide range of services that cover both men's and women's reproductive health needs from adolescence to old age. However, current reproductive health services provided by the health sector in poor rural China have been narrowly confined to MCH services for a number of reasons. Among these reasons, lack of financial resources is a crucial factor. Limited reproductive health service provision means even some basic services are unavailable, such as screening and treatment for common RTIs and pap smears.
- *Lack of training opportunities to upgrade providers' knowledge and skills*  
Health workers in poor areas seldom receive any training to enhance their ability and upgrade their knowledge (excluding areas where some projects supported by state or outside donors have been ongoing), which in turn affects the quality of services provided by those workers. A survey conducted in four poor counties in Yunnan Province reveals that of reproductive health service providers, 29–55% at the township level and 71–91% at the village level did not have the competence to diagnose and treat common RTIs such as trichomoniasis and candidiasis – the most common cause of morbidity suffered by local women (Fang et al. 1997). A study undertaken in rural areas of Yunnan Province stated that the prevalence of trichomoniasis and candidiasis among common rural women was 16% and 20%, respectively (Kaufman et al. 1999).
- *Weakening the supervision and technical guidance from the upper level health institutions to the low level ones*

Due to serious financial constraints, technical support and supervision as well as monitoring and evaluation given to low level facilities by higher level health institutions has been weakened in terms of quality, frequency and coverage. County MCH stations that are supposed to provide supervision and guidance to all township and village MCH health workers tend to conduct supervision and guidance only in nearby townships and villages because of the lower cost and convenience. Thus remote townships and villages, where health service provision is already usually weaker, come under much less scrutiny. In addition, all health institutions have to generate income from the medical service market, which eventually causes competition between different levels of health institutions. This further damages the supervision and technical support from higher levels to the lower levels.

- *Curative-oriented service provision*  
The pressure for health institutions to provide curative-oriented services is driven by lack of funds, the common practice of paying for services and the need to make money and have the autonomy to do so. Health institutions thus focus on providing curative services and selling medicine, largely ignoring preventive care. Reproductive health services are likely to be heavily affected as many reproductive health service items fall into the preventive care category. Some essential services such as pap smears, screening for asymptomatic RTIs and health education are inadequately provided or not available at all at county and township level. Poor women do not have the financial resource to pay for these services, thus discouraging health facilities from providing them.
- *Dependency on projects sponsored by donors and national government*  
Since the 1980s, many donor-sponsored programmes and projects have been introduced into the MCH arena, and more recently into the reproductive health field. A large proportion of these programmes have been conducted in poor counties where health funds are extremely limited. These projects have improved MCH indicators such as maternal mortality ratios and infant mortality rates. However, such projects may make local governments become dependent on sponsors and donors to fulfil MCH work. Although many projects also required some level of funding from local governments, the funding has been difficult to meet in many poor places. Funds brought in, however, by such projects have exerted a crucial role in health service provision, particularly preventive care provision. As one staff member at the health bureau of a poor county in Guizhou Province reported: "We cannot even maintain our office telephone line without these projects" (Fang 2001, unpublished research report). However, a major concern among health institutions and providers is: "What are we going to do if these projects finish?"

*Multiple service providers and inadequate regulation*

Except for public health institutions, the health sector reform has brought other actors into the arena of health service provision. The openness and emancipation of the medical care market has produced multiple service providers. Such

providers consist of public health facilities, private hospitals and clinics and the township health centre and village clinics, the identity of which is contested since they are run by government but operate like private health institutions. People have more choice in health care than they had before the reforms. Reproductive health services, such as treatment for sexually transmitted infections and institutional birth deliveries, are now more widely available and physically more accessible to the rural population. Nonetheless, the regulation by government of these institutions and actors is inadequate, as indicated by Bloom (2001). Over-prescription, rapid rising of medical service costs to patients, low service quality and competition among different providers has been well documented in a number of studies (Gu et al. 1995; World Bank 1996; Zhan et al. 1997; Du 2000; Meng 2000; Liu and Bloom 2001). In addition, the rapid growth of the pharmaceutical industry has brought a new actor into the market: the drug shops and stores which are far less regulated than other health care providers in terms of selling medicine. Meanwhile, the voice of the people, particularly poor women, is very weak in influencing service delivery and monitoring service quality.

### Reproductive health service utilization in poor rural areas: the remaining challenge

In the last decade, a number of empirical studies conducted in poor counties shed light on some aspects of reproductive health service utilization, which allows us to look into

reproductive health service utilization by poor women in the context of socio-economic change and health sector reform.

#### Low utilization of basic reproductive health services

A study in three townships of two counties of Yunnan Province in 1995 showed that the health care service utilization by poor rural women who reported specific symptoms associated with pregnancy, delivery and the postpartum period, as well as contraceptive use and gynaecological conditions, was very low (Kaufman et al. 1997, 2002). Surveys undertaken in rural areas of western China, such as the provinces of Shanxi, Henan, Qinghai and Guizhou, all revealed surprisingly low utilization of basic reproductive health services by poor women (He et al. 2000; Ma et al. 2000; Yan et al. 2000). Prenatal care, hospital delivery or delivery attended by a trained attendant, and postnatal visits are the very essential basic elements of the reproductive health service package.

However, as shown in Table 2, poor women's utilization of these services was very low. Numbers of women giving birth in hospital were particularly inadequate, despite delivery being the time when medical complications of both mother and baby are most likely to occur or worsen. Studies also show that many women reported abnormal conditions during delivery, such as excess bleeding, tearing of the vagina and prolonged labour; only a small percentage however sought health care, as shown in Table 3.

**Table 2.** The utilization of some basic maternal health care services by poor women, by province

	Yunnan (1988–95) (n = 574)	Guizhou (1996–98) (n = 200)	Henan (1996–98) (n = 200)	Shanxi (1996–98) (n = 200)	Qinghai (1996–96) (n = 200)
Prenatal check-up rate	44.22	18.7	74.5	84.4	n.a.
Hospital delivery rate	5.14	15.4	12.8	8.9	11.1
Modern delivery rate	16.88	n.a.	85.8	53.3	n.a.
Postnatal visit rate	13.76	54.9	45.1	n.a.	n.a.
Postnatal exam rate	3.67	n.a.	29.4	3.3	n.a.

Sources: Fang et al. (1997); Yan et al. (2000); Ma et al. (2000); He et al. (2000).

**Table 3.** Symptoms related to pregnancy and delivery and healthcare seeking rates

Period	Yunnan Province (1986–95) (n = 574)		Guizhou Province (1996–98) (n = 200)		Henan Province (1996–98) (n = 200)	
	Symptom rate	Healthcare seeking rate	Symptom rate	Healthcare seeking rate	Symptom rate	Healthcare seeking rate
Pregnancy	59.63	25.85	30.77	28.57	36.3	32.4
Delivery	55.23	12.96	61.54	28.57	n.a.	n.a.
Within 1 month after delivery	59.82	15.95	40.65	24.32	n.a.	n.a.

Note: Symptoms during pregnancy include swelling remaining after sleeping; headache with swelling; abnormal weight gain; excess vaginal discharge; vulva itch or burning; bleeding. Symptoms during delivery include vaginal tearing; excess bleeding; prolonged labour; ruptured cervix. Symptoms after delivery include bleeding more than 2 weeks; fever; painful breastfeeding; incontinence.

Sources: Fang et al. (1997); Yan et al. (2000); Ma et al. (2000).

Although more than 80% of poor women in these counties adopted a modern form of contraceptive, their utilization of follow-up services was disproportionately low. A large proportion of women reported symptoms that suggest the existence of some type of RTI; however, less than 30% of women had sought medical care, as shown in Tables 4 and 5.

**Table 4.** Symptoms and healthcare seeking rates after family planning operations

	Yunnan (1995) (n = 574)	Shanxi (1998) (n = 200)
Symptom rates	71.70	44.44
Healthcare seeking rates	25.38	45.00

*Note:* Symptoms reported by women after receiving family planning operations include waist pain; excess bleeding; irregular bleeding; backache; fever; pain during intercourse; abnormal discharge.

*Sources:* Fang et al. (1997); He et al. (2000).

The studies concluded that the factors contributing to the low utilization of health care services included the unavailability of services; lack of health education and low health awareness of women and their families; financial constraints; difficulty of travelling to and from clinics; and the time constraints that poor women face. Evidence provided by such studies, however, comes from cross-sectional surveys, making it hard to determine whether the inadequate provision and low utilization of reproductive health services was actually caused by the rural health sector reform. Nonetheless, it can be acknowledged that the reforms fail to address unmet reproductive health needs of poor women.

#### *Use of alternative or informal health care by poor women*

Due to the unavailability, inaccessibility and un-affordability of public health services, poor women tend to use services perceived to be less expensive, such as health care provided by private practitioners, traditional healers, village doctors or drug stores. Women may also rely on self care and family-based health care provided by family members and neighbours. This is particularly true in the case of reproductive health services. Except for the abovementioned constraints, many reproductive health conditions are perceived by poor women and the community as natural events that do not need medical attention. Many women learn to endure RTI symptoms, but if the infection becomes too severe then they often buy medicine from drug stores to self-treat or seek care

provided by a traditional healer who is perceived to be cheap and easy to access. As revealed by a study conducted in Yunnan Province, for the women who gave birth at home, 50–60% of births were attended by a family member or neighbour, but only a few were attended by a health worker from the township health centre (Fang et al. 1997).

## **Discussion and conclusions**

Any attempt to investigate health sector reform in China must be made clearly aware of the two different health sectors in China: the urban and the rural. This paper exclusively focuses on the rural health sector; it reviews and summarizes the major reforms and changes that have occurred and reviews research findings on reproductive health service provision and utilization revealed by some empirical studies conducted in poor rural China. Rural health sector reform is still ongoing and the complicated and dynamic nature of the reform makes it hard to draw any final conclusions. However, some current conclusions can be made.

### **Reproductive health: a missing component in the health reform agenda**

Except for MCH, all policies on rural health reform enacted by the central government make little mention of reproductive health. On reviewing a number of important health sector reform policies, the term reproductive health can hardly be found. A lack of using the term reproductive health does not necessarily mean a lack of all reproductive health services in the health system, but it implies that the highest level health reform policymakers have not paid enough attention to the Programme of Action of the ICPD. This lack of acknowledgement and commitment to reproductive health at the highest level makes the health sector at the lower level ignore reproductive health in its reforms. Health sector reform measures taken by many counties have paid little attention to reproductive health. Important reproductive health services, especially those needed by women such as screening, diagnosis and treatment for RTIs, diagnosis for cervical and breast cancers and sexual education for adolescents, are either not available or are inadequately provided. Even the traditional reproductive health services, for example, prenatal care, postnatal care and safe delivery, are not provided and/or well utilized, as confirmed by empirical studies. Although as mentioned, the evidence provided by studies comes from cross-sectional surveys, making it hard to argue that the inadequate provision and low utilization of

**Table 5.** Reproductive tract infection symptoms and healthcare seeking rates reported by poor women (%)

	Yunnan (1995) (n = 574)	Guizhou (1998) (n = 200)	Henan (1998) (n = 200)	Shanxi (1998) (n = 200)
Symptom rates	80.64	84.60	73.33	70.56
Healthcare seeking rates	17.54	12.98	27.70	25.19

*Note:* Symptoms reported by women include vulva itching or burning; abnormal vaginal discharge; abdominal pain and waist pain.

*Sources:* Fang et al. (1997); Yan et al. (2000); Ma et al. (2000); He et al. (2000).

reproductive health services was caused solely by the rural health sector reform, it could be argued that the current rural health reform fails to address those reproductive health issues timely and effectively.

An encouraging sign is the active responsiveness of the Chinese family planning system to the Programme of Action of ICPD. Given its more comfortable funding situation and its willingness to work towards better reproductive health, the family planning system might play a bigger role in providing integrated reproductive health services, particularly those services ignored by the health sector. However, a number of political, institutional, financial and technical constraints need to be tackled if this possibility is to be realized.

### **Passive adaptation rather than active reform**

By reviewing the process of rural health sector reform in China, it is easy to recognize that the reform that has occurred in the rural health sector is largely derived from the huge rural socio-economic reform. It may be argued that the rural health sector reform is a passive adaptation by health authorities and facilities to the changing socio-economic context rather than a well-planned active strategy; this may be particularly true during the 1980s–90s. Two facts support this argument. First, there was no active and effective measure that had been taken to deal with the issue of farmer's medical insurance after the demise of the rural CMS. Although the central government constantly called for the re-establishment of the rural CMS and many projects paid great efforts to respond to the call, there was no effective policy until 2002.

Secondly, when China moved from a command economy to a market economy, it could be predicted that inequality would eventually occur in many aspects of social life, including health care. However, no measures have been taken to address health inequity issues, further reinforcing the huge health disparities between rural areas and urban areas and between poor rural areas and rich rural areas. Although the promising document 'The Decisions on Health Reform and Development', issued by the Chinese Communist Party Central Committee and the State Council in early 1997, provides some outline on rural health reform, a clear, concrete and workable active reform strategy is still lacking. The policy was issued in 1997, but there was a long time lag before the actual changes happened on the ground. It is acknowledged by both national health policy makers and researchers that health sector reform in China was made long after reforms had been made in other sectors (Li, 2004; Wang, 2004). For example, it was not until 1997 that the first comprehensive national health reform policy was spelt out, almost 20 years later than the policies on rural economic reform. In addition, policies on rural health sector reform and development issued after 1997 contain little new content, but restate many old approaches that appear to be aimed at solving the problems brought about by the huge rural social and economic reform, rather than designing a coherent health sector reform strategy that is appropriate for the changed rural social and economic environment.

### **Rural health reform produces both negative and positive implications for reproductive health**

The reforms that have occurred in the rural health sector have implications for reproductive health services. On the supply side, negative implications include: the neglect of preventive reproductive health services; a weakening of supervision and referral systems; harsh competition among providers; and a lack of, or inadequate provision of, reproductive health services that are needed by women. Potential positive implications may be the pluralities of service provision forcing providers to upgrade the quality of their services in order to attract more clients. Although there is no hard evidence to support this claim, the fact that health care providers are nicer to clients than in the past cannot be ignored.

On the demand side, a negative implication is the increase in health and gender inequity, for the utilization of health services largely depends on the ability to pay. Fee-for-service mechanisms and the rapidly rising medical costs, as well as the lack of a well-established social policy and safety net in rural areas, make it difficult for poor people to have economic access to health services. Many poor families have fallen into debt and poverty due to the ill health of family members, which has been well documented by many studies (Gu 1998; Cai 2000; Meng 2000). In the reproductive health sphere, inequity in service utilization is further aggravated by gender inequity. Many women in need of medical attention due to their reproductive health problems do not seek care; this is further enhanced by the community and family who consider such problems as normal occurrences. Thus women are not encouraged to utilize reproductive health services given the very limited financial resources.

The positive implication on the demand side is again related to pluralistic service provision. Service availability is improved, allowing people to have more choice and alternatives. People can 'exit' if they are dissatisfied with the services they receive and try another provider. The availability of medicine and drugs has been improved in poor rural areas, although accessibility of drugs to the poorest people, drug abuse and service quality remain major concerns.

### **The state needs to play a much stronger role in reproductive health**

The Chinese government made its commitment to reproductive health by endorsing the 1994 ICPD Programme of Action; this explicitly indicates that the government would take action to improve the reproductive health of its population. In poor rural China, the inherent problems derived from the old health system intertwined with the new challenges posed by the reform process make it hard for the health system and community to achieve the reproductive health objectives by merely relying on their own efforts. The state definitely has a crucial role to play in helping poor areas achieve better reproductive health.

However, what specific role should the state play? Although a loose framework has been outlined that defines the state's

role in market regulation, public goods provision and helping the poor access services through poverty alleviation funds or other strategies, the following questions still need answering. Through what mechanisms and measures can a health service market that is a mixture of public, private and commercial service providers be regulated? How can public health services be defined in general, and reproductive health services in particular? How much money is needed to help poor areas be able to provide these public goods? Where do the funds come from? How can the funds be used in a transparent and accountable way? How can a fair and sustainable medical aid strategy for the poor be established? Currently, far from enough studies have been conducted on these questions.

### A stronger role for women and their representatives

The success of putting reproductive health onto the international population and development agenda was largely attributed to the International Women's Health Movement and the participation of women health advocates and activists in setting up the agenda. The 1994 ICPD Programme of Action also stated that governments should ensure the essential role and participation of women's organizations in the design and implementation of a population and development programme. Involving women at all levels, especially managerial levels, is critical to meeting the objectives and implementing this Programme of Action.

In China, there are few independent women's health organizations, let alone participation by them in policy making. This might partially explain why reproductive health was missing from the rural health reform policy. At grassroots level, poor communities and women are not able to exercise pressure on local government and providers for better reproductive health services. This might also contribute to the ignorance regarding reproductive health services at the grass roots. Poor women are the most vulnerable group in terms of adverse reproductive health outcomes. Socio-economic changes and rural health reform further put poor women into a marginalized and invisible position. They tend to hide their reproductive health needs and treat them as the last priority of family needs, thus they are far from having a voice in health reform policy making.

Therefore, how to improve poor women's accessibility to reproductive health services remains a major challenge. Although the state should play an active role in helping poor women acquire basic reproductive health services, this is not enough. Passively taking up the offer of assistance by the state without any input by poor women themselves will not produce a sustainable and stable effect. Thus, poor women should also play important roles so as to ensure their reproductive health needs are being met. However, again, a number of questions need to be answered by studies and actions. What roles should poor women play? What roles could poor women play in the context of present day China? How do we design a mechanism to bring the voice of poor women into reproductive health service delivery? Given their marginalized position and powerless status, it is very likely that poor women need somebody who can speak out

and negotiate on behalf of their interests in the policy making process. More importantly this somebody should mobilize, sensitize, organize and facilitate poor women to act for themselves, and finally make poor women into true stakeholders who can have an influence on the policy making process. Who can best undertake this? Women's organizations? Other NGOs? All of these questions need to be answered by research and action.

### Recommendations

Based on the conclusions made here, the following four recommendations have been made in order to achieve better reproductive health outcomes in China and to achieve the goals and objectives of the International Conference on Population and Development (ICPD).

- *Recommendation for researchers:* Further research is needed to explore critical issues such as the role of the state and public service accountability. Findings should be used to inform the formulation of health reform policies and programmes.
- *Recommendations for the state:* 1) Active rural health sector reform strategies need developing that address reproductive health needs as well as health and gender equity. 2) Strengthen the role of the state in issues related to health in rural China by transferring financial resources from the national budget to help local governments develop health care. Health care should include basic reproductive health services and mechanisms should be set up to monitor the use of the funds.
- *Recommendations for advocates and NGOs:* Develop and strengthen organizations that can act on behalf of the interest of women in poor rural areas.

### References

- Bloom G, Lucas H. 1995. *Financing health services in poor rural areas: adapting to economic and institutional reform in China*. IDS Research Report, No.30. Brighton: Institute of Development Studies.
- Bloom G. 1997. *Primary health care meets the market: lessons from China and Vietnam*. IDS Working Paper no. 53. Brighton: Institute of Development Studies.
- Bloom G. 2001. China's rural health system in transition: towards coherent institutional arrangements? Institute of Development Studies, University of Sussex, UK. Paper presented at the conference on 'Financial sector reform in China' organized by the Centre for Business and Government John F. Kennedy School of Government Harvard University, USA, 11-13 September 2001.
- Cai R. 2000. Comments on some issues of China rural health development. Paper presented on the conference on China rural health reform and development, held by CHEI and the Institute of Development Studies, UK, in Beijing in 7-9 November 2000 (in both Chinese and English).
- Chen X. 2000. Consideration on the development of western rural health care in China. *Chinese Health Resources (Zhongguo weisheng ziyuan)* 3: 243-5 (in Chinese).
- Du Y. 2000. Several opinions on rural health system reform. Paper presented on the conference on China rural health reform and development, held by CHEI and the Institute of Development Studies, UK, in Beijing in 7-9 November 2000 (in both Chinese and English).
- Fang J, Kaufman J, Zhang K. 1997. A study of women's needs for

- and utilization of basic reproductive health services in rural China. Research report of financing, provision and utilization of reproductive health services in Rural China. Bethesda, MA: Abt Associates Inc., pp. 71–77.
- Fang J, Kaufman J, Zhang K. 1997. Women's reproductive tract infections: an important reproductive health issue. *Chinese Primary Health Care* (Zhongguo Chuji Weisheng Baojian) **11**: 54–56 (in Chinese).
- Fang J. 2001. The Situation analysis of current health planning in China. Unpublished research report.
- Fu W, Chen Y, Yao L, Li W. 2000. The background paper of China Rural Health Reform and Development. Conference proceedings on China Rural Health Reform and Development Forum, Beijing.
- Gu Z. 1994. An epidemiological investigation of IMR, U5MR, MMR and death causes in Guangdong in 1991. *China Maternal and Child Health Care* (Zhongguo Fuyu Baijian) **9**: 54–56 (in Chinese).
- Gu X, Tang S, Cao S. 1995. The financing and organization of health services in poor rural China: a case study in Donglan County. *International Journal of Health Planning and Management* **10**: 265–8.
- Gu X. 1998. *Intervention study on health financing system in China's poor rural areas* (Zhongguo Pingkun Diqi weisheng chouzi Yanjiu). Shanghai: Shanghai Medical University Publishing House.
- He Y, Zhang J, Han H et al. 2000. An investigation of reproductive health services status in Yusher County of Shanxi Province. *Chinese Primary Health Care* (Zhongguo Chuji Weisheng Baojian) **14**: 44–47 (in Chinese with an English title and abstract).
- Health News* (Jiankang Bao), 31 October 2002.
- Hillier S, Zheng X. 1991. Township hospitals, village clinics and health workers in Jiangxi Province: a survey. *China Information* **VI**: 51–61.
- Hou M. 1994. Comparison and Analysis to Characteristics of the Development in Hygiene and Cause Between Rich and Poor Areas. *China Primary Health Care* (Zhongguo Chuji Weisheng Baojian) **8**: 3–6 (in Chinese).
- Hu A. 2001. One China four worlds – analyzing the district disparity in Development. China Economy Time paper, [http://finance.sina.com.cn].
- Kaufman J, Zhang K, Fang J. 1997. Reproductive health financing, service availability and needs in rural China. *IDS Bulletin* **28**: 61–65. Brighton: Institute of Development Studies.
- Kaufman J, Fang J. 2002. Privatization of health services and the reproductive health of rural Chinese women. *Reproductive Health Matters* **10**: 108–16.
- Kaufman J, Yan L, Wang T, Faulkner A. 1999. A study of Field-based methods for Diagnosing Reproductive tract Infections in rural Yunnan province, China. *Studies in Family Planning* **30**: 112–19.
- Liu Y, Bloom G. 2002. *Designing a rural health reform project: the negotiation of change in China*. Social Policy Program. IDS Working Paper 150. Brighton: Institute of Development Studies.
- Li T. 2004. Re-scrutiny of Chinese health system. Conference proceedings on seeing NGOs and public health from SAES epidemic, Xian.
- Ma B, Zou L, Huang X. 2000. A quantitative survey on improving reproductive health services in Song County of Henan Province. *Chinese Primary Health Care* (Zhongguo Chuji Weisheng Baojian) **14**: 38–41.
- Meng Q, Hu A. 2000. Health Poverty Reduction: strategic priority of China's rural health reform. *Chinese Health Resources* (Zhongguo weisheng ziyuan) **3**: 245–9 (in Chinese with English title and abstract).
- People's Daily* online. 2003. China makes remarkable progress in reducing poor population. 21 October 2003.
- State Council. 2001. Guidelines on rural health reform and development by the institutional reform office of the State Council, the State Commission on Planning and Development, the Ministry of Finance, the Ministry of Agricultural and the Ministry of Public Health. Beijing, May 2001.
- State Council. 2003. Opinion on the establishment of new type of rural Cooperative medicine system by the Ministry of Health, Ministry of Finance and Ministry of Agricultural. Beijing, January 2003.
- Wang J, Chen Q. 2004. Analysis on medical and health system of rural Areas in China. *Chinese Primary Health Care* (Zhongguo weisheng ziyuan) **18**: 1–4 (in Chinese with English title and abstract).
- World Bank. 1996. *China: issues and options in health financing*. Report No: 15274 CHA. Washington, DC: World Bank.
- Wu X. 2003. The report on the implementing of the financial budget in 2002 and the draft plan of financial budget in 2003 of Dafang County. No 16 Document of the first session of the 14<sup>th</sup> meeting of the People's Congress in Dafang County.
- Yan J, Shan Y, Liu J, Deng S, Du M, Li Z. 2000. An investigation of the current status of reproductive health service in Dafang County, Guizhou Province. *Chinese Primary Health Care* (Zhongguo weisheng ziyuan) **14**: 41–43 (in Chinese with English title and abstract).
- Zhan S, Tang S, Guo Y. 1997. Drug prescribing in rural health facilities in China: implications for service quality and cost. *IDS Bulletin* **28**: 66–70. Brighton: Institute of Development Studies.
- Zhang K, Wang A, Du K, Jiang T. 1997. A study of the maternal and Child health prepay scheme in rural Yunnan. Research report of financing, provision and utilization of reproductive health services in Rural China. Bethesda, MA: Abt Associates Inc., pp. 219–61.

## Biography

Fang Jing, MD, MPH, is a PhD candidate at the Institute of Development Studies (IDS), Sussex University, UK. She is Former Deputy Director of Yunnan Reproductive Health Research Association (YRHRA), an NGO based in Yunnan Province, China and a Professor at the Institute for Health Sciences, Kunming Medical College, Yunnan Province, China.

*Correspondence:* Fang Jing, MD, Western Renmin Road 191#, P.O. Box 43, Kunming Medical College, Kunming City, 650031, Yunnan Province, China.