Primary Health Care

Bringing basic health care to the rural poor

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In the 1960s and 1970s China provided a good model for financing and delivering rural health services in developing countries. Since the implementation of economic reforms which began in the 1980s, however, health services in poor areas have been showing signs of declining, with fewer people able to pay for the services they need. This article examines major problems of access to basic health care faced by the poor, and proposes a strategy for improving health service delivery in the poor areas.

From the 1950s to the 1970s, the health status of the Chinese improved significantly while the national economy and household incomes remained low. This was true largely because rural health care had strong political backing. Peasants were generally given easy access to health care at village health stations, township health centres, and county hospitals, regardless of ability to pay. Inpatients were allowed to postpone paying for services rendered if they had financial difficulties. Nowadays, people who are referred for hospital care, even in emergencies, have to pay a deposit in advance or they are not admitted to the hospital. Many cannot afford these fees and therefore fail to receive needed medical care. Some health indicators for rural China have consequently not changed since the mid-1980s.

Health care costs in China have risen rapidly in recent years. A household health survey (1) shows that the poor spend a higher proportion of their income on health care than the rest of the population. Rich people are more likely to use health services of high quality while the poor tend to use services of low quality. More importantly, about 95% of low-income consumers who were referred to hospital by doctors did not receive the services, because they were unable to afford hospital care. Paying for medical care is making the poor poorer.

Preventive health care programmes used to be fully funded by the government. They are now in jeopardy because most government funding for preventive services barely pays the salaries of health workers, leaving little money for operations. To provide operating funds, health care facilities have begun to charge for such preventive services as child immunization. The poor, unable to afford these services, have given them up, for the most part. A case study of the township of Donglan County shows that participation in the child immunization programme fell from over 85% in the late 1980s to under 40% in 1993.

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Financial problems in villages and townships

The village economy has weakened and its welfare funds have shrunk since the introduction of socioeconomic reform and the household responsibility system. As a result, the cooperative medical system, which used to be supported by village welfare funds and household contributions, has collapsed in most rural areas of China. In many townships, village health stations no longer exist and village health workers have been practising medicine privately, living on service charges and profits from drug sales. The village health workers are unwilling to provide preventive services because the fees for them are too low to cover the time spent providing the services.

At the next level up from village health stations, township health centres have concentrated on providing curative services, which generate revenue, and have neglected preventive programmes. The township health centres have little incentive to provide village health workers with the training and supervision they used to provide, since they make more money providing curative services. Drug prescriptions have been one of their most important sources of revenue. Moreover, some qualified doctors have left township health centres for jobs that pay better. The number of employees at the township level is stable, but the proportion of professional staff has declined.

Health facilities at the county level are supposed not only to provide local health services, but also to offer training and supervision to lower-level health workers. Because government funding to these facilities has declined proportionally, they have to rely largely on revenue from user charges, and limit their technical support to village and township facilities.

Village health workers earn much more if they work in rich areas than if they work in poor ones. Many of them not only receive salaries from village welfare funds, but also generate extra income from fees and drug sales. In most areas, the only support provided by the government is small payments for preventive programmes. Village health workers in poor areas cannot afford to spend much time on activities for which they are not adequately paid. Consequently, some spend a great deal of time in non-health activities and many concentrate on providing curative care and selling drugs, neglecting preventive work. They are also unwilling to spend money on such items as equipment and maintenance.

The government grants to county and township health facilities have not kept pace with salary increases. These facilities find it difficult to pay their wage bills and have had to cut spending on maintenance and consumable inputs.

A seven-point strategy

To date, the Ministry of Public Health has responded to these problems by urging local governments and health authorities to establish innovative schemes for financing rural health services. Since the mid-1980s some counties and townships have been developing similar schemes, but using different names for them. For simplicity’s sake, we will use the term “cooperative health care scheme” for them in this paper. The idea behind the cooperative health care scheme is to collect revenue from a number of sources, and use it to reimburse members for part of what they spend on medical care,

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thereby improving access to health care and at the same time increasing the income of service providers. In 1994, only 7% of the rural population was enrolled in such a scheme.
Rebuild village health stations. Village health stations should be strengthened by building appropriate facilities, supplying needed medical equipment, and attracting skilled staff to work in them. The village collectives themselves can provide at least part of the funds needed for construction. They should encourage local people to contribute money, labour, building materials and the like. Government and health authorities at higher levels may allocate special funds to help the village health stations obtain the equipment they need. The government should also help establish incentives for health workers to relocate in rural areas. In the meantime, village health workers need to be properly supervised and trained by higher-level health professionals.

Strengthen township health centres. First, the proportion of non-health staff needs to be reduced and the proportion of health workers increased, in line with criteria proposed by the Ministry of Public Health. Second, since most health workers at the township level are inadequately trained, it is imperative to provide them with more in-service training. Finally, funding must be provided for health education and preventive care.

Define the basic health service package to be covered by the scheme. The government needs to define a minimum package of basic health care services to which all residents of poor areas are entitled. The package (see box) should include preventive programmes and access to outpatient care and basic inpatient treatment. Rural residents would be ensured access to these services by participating in the cooperative health care scheme. The government should also clearly define the respective roles of village health stations, township health centres, county hospitals and preventive institutes in providing each component of the package. Each locality must decide precisely what services to provide and how to organize them, which will depend to some extent on the proportion of fee-paying and subsidized patients in each area.

Determine the cost of services. The cost of providing the package of basic health services has to be determined. The starting point may be current levels of spending by health services in areas where coverage is good. Eventually cost must be rationalized to correct for under-spending or over-spending on particular components. There is considerable potential for savings by cutting drug costs and reducing the number of non-health personnel. However, the pay for some health workers needs to be increased, and many poor areas need to spend more on consumable inputs, maintenance, replacement of equipment, supervision, and in-service training.

Explore potential sources of finance. After establishing the cost of the basic health care package, the government must formulate a strategy for financing it. Patients will continue to pay directly for most of their care, but the government and the health care schemes together should ensure that enough funds are raised to give the rural poor access to health care.

The government already provides support for rural health services. The county health bureau and township governments provide budgetary support for county hospitals, township health centres and other preventive institutes. But funding for preventive programmes, which cannot completely recover costs, tends to be inadequate. Many county governments will have to increase their total spending on health to meet obligations for preventive care.

<table>
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<th>Health services covered by the scheme</th>
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<td>■ Children under seven get free vaccinations.</td>
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<td>■ Pregnant women get free prenatal and postnatal care and safe delivery of their babies.</td>
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<td>■ All childbearing women get family planning services.</td>
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<td>■ Participants in the scheme get partial reimbursement for medical care expenses.</td>
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One option would be for the government to provide subsidies earmarked for basic health care. This would build upon the present system, which partially funds preventive programmes down to the village level. For instance, a small portion of the funds allocated to the anti-poverty programme in the poor areas could be used to support rural health development by helping to establish the cooperative health care scheme there.

Another option for increasing funding by provincial and prefectural health departments and county health bureaux would be to shift the emphasis from sophisticated and expensive curative care to basic care. All of these options would involve substantially changing the pattern of allocation of government resources. First, it will be necessary to build a political consensus on the importance of providing basic health services to everyone in the vulnerable group.

**Change the payment system for health care providers.**
Most of the village health workers formerly supported by the village collectives have gone into private practice. To get them to work in preventive care, they need to be subsidized by local collectives. Because local collectives are currently weakened, a new way of providing funds may have to be developed.

Under the present system, pay for health workers is to some extent linked to the amount of revenue generated from service fees and the sale of drugs. This system must be changed, especially for village health workers, many of whom earn most of their income from payments by patients. Village health workers should receive most of their income as salary. Their salary should reflect their qualifications, their experience, their duties, and the number of people for whom they are responsible. Pay levels should also be tied to the achievement of targets, such as preventive coverage, patient satisfaction, and improvements in efficiency. Any bonuses paid to county and township health workers should be linked to measures of performance other than revenue generation. Changing the pay system for health workers would mean changing the organization of the cooperative health care scheme, which now issues payments to reimburse members for out-of-pocket expenses. The new scheme would reward health service providers for meeting their commitment to specific service targets.

**Improve organization and management.** To some extent, the government and local collectives will finance rural health services, but they should also find a way to get the rich to subsidize the health care of the poor. One function of the cooperative scheme is to redistribute resources from those who are healthy to those who are sick. People contribute to protect both themselves and others against the high cost of treating a serious illness. It is probably important to make participation compulsory. Voluntary schemes, which allow people to decide on a year-to-year basis whether to buy coverage, face the problem of adverse selection—that is, healthy people will tend to drop out while unhealthy people tend to join. Voluntary schemes also provide little opportunity for the rich to subsidize the poor. Better-off households have little incentive to join if they have to contribute more than the value of the services they expect to receive. That is why voluntary schemes tend to charge a fixed amount per person or household regardless of ability to pay. For reasons of this kind, voluntary schemes often do not work.

In some areas, local Chinese political leaders have already successfully mobilized people to participate in the cooperative health care scheme (2). To reach a satisfactory level of enrolment, newly established schemes may have to apply social pressure or make contri-
bution to the scheme compulsory. Households are more likely to join if they can expect to receive services worth more than what they contributed. Hence it is important for village collectives and the government to subsidize village health workers for the time they spend on the services.

Whatever the scheme, some households will be too poor to contribute. Very poor families tend to allocate most of their resources to food, housing, and the necessities of agricultural production. They pay for medical care only when absolutely necessary. In theory, the social relief system should provide a safety net for these households. In practice, the poor do not have access to health care when they fall ill. Some mechanism must be set up to subsidize the contributions of these households to the scheme. Otherwise, the problem of providing basic health care to the poor will have to be dealt with as part of reform of the social relief system.

It is not necessary to wait for economic development for the health status of the Chinese to improve. As China itself in the 1960s and the 1970s and other developing countries have learnt, health status can improve even when the national economy is weak and household incomes are low. Attitude is an important component of good health. When the will for good health is there, health-building behaviour becomes more likely. Our interviews with peasants convinced us that people badly want the cooperative health care scheme to be established. Now it is the government's turn to respond.

Acknowledgments
This article draws on research work jointly funded by the International Health Policy Program (IHPP), Washington DC, USA, and the International Development Research Centre, Ottawa, Canada. It was written in the IHPP Research, Writing and Dissemination Workshop, Washington DC, March 1-9, 1995.

References


The city boom

The increasing proportion of people living in cities and towns is now one of the main features of world development. ... The urban population of developing countries is already larger than the combined urban populations of Europe, North America, and Japan. ... The relatively young age of new migrants to cities contributes to the high fertility rates and the low crude death rates.