

**Financial Reform, Poverty, and the Impact on
Reproductive Health Provision: Evidence from Three
Rural Townships**

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It is widely recognized that the fiscal decentralization that has been a key component of economic reforms in China has had a significant impact on the provision of public goods and services. Reforms have produced new inequalities, a dramatic rise in the disparity between welfare provision in rural and urban China, and an abandonment of the compact for cradle-to-grave social welfare for the privileged working-class. While the reforms may have raised the standard of living for the vast majority and shifted China along the road to a market economy, China's policy-makers have not been so successful in devising policies to bridge the social transition. In this respect China has fared no better than other transitional economies where economic gains have not been matched by significant improvements in welfare provision.¹ This is not surprising, as reforms entailing major institutional change are inherently slower and more complex than macroeconomic stabilization and liberalization measures.²

Financial pressures resulting from the reforms have caused many work-units and local authorities to cut services or turn them over to a fee-for service system. Individuals are left increasingly to find the best support available with their own resources. This has been particularly noticeable in the provision of healthcare.³ In the mid-1970s China received

¹ On the problem generally see J. Kornai, 'Reform of the Welfare Sector in Post-Communist Countries: A Normative Approach', in J. M. Nelson, C. Tilly, and L. Walker (eds.), *Transforming Post-Communist Political Economies* (Washington, DC: National Academy Press, 1997). With respect to the problem of securing a sound funding base for the provision of public services at the local level see R. Bird and C. Wallich, 'Fiscal Decentralization and Intergovernmental Relations in Transition Economies', *Policy Research Department Working Paper WPS 1122* (Washington DC: The World Bank, 1993).

² J.M. Nelson, 'Social Costs, Social-Sector Reforms, and Politics in Post Communist Transformations', in Nelson, Tilly, and Walker, *Transforming Post-Communist Political Economies*, p. 256.

³ See for example, G. Bloom, S-L Tang, and X-Y. Gu, 'Financing Rural Health Services in China in the Context of Economic Reform', *Journal of International Development*, vol. 7, no. 3, 1995, pp. 423-41; Y. Liu, W.C. Hsiao, K. Eggleston, 'Equity in Healthcare: the Chinese Experience', *Social Science and Medicine*, no. 49, pp. 1349-56, 1999; V.C.W. Wong and S.W.S. Chiu, 'Healthcare Reforms in the People's Republic of China. Strategies and Social Implications', *Journal of Management in Medicine*, vol. 12, nos.

frequent praise from international organizations for the level of healthcare provided given its low-income level. In fact, China's barefoot doctor approach was held up as the model for community based health care at the WHO's Alma Ata Conference in 1978 where the slogan 'health for all by the year 2000' was adopted. Yet in the World Health Report 2000 the WHO ranked China 188 out of 191 countries in terms of fairness in financial contribution, 144th for the overall performance of the health system, and 139th in terms of healthcare expenditure per capita in international dollars. While ranked above most African countries, it is ranked below other large developing countries such as India, Bangladesh and Indonesia. In terms of health quality achieved, it ranks somewhat better (61) but this may be because of the residual impact of the old collective medical system.⁴

This paper reviews first the nature of the impact of fiscal decentralization on local governments and how this and other reforms have affected the provision of healthcare in rural China. Then we outline the key findings from the 1994-95 survey of three rural townships in Yunnan Province to understand how the reforms have impacted on the provision and utilization of reproductive health services. Finally we conclude with a set of policy recommendations.

Financial Decentralization and the Impact on Local Governance

The reforms since 1978 have brought a progressive decline in direct state control over the economy, with powers devolved from state agencies to enterprises, a decrease in the use of mandatory planning mechanisms and a concomitant increase in the use of market forces to guide distribution and increasingly production choices. Local governments have been

4-5, pp. 270-86; and Tony Saich, 'Social Policy', in *Governance and Politics of China* (Basingstoke: Palgrave, 2001), pp. 241-71.

accorded greater control over local economic activity and the redistribution of economic rewards. However, there has been little incentive to prioritize access to healthcare. As Lu Mai has pointed out policy has not favored investment in areas such as health as the Marxist canon did not consider them a part of the productive forces.⁵

Most writers have correctly pointed to the decline in central state revenue as a primary cause of the decline in the provision of public goods and services in poor areas. However, the more important factor is the shifting balance between central and local budgetary streams and the incentive system for local officials. State revenues only amounted to 14.2 per cent of GDP in 1999, down from 36 per cent in 1978 and they had dropped as low as 11 per cent. This has severely restricted the central state's redistributive capacity and has meant that local governments have been largely left to their own devices to raise the necessary funds for development priorities. The relative decline in state revenues has created pressures at all levels and in all Chinese government agencies to meet recurrent costs from the locally generated revenues. This means that local resources and power structures determine increasingly political outcomes. Within the same province and even in adjacent counties one can see radically different socio-political outcomes deriving from the reforms.

Before the most recent fiscal reforms, only about one quarter of all state expenditures occurred at the central level and the major responsibility for financing infrastructure and providing social welfare occurred and still occurs at the local level. Much research has seen the decline of state revenue as a percentage of GDP as a clear sign of weakening state capacity. This may be true for the central state but if one adds the revenues that the local governments gather from a variety of resources, the percentage has not

⁴ *The World Health Report 2000: Report of the Director-General* (Geneva: World Health Organization, 2001), p. 152.

changed much over the last thirty years. There has not so much been a decline in the extractive capacity of the state under reforms but rather a realignment between the Center and the localities with the localities controlling far greater amounts of revenue than previously.⁶ This realignment has had a significant impact on the nature of local government in China. By 1992, the central government's share of revenue was almost 39 per cent, having declined from 51 per cent in 1980, while collection had risen to 28 per cent from 20 per cent, and expenditure had dropped from 51 per cent to 31 per cent.⁷ The 1994 fiscal reforms have redressed this situation somewhat. The ratio of the budget to GDP has been raised as well as the ratio of centrally collected revenue to total budget revenue. The share of centrally collected revenue rising from 22 per cent in 1993 to 56.5 per cent by 1997.⁸ For the first quarter of 1997, the growth of centrally collected revenue was reported to be on a par with that of locally collected revenue, thus overcoming the initial tendency of the localities only to collect for themselves. The Center's share of budgetary revenues grew from 2.8 per cent of GDP to 6.2 per cent in 1998.⁹ This is not sufficient, however, for the central state to play a major role in redistributive policy given its other financial obligations. The original objective was to provide the Center with a sufficient financial surplus so that it could cover both its own obligations and certain redistributive needs. It was estimated that the Center would

⁵ M. Lu, 'China's Urgent Challenge—To Provide Public Goods in a Market Environment', unpublished paper, 1999.

⁶ D. Yang, 'Reform and the Restructuring of Central-Local Relations', in D. S.G. Goodman and G. Segal (eds.), *China Deconstructs: Politics, Trade and Regionalism* (New York: Routledge, 1994), especially pp. 61 and 64.

⁷ L-Y. Zhang, 'Chinese Central-Provincial Fiscal Relationships, Budgetary Decline and the Impact of the 1994 Fiscal Reform: An Evaluation', *The China Quarterly*, no. 157, March 1999, p. 120.

⁸ *Ibid.*, p. 131.

⁹ J.H. Chung, 'Regional Disparities, Policy Choices and State Capacity in China', *China Perspectives*, no. 31, September-October 2000, p. 46.

need some 60 per cent of collected revenues; of which 10 per cent could be used to meet the redistributive and related goals.¹⁰ This objective of the 1994 reforms has not been met.

Thus, the localities are still dependent on their own income generation to fund activities. This comes from two main sources: extra-budgetary funds (EBF) and self-raised funds (*zichou zijin*).¹¹ Not surprisingly, it is difficult to calculate what the real value of the EBF is and one official review reported that the real amount for 1995 was probably 1.6 times that recorded in official statistics. Christine Wong has estimated that the EBF amounts to 12 per cent of GDP, compared to an official budget of 14 per cent.¹² If one adds the self-raised extra funds that by their very nature do not turn up in the statistics, the total sum of revenues available were the same in the early 1990s as at the start of the reforms; 39.5 per cent as compared with 40 per cent.¹³ This means that those observers who have suggested that there has been a major decline in the state's extractive capacity have relied on the official budgetary revenue and this has indeed declined by almost 60 per cent (but not in absolute terms as the economy has been growing at a rapid rate). What is important is the changing nature of the center-local fiscal relationship and the changing role and importance of the different funds as controlled by the Center and the localities.

This is of vital importance for understanding the incentives for the local state. One inheritance of the Soviet fiscal system has been that the local government has always provided the provision of basic public goods, with very few exceptions. Apart from nationally designated poor counties that receive transfers and those that receive such transfers from the province, localities are by and large on their own to raise funds. This

¹⁰ Our thanks to Pieter Bottelier for this information.

¹¹ For township revenue sources see X. Li, Z. Wang, and J. Tang (eds.), *Zhongguo xiangzhen zhengquan de xianzhuang yu gaige* (The Current Situation and Reform of Chinese Township and Village Regimes) (Beijing: Zhongguo shehui chubanshe, 1985), pp. 35-36.

¹² Presentation by Christine Wong at the workshop on 'Mapping the Local State in Reform-Era China', Los Angeles, 8-9 June 2000.

concern with revenue generation is exacerbated by the fact that despite fiscal decentralization the central government has retained control over the policy agenda. While the accounts of localities avoiding or deflecting central policy are many, the Center still sets many tasks that must be carried out and imposes burdens to be met.

The interest for local governments is still to concentrate on raising EBF and self-raised funds. Once a fee collected by a local government is reclassified as a tax, it is subject to revenue sharing agreements with higher level administrations. The fees are the funds that the localities can use to finance their own requirements, including their own salaries and related administrative costs. Particularly important are the management of local enterprises that can provide revenue to the local government and the use of other state assets such as land to rent out for commercial activities.¹⁴ In fact, rather than frowning on commercial activity, local governments are positively encouraged to use state assets to raise funds to cover their management and operational costs. The 1994 reforms have heightened the tendency to seek off-budget revenues, as they require local counties to hand-over 75 per cent of value added taxes but they have increased obligations.

The use of extra-budget funds and the self-raised funds has clearly been increasing. In poor and remote communities where marketization has barely begun and where the scope of economic activities will always remain limited, local treasuries have little recourse other than the elimination of services. In many poorer parts of China, rural medical health schemes have been effectively wiped out and the access to schooling has been drastically reduced.

¹³ Zhang, 'China Central-Provincial Fiscal Relationships', p. 123.

¹⁴ This tendency was increased by the decollectivization of agriculture and a return to a household based farming system that removed agriculture as a source of viable financing for local governments. See J. Oi, 'Fiscal Reform and the Economic Foundations of Local State Corporatism in China', *World Politics*, vol. 45, no. 1, October 1992, p. 115.

Increasingly, many poor regions rely on extra budgetary revenues for even the reduced services they can provide and evidence suggests that this is increasing. According to Yasheng Huang, in 1991 extra budgetary expenditures for education were around 15 per cent of budget expenditures as compared with 8 per cent in 1979.¹⁵ Guizhou Province derives fully 80 per cent of its educational funding from such sources.¹⁶ Albert Park and his colleagues calculated that in Shaanxi 86 and 89 per cent respectively of provincial consolidated revenues and expenditures were from EBF. It is precisely this kind of funding that is most vulnerable in an economic downturn.¹⁷

The Impact on Healthcare Provision

Combined with the rising income inequality,¹⁸ the financial pressures on the local state in China are accounting for the huge variation in the provision of public goods and services during the transition. As the World Bank has shown, access to health and education services was still widely available in the 1980s but became more dependent on incomes in the 1990s.¹⁹ In 1998 22.2 per cent of those in high-income areas were covered by co-operative medical facilities but only one to three per cent in poorer areas were covered.²⁰ This despite

¹⁵ Y. Huang, 'Fiscal Reforms and Political Institutions', *Problems of Post-Communism*, vol. 48, no. 1, January/February 2001.

¹⁶ Discussion with provincial vice-governor, May 1997.

¹⁷ A. Park et al, 'Distributional Consequences of Reforming Local Public Finance in China', *The China Quarterly*, no. 147, September 1996, p. 767.

¹⁸ The Gini ratio for urban-rural per capita income inequality was 0.452 in 1995, higher than for India and Pakistan and roughly the same as the Philippines. For the rural areas, the coefficient for 1995 (0.416) is at the high end for developing countries. A.R. Khan and C. Riskin 'Income and Inequality in China: Composition, Distribution and Growth of Household Income, 1988-1995', *The China Quarterly*, no. 154, June 1998, pp. 246 and 238.

¹⁹ World Bank, *Sharing Rising Incomes: Disparities in China* (Washington, DC: The World Bank, 1997), p. 23.

²⁰ Zhu Ling, 'Shei lai wei nongmin kanbing chiyao tigong shehui baozhang' [Who can Provide the Farmers with Medical Services], *Liaowang [Outlook Weekly]*, no. 16, 17 April 2000, pp. 41-43.

the intention of the Ministry of Public Health to have 70 per cent of the population in some form of cooperative health care scheme by the year 2000.²¹

Government health spending has been inadequate and the budgetary allocations are heavily biased towards the urban areas. Annual healthcare spending is only around 3.8 per cent of GDP, as against WHO recommended levels for developing countries of 5 per cent.²² In fact the state's financial commitment to rural health services has been declining as a percentage of the total medical and health expenditure from 21.5 per cent in 1978 to 12.1 per cent in 1985 to 10.5 per cent in 1991.²³ In 1998 per capita health expenditure for rural China was 193.91 *yuan* (up from 38.81 in 1990) while that for urban China was 595.27 *yuan* (up from 158.82). Rural spending was two-thirds of the national average while that for urban China was almost twice the national average.²⁴ During roughly the same period, the actual cost of care increased dramatically. In 1998 the unit cost of an outpatient visit at a county hospital was roughly four times higher than the cost in 1993. At the township level, the cost in 1998 was more than twice what it was in 1993.²⁵ Annual medical expenses per capita rose from between 2 to 3 per cent of total income around 1990 to eight to eleven per cent of income in poor areas 1998 and has continued to rise.²⁶

The effects of this are becoming readily apparent. Thus, in relatively wealthy Zhejiang province infant mortality per 1000 live births was around 20, whereas in poor Guizhou it was 60. This mirrors the findings in a study of health conditions in 30 poor

²¹ Bloom, Tang and Gu, 'Financing Rural Health Services', p. 426.

²² Ian Bland, 'Medical Services in China', *Australia New Zealand Journal of Medicine*, no. 30 2000, p. 273.

²³ Wong and Chiu, 'Healthcare Reforms', p. 274.

²⁴ Economics Research Department of the Ministry of Public Health and the Institute of Development Studies, *Zhongguo nongcun weisheng gaige yu fazhan guoji yantaohui* (International Conference on China's Rural Health Reform and Development) (Beijing, November 2000), p. 25.

²⁵ See Ministry of Public Health data on government health expenditure.

counties that found an infant mortality rate of 52.3 per 1000 live births compared to a national average for rural areas of 21.5. The rate of maternal death during childbirth was 216.8 per 100 000 as compared to a rural average of 114.9.²⁷ Both the Infant Mortality Rate and Maternal Mortality Rate are closely correlated with the use of prenatal care and attended safe delivery, two preventive services that have been adversely affected by the privatization of health care in rural China (see data below).

The focus on cost recovery has hampered poorer areas from providing good facilities and the capacity for richer areas to invest more in education, health and infrastructure means that the inequalities will increase further over time. For example, while a strong logic for the establishment of the elected villagers' committees might have been to enforce state policy, those in richer areas actually preside over quickly growing revenues. Even those in poor areas have the fees they collect and, when market price is above state price for grain the differential to expend. While villagers' committees in poorer areas might be more concerned with how to raise the revenues to cover basic welfare requirements, richer villages preside over an extensive income from local enterprises and make decisions that concern village investment in road building, hospital development etc. According to John Dearlove, in the early 1990s in Fujian, committees had revenues for public expenditure that amounted to 44 per cent of total *per capita* village income.²⁸ In Guankou village Henan, the committee presides over 13 companies ranging from building materials to processing

²⁶ W. Liu, X. Zhen, and M. Wen, 'Gender Analysis on Household Health Expenditure in Rural Areas of China', paper presented to Conference on Rural Health Reform and Development, Beijing, November 2000.

²⁷ Q. Meng and A. Hu, 'Xiaochu jiankang pinkun ying chengwei nongcun weisheng gaige yu fazhen de youxian zhanlue' (Eliminating Health Poverty Ought to be a Top Strategic Priority in Rural Health Reform and Development), in Ministry of Public Health, *International Conference*, p. 67. Liu and colleagues report similar findings with a rural infant mortality rate according to the 1990 census ranging from 29.3 to 72 and with Zhejiang having a maternal death rate of 23.74 per 100 000 and Qinghai at 215.37. Liu, Hsiao and Eggleston, 'Equity in Healthcare', p. 1351.

agricultural products to a 1000 head pig farm. This has enabled the committee to avoid illegal levies and fines and have one agricultural tax for all. In addition, funds cover all road-building costs and it was able to build a two-story 100-bed hospital. Even in the poorer nearby Fanghsan village 350 000 *yuan* had been invested for road repair and relieving farmers from forced unpaid labor.²⁹

The impact for poor rural households on health care access is particularly dramatic. With the loss of the pre-paid collective medical system with the disbanding of the communes in the early 1980s, some 90 per cent of rural households have to pay directly for almost all of the health services used.³⁰ Thus, not surprisingly, illness has a close correlation with poverty and cost of provision is a major factor influencing utilization by the poor. One 1995 survey of 60 poor families cited major medical expenses as the most important cause of poverty.³¹ A 1999 survey of poor households, found 23.28 per cent of rural households citing illness as the main reason for being poor (for urban poor the figure was 13.27 per cent), second only to insufficient labor power (25.73 per cent).³² Cost affects hospital utilization with one survey finding that 65.25 per cent of rural dwellers cited economic hardship for not staying in hospital (63.13 per cent in urban areas).³³ Bloom and his colleagues note that 45 per cent of people in moderately poor counties did not receive

²⁸ John Dearlove, 'Village Politics', in R. Benewick and P. Wingrove (eds.), *China in the 1990s* (Basingstoke: Macmillan Press, 1995), pp. 126-27.

²⁹ Interviews with village officials, June 1996.

³⁰ World Bank, *Financing Health Care: Issues and Options for China* (Washington, DC: The World Bank, 1997), p. 47.

³¹ J. Kaufman, 'Financing, Provision and Use of Reproductive Health Services in Rural China', in The Working Group on Reproductive Health and Family Planning, *The Implications of Health Sector Reform on Reproductive Health and Rights* (Washington, DC: The Population Council, 1998), p. 68.

³² Meng and Hu, 'Eliminating Health Poverty', p. 68.

³³ *Ibid.* p. 67.

hospital care when needed (only 9 per cent in rich counties) and 63 per cent of these said the reason was cost.³⁴

From 1981 health care facilities were instructed that they should cover recurrent costs, with the exception of staff, from user charges and by the mid-1980s preventive care facilities were also charging on a fee-for-service basis.³⁵ Coverage in the collective system has dropped dramatically, from almost 80 per cent in 1979 to only 2 per cent in 1987 before improving to 6.57 per cent by 1997.³⁶ Thus in terms of national health spending, while the collective schemes accounted for 20 per cent in 1978, by 1993 they only accounted for 2 per cent.³⁷ As the World Bank concluded in its 1996 report, ‘the downturn in China’s health

³⁴ Bloom, Tang, and Gu, ‘Financing Rural Health Services’, p. 430.

³⁵ H. Shanlian and M. Jiang, ‘The People’s Republic of China’, in D. H. Brooks and M. Thant (eds.) *Social Sector Issues in Transitional Economies of Asia* (Oxford: Oxford University Press, 1998), p. 192.

³⁶ See ‘Zhongguo nongcun weisheng gaige yu fazhan beijing ziliao’ (Background Materials on Rural Health Reform and Development) in Ministry of Public Health, *International Conference*, p. 21; and J. Kaufman, ‘Financing, Provision’, p. 68. However, it is debatable whether the commune-based medical system would have survived in tact. According to Du Ying, by the mid-1970s the majority of commune and brigade-run health cooperatives had already collapsed or existed in name only. He attributes the lack of sustainability to a limited capacity to raise funds, poor financial supervision, and misuse of the system. In particular, peasants were unwilling to entrust cadres to manage their funds and many officials took advantage of the system to gain priority access for their family and friends. This resulted in a moral crisis and a breakdown in trust. Thus, he sees the main cause of the collapse as lying with the structural logic of the system rather than the economic reforms and implies that collapse would have happened in any case. Du Ying, ‘Guanyu nongcun yiliao weisheng tizhi gaige de jidian kanfa’ (Some Ideas on the Reform of the Rural Medical Health System), Ministry of Public Health, *International Conference*, pp. 36-37.

³⁷ United Nations Development Programme [UNDP], *China: Human Development Report: Human Development and Poverty Alleviation 1997* (Beijing: UNDP, 1998), p. 37. Before the communes were dismantled these cooperative medical schemes relied on yearly contributions from participants, ranging from 0.5 per cent to 2 per cent of annual income, with subsidies from collective welfare funds covering about 50 percent of the medical costs. When revived one of the first experiments was in Sichuan in 1989-90 involving 26 villages in two counties. Premiums were 1.5 per cent of average income and those insured could freely visit village and township facilities but visits to the county level were only in emergency or on referral from the township. Participation rates were high: 90 per cent with a reenrolment of 95 per cent after the first year. Administrative costs were kept low at only 8 per cent of total reimbursements. The need for some kind of catastrophic insurance was clearly shown as 11.5 per cent of the covered population used 70 per cent of total health expenditures. In poor areas for such a scheme to work, it is necessary to diversify contributions away from the household and to use the village social welfare funds, if they exist, and government allocations for poverty relief. One study of 30 poor counties in the mid-1990s found that household contributions to funding cooperative health funds make up about 50 per cent, with about 20 per cent from the village funds and 16 per cent from the government. See The World Bank, *Financing Health Care: Issues and Options for China* (Washington, DC: The World Bank, 1997), pp. 49-50 and Saich, *Governance and Politics*, p. 262.

performance relative to its income level coincided with agricultural reform that reduced the ability of the village to tax the peasants'.³⁸

The basic problem of healthcare delivery derives from the change of the ownership structure of village networks and the nature of the incentive system that has arisen from these changes.³⁹ With medical facilities there has been a growth in private medical provision and a shift away from preventive medical care to fee-for-service with local governments in poor areas less able to provide adequate support. This increases the financial burden on the rural household that in the absence of sufficient state financing must provide the necessary social support. The rural healthcare apparatus has a three-tier structure. At the village level, there are some 1.44 million health workers supposedly trained in the basics of care, but often really only self trained traditional doctors or former barefoot doctors with only minimal supplemental training by township or county health institutions. For example in the Yunnan counties covered by the survey, 68 per cent of rural doctors providing reproductive health services had less than six months of one-time training.⁴⁰ Supervision by higher levels is irregular or often non-existent. Essentially, they are supposed to provide a referral system to the higher levels, but rarely do anymore as most rural citizens can not afford care at higher levels. Importantly they charge a fee for their services, unless it is a specifically subsidized service, and are allowed to prescribe medicines for which they can charge.⁴¹ At

³⁸ World Bank, *Country Report: China* (Washington, DC: The World Bank, 1996), p. 127.

³⁹ UNDP, *China*, pp. 36 and 38.

⁴⁰ J. Fang, 'Reproductive Health Service in Rural Yunnan: Needs, Finance, Resources, Problems, Approaches', paper presented at the Asia Pacific Conference on Reproductive Health, Manila, Philippines, February 2001.

⁴¹ The provision of medicines is a major source of income at all levels. Sellers of Western drugs receive a 15 per cent mark-up and 20 per cent from Chinese drugs. However, given the higher price of Western drugs there is a tendency to prescribe them. This has caused an overuse of drugs on prescription and has been a major factor contributing to the rapid increase of health costs during the 1990s. See Bloom, Tang and Gu, 'Financing Rural Health Services', p. 433. Drug costs are estimated to comprise 55 per cent of total hospital costs, much higher than in the West. Bland, 'Medical Services in China', p. 272. Importantly, the fact that doctors provide drugs to generate income has contributed to the problem of antibiotic resistance in rural China.

the township level, there are some 49 694 hospitals that carry out basic medical tasks such as simple surgery and treating infections. At the county level, there are 3687 hospitals that carry out major operations and care. Above this, the province funds the referral and specialist hospitals,⁴² but most of the recurrent funds are used to support staff salaries.

As noted, in the villages most of the health workers no longer work in a cooperative but for themselves and the number of private clinics has risen rapidly. This is also true for the urban areas, and the quality is very variable. The number of health professionals in private practice rose from 18 000 in 1981 to 172 185 in 1995.⁴³ Of 796 5234 health clinics by 1992 about 52 per cent had been sold to individuals or contracted to private practitioners on an individual or group basis. The number of village doctors dropped from 1.8 to 1.3 million between 1978 and 1993.⁴⁴ Indeed by 1999, the number of health clinics had dropped to 716 677.⁴⁵ The buildings they use are often unsanitary, staff can be poorly trained,⁴⁶ and there is little incentive to up grade facilities.

Correspondingly, direct government support has been dropping. One intent of the financial decentralization was to allow townships to increase healthcare funding. This may have been the case in wealthier areas but on average it has not been the case, especially in the poorer townships. In Donglan County, Guangxi Autonomous Region, government covered 46 per cent of the income of the county's health centers in 1981 but this had declined to

⁴² The statistics are from 'Background Materials', Ministry of Public Health, *International Conference*, p. 21-22. On the funding system see G. Bloom et al, 'Financing Health Services in poor Rural Areas: Adapting to Economic and Institutional Reform', *IDS Research Report*, no. 30 (Brighton, 1995).

⁴³ S. Hu and M. Jiang, 'The People's Republic of China', in D. H. Brooks and M. Thant (eds.), *Social Sector Issues in transitional Economies of Asia* (Oxford: Oxford University Press, 1998), p. 194.

⁴⁴ Wong and Chiu, pp. 272-73.

⁴⁵ Background materials, p. 22.

⁴⁶ A 1998 survey revealed that of medical and technical staff working at the county level only 10,6 percent had completed a basic college training with 57 per cent having completed technical middle school and some 15 percent having had no specialized training. For the township level the percentages are 1.4, 53.2, and 36.4 respectively. At the village level, the average training period received is 7.3 months (you only require three months training to prescribe drugs), with the average rising to 7.8 months in wealthier areas and dropping to 5.7 months in poor areas. Background materials, p. 22.

only 32 per cent in 1994.⁴⁷ A 1992 study of three poor counties showed that government funds supported 18 per cent of county hospital budgets and 26 per cent of those for township health centers, down from 34 and 38 per cent eleven years earlier. This means that increasingly such facilities are raising funds from fees from patients and from drug prescriptions. These made up 63 per cent of the county hospital budgets and 61 percent of the health center budgets in 1981 rising to 78 and 74 percent respectively in 1992.⁴⁸ Drug fees accounted for around 90 per cent of outpatient fees at the village level in one study conducted by Shanghai Medical University and published in the mid 1990s.⁴⁹

Before reviewing the survey data, two further institutional disincentives for providing good health care need to be mentioned. Where attention is paid to health both favor family planning activities over broader based healthcare and reproductive health. Beyond the need to derive revenue, the other major pressure on local officials is the political contract system and the performance contracts (*gangwei mubiao zerenshu*) that local governments and officials have to sign.⁵⁰ The precise nature of the contracts varies across time and place but they do set out performance expectations that provide the basis for official evaluation. Each county will set out performance contracts for the mayors and party secretaries of the townships under their jurisdiction to sign. Then contracts are signed between the towns and townships and the functional departments under their jurisdiction and then finally between the heads of these functional departments and their work personnel. Work personnel are often required to make a financial deposit when they sign their contract and this will be returned if they

⁴⁷ S. Tang and G. Bloom, 'Decentralizing Rural Health Services: A Case Study in China', *International Journal of Health Planning and Management*, vol. 15, 2000, p. 194.

⁴⁸ Bloom, Tang, and Gu, 'Financing Rural Health Services', pp. 426-27.

⁴⁹ X. Gu and H. Yu, 'The Peasant's Expenditure on Basic Medical Care in Poor Rural China', *Chinese Primary Health Care*, vol. 9, no. 8.

⁵⁰ See T. Saich, 'The Blind Man and the Elephant: Analysing the Local State in China', in L. Tomba (ed.), *On the Roots of Growth and Crisis: Capitalism, State and Society in East Asia* (Milan: Annale Feltrinelli, No. XXXVI, forthcoming).

accomplish their tasks.⁵¹ This weakens the capacity for comprehensive development by township governments and disfavors social development. The party and administrative organizations at the county level divides up the tasks and sets the targets for the organization and individuals at the lower levels and requires them to accomplish them within a prescribed period of time. There are usually one, three and five year contracts. The higher level makes its decision on political and economic rewards and penalties for organizations and individuals at the lower levels according to how well they have accomplished these tasks.⁵²

The targets are divided into a mixture of priority, hard and soft targets. The priority targets are set nation-wide and usually are more political or policy oriented in nature. They would include, for example, the maintenance of social order, most recently including the eradication of the influence of *Falun gong* practitioners, and of course meeting the targets for family planning quotas. The hard targets concern primarily economic ones set by the county for the township and would include meeting tax revenues and meeting certain levels of growth. The soft targets tend to relate to questions of social development such as health and education provision and the concern for environmental protection. Clearly meeting the hard and priority targets are the most important as failure to meet them will mean that the rest of the work for the entire period will be discounted and there will be no promotions, titles or economic rewards distributed. It is especially important to meet the targets for family planning and failure to do so will annul good performance in other areas of work. This system produces a number of perverse outcomes and explains why officials will often pursue

⁵¹ See also Maria Edin, *Market Forces and Communist Power: Local Political Institutions and Economic Development in China* (Uppsala: Uppsala University Press, 2000), Susan Whiting, *Power and Wealth in China's Rural Industry: The Political Economy of Institutional Change* (New York: Cambridge University Press, 1999); and especially Rong Jingben et al, *Cong yalixing tizhi xiang minzhu hezuo tizhi de zhuanbian* [The Transformation from a Pressurized System to a Democratic Cooperative System] (Beijing: Zhongyang bianyi chubanshe, 1998).

unpopular policies with such zeal. One survey of 89 villages in Fuquan county (Guizhou province) found that village leaders spent 80 per cent of their energy and 70 per cent of their time on 'the most disliked' administrative affairs, such as enforcing birth control.⁵³

The tendency to concentrate on family planning is exacerbated by the division of family planning services from maternal and child health care in the early 1980s. Prior to this time all reproductive health services, including family planning, were the responsibility of the Ministry of Public Health and its network of health bureau and institutions at the provincial, county, township and village levels. Subsequently a new system was set up under the Family Planning Commission with its own network of offices and personnel at the various administrative levels.⁵⁴ Since family planning is a state subsidized national program, resources for service provision are guaranteed from higher levels. The withdrawal of most family planning funds from the health system has removed a guaranteed funding stream that helped subsidize related services such as gynecological care and follow-up for contraceptive side effects and problems. The separation of family planning from maternal and child health and other women's health services has to a great extent fragmented the care that rural women receive. This has resulted in an increase of scarce resources going to family planning and a decrease in funding for maternal and child health provision. By 1990, budgetary expenditure on family planning increased to 1345 million *yuan*, over five times the amount expended on maternal and child health.⁵⁵

⁵² It is rare to use financial penalties for officials at the township level, as their salaries are considered too low. However, a failure to meet priority targets will lead to demerits on file, possible transfer and certainly to future financial gains forgone.

⁵³ X. Li, *Zhongguo chengxiang jiceng zhengquan jianshe gongzuo yanjiu* [A Study of Urban and Rural Grass-Roots Regimes] (Beijing: Zhongguo shehui chubanshe, 1994).

⁵⁴ J. Kaufman, Z. Zhang, X. Qiao, and Y. Zhang, 'The Creation of Family Planning Service Stations in China', *International Family Planning Perspectives*, vol. 18, no. 1, March 1992.

⁵⁵ See X. Zuo, 'China's Fiscal Decentralization and the Financing of Local Services in poor townships', in *IDS Bulletin*, vol. 28, no. 1, 1997, p. 90 and C. Wong, C. Heady, and W.T. Woo, *Fiscal Management and Economic Reform in the People's Republic of China* (Oxford: Oxford University Press, 1995).

The Results of the Survey

The trends outlined above are, not surprisingly reflected in the results of the survey that was conducted in 1994-95. The three rural townships are situated in Yunnan province in Southwest China. The province as a whole is relatively poor with rural per capita net income in 1998 amounting to 1387.25 *yuan*, the national average being 2161.98. Only Tibet and Guizhou have a lower average.⁵⁶ The province borders Burma, Laos and Vietnam and the mountainous terrain complicates the extension of health services to the rural poor. By the end of 1991 already 71 per cent of counties in Yunnan had shifted to a fee-for-service financing mechanism, while 28 per cent maintained a combined system under which some services were provided free while for others a fee was required.

The study was designed to look at how the macro policy changes outlined above had impacted on the delivery of reproductive health services in rural China.⁵⁷ Six major objectives were set in the survey:

- To identify reproductive health morbidity and the use of services for reproductive health problems;
- To assess the impact of fees on the use of reproductive health services;
- To identify other constraints to service utilization;

⁵⁶ National Bureau of Statistics, *Zhongguo tongji nianjian, 1999* (China Statistical Yearbook 1999) (Beijing: Zhongguo tongji chubanshe, 1999), p.339.

⁵⁷ Reproductive health services comprise a wider range of preventive and curative activities than maternal and child health. However, given the lack of equipment and trained personnel, it would be unrealistic to expect that the whole range of services would be available in a poor rural setting. As a result, a minimum set of low technology services aimed at screening for common reproductive problems of rural Chinese women are included in the definition. This comprised: the provision of contraceptive services, follow-up for contraceptive side effects, diagnosis and treatment of common reproductive tract infections (candida, trichomonas, bacterial vaginosis) and gynecological problems (prolapsed uterus and urinary fistulas), prenatal and postnatal care and delivery, and health education related to family planning, pregnancy and gynecological health.

- To assess the impact of fees on providers' time allocation and motivation to provide preventive versus curative services;
- To assess the impact of the loss of revenue to maternal and child health that accompanied the separation of family planning and health services; and
- To assess the effectiveness of certain financial mechanisms that have been instituted in several parts of China, including the maternal and child health (MCH) prepay schemes to see if they ensure coverage of preventive MCH services.

The survey used a variety of methods including household surveys of reproductive age women, interviews with providers, the collection of routine financial data and service statistics and qualitative interviews to investigate resource flows for reproductive health services, service needs and availability and user and provider constraints to optimal utilization of the services that exist. Information was collected on user needs and utilization; pregnancy and delivery; current contraceptive use; gynecological problems and check-ups; perceived needs for services; expenditures for reproductive health and other services, attitudes toward fee-for-service financing mechanisms and willingness to pay for comprehensive service packages. Qualitative interviews were also conducted with women and local service providers, including in-depth interviews and participatory rural appraisal techniques to gather information on reproductive health beliefs and behaviors and perceived barriers to service utilization.⁵⁸

The results presented here focus on three townships, two of which are in a poor county and one in a relatively better off county, albeit still extremely poor. All five enjoyed varied access to the capital city of Kunming, although it entails several hours of travel in all cases. The poorest is Ejia Township (Shuangbei County) with a per capita income of around 325

yuan per year. Dazhuang Township, also in Shuangbei, had a per capita income of 340 *yuan* while the richest township was Pubei (Yimen County) with an annual per capita income of around 905 *yuan*. Another factor contributing to their poverty is the distance from the county town, where the county hospital and reasonable medical care is to be found. Ejia is 176 kilometers from the nearest town, while Dazhuang is 31 kilometers and Pubei is only eight kilometers away.

The survey confirmed the expected distortion in provision of services with family planning privileged over maternal and child healthcare [see Table 1]. Family planning costs per married woman of reproductive age in Dazhuang increased from 13.74 to 32.28 *yuan* and in Ejia from 10.00 to 22.22 *yuan*. By contrast, the MCH costs declined in Dazhuang from 1.74 to 1.05 *yuan* and from 1.59 *yuan* to 0.66 *yuan* in Ejia. When the data are broken down by county and use, the huge decrease in the spending on MCH compared with family planning is even more obvious. The budget allocation data show that when held to 1985 levels, there has been a decrease in the amount of funds allocated for MCH from the government's health budget. This decrease was 6.6 per cent in Yimen (Pubei Township) and 1.2 per cent in Shuangbei (Ejia and Dazhuang) from 1990 to 1995 [see Table 2]. Family planning funds were increased by 1.6 per cent in Yimen and 8.9 per cent in Shuangbei over the same period. While the financial resources are greater for the family planning system, the greater burden of care falls on MCH workers. In addition, the client burden of cost for MCH is substantial when compared with income. The government MCH resources are too limited at the township and village level, where the need is immense, and too great at the county level, where there is less need. Subsidies are being used to finance county-level MCH salaries, which are disproportionately high. The subsidies for township and village-level MCH

⁵⁸ J. Kaufman, K. Zhang, and J. Fang, 'Reproductive Health Financing, Service Availability and Needs in

workers are very low, creating incentives for providers to concentrate on curative care rather than on preventive care and education. In the Yunnan survey at the county MCH hospital, government budget accounted for between 37 and 45 percent of total revenue with more than 70 per cent of it going to salaries for county level MCH center doctors who serve mainly county center residents. In Shuangbai county the annual county budget for MCH remained the same from 1983 to 1985: 8000 *yuan*. Of this only 3000 *yuan* was used for the MCH system salary subsidies, an inadequate amount to fund MCH preventive work at the community level. There are also distortions in the family planning system. The contraceptive services are oriented toward ‘acceptors’, with very little counseling and follow-up aimed at improving client satisfaction. Therefore, while contraceptive services are provided for free, follow-up has to be paid for by the client.

This structure and the associated incentives are having a significant effect on the percentage of costs that are being generated from client fees. We have seen above how the system has generated incentives to move to fee-for-service. Government contribution to health facilities can be as low as 10 to 15 per cent, a marked contrast to other low to middle income countries where government funds make up as much as 80 per cent of support.⁵⁹ In a study of three poor counties, Gu found that in 1992 client fees accounted for over 75 per cent of revenue of county hospitals and township health centers up from 50 per cent in 1981.⁶⁰

The survey did not discover such high percentages but it is clear that the percentages have risen rapidly [see **Table 3**]. They are also, not surprisingly, much higher for MCH than

Rural China’, *IDS Bulletin*, vol. 28, no. 1, 1997, p. 63.

⁵⁹ G. Bloom and S. Tang, ‘Rural Health Prepayment Schemes in China: Towards a More Active Role for Government’, *Social Science and Medicine*, vol. 48, 1999, p. 954. On this more general issue see A. Creese and J. Kutzin, ‘Lessons from Cost Recovery in Health’, in C. Colclough (ed.), *Marketizing Education and Health in Developing Countries* (Oxford: Clarendon Press, 1997), pp. 37-62.

for family planning. In Dazhuang the percentage of costs derived from client fees for family planning rose from 12.5 per cent to 25.15 per cent, while in Ejia it rose from 9.61 per cent to 21.96 per cent. The corresponding figures for MCH are in Dazhuang a rise from 37.84 per cent to 54.57 percent and in Ejia from 31.88 per cent to 51.31 per cent. Thus, while around one-quarter of costs in family planning are derived from client fees, over one half are now derived for MCH activities.

These financial changes are impacting on the use of the services that are available. The survey was also designed to answer this by interviewing women about their reproductive morbidities in order to learn whether the services available to them were appropriate to their needs. Based on the interviews a list was developed of specific morbidity-related symptoms associated with common problems of five reproductive periods (pregnancy, delivery, postpartum period, post IUD insertion, and post abortion). These included problems such as excess bleeding, swelling or headache during pregnancy (signs of hypertension of pregnancy), vulval itch or abdominal discharge (signs of reproductive tract infection), backache within the last six months, ruptured uterus, and vaginal tearing or prolonged labor during delivery. Women were also asked if they had observed any gynecological symptoms in the last six months. This is included as a sixth category for which data were collected. These common symptoms do not always represent a genuine medical problem but they do require assessment by a doctor to rule out potential serious medical conditions.

Figures 1 and 2 show a striking gap between women's self-reporting of a symptom and the likelihood that they would seek help. In Ejia, the poorest township, 55-60 per cent of women reported at least one symptom during pregnancy, delivery, or the postpartum period, 80 per cent reported at least one gynecological symptom suggestive of reproductive tract

⁶⁰ G. Bloom and X. Gu, "Health Sector Reform: Lessons from China", *Social Science and Medicine*, vol.

infections (RTIs) during the past six months and 90-95 per cent of women reported a contraceptive problem. As many as 45 per cent of women in Ejia township experienced vaginal tearing during delivery and RTIs caused the greatest morbidity. By contrast the use of reproductive health services was extremely low. In particular, there were low rates of attended delivery (only 22 per cent had a 'safe delivery'), few repairs of vaginal tears (nine per cent), and a poor level of seeking service for problems related to pregnancy or contraception and for symptoms of RTIs. Only 26 per cent of women sought care for self-reported symptoms during pregnancy, delivery or post-partum period, 17.5 per cent for gynecological symptoms, and only 25-31 per cent for problems following IUD insertion or abortion. Interestingly, Pubei the richest township had no better care seeking for after IUD insertion or abortion, even though the rates are considerably higher in all other categories, reaching over 50 per cent for help during the period of pregnancy and during delivery.

The data show that in the poorest township, Ejia, only five per cent of women had an in-hospital delivery [see **Table 4**]. The rate for delivery in hospital for Pubei was 42.55 per cent and 61.64 per cent had a modern delivery. This is not only related to proximity to a facility but also to cost and perception about the poor quality of service provision. In Ejia, a delivery in a township hospital costs approximately 200 *yuan*, an amount that is beyond the financial capability of the vast majority of families in poor areas. In addition, the inadequate financing of the system means that women perceive the quality of service to be poor and that local practitioners are poorly trained. They are almost certainly correct in these assumptions.

Certainly, the lack of financing means that health education has suffered in these townships, as there is no subsidy available to health workers to cover their time. This causes

them to concentrate on revenue generating aspects of their job. This is reflected in the reasons given by women for not seeking any prenatal care [see **Table 5**]. In Ejia, almost 75 per cent of the women responded that they did not seek care either because they did not think it necessary or because they did not think that it was serious. The percentages are similar for Dazhuang (77.5 per cent) and Pubei (72.7 per cent).

The newly established MCH insurance schemes did little to improve the utilization of prenatal care and attended delivery. A review of this system in Yimen County revealed that many women who had contributed to the scheme did not realize that they were entitled to prenatal services. In addition, in some cases the scheme requires that women utilize the services at the county level, which often requires substantial amounts of travel for rural women. Under these circumstances, the funding has become a way to support salaries at the county MCH hospital that has lost its guaranteed funding under the financial reforms. However, this use to provide salary support has come at the cost of locating the services conveniently for the rural poor, even those these women are willing to pre-pay for with the MCH insurance. Where the pre-pay scheme is located at the township level, township MCH providers whose salaries are paid by the MCH prepay schemes more actively provide prenatal and postnatal care in their nearby communities in order to meet provincial MCH targets, rather than provided badly needed outreach to more remote rural villages. Last but not least, the Yimen scheme does not provide coverage for delivery. Reluctant to pay, families frequently chose to deliver at home, especially for second births that are thought to be easier. It is noticeable that the rate for Pubei, the richest township and closest to a county town has a much higher rate of delivery at hospital than the poorer townships.

Concluding Comments

The changes in the financial sector and their impact on rural healthcare have had a detrimental effect on the provision and utilization of reproductive health services for the poor. The major reproductive health problems center around childbirth, use of contraception and chronic reproductive infections. The need to focus on curative care to derive income and cover salary, the lack of funds and provider incentives for health education activities, and the shortage of female doctors contribute to very poor utilization by women for the services that do exist. Moreover, service availability does not adequately match need. Child delivery is not covered by pre-payment schemes and family planning services are too oriented toward the promotion of contraceptive use and they do not pay enough attention to the follow-up of problems from use in many poor rural areas. Last but not least the screening and treatment for RTIs is virtually non-existent. This takes on greater import with the spread of HIV/AIDs. Chinese official figures significantly underestimate the spread not only because of local official reluctance to report cases but also because of the lack of diagnostic capacity and incentive for local officials. With infection spreading from IV drug users and sex workers to the public at large, including through contaminated blood supplies, the cost of care will overwhelm the financial capacity of local governments leaving the central state with a major dilemma of how to step in.

The Central government has now recognized that its health system is in significant distress, especially in the rural areas. The change in tone at the December 1996 National Conference on Health was remarkable as the leadership shifted from presenting its system as a shining example to other developing countries to one of concern about its collapse.⁶¹ This

⁶¹ Discussions with participants. See also C.Cailliez, 'The Collapse of the Rural Health System', *China Perspectives*, no. 18, July-August, 1998, pp. 42-43. For the joint Central Committee and State Council Decision, see *Health Daily*, 18 February 1997.

Conference led to the January 1997 legislation issued by the State Council and the Chinese Communist Party Central Committee, 'Decisions on Health Reform and Development: Focus on Rural Health and Prevention'. However, its proposals alone will not remedy the situation. The Conference called for spending in the national budget to be raised from two to five per cent, something that has not been achieved. It is unlikely to be raised given both the fact that the central leadership does not consider health to be a productive force and that it does not seem aware of the relationship between good health and economic development.⁶² In addition the Ministry of Public Health is a weak player institutionally and does not have the power to keep health care at the top of the political agenda. It may only be once the full impact of the economic cost of an AIDs pandemic becomes clear that the leadership will be forced to shift more resources to this sector. Most recently, the State Family Planning Commission has begun to address the widespread problem of untreated reproductive tract infections as part of routine family planning services and has included this as part of its plans for delivering comprehensive reproductive health services during the next five-year plan.⁶³

In a very traditional approach the leadership has sought to revive preventive healthcare and public hygiene awareness through education. The proportion of the government's budget for spending on preventive care dropped from 23 per cent in 1978 to 18 per cent in 1994.⁶⁴ However, as we have seen above without a shift in incentives this is unlikely to be effective. Nor will the declared pay boost for village doctors help. This was intended to bring them into line with government officials and to stop the reliance on kick-

⁶² In this respect, it is interesting to note that in the Center's ambitious plans to develop the poorer Western provinces little attention is paid to investing in health.

⁶³ National Conference on Comprehensive Reproductive Health Services, State Family Planning Commission and WHO, Beijing, June 2001.

⁶⁴ S. Hu and M. Jiang, 'The People's Republic of China', p. 192.

backs and other non-sanctioned revenues. The problem is that in poor areas the local government does not have the funds available to cover such a pay increase and it also has to contend with Premier Zhu Rongji's instruction to increase all local government officials' salaries. At the same time, local governments are not meant to levy more than five per cent of the annual income on the farmers under their jurisdiction. This is honored more in the breach than the observance but it does constrain the financial base of the local authorities. Given the reality, village doctors in poor communities will remain on their own to raise income. The government has also committed itself to supporting the revival of the cooperative medical system but as noted above this has been slow in expanding and cannot be counted on any time soon.

There a number of things that could be done to improve the lot of the poor regions but without a strong constituency of support at the political center it will be very difficult. The tension between resource spending for urban over rural health has strong historical roots and one of the underlying criticisms of Mao Zedong that launched the Cultural Revolution was of the urban bias of the health system. The most beneficial change would be to abandon the urban bias of development policy that has been a hallmark of Chinese Communist Party (CCP) rule since 1949. This will not happen given the strong vested interests of the CCP and the marginality of rural constituents in the policy process. However, if the CCP could clear up the state owned enterprise sector, a prime destroyer of state assets, this could have enormous beneficial effects for rural China if part of the current subsidies were diverted to productive investment in the countryside.

More possible measures would be to integrate the family planning network with the health system at the local level. This would have the effect of restoring funding to the impoverished MCH system. This revived funding stream could help subsidize related service

such as gynecological care and follow-up for contraceptive side effects and problems. This topic has been the subject of much discussion and debate in recent years, was hotly debated at the recent conference on Health Reform and Development, and has been identified as one for further immediate policy analysis and discussion through the newly launched China Health Development Forum.⁶⁵ China has been moving in the opposite direction to most of the world that has sought to integrate better health services. However, China's engagement in international health discussions and its acceptance of the international reproductive health agenda has caused some to realize that this fragmentation may not be beneficial.

Finally, rural reproductive healthcare provision appears to be a clear case where the 'public goods' argument applies. The central government needs to tighten the regulatory framework to ensure that guidelines on health are followed and that in poor areas better provision needs to be provided at central government expense. The Central government would be well served to be the provider and supporter of public health, ensuring more equitable access, rather than focusing its efforts on subsidizing the salaries of those in the health system.

⁶⁵ See China Health Development Forum, Beijing, November 2000.

Table 1

Family Planning and MCH Costs per MWRA in Dazhuang and Ejia Townships, 1985-95 (cost in rmb, deflated to 1985 levels)

<u>Year</u>	<u>Dazhuang</u>		<u>Ejia</u>	
	<u>FP costs</u>	<u>MCH Costs</u>	<u>FP Costs</u>	<u>MCH Costs</u>
1985	13.74	1.74	10.00	1.59
1987	14.19	1.77	22.30	1.27
1989	15.09	1.11	12.03	.84
1991	26.58	1.48	20.88	1.07
1993	31.25	1.02	22.25	.82
1995	32.28	1.05	22.22	.66

Table 2:

Costs of Reproductive Health Services in Surveyed Counties (1000 yuan)

	<u>Yimen</u>	<u>Shuangbei</u>
Government RHS Budget		
1990	841	650
1995	1288	1568
Annual Increase, %	8.9	19.3
After deflation, %	-2.0	7.3
Government RHS Budget for MCH		
1990	406	118
1995	490	188
Annual Increase, %	3.9	9.8
After Deflation, %	-6.6	-1.2
Government RHS Budget for FP		
1990	435	532
1995	798	1380
Annual Increase, %	12.9	21
After Deflation, %	1.6	8.9

Table 3

Percentage of FP and MCH costs generated from client fees in Dazhuang and Ejia Townships, 1985-95 (in rmb, deflated by overall consumer price index)

<u>Year</u>	Dazhuang		Ejia	
	<u>FP</u>	<u>MCH</u>	<u>FP</u>	<u>MCH</u>
1985	12.56	37.84	9.61	31.88
1987	13.77	43.33	28.27	32.52
1989	20.86	44.19	16.98	41.09
1991	25.76	53.81	19.71	51.76
1993	26.22	59.18	24.10	50.47
1995	25.15	54.57	21.96	
51.31				

Table 4:

Service utilization during delivery, 1988-1995

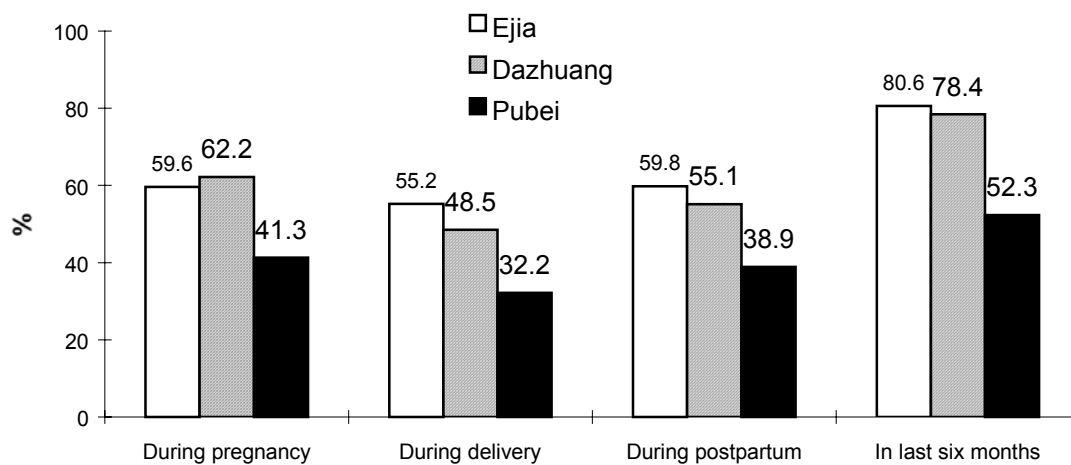
	Ejia		Dazhuang		Pubei		X²	p
	number	%	Number	%	number	%		
Delivery in hospital	28	5.14	56	13.24	234	42.55	252.36	<0.01
Modern delivery*	92	16.88	100	23.64	339	61.64	381.15	<0.01

*Modern delivery: woman is lying down for delivery and the hands of birth attendant, tools, vulva of woman and umbilical cord are sterilized.

Table 5
Reasons Women Gave For Not Having Any Prenatal Care

	Ejia		Dazhuang		Pubei	
	#	%	#	%	#	%
Didn't think it necessary	148	48.84	49	67.61	29	63.64
Didn't know should have	81	26.07	7	9.86	4	9.09
Far away	16	5.28	6	8.45	4	9.09
Too busy	17	5.61	8	11.27	7	15.91
Too expensive	5	1.98	0	0.00	0	0.00
Shy	21	6.93	2	1.41	0	0.00
Others	16	5.28	2	1.41	1	2.27

**Women's Self-Reported Symptoms by Reproductive
Period
(Reported at least one symptom)**



Women Seeking Care For Symptoms, By Reproductive Period

