Health Care in Rural China

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General Information

- Population: 1,295,000,000 (2002 National Census)
- Health Expenditure of GDP: 3.7%, less 4%
- Maternal Mortality Rate (MMR): 43.8/100,000 Live Birth
- Infant Mortality Rate (IMR): 28.7/1000 Live Birth
- Hospital Delivery of Birth: 73% (urban: over 99%, rural: less 60%)
The Distribution of Maternal Mortality in China, 2002 (1/100,000)
Health Administration System

- Central Government:
  - Ministry of Health
  - Food & Drug Administration
  - Traditional Medicine Agency

- Health Bureau in each level
  - Provinces
  - Cities
  - Counties
Health Service System in Rural Area

- **County**: Hospital, Center of Disease Control, MCH Hospital, Chinese Medicine Hospital

- **Township**: Township Health Center (integrated county health facilities)

- **Village**: Clinics hosted by barefoot doctors (More than 60% belong to private and others supported by the local government or collective income)
Before 1980’s, all of the health facilities in rural areas are public property

- Three-tier health network: county, township, village
- Cooperative Health System
- Barefoot doctor – village doctor, including traditional doctor worked in villages
After 1980’s:

- With the transition from planned-based to market-based economy developing, the rural health system lacks support and is incompatible with the marketing economy.

- Health facilities in poor settings could only get very limited fund due to the serious financial resources shortage of local governments, and the limited fund is entirely used to cover the wages of the staff.
Coverage rate of cooperative health system in rural is reducing gradually, less 10% (from 90%, in 1980)

90% farmers get fee-for-service for theirs health. Large numbers become poor or fall back into poverty because of illness.
Lacking of Finance Resource Lead to the Following Consequences.

- Hard to expand service scope
- Lack of training opportunity to update providers’ knowledge and skills
- Weaken the supervision and technical guidance from upper level health institutions to lower level ones
- Curative – biased service provision
Privatization of health service occurred in grass root

- Many village doctors who used to be the barefoot doctors of the CMS became private doctor in village due to the collapse of collective support in most rural areas.
Some rural public health facilities, mainly refer to township health centers, have not been renewed due to the fund burden.

Large number of private drug stores and shops occurred in rural areas, even the poor areas, due to the rapidly growth of pharmaceutical industry.
By the year 2003, Strengthening and reform for rural health reform decision issued by the central government:

Key points of the decision:

1. Recovering new CMS and initial pilot counties

Funding Resources:

- 1/3 from farmer and family
- 1/3 from local government
- 1/3 from central government
2. Decentralization of the fiscal and management responsibilities of rural health facilities

- Local governments have been assigned the responsibility of financing local public health facilities.
- The management and supervision responsibility of local health facilities has been shift to local governments.
3. Village doctor regulation issued

- set up registration procedure
- strengthening training
- old village doctor will be replaced by professional physician, eliminated generally.
- clarified the duty of village doctor: basic medical service, preventive, health information collection and report, health education to folks, infectious disease report, etc.
4. Developing primary health care program in rural China (2001-2010)

- Building comprehensive disease control mechanism;
- Focused on the maternal and children health;
- Sanitation and safe water;
- Supervision and monitoring;
- Developing traditional medicine;
- Developing new cooperative health system;
5. Reform and strengthening rural health facilities

- Improving the quality of health facilities network;
- Limited the scope of township health centers;
- Electing the director of THC;
- Integrated the service between township and village;
- Changing service model: curative to comprehensive, focusing on preventive service
- Technology support from urban hospital;
6. Training health staff in THC and village clinic

- Encourage medical professionals to go to rural areas, with higher salary standards than those working in urban areas;
- THC directors are appointed and trained by the county health bureau;
- Extend existing medical courses and develop traditional medicine courses in secondary health schools;
- Encourage health workers in THC and village doctors to take continuing education.
Action in 2004

- Strengthening government role in health issues of poor rural areas.
- Collaborating among government components to implementation policy formulation.
- Central government have allocated the fund to west provinces for rural health and required matching fund by local government.
- Development of an feasible and practical rural health sector strategies actively that address basic health service and public health service to reduce difference between urban and rural.
Thank You!