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Local governance, health financing, and changing patterns of inequality in access to health care

Jane Duckett
University of Glasgow

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Introduction

This paper examines how changing systems and practices of local governance and health financing in China have influenced patterns of inequality in access to health services.[1] These patterns of inequality are important because they can be closely connected to the patterns of income inequality discussed in other papers in this volume, as well as to experiences of poverty and social inequality, and to health inequalities.[2] First, for example, in health financing systems like China's today, where health insurance participation is low and most people have to pay directly for health services, patterns of inequality in access map onto patterns of income inequality. In turn, people—particularly those with low incomes—who do not have health insurance are vulnerable to impoverishment due to ill health, so that inequalities in access may contribute to rising poverty and income inequalities. Second, where access to care is dependent on ability to pay, those on low incomes may be unable to afford the medical treatment they need, meaning that in China as elsewhere 'unequal legitimate claims upon a health system, and unequal experiences of seeking care are important elements of poverty and inequality in people's experience' (Mackintosh 2001: 175). Third, inequalities in access to health services can interact with factors such as age, socio-economic differences or diet to contribute to increasing or reducing health inequalities (Peter and Evans 2001).

The paper is divided into four main sections. Section 1 looks at institutions of local governance and their relationship with the provision and financing of health, and particular patterns of inequality in access to health services in the late 1970s, while Section 2 examines how changing institutions of governance and health financing produced substantially re-shaped patterns of inequality in the 1980s-1990s. Section 3 considers how reforms since the

[1] Financial access relates to how financing arrangements affect ability to utilise health services. Physical access relates to how location or proximity of health service providers may affect utilisation. This paper concentrates on financial access, but its discussion of local differences in health service provision helps understand changing patterns of physical access.

[2] Health inequalities are inequalities in health status as evidenced by for example differential life expectancy or experience of ill health.

late 1990s are affecting the patterns of inequality that emerged that decade. The concluding section discusses how evolving patterns of unequal access to health services relate to income, social and health inequalities in China, and what changes in wider systems of governance and public finance would be needed to provide health services and medical treatment more equally.

The paper argues that in the late Mao era systems of health financing (state budgetary investment, co-operative medical systems in rural areas, and employer-financed health insurance in the cities) were tied closely to systems and practices of local governance (notably state planning, rural communes, and the urban work unit) and produced patterns of inequality characterised by a rural-urban divide, with the main differences in the countryside between localities and in the cities between work units. Since the late 1970s, rural-urban differential access has increased and neither health financing nor governance reforms have significantly challenged this divide. In the countryside, changes to systems and practices of local rural governance, notably the end of the commune system and fiscal decentralisation, led to changes in health financing and re-patterned inequality in financial access to health care so that interpersonal inequalities now overlie inter-local ones. In the context of continued fiscal decentralisation, attempts to re-establish cooperative systems of health financing (CMS) since the late 1980s have had limited success in most parts of the country, although, there has perhaps been more progress in wealthier rural areas. Unless fundamental financing and governance problems are tackled, progress with this reform and rural medical finance assistance (MFA) will be slow and both interpersonal and location-based inequalities in access are unlikely to be fundamentally challenged in the near future.

In urban China, some changes in health financing (such as allowing health service providers to earn income from sales of medicine) preceded and contributed to changes in governance institutions (especially the erosion of the work unit system) in the 1980s and 1990s by pushing up health costs for both government and enterprise work units. As work units reneged on health insurance payments, made workers redundant, and went bankrupt, growing numbers of urban dwellers had to pay directly for their own medical treatment. This transformed patterns of inequality in access to health care from mainly employment-based ones determined by work unit to interpersonal (or household) ones based on ability to pay. Compulsory basic social health insurance (BSHI) introduced across urban China since the late 1990s involves risk-pooling at the city level and so reduces some of the interpersonal inequalities in financial access among those who participate. A shift to a location-based differentials in access is now emerging, though the differences between cities are limited by a national framework of provision. BSHI also involves an important change in systems and

practices of local governance because along with urban MFA for the poorest, it has shifted responsibility for provision from employers to the local government. However, some continuities in wider governance practices mean that many working in the private sector, or informally in the state sector, as well as the non-working population, are excluded, leaving them and their families vulnerable to impoverishment due to illness. Although MFA is now being extended, it is not yet adequately financed and administered and so remains an unreliable safety net for the poor. The paper concludes that contemporary patterns of inequality in access can be tackled by reforms of financing systems as well improvements in local government capacity in the health sector.

Late Mao local governance, financing, and inter-local and inter-work unit patterns of inequality in access to health care

By the late 1970s, health service provision and financing in China was linked to wider systems and practices of governance in at least two important ways. First, the organisation of health services was mapped onto structures of local government administration, economic production, and social control. Health services were organised and administered by local government health departments and the key organisations of rural and urban governance, the commune and the work unit. Second, health was financed through a combination of local government budgetary investment, rural collective funds, and urban employers, in line with the wider planning and fiscal practices of the command economy. In both cities and countryside local governments allocated parts of their budgets to capital investment, preventive public health programmes, and the running costs of hospitals, including salaries. This helped extend health services across China from the 1950s, improving the availability of at least basic services. A World Bank study has noted that by 1975 ‘almost all the urban population and 85 per cent of the rural’ had insurance or CMS, and this provided people with ‘access to cost-effective preventive and curative health services and some sharing of the risks of medically caused financial misfortune’ (World Bank 1997: 2). The system is generally credited with contributing to significant gains in health and life expectancy (World Bank 1992).

Rural governance, health financing and inter-local patterns of inequality

In the countryside, a three-tier system of counties, communes, and production brigades administered and delivered health services and programmes (World Bank 1983). There were hospitals at county level, communes would have a health centre that provided referral services and supervised preventive work, and many villages (or production brigades) had a health station staffed by ‘barefoot doctors’ (Bloom and Gu 1997b). Commune health centres were

administered by the local commune management committee and party committee. They were supervised and supported technologically by the county level general hospital, maternal and child health hospital, and anti-epidemic station. These three county health care institutions were in turn administered by the county health bureau. This brought a network of health services to many rural areas that had not had them before.

During the late 1960s and 1970s, within governance structures shaped by the commune system some form of CMS was established in most villages.[3] As some authors have noted, this system of health financing 'was an integrated part of the overall system of collective agriculture production and social services' (Liu et al. 1999: 1354). Although CMS schemes were sometimes subsidised by government budgets, especially for vaccines and contraceptives, health campaign materials, and training of local medical personnel[4], they were mainly funded by households, brigades and commune welfare funds so that in effect rural communities financed most of their own health services, especially curative care (Huang 1988; Kan 1990:42).

In terms of the three-tier system of health service providers, this meant that there was more state financing for county and sometimes commune level, but little for the level below that. County level service providers were funded entirely from the state budget, while commune health centres, often small hospitals, were funded from a combination of 'contributions from the commune welfare fund, transfers of funds from the co-operative medical funds of the brigades under its jurisdiction, cost-sharing with users, and subsidies from the county and provincial government' (World Bank 1983: 49).[5] Brigade medical stations were financed co-operatively by premiums from members of the production brigade and contributions from the brigade's welfare fund, as well a user fees, income from sales of medicinal herbs, and 'various subsidies from the commune, county, province and state' (World Bank 1983: 49).

As a result of tying health service provision to a penetrative government administrative system, physical access to health services were improved for many rural dwellers in the late Mao era. However, for people living in mountainous areas or those without good transport

[3] The first CMS-type schemes were introduced experimentally from 1955 in Henan and Shanxi. They were established more widely from the late 1960s. By the mid-1970s more than 90% of brigades are thought to have had such a scheme (Feng et al. 1995; Kan 1990).

[4] There was also effectively government subsidy for western drugs because their prices were set artificially low (World Bank 1983).

[5] There was, however, great variety in the detail of local funding arrangements. For example, higher levels might fund all the salaries of the commune hospital, or only some of them.

connections, the nearest hospital could be beyond easy reach. Inequality in financial access to health services was also patterned primarily on an inter-local basis. While risk-pooling at brigade level ensured that its members probably had relatively equal access to basic outpatient medical treatment, the quality and range of treatments available were dependent on the amount of money raised by members of the production brigade and the amount that the brigade, commune and county were able and willing to subsidise the co-operative funds. 'The more affluent communities can afford to subsidize health care costs, invest more to increase the quantity and raise the quality of their health personnel, and enjoy easier access to better health care, relative to the less affluent communities', whereas 'some of the poorest brigades and teams hav[e] reportedly cut back their provision of services in recent years' (World Bank 1983: 50, 9).

Urban governance, health financing and work unit-based patterns of inequality

Urban health services were provided through hospitals and clinics beneath the Ministry of Health and its municipal and district health bureaux, and separately though the military, some large state enterprises, and public institutions such as universities, which often had their own clinics and hospitals that provided health services direct to their personnel and dependants (World Bank 1983). Within the Ministry of Health system, there were in addition to municipal and district hospitals, small neighbourhood hospitals or health 'stations', which were relatively autonomous during the Cultural Revolution. Finally, there were health stations organised around resident committee organisations and staffed by supervised paramedics called 'red medical workers' who assisted with neighbourhood preventive work and offered some very simple diagnostic and curative services (Sidel and Sidel 1982). Local governments (cities and districts) funded Ministry of Health system hospitals while military and work unit hospitals were funded through budgets for their own systems (*xitong*), all within the wider planning and budgetary arrangements of the command economy.

In addition to municipal and district government financing of health service provision within state plans, from the 1950s many urban dwellers' medical expenses, paid for by employers, or 'work units' (*danwei*), formed another important source of investment. Work units were state or collective sector employers that provided for urban workers and delivered urban public goods, while at the same time were a mechanism for their control and a cornerstone of structures and practices of urban governance (Lü and Perry 1997). There were two programmes of work unit-financed medical care: one for workers in enterprises (mainly state and collective enterprises) under 'labour insurance' (*laodong baoxian*, hereafter LI) and one for government and public sector employees (such as officials, teachers, doctors, students) under 'publicly-financed health insurance' (*gongfei yiliao baoxian*, hereafter PHI). LI was

financed by enterprises, though of course within the planning system, so that expenditures on employees' medical treatment were factored into enterprise plans under soft budget constraints. PHI was financed directly from the budgets of the relevant level of government, so that for example central government financed the payments of public sector institutions at the centre. Neither LI nor PHI involved individual employees making contributions or significant co-payments[6], and patients usually received treatment free at the point of delivery, paying only a nominal registration fee on arrival at a clinic or hospital (Yin 1997). Additionally, enterprise work units paid half the medical expenses of their employees' dependants.

Patterns of financial inequality in access to urban health services in the late 1970s were thus based mainly on employer and employment status, and tied to the fundamental institution of urban governance, the work unit. The generosity of health insurance varied, and was influenced by a work unit's administrative level as well as individual factors such as an employee's rank, contract type, or political label.[7] Thus those with access to the best curative services free at the point of delivery were central government officials and workers in central government-level state enterprises, while local officials and workers in small urban government collectives received less generous assistance.[8] And provision was better for employees with high rank and/or permanent posts than for lower-ranking officials, workers with temporary contracts and rural migrants to the cities, while political 'rightists' were deprived altogether of any entitlements.[9]

Overlapping and intersecting patterns of inequality

As well as the intra-rural and intra-urban inequalities in access to health care discussed above, there were also in the late Mao era significant inequalities in access between urban and rural areas. Cities received a greater share of government investment in health, resulting in more hospital beds and doctors per head of population and meaning better *physical* access for urban dwellers (World Bank 1983). In 1975, for example, there were 4.6 hospital beds per thousand people in the cities, but only 1.2 per thousand in rural counties, and 2.7 doctors per thousand in the cities but only 0.7 per thousand in the countryside (Ministry of Health 2000: 426). Both

[6] Co-payments refer to direct out of pocket payments by patients alongside those made by the insurer.

[7] Negative political labels (such as 'rightist' or 'capitalist roader') assigned to individuals in the leftist Mao era were often accompanied by sanctions and persecution ranging from social exclusion through withdrawal of entitlements to imprisonment.

[8] On how state enterprise employees get 'more extensive benefits', including health care, in terms of both quantity and quality, than collective sector employees, see Whyte and Parish (1984), and Davis (1988).

[9] See Duckett (2004), drawing for this information on Dixon (1981).

this and rural-urban inequalities in *financial* access to health services were due to high levels of funding for LI and PHI by enterprises and the state, while in rural areas CMS was self-funded and much less generous. In terms of health expenditures, in 1980, 34 per cent of health spending was on urban PHI and LI alone, when China's urban population was only 19 per cent of the total (Hossain 1997; State Statistical Bureau of China 1992). In addition, central and local government budgetary spending on health (excluding PHI and LI), which was about 25 per cent of total health spending, will have been disproportionately targeted at urban areas (Hossain 1997). Studies in the early 1980s showed that total urban per capita expenditure on health was three times that in rural areas (Liu et al. 1995).

Overlapping patterns of inequality in access between and within countryside and city arising from unequal government budgetary spending and differences in local and work unit resource endowments will also have contributed to other still poorly-understood intersecting patterns of inequality caused by factors such as age and gender discrimination in employment. For example, because higher ranking (often heavy industrial) work units tended to employ men, while less well-resourced urban local government collectives tended to employ women, women were less likely to be directly entitled to better quality health care.[10] Indeed, access to health care for many women (as well as children) will have been through their status as dependants of male workers. And the fact that enterprises usually paid for only half the medical costs of dependants can be expected to have had real effects on their abilities to seek treatment.[11]

Local governance and health finance in the era of market reform: growing individual inequalities in access to health care

As is well-known, key features of the late Mao systems and practices of local governance underpinning health service provision and finance were transformed with the turn to market-led economic growth in the 1980s. The system of rural governance based on the communes was dismantled as townships replaced the communes and agricultural production was devolved to rural households. Urban governance practices centred on the work unit eroded over this period as state and collective enterprises were encouraged to become more efficient

[10] Bauer et al. (1992) report that a survey in 1987 found that women were only a third of employees in state enterprises, but almost half of those in urban collective enterprises. They also found men to be more concentrated in higher-paying industrial sectors and to be a large proportion of employees in government and party organisations.

[11] See for example Östlin et al. (2001) on how a range of intra-household and other factors can limit women's access to health services.

and competitive while growing numbers of urban dwellers worked in the private sector.[12] Underpinning all this was the introduction of market mechanisms to replace planning ones in the allocation of goods and resources, and fiscal decentralisation that increased local government autonomy and reduced the state's redistributive capacity (Naughton 1996; Park et al. 1996).

These transformations in wider systems and practices of governance had direct and dramatic effects on the provision and financing of health services. Dismantling rural communes led to a collapse in CMS, while market competition meant that poorly performing enterprise work units were no longer able to afford generous health provision for their workers. At the same time, fiscal decentralisation caused budgetary investment in health services to become less redistributive so that many hospitals were short of finance and increasingly reliant on generating their own income. The decentralisation of government responsibilities for hospitals that accompanied fiscal decentralisation has also contributed to problems regulating them. These changes together with the growth of private practice have raised the costs of health care and resulted in increased inequalities in patterns of provision as well as increased and re-shaped patterns of inequality in financial access. The transformations in health services provision and financing and their effects on access are set out in more detail below.

The collapse of CMS

The abolition of communes and introduction of household farming in the late 1970s and early 1980s led to the collapse of cooperative health financing in many parts of rural China. The share of villages with CMS fell from an estimated 90 per cent in the late 1970s to less than five per cent by 1984 (Carrin et al. 1999; Feng et al. 1995: 1112; Grogan 1995). This had an enormous impact on patterns of inequality in financial access to health services because it meant that in most villages risk-pooling and collective cover ended as CMS funds ceased to exist.[13] Individuals and households increasingly had to pay for their own curative treatment, and often even for preventive services such as vaccinations and immunisations. In 1980, individual patient fees were 23 per cent of total health spending, but the share had risen to 39 per cent in 1991 (Hossain 1997). On one mid-1990s analysis, approximately 95 per cent of rural residents were paying for their own care (Grogan 1995). Where CMS funds could no longer pay village health workers (formerly 'barefoot doctors'), they could be forced to

[12] Most private sector employers do not provide the same range of benefits as state and collective work units once did (though for a discussion of some exceptions see Francis 1996).

[13] Rural cooperative health funds accounted for 17 per cent of total health spending nationally in 1980 but had declined to less than 6 per cent in 1983 (Hossain 1997).

charge fees, sell medicines, be driven out of medical practice, or have to move to other areas (Feng et al. 1995: 1113). As a result there was a decline in the number of village health stations and rural health services had lost 3.7 million employees by the late 1980s (Hillier and Jie 1996; Hillier and Zheng 1991).

Uneven urban work unit health finance and provision

In the cities, the key institution of local governance, the work unit, was not suddenly dismantled, but eroded more gradually, in part due to the growing burden of the health benefits it provided. From the late 1980s, as urban industrial reforms began to encourage greater competition among enterprises, the numbers of employees entitled to benefits increased (particularly in older enterprises with larger numbers of retired workers), and medical costs rose (due to policies discussed below), health financing began to feel more burdensome for employers.[14] As a result, they increasingly either reneged completely on their commitment to pay for their employees' health treatment, introduced patient co-payments, or simply paid small annual or monthly lump sums to employees for health care regardless of their actual health care needs. As cities, government administrative systems (*xitong)*, and employers across the country experimented with different arrangements, work unit provision began to vary, and increasingly employees found that they had to pay directly for their own curative care. The likelihood of this grew during the 1990s as more and more people became self-employed or shifted to private sector or informal employment, where they were much less likely to have work unit assistance with their medical costs.[15] The 1993 and 1998 National Health Services Surveys revealed that the percentage of urban dwellers without health insurance had increased from 27 to 44 per cent between the two survey years (Liu et al. 2002).[16] And by the 1990s, whether someone had LI or PHI (or assistance with medical costs of any kind) was still dependent on whether or not they had work and their employer provided such benefits. Those most likely to have good access were still higher ranking officials and

[14] Total expenditures on labour and government employee health insurance had risen almost five times between 1980 and 1990, from 670 million yuan to 3,236 million yuan (at 1980 prices) (Gu and Tang 1995).

[15] The numbers employed in state work units (*guoyou danwei*) declined from a peak of 112 million in 1995 to 76 million at the end of 2001, and the number in urban collective enterprises declined from 36 million in 1991 to 13 million at the end of 2001. Meanwhile the number employed in private enterprises rose from 0.7 million in 1991 to 15 million at the end of 2001, and the numbers of self-employed rose from 7 million to 21 million over the same period (State Statistical Bureau of China 2001, 1996). The registered unemployed, who are entitled to unemployment benefits, should also have their medical costs paid, but only during the period they are entitled to benefits, a maximum of two years. Many of the unemployed are not actually registered as such.

[16] And a restricted access official source noted from a survey of 11 cities in the late 1990s found only 14% of urban dwellers to have health insurance (cited in Duckett 2004) . Only 3.17% of urban dwellers and 1.4% of rural dwellers had private health insurance in 1998 (Liu 2002).

people in public institutions, as well as workers in state enterprises that continued to do well (Tang and Parish 2000).

Decentralisation and the emergence of private practice

In addition to these changes to rural collective and urban work unit sources of finance for health, a number of other transformations to health system finance also affected provision of, and access to, health services. First, fiscal decentralisation in the health sector meant that budgetary finance for health came from local government coffers, so that for example, in rural areas township hospitals were no longer subsidised by counties and the task of handling local health policy at sub-county level was left to township officials who did not understand it well.[17] Second, because local government officials were given incentives to prioritise economic growth through the inclusion of economic indicators in their performance targets, spending on health was relatively neglected (Edin 2003; Park et al. 1996). Third, another series of policies has increased all state (including township) hospitals' autonomy and financial self-reliance. In 1983 a State Council circular began the practice of permitting hospital staff to earn bonuses for extra work and hospitals to retain profits for reinvestment (Hillier and Jie 1996: 261). This resulted in incentives for them to provide unnecessary diagnostic tests, medicine and curative care, as well as meaning that patients have become prey to unethical treatment by medical professionals. Together, all these factors contributed to hospitals receiving a declining share of state budgetary support, so that by the early 1990s only about 20-25 per cent of hospital expenditures were financed in this way (Hsiao and Liu 1996).[18] In some areas, health centres closed, with the total number of township health centres falling by 14 per cent between 1980 and 1990, probably reducing the availability of health services for some rural dwellers, especially those in poorer areas (Feng et al. 1995).

Further changes resulted from allowing private doctors to practice and the private ownership of health facilities (Hsiao 1995).[19] Village (formerly brigade) health stations, previously run and financed through CMS, were often sold off to private practitioners, and medical personnel were permitted to provide private services outside their state hospital shifts (Ho 1995). Between 1980 and 1995, the share of the medical personnel in private practice grew from zero to five per cent, though private hospital numbers have grown much more slowly (Hindle

[17] Similar decentralisation has taken place in urban areas, but there are no accounts of the effects in terms of management capacity and investment of urban districts.

[18] Overall there was, as a result, a decline in the government budgetary share of spending on health as a percentage of total health spending from 36% in 1980 to 15% in 2002 (Ministry of Health 2004). Central government funding of health care had fallen to less than 1% by the early 1990s (Hesketh and Zhu 1997).

[19] Doctors were encouraged to set up private practices from 1980 (Ho 1995).

2000). The result of the expansion of private services has been that in wealthier areas provision has increased, and better technology has been available, while in poorer areas where medical practice incomes are lower, practitioners have financial problems, and so have been leaving for wealthier areas where they can make a better living (Feng et al. 1995). There has also been a decline in preventive programmes in some rural areas (Bloom and Gu 1997a).

Changing patterns of unequal access

These fundamental transformations to rural communes and the urban work unit, along with the decentralisation of health service finance, and permission for private practice, reconfigured locality- and work unit-based patterns of unequal access to health services in the 1980s and 1990s. Locality still affected the quality of services available, and differences between localities in the quality and quantity of provision increased, widening the rural-urban divide.[20] But an interpersonal pattern of inequality in financial access to health care had begun to overlie those based on locality and work unit. For the many no longer participating in CMS or protected by work unit provision, access was dependent on individual (or household) ability to pay, and individuals and families on low incomes were more likely to defer care or leave their illnesses untreated. Gu and Tang (1995) report that the 1988 National Household Survey showed 25 per cent of the rural population referred to hospital were unable to attend for treatment because they could not afford it. Similarly, the 1993 National Health Services Survey found that almost 40 per cent of the urban population reported that they could not afford the medical treatment they had been diagnosed as needing (Liu et al. 1999). And there had been little improvement toward the end of the decade, with research in 1998 finding that among poor urban households between 50 and 70 per cent could not afford medical treatment.[21] Another study has shown that those with government or labour insurance were more likely to seek medical treatment and twice as likely to receive hospital treatment (Grogan 1995).

These emergent patterns of interpersonal inequalities in access may have overlapped with and reinforced growing income inequalities that are often themselves influenced by interactions

[20] The World Bank reports that in 1993, average health spending per capita was four times higher in urban than in rural areas and 'the poorest quarter of the rural population accounted for only about 5% of all health spending' that year (World Bank 1997: 3). This source also notes that although the urban PHI and LI systems covered only 15% of the population, they accounted for 'two-thirds of public spending on health and 36 per cent of all health spending' (Ibid).

[21] The figure was 50% in Shanghai, and 70% in Tianjin (see Cui 2004 citing Tang 2002). Note, however, that according to the Ministry of Health in 1999 20% of the urban population went without hospital treatment because they could not afford it (Liu et al. 2002).

among household registration, gender and employment status.[22] For example, Grogan (1995) shows how in urban China in the market reform period those with the highest wages receive the best benefits, while the growing numbers of people with agricultural household registration working in the cities on low incomes are unlikely to be given assistance (Solinger 1999). And women were more likely to be employed in low-paying urban collectives that found it harder to provide assistance with medical treatment costs. Those without work and income, particularly the long-term unemployed, were increasingly likely to have no health insurance, while middle-aged men and especially women were disproportionately represented among urban unemployed and laid-off workers, and usually among the first to lose their jobs when enterprises retrench. They were therefore less likely overall to be receiving work unit assistance with health care.

The limits of reform to health system financing and new patterns of unequal access

This section examines late 1990s' attempts to reform the system of health financing and their outcomes in terms of inequality in access to health services. In rural areas since the mid-1990s, reforms have focussed on the re-establishment of cooperative, risk-pooling financing based on voluntary payments by rural dwellers.[23] In urban areas, LI and PHI are being replaced by a single basic compulsory social health insurance system for people in work, with risk-pooling at city level, and contributions made by employers and employees. In both countryside and cities, medical financial assistance (*yiliao jiuzhu*, MFA) programmes have begun to be introduced to help the poor with their medical costs. While indicating that collective (redistributory, risk-pooling) solutions have not entirely been abandoned, these reforms are all encountering problems so that interpersonal inequalities remain significant.

Attempts to re-establish CMS, continuing patterns of inequality, and local governance problems

Since 1993, the Chinese central government has attempted several times to re-establish some form of CMS in rural areas, but to little effect. In 1994, in conjunction with the World Health Organisation (WHO), trials were initiated in 14 counties across seven provinces[24], and efforts were again renewed in 1997, when a target was set of extending the system to most of the

[22] 'Household registration' refers to the system by which everyone in China is assigned at birth either 'agricultural' or 'non-agricultural' registration that entitles them to different public goods and benefits. The urban 'non-agricultural' registration brings better entitlements.

[23] There have also been attempts to establish 'prepaid prevention programmes', but there is not the space to discuss them here. See Liu et al. (2002).

[24] These experiments included some county and/or township government budgetary contribution, with different arrangements in different localities.

rural population by 2000 (Shi 2003; Xinhua (Anhui) 2002). Despite this, the second National Health Services Survey in 1998 found that only about seven per cent of rural dwellers were participating in CMS, and thereafter the trials received little publicity (Liu et al. 2002). In May 2001, a State Council document on rural reform and development mentioned CMS, but without setting targets or prioritising it (State Council System Reform Office et al. 2001).

From 2002, there was renewed central policy emphasis on re-establishing CMS. In October that year the Party Central Committee and State Council issued a 'Decision' on improving rural health work that instructed all areas to set up CMS pilots and gradually promote 'new-type' CMS with the target of 'basically covering rural dwellers' by 2010 (Central Committee of the Chinese Communist Party and State Council 2002). Since then, there have been concerted efforts to make progress with these trials (Ministry of Health, Ministry of Finance, and Ministry of Agriculture 2003; Ministry of Health Office 2003; State Council 2003), and the importance of the CMS work has been reiterated by the Vice-Premier and Minister of Health, Wu Yi, and Deputy Minister Gao Qiang (Gao 2004; Wu 2004). Although these speeches and documents reveal that there have already been problems, particularly with local governments overstating participation in the pilots, and in August 2003 they were narrowed to four provinces, CMS does now seem to be a priority for the State Council and the Ministry of Health. By June 2004, 69 million rural residents were reported as participating in 'new-type CMS' trials, equivalent to just under nine per cent of the 768.5 million rural population (State Council 2004).

MFA schemes aimed at improving access to health care for the poorest were piloted in rural areas from 1998 through World Bank and UK government-funded programmes in conjunction with the Chinese Ministry of Health, and in 2002 were introduced as national policy. Those eligible for MFA are the poorest households, including but not limited to families receiving poverty relief (*wubaohu*). MFA can take the form of direct assistance with health expenses for preventive as well as hospital treatment costs, or assistance to allow households to participate in CMS. Although local governments are required to help fund MFA, from 2003 the central government announced that it would contribute 10 yuan per CMS participant in China's middle and Western regions (Central Committee of the Chinese Communist Party and State Council 2002). In November 2003 it was announced that the MFA system should be set up by 2005, beginning with 2-3 pilots in each province (Ministry of Civil Affairs, Ministry of Health, and Ministry of Finance 2003). While a significant step toward tackling inequalities in access to health care and improving the access for poor rural dwellers, because MFA pays only a share of expenses it does not protect the poorest, and may not be affordable for governments in the poorest localities where they are most needed. By

1999, the Ministry of Health was still reporting that 23 per cent of the rural population had to forego hospital treatment because they could not afford it (Liu et al. 2002).

With less than ten per cent of the rural population participating in CMS, patterns of inequality in financial access to health services in rural areas that appeared after the abolition of the communes remain, and are still mainly interpersonal or inter-household and closely connected with income inequalities.[25] While some rural dwellers participate in collective systems and have access to MFA or may be able to afford to take out private insurance, most must still pay directly for their own medical treatment and risk impoverishment from serious illness. Since CMS and MFA are most likely in the wealthiest areas, inter-local inequalities underlie interpersonal ones.

Problems establishing some form of CMS (as well as institutionalising MFA) are due in part to the fact that structures and practices of local governance resulting in the initial collapse of co-operative medical systems are still in place: notably decentralised production and local government finance. When coupled with prioritisation of economic growth throughout the political system that produces local government leader performance evaluations based mainly on economic indicators, there is a local unwillingness to subsidise CMS or raise investment in the health system. At the same time, these governance structures and practices have led to problems of predatory local government and low levels of trust in it. Thus attempts to establish CMS are met with suspicion from farmers who see it as yet another means to extract income from them.[26] Indeed, central policies to tackle the problem of farmers being burdened with local taxes and fees have also damaged efforts to re-establish CMS (Liu et al. 2002).[27]

Recent developments indicate that top leaders, particularly Vice-premier Wu Yi, now also Minister of Health, seem to be pushing for real progress in the implementation of CMS and MFA. Importantly for local level prioritisation of and investment in health, the Party Central Committee and State Council have issued a decision that instructs city and county people's congresses to make achieving targets in establishing CMS and reducing the numbers of people impoverished by ill health 'an important part' of local leaders' performance assessment (*zhengji kaohe*) (Central Committee of the Chinese Communist Party and State

[25] Note that there may be inequalities based on employment status even where CMS is implemented. According to Carrin et al (1999) some of the 1994 county level experiments established separate funds for farmers and rural enterprise employees. Since enterprise employees paid more into the funds their reimbursement rates were higher.

[26] Author's interview, Shanghai, 2001.

[27] According to Liu et al (2002), in some areas, CMS contributions were included in lists of illegal fees that local governments were no longer permitted to levy on villagers.

Council 2002). Moreover, central policy documents on CMS have recently begun to argue against the view that CMS contributions are unreasonable fees that increase farmers' burden, pointing out that in fact they can reduce farmers' vulnerability to impoverishment through ill-health (Ministry of Health, Ministry of Finance, and Ministry of Agriculture 2003). Despite this, the obstacles to establishing CMS (and MFA) nationwide are still enormous. Participation remains voluntary and so CMS continues to be undermined by lack of trust in local government as well as problems created by weaknesses in the health system, such as poor or costly provision.[28] Local government mismanagement of funds and over-reporting of participation (so as to obtain higher level subsidies) has been reported even in pilot schemes in 2003, indicating that the goal of establishing CMS nationwide will be difficult to attain (Gao 2004).

Urban Employee Basic Social Health Insurance, inequality and local governance

Experimentation with new programmes of urban health insurance began in the early 1990s and resulted in the introduction of a new compulsory national framework for urban BSHI in December 1998 (State Council 1999). This framework stipulates that city governments must establish social health insurance funds into which employers and employees contribute a share of their wage bill and wages respectively. Some of the contributions are channelled into individual health accounts for participating employees. The insurance fund and the health accounts are then used to finance outpatient and inpatient treatment, with patients making co-payments (either from their accounts or out of their own pockets) alongside those from the fund. Gradually since 1999 cities across the country have begun implementing the framework.[29]

The new framework is designed to include employees not only in public institutions and the state and collective sectors (that is those who formerly participated in PHI and LI), but also private and foreign-invested enterprises, and the self-employed. For those in work, therefore, there is now in principle a single system that delivers the same benefits for uniform contribution rates (though officials receive some enhanced provisions). This means that the late Mao intra-urban pattern of work unit-based inequality in access within cities has been tackled. Moreover, where the framework is implemented fully, city-level risk-pooling limits the interpersonal inequalities in financial access of the post-Mao period, since some

[28] Farmers are unwilling to contribute to CMS if they think it entitles them to only poor quality services; or if it is insufficient to pay for their health expenses. See discussion in (Liu et al. 2002).

[29] For a discussion of local pilots and the 1998 programme see Duckett (2001), Liu (2002), and Duckett (2004).

employees whose employers had not been paying for their health care are now participating in the schemes and so once again have insurance (Duckett 2004). [30]

However, there are limits to the redistribution involved in BSHI. First, with risk-pooling at city level, there are still differences in provision between cities. Although central policy is to establish province-wide risk-pooling, this does not seem likely in the short term. Second, individual health accounts institutionalise some interpersonal inequalities in financial access because employees with higher salaries will accumulate more in them. Third, significant interpersonal inequalities in financial access will remain due to the exclusion from the new system of the non-working population, notably the long-term unemployed and dependants. Although a safety net, Minimum Living Security, has been established in China's cities to provide low-level, means-tested, income support to the poorest urban dwellers, in most cities it includes only a very small nominal standard amount for health expenses. And although some cities have now also established MFA to assist the poor that mitigates some interpersonal inequalities[31], it still leaves some vulnerable to impoverishment or at risk of going untreated because there are upper limits on the amounts awarded to individuals and co-payments are required. [32] As in rural areas, continued local fiscal decentralisation and prioritisation of economic growth means that local governments are unwilling to commit themselves to funding means-tested provisions for the poor. However, recent announcements of central government financial assistance of 300 million yuan per year for urban MFA does signal that central government is beginning to give financial backing to support and that there is therefore also likely to be improvement in implementation of this policy (*Taiyuan Daily* website, 13 September 2004).

Fourth, the national framework for BSHI is not always fully implemented, and in practice many enterprises, particularly urban collective and private ones, do not participate in the schemes—either because they cannot afford to or because participation would increase their

[30] The inclusion of rural enterprise employees (92 million people, 30% of the rural labour force (Hussain 2000)) in urban BSHI means that in principle at least participation in urban health systems for those with rural agricultural registration has been accepted, an important step (though it might reduce the viability of CMS schemes).

[31] The State Council in January 2002 announced the medical treatment assistance for the poor was a priority and since then urban governments have been instructed to establish them. Author's interview, Ministry of Civil Affairs, 2002.

[32] The upper limit was, for example, 10,000 yuan in Chengdu and Beijing in mid-2004 (*Renmin ribao*, 4 February 2002, *Sichuan Daily* website, *Sichuan lianbo*, at http://sichuan.scol.com.cn, accessed 24 August 2004, and the China National Population and Family Planning Commission website, *Zhongguo renkou wang*, www.chinapop.gov.cn, accessed 25 September 2004).

expenditures on health or reduce the quality of their own employees' health provision (Duckett 2001). Moreover, despite the growth of rural-urban migration, there is still inequality in access based on household registration. Although in principle the new BSHI allows the employees of urban enterprises who have agricultural registration and long-term (more than one year) contracts to join the scheme, there is as yet little evidence that they are participating in significant numbers.[33] Inequalities based on household registration are in part due to fiscal decentralisation, which means that local governments are unwilling to finance provisions to people from outside their own administrative jurisdictions. The result is a mix of eroded or modified late Mao and reform era arrangements that co-exist to create a very varied picture across China in which because many individuals do not participate in BSHI, there are still significant intra-local inequalities in access. Still, the trend has been strongly toward extending the programme to include more urban residents. Nationally, participation in BSHI has increased rapidly from just under 19 million in 1998 to 109 million at the end of 2003, about 21 per cent of the urban population and 42 per cent of the urban working population (Ministry of Labour and Social Security 2003; State Council 2004).[34] The challenge now is to sustain the improvement in participation so that those in collective and private employment are also included.

Although (enterprise) work units are still the main source of finance for urban social health insurance, it is no longer organised, administered and delivered by them. These tasks have been transferred to urban government social health insurance agencies (part of the new Ministry of Labour and Social Security system) who are responsible for administering the new social health insurance funds, collecting contributions to them and organising payments to health service providers (this involves selecting hospitals and clinics as well as arranging and overseeing payment mechanisms). Thus the creation of urban basic social health insurance has involved transforming institutions and practices of local governance in a way that CMS reform attempts have not. First, responsibility for administering the financing and delivery of social insurance benefits has been transferred from work units to local governments, which along with other measures such as those to halt the provision of work unit housing, constitutes a deliberate move toward abandoning the work unit as an institution of governance. This transformation entails a concomitant increase in government responsibility for provision although there has been a lag in establishing the mechanisms that

[33] Shanghai and Chengdu are reported to have launched a social security scheme, including medical insurance, for migrant workers, in late 2002 and early 2004 respectively (*Xinhuanet* 23 February 2003, 26 March 2004). Zhejiang is reported to have introduced MFA for both urban and rural dwellers (Ministry of Civil Affairs website, at www.mca.gov.cn, 20 September 2004, accessed on 25 September 2004).

enable social health insurance agencies to enforce employer participation in BSHI and deal effectively with the hospitals to which they now provide channel finance.

Concluding remarks

Inequalities in access to health services: relationships with income inequality, health inequalities, and experiences of poverty and social inequality

Attempts over the 1990s to re-establish some form rural CMS, urban BSHI, and MFA show that redistributive, collective solutions have not entirely been abandoned. But governance problems are undermining their implementation and reducing the amounts of finance available to them. As a result, direct payments 'out-of pocket' for health care had risen to 61 per cent of spending in 2000, something that has contributed significantly in highly unequal access to health services (Ministry of Health 2002). It is because of this that in 2000 the WHO ranked China only 188th out of 191 countries in terms of the fairness of its health financing system (World Health Organization 2000). The primary patterns of inequality are still those between countryside and city, and within these sectors between localities and individuals. As discussed above, these patterns may also through social institutions such as household and workplace interact with and reinforce inequalities due to gender or age.

Inequalities in access to health care are also connected to other dimensions of inequality, notably those in income and health, as well as contributing to experiences of social inequality and poverty. Interpersonal inequalities in access to health care due to the absence of risk-pooling CMS or insurance are closely related to income inequalities and may contribute to their increase, while illness can also increase poverty. Gu and Tang (1995) cite a 1991 study of 60 poor families in Yuhan county in Zhejiang which found that 47 per cent said family members' medical care had forced them into poverty. According to other sources, 30-50 per cent of rural households living beneath the poverty line had become impoverished due to illness (Liu et al. 1999). In urban areas, too, declining participation in labour insurance means risk of impoverishment due to ill health increased in the 1990s.

Local and individual inequalities in access to health services in China also may have contributed to growing health inequalities. Despite limited data on the health status of the Chinese population in the late Mao era, we know that there were significant health inequalities. For example, the World Bank in 1981 reported higher mortality rates and poorer nutrition in the countryside than in urban areas (Hillier and Jie 1996: 263). However, there are some indications that despite sustained growth in China's economy health inequalities have

[34] Population data for 2003 from the State Statistical Bureau (State Statistical Bureau 2004).

on some indicators increased since then. Data on inter-provincial and rural-urban differences, for example, indicate increases for indicators such as life expectancy and infant mortality (Hossain 1997; Liu et al. 1999).[35] Although health inequalities are caused by a combination of many factors including age, diet, access to clean water, as well as housing conditions, working conditions and perhaps social status and social inequalities, inequalities in access to health services are likely to have had an influence. Since ill-health is likely to be more prevalent among the poor, the fact that health service provision is weakest in areas where risk of poverty is highest means that provision is particularly inequitable. And since ill-health may also increase the risk of poverty, inequalities in health service provision may be contributing to a vicious circle of deepening poverty and ill-health.

Finally, since those on the lowest incomes in China are the least likely to have adequate health protection, poor access to both preventive services and especially medical treatment has added a new dimension to experiences of poverty in China. Being poor now means being more vulnerable to disease, having to suffer illness without access to many medicines and treatments or only to very low quality services in often unsanitary conditions, and so living with the fear of serious disease and ill-health.

Health financing, local governance and the prospects for improving access to health services

The national policy initiatives since 2003 may indicate a new political will among leaders at the centre to prioritise health. The SARS outbreak that year, as well as China's low WHO ranking for the fairness of its health system in 2000, and the spread of the HIV/AIDS epidemic have focussed more attention on the health system, and apparently created a determination to push things forward not only in relation to HIV/AIDS and other communicable disease prevention, but also with improving access to health services through 'new-type' CMS and MFA. Central government budgetary investment has increased in support of these policies.

However, improving access to health services in China requires more than political will at the top, new policy initiatives, and the allocation of ad hoc earmarked central government investment. Although these are all important, access is significantly influenced by modes of health financing and provision that are closely tied into wider local governance systems and practices. The commune, work unit, and planning system that contributed to more equitable

[35] In 2001, for example, the infant mortality rate in Beijing was 6 per thousand live births, while that of Ningxia was 33 per thousand. There was also a gap in maternal mortality rates, with Beijing reporting a rate of 12 per 100,000 live births while Ningxia reported 73 per 100,000 (Ministry of Health 2002).

access in the past are no longer functioning, while new systems and practices in the era of market reform such as fiscal decentralisation, local government administration of social insurance, and the prioritisation of economic growth through new incentive systems for officials, create new obstacles to rebuilding CMS and extending urban BSHI.[36] Perhaps the most important steps towards tackling the problem would be those in the sphere of health financing to deal with the negative consequences of fiscal decentralisation, and those in the sphere of local governance to improve the capacity of the new social insurance and other government agencies.

In terms of health financing, first, there is a need for more central government financial intervention. As Wong notes in her contribution to this volume, central government transfers back to the provinces have shifted significantly away from disequalising tax rebates towards a greater share of more redistributive earmarked grants.[37] However, these earmarked grants need to be reviewed, rationalised and better targeted, and they need to operate alongside more and better local health financing (World Bank 2002). Second, to tackle the problem of disincentives for local governments to invest in health (both in services and health protection systems for their populations) that has been created by fiscal decentralisation, governance reforms are important. Decentralisation hinders the creation of a nation-wide (even province-wide) health insurance system and a more equitable health system. Central co-ordination of health planning and resource allocation, including prioritisation of redistribution within the health system could contribute to tackling this problem, but both local investment in health and the implementation of urban social health insurance could be improved by making them an important component of local leaders' performance targets.[38]

But simply increasing finance alone will not tackle some of the most serious obstacles to improving access. To ensure that government investment is used effectively and more efficiently, certain local governance systems and practices need to be improved. Two issues

[36] I assume here that a first practical step toward equalising access would be to fully implement CMS and BSHI so that most of the population has some health protection, though this would not in itself tackle the problem of the rural-urban divide. Nor would it provide for urban dwellers without work, who are not eligible to participate in BSHI. A long list of other recommendations relating to improvement of health service provision, especially in rural areas, are give in by the World Bank (2002), and Liu et al. (2002). I deal here with those that are most fundamental to the issue of equality, financing, and local governance.

[37] See also a report by the World Bank that shows tax rebates to have fallen from 72% of central transfers in 1996 to 45% in 2001 (2002: 19).

[38] In 2002, the central party and government announced that health targets would be included in the performance targets of officials (Bloom and Fang 2003). And this has been reiterated more recently (see above). Much depends on how this is done—which officials, and how important the health targets are in evaluations of performance.

are central here: first, delineation of responsibilities need to be clearer. For example, in the countryside CMS work needs to be better integrated into county and township administration. Second, administrative capacities of new government agencies could be improved. For example, new urban social health insurance departments' capacity to monitor employers and ensure all their employees participate in BSHI would increase participation in this scheme. At present, departments are better at ensuring the participation of state enterprises (though they do not always ensure that their all their employees participate) than private sector businesses. Social health insurance departments, as 'third party payers' of patients' medical expenses, could through better systems for monitoring and paying health service providers, strengthen their capacity to tackle the incentives to over-prescribe medicines, provide unnecessary diagnostic tests and require informal payments. At present they lack experience in dealing with providers, and while participation in BSHI is low, they are not major purchasers of health services and so lack influence. Thus improving participation in BSHI can help increase departments' capacity to deal with service providers.

Should these and the recommendations for improving the quality of basic health services be implemented, the prospects for reducing interpersonal inequalities through re-establishing CMS and extending BSHI would be significantly improved, though the re-establishment of CMS may also require tackling the wider lack of trust in rural government, while extending BSHI to urban dwellers without work would require substantial state investment.[39] This would in itself be a major accomplishment, even though it would neither tackle the entrenched rural-urban inequalities in the system nor the new and growing inequalities in the cities. China's rural dwellers continue to be those to whom progress comes most slowly and with least state budgetary support, though there is now a growing urban underclass that is little better off.

[39] While village elections have been introduced in part to try to deal with such problems, there as yet no evidence that they result in the development of collective mechanisms for financing health or the provision of other public goods.

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