

# HEALTH CARE IN RURAL CHINA

Lessons from HeBei Province

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ASHGATE

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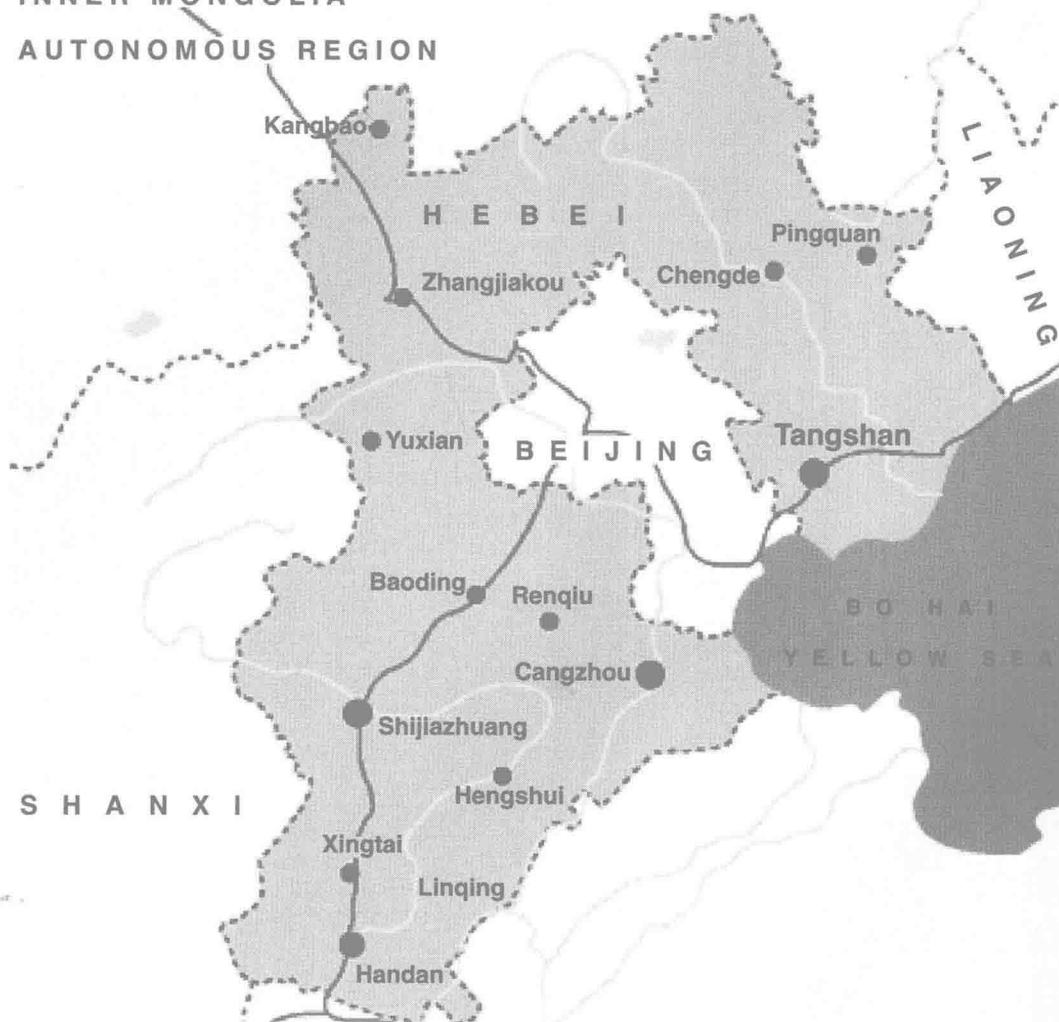
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# HEALTH CARE IN RURAL CHINA

INNER MONGOLIA  
AUTONOMOUS REGION



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# Introduction

Periodic social, political, and economic transformations sweeping through mainland China have attracted worldwide attention for over five decades, ever since the Chinese Communist Party assumed power in 1949. But the world's absorbing interest in the People's Republic of China (PRC) cannot be attributed solely to its political and economic systems. China is home to one-fifth of the world's population (1,248,100,000 people in 1998). Almost 70 percent of the population lives in rural communities spread over 2,126 counties throughout the 9,600,000 km<sup>2</sup> mainland area and along its 18,000 kilometer long coastline. China has an area almost equivalent to that of the continental United States, but houses a population roughly five times the size. Providing adequate shelter, food, education, and health for a population of this size is an enormous challenge.

By international standards, China was a low income country until recently (World Bank, 2000, 2004). In 1998, the per-capita Gross National Product of the PRC was 750 US dollars a year, or \$3,051 in terms of the international standard of Purchasing Power Parity rates (PPP). The average per-capita GNP in the world that year was 6.5 times higher (\$4,890), and the world's average per-capita PPP was \$6,300, twice that of the PRC. These figures ranked the People's Republic of China 145th and 132d, respectively, among the 206 countries listed by the World Bank. Nonetheless, China has made remarkable progress and recorded admirable achievements in providing health care for its population. By all accepted indicators, the PRC has reached mid-point in its 'epidemiological transition' within less than 50 years, a feat that took Western Europe at least twice that much time to accomplish (Omran, 1971).

As was the case in many countries, the PRC's health care system underwent important reforms during the 1980s (Chernichovsky, 1995; Twaddle, 2002). These reforms resulted largely from the dismantling of the rural collectives as part of the transition from centrally planned to free market economy and were thus more profoundly felt in the rural areas, where they affected the majority of the population. Two aspects of these reforms, the collapse of the collective medical insurance scheme and the introduction of private medical practice, raised concerns regarding equity in the distribution of health services, access to health care and treatment, and cost containment that are shared by other developing and industrially developed societies. It is these features that make the study of the PRC's rural sector interesting to students of the various disciplines of health care, and that have motivated us to write this book, which presents an analysis of the current health conditions of rural China, in their broadest definition, within their social and historical context. It endeavors to explore current social health patterns, behavior, and care, together with the processes leading to their development.

Health, however, is closely associated with cultural attitudes and beliefs, with the social structure and the distribution of goods, ideology and values, political and economical processes and patterns of behavior, in addition to the distribution and utilization of resources for coping with health problems. The book, therefore, seeks to examine the picture of health and health care in rural China by focusing on some of the primary issues studied by health specialists from various social science disciplines, as seen in the specific context of rural China. By exploring universal questions in the unique social, historical, and political context of the PRC we hope to advance understanding of the social processes which shape the social distribution of health care everywhere and to reveal implications of health care policy that are relevant to the PRC as well as to post-industrial and developing societies. Taking this approach, we set out to explore three main questions in this book:

*1. What is the role of ideology, politics, and economic processes in shaping the rural population's access to health care? What are the unique ways in which the PRC copes with the tension between economic constraints and ideological commitments?*

When the Chinese Communist Party came to power in 1949, the health status of the population was extremely poor. Poverty, inadequate living and sanitation conditions, and illiteracy, wars, and exploitation all contributed to the generally poor health status. Health services were scarce and inaccessible to the great majority of the population, who could not in any case have afforded them. Within 30 years (except for the period of the 'Great Leap Forward' and the famine of 1960–61), the health status of the rural population was dramatically improved, mainly as a result of an improved standard of living, raised levels of education, and effective public health programs. A three-tier health care system was built up in most parts of the country, in which more than 90 percent of the farmers were covered by cooperative medical insurance schemes. Health services became accessible and affordable to almost all.

The economic reforms of 1979 raised the rural standard of living, but also brought with them major, largely unforeseen, changes in the rural health care delivery system. Much of this change was a result of de-collectivization, which undermined the financial basis of the village as a unit. The village administration could no longer support the training of health personnel and the maintenance of the village clinic, nor could it retain the welfare safety net, including cooperative medical insurance. Within a few years, more than half of the rural health services were operating on a fee-for-service basis.

The first aim of the book is, therefore, to explore the ways in which the political, economic, and social transitions and processes experienced by the PRC since the establishment of the Republic have affected the health and the access to health care services for the rural population. Our analysis focuses on the most recent economic developments, that is, the transition from a centrally planned to a free market economy since 1979.

The health status of any population is closely related to health behavior, socioeconomic status, social support, and access to therapeutic and preventive

health services. These issues will be dealt with in the book on three levels: the village, the household, and the individual. The second purpose of the book is, then

*2. To explore behavior patterns among lay persons and health professionals. To what degree are different aspects of health behavior and professional practice shaped by the specific social context in which they take place?*

The behavior of the rural population in sickness and health will be portrayed, including the assumption of health risks such as smoking and drinking alcohol, and patterns in seeking medical help. Like all other types of behavior, these patterns are largely non-random, tending to be shaped by structural factors, health values and attitudes, and the social characteristics of individuals and groups. The social patterns of health and illness behavior and the degree to which these follow the patterns observed in other societies will be presented and discussed.

The professional training of most village doctors in the PRC is very different from the medical education of their counterparts in industrial societies. Moreover, it has been argued that the economic reforms and the privatization of a large portion of the primary care services have increased profit-generating care on the one hand, and decreased the provision of preventive care and participation in continuing professional education on the other. The interactions among professional training, employment status, structural constraints and professional practice will be examined in the book.

Finally,

*3. The book strives to examine inequalities in health, in the provision of health care and to evaluate the equity of health service distribution. Are health resources available to all in the post-collective economy of rural China today, and particularly to groups that in other societies are often disadvantaged (women, the elderly)?*

The fee-for-service health delivery system often creates inequities in the distribution of health resources and unequal access to health and health care. In light of the mass privatization of primary care in rural China, we will look into the question of equity, that is, the quantity and the quality of health services available to those with greater need. The degree to which the availability of health care service is related to the social, economic, and geographical characteristics of a village will also be discussed.

The question of inequalities in health will also be addressed with respect to the individual. We will explore the well-documented relationship between the socioeconomic attributes of individuals and households, health and access to health care in rural China, with special consideration given to disadvantaged social groups, such as the poor, the elderly, and women.

## **Theory and Methodology**

Our approach to the study of health and health care in rural China is commensurate with current trends in the sociological study of health. As a sub-discipline, medical sociology has not yet developed a comprehensive theoretical approach (Turner, 1997; Cockerham, 2001). It draws on the main theories of sociology, its mother discipline, in its effort to understand the social processes that bring about the observed distribution of health status, health behavior, and health resources in a given society. Thus, medical sociologists, or sociologists of health and illness as some prefer to call themselves, base their discussion on hypotheses submitted by structural-functionalists, symbolic interaction, and theories that place social conflict at the center of their understanding of social life in a rather eclectic manner.

This volume draws particularly on three traditions: the Weberian approach by which we seek to understand the individual actor, the structural/functionalist view of the interrelationships between social units, and the Neo-Marxist conflict theories, which guide us in our exploration of the conflicting interests within the health sector and in the doctor-patient dyad. Within the Weberian tradition, we search for the meaning attributed by the actors to their social actions, whether the actions concern their own health or the health of others. The two concepts, life chances and life style, are most useful for our discussion of health differentials, social distribution of health behavior and cultural meanings attributed to these types of behavior. The notion of a sense of 'calling' provides us with a helpful framework for analyses of the behavior patterns of care providers.

During the 1950s and 1960s, it was widely accepted that one basic characteristic of a service profession is a 'calling' orientation. Structural functionalists argued that this 'calling' orientation dictates professional behavior, which places service before personal interests. This school of thought, however, rarely dealt with the arguably paradoxical interpretation of the primacy of service that stems from the Weberian concern with bureaucracy and bureaucratic organization. The question of whose interests are to be served, those of the organization, of the professional group, or of the client, were not raised until the 1970s (Freidson, 1970).

Neo-Marxist analysis, conflict theory, and political economy have prevailed in the sociology of health and illness since the 1970's (Turner, 1997). Our book draws heavily on this tradition, particularly on current sociological critiques of the health reforms that have gained currency in Western countries during the past two decades. Central to these critiques is the withdrawal of the welfare state and the increasing privatization of social services, including medical care. These critiques suggest that vested interests of powerful social groups, that is, their efforts to retain power and economic privilege, have motivated the changes in the magnitude and the mode of the provision of welfare services and their ideological basis. These processes have led to increased emphasis on cost containment and profit generation. Competent management and competition between providers became magic means for achieving financial efficiency, quality of services, and patient satisfaction. Freedom of choice, autonomy,

and individual responsibility for one's health and welfare have become central themes in the emerging ideology that underlies the new policies of many welfare states.

Current critiques posit that hidden motives behind the transitions in health and welfare policy of the state have legitimized increasing focus on the rewards of power and financial gain among both health organizations and individual practitioners. Consequently, equity in the distribution of health services has declined, while health differentials and inequalities in access to health care have increased. These theoretical propositions will guide our analyses of the health processes adopted by the PRC after the economic reforms of 1979 and the consequent reforms in the rural health care system during the early 1980s.

Given the size of the PRC in terms of area and population, and the enormous variability in its topography, resources, and economic development, a thoroughgoing and comprehensive analysis of health in rural China as a whole is not possible. The health consequences of the social, political, and economical processes discussed in this volume will therefore be demonstrated by focusing on just one of the 31 provinces, municipalities, and autonomous regions, HeBei Province in Northern China. Our analysis will concentrate on data collected by the authors as part of a joint Chinese-Israeli-Dutch research project. A random sampling of 288 villages in 9 counties was chosen to represent the geographical and economic development variability of rural HeBei. Between 1996 and 1999, information was collected by native interviewers from 14,895 persons of all ages belonging to 4,319 households. In addition, 416 doctors were interviewed and 1,262 patient records were collected. This data base will be supported and placed in focus by reference to published secondary sources. In so doing, we furnish the reader with a comprehensive review of the literature and a summary of the accumulated body of knowledge related to the transitions in health status and health delivery in rural PRC, in addition to extensive empirical evidence recently gathered in a specific province.

We wish, however, to call the attention of the reader to two limitations of the data presented in this book. First, we followed Riley and Gardner (1997), relying almost exclusively on the scientific literature published in the English language international scientific journals. There were two reasons for this choice, both related to the quality of the material. The articles published in scientific journals deal with universal questions and debates that are relevant to the international scientific community. Because our aim is to examine health issues which are universal, the body of knowledge seemed more relevant than studies published in Chinese alone, which usually reported data with limited, local relevance reflecting a more specific, narrower interest.

Moreover, in the past few years China's health and population policies seem to have lost their appeal to social scientists, and the number of publications appear to have declined particularly after 1997, the year of the IUSSP General Population Congress in Beijing. The reader will note that the bulk of the relevant literature was published during the 1980s and early 1990s.

The second limitation is our use of formal secondary data and statistics, which are also available to international organizations. The quality of these data is not always clear, because the PRC depends on the competence and understanding of local administrations

with respect to the importance of accurate data. It is generally accepted that vital statistics and other data concerning the PRC before the 1980s is of relatively poor quality (Banister, 1998; Riley and Gardner, 1997). Because evaluations of corrections necessary to improve their accuracy vary considerably, we chose to use the data published by the PRC related to long term trends in population health and the general resistance resources available to it.

### **The Structure of the Book**

The concept of health, as broadly defined by social scientists, is multifaceted. Each aspect reflects and interacts with other social aspects of life, such as cultural values, health attitudes, behavioral patterns, and access to social goods. In order to fulfill the three main goals of this volume, we decided to examine in detail several selected health issues before drawing conclusions. Each of the first eight chapters considers a specific aspect of health; each presents a focused analysis of one facet of the current health status and the provision of health care and explores the processes leading to its current status. The final chapter builds on the findings presented throughout the book, in light of the three stated aims of our research.

The first chapter sets the scene in which access to health care has increased since the establishment of the PRC in 1949, briefly reviewing the development of the rural health service system and health-related social criteria, such as standard of living, education, and social support.

Chapter 2 looks at the consequent health status and examines the health-related resources involved in the social, political, and economic processes described in Chapter 1. It presents long-term trends in health status, social investment in health, and health resources allocated to the rural population. Special emphasis is placed on the health reforms initiated as part of the transition to a market economy. Current health indicators and health resources in the PRC are compared with those of eight other Asian societies.

Chapter 3 presents the unique and innovative ways in which the PRC has achieved the remarkable improvement in the health of the rural population. The applicability of the PRC's experience in coping with extreme health difficulties as well as public health problems currently faced by China and other developing and post-industrial societies are also discussed in this chapter.

Chapters 4 and 5 focus on patterns of health behavior and their social context. Chapter 4 examines patterns of health care delivery as shaped by professional training on the one hand and the social setting of the practice on the other. Chapter 5 concentrates on the social patterns of lay health behavior, from confronting health risks to consumption of health services.

Chapter 6 addresses the most debated consequence of the economic and health reforms instituted in the rural sector of the PRC since the early 1980s: equality of access to health and health care and equity of health service distribution. These issues are discussed on two levels, that of the individual and that of the village as a social