公共经济与公共政策 齐鲁文库

国家社科基金项目“基本公共服务均等化：基本理论与实证研究”研究成果

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On the Equalization in Health and Medical Service in Urban and Rural Areas

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公共经济与公共政策齐鲁文库

编　委　会

总 序

又是一个秋高气爽、硕果累累的十月。恰逢新中国六十华诞，盛世强国，蒸蒸日上，庆典隆重，举国欢腾；又迎十一全运泉城举行，健儿齐聚，英姿勃发，民心振奋，人人欢颜。

再经山东省公共经济与公共政策研究基地学术委员会认真甄选，山东大学应用经济学博士后流动站的杨国涛博士的专著《中国西部农村贫困的演进与分布研究》入选《中国公共经济与公共政策研究报告》（第三辑），解垩博士等人的《城乡卫生医疗服务均等化研究》、《城乡基础设施均等化供给研究》、《经济增长视野下的中国财政分权实证研究》和《新型农村合作医疗统筹补偿方案研究》等4本专著纳入《公共经济与公共政策齐鲁文库》系列出版。这是研究基地成立之后的第三批研究成果。与前两批成果相比，这些专著同样具有研究选题的前沿性、研究方法的规范性、学术观点的创新性等共性，特别值得提及的是，在研究问题的选择上，结合中国当下轰轰烈烈实践着的改革与发展进程和突出矛盾，这些年轻学者不仅密切关注关乎中国经济增长的问题（如财政分权与经济增长），而且更为关注关乎中国社会公平的问题（如西部农村贫困问

题，城乡卫生医疗服务均等化，城乡基础设施均等化）；在研究方法上，不仅进行了较为深入的规范的理论分析和实证的计量分析，而且更加注重深入基层实地调查，通过入户访谈和问卷调查方式掌握第一手资料，进行统计分析，来得更加勤奋扎实；在研究结论上，更加贴近中国实际，更加接近政策，更加务实具体。这些无疑都令人欣喜、令人鼓舞！

光阴如梭，转眼之间研究基地即将迈入第四个年头。回首三年，多学科师生同心同德，共筑平台，收获颇丰。主要收获有三：一是人才培养，探索了一种富有特色的研究生培养模式，即利用一个平台实现跨学科、跨领域、与科学研究紧密结合的人才培养，全面实行研究生“双导师”制，着力增加研究生的“五种经历”（10%以上的同学拥有第二校园经历，10%以上的同学拥有海外学习经历，100%的同学拥有专业实习或社会调查、社会实践经历，100%的同学拥有参与课题研究的经历，100%的同学拥有参加全国性或国际学术会议进行学术交流的经历），扎实进行研究方法与学术规范的指导；二是科学研究，探索着一条多学科增进交流、增加了解、增进合作的路子，即设立交叉研究基金鼓励合作研究，多学科师生共同讨论公共政策问题和方法运用问题，开拓国际交流与合作途径，产生了包括《公共经济与公共政策齐鲁文库》、《中国公共经济与公共政策研究报告》和《山东大学公共经济与公共政策研究报告（Working Paper）》在内的一系列成果，繁荣学术，资政谏言；三是扶持新人，在基地的平台上锻炼成长，一批30多岁的青年才俊思维活跃，羽翼渐丰，势头强劲。

再次衷心感谢经济科学出版社的吕萍副总编和中国财

经出版社的赖伟文副总编及赵力女士。您们的鼎力相助使两个研究系列的高质量编辑出版成为可能。衷心感谢专业读者的积极回应和热心讨论，您们的关心关注是我们前行的动力之一。

谨为序。

樊丽明

2009 年 10 月 26 日于山东大学

摘　要

卫生医疗服务在许多方面表现出巨大的城乡差异，如医疗资源占有、卫生筹资、健康消费、医疗保障等的城乡不均等。城乡卫生医疗服务不均等不仅影响到国民的健康，也会带来一系列社会问题。国内外现有研究在揭示城乡卫生医疗服务均等化的特征及原因方面虽然做出了一些很好的尝试，但总体而言尚不够全面和深入，忽略了一些重要问题，如城乡卫生医疗服务均等化的范围是什么？如何为城乡卫生医疗服务均等化制定标准？城乡卫生医疗服务均等化的实质是什么？城乡卫生医疗服务不均等有什么负面效应？卫生体制和其他的制度安排在城乡卫生医疗服务不均等中扮演了什么角色？而这些关键问题的解答显然对于我们更深刻地认识我国的城乡卫生医疗服务均等化具有重要意义。为此，本书在国内外已有研究的基础上，运用国际上较为先进和流行的方法对我国城乡卫生医疗服务均等化进行全面、系统的研究，以期完善有关城乡公共服务均等化基本理论，对我国城乡卫生医疗服务均等化及医疗体制改革实践提供科学的政策建议。

全书共8章，除第1章绪论以外，第2～4章是本书分析的基础和前提：第2章是有关城乡卫生医疗服务均等化的理论及实证研究综述；第3章是城乡卫生医疗服务均等化的机理分析；第4章是城乡卫生医疗服务均等化的国际经验。第5～8章具体考察中国城乡卫生医疗服务的公平性、城乡卫生医疗服务不均等的效应、中国城乡卫生医疗服务不均等的原因并提出对策建议：第5章从卫生筹

资、健康消费、医疗服务利用和健康公平等视角出发，对城乡卫生医疗服务的公平性进行分解分析；第6章剖析城乡卫生医疗服务非均等的经济和社会效应；第7章，从政府方、需求方、医疗保障方探究我国城乡卫生医疗服务不均等的原因；第8章为本书的政策建议部分。

第2章是文献综述。首先，梳理了西方的卫生医疗服务公平理论，即公共品理论、福利经济学理论、超福利主义理论、最大最小理论、平均主义理论，为我国城乡卫生医疗服务均等化研究奠定理论基础；其次，对卫生医疗服务公平的实证文献进行了回顾。第3章是城乡卫生医疗服务均等化的机理分析。首先从城乡卫生医疗服务均等化的内涵及实质出发，分析政府、供需双方、第三方四者在城乡卫生医疗服务均等化中的关联及其运行机理，并设计了城乡卫生医疗服务均等化的指标体系。第4章的经验借鉴部分，通过对亚洲的日本、韩国、中国台湾地区及欧美国家城乡卫生医疗服务均等化的制度安排进行考察，总结出其一般规律及启示。

第5章对城乡卫生医疗服务公平性进行分解分析。此章使用类似于税收再分配的方法对我国卫生筹资进行了分解分析；在医疗服务利用和健康公平性的分解分析上使用了集中系数分解方法；利用泰尔指数、基尼系数和阿特金森指数对居民健康消费不平等进行的分析。第6章对我国城乡卫生医疗服务非均等的效应进行分析。此章首先从公共健康消费和个体健康消费两个方面切入，利用面板数据模型分析城乡卫生医疗服务非均等造成的收入差距扩大效应。并分析了城乡医疗保险发展的经济和社会效应，使用倍差方法对城乡医疗保险改革的福利效应进行研究，利用TIP贫困曲线和PEN队列描绘我国医疗保险与城乡反贫困的关系。本章还利用健康绩效系数对健康效率和健康公平的权衡进行了计算。第7章对城乡卫生医疗服务非均等的原因剖析。此章首先使用空间计量经济学方法、面板数据分析了政府行为对我国城乡卫生医疗服务均等化的影响，然后分析城乡收入差距对卫生服务利用、健康、筹资的影响。

通过上述这些研究，本文得到了如下主要结论。

1. 城乡卫生医疗服务均等化是指政府参与其中的使城乡居民能无差别地享受同质的公共卫生服务、基本医疗服务和医疗保障服务的过程。城乡卫生医疗服务均等化的实质是公平，并且是公平与效率的统一；城乡卫生医疗服务均等化的目标是保证城乡居民生存和发展的起点公平、城乡居民基本就医权的平等以及公共卫生与基本医疗服务均等；城乡卫生医疗服务均等化的指标体系应由三个系统组成，即公平系统、效率系统及政府责任系统。发达国家（地区）的城乡卫生医疗服务均等化给我国的启示是：医疗保障模式应以社会医疗保险为主，必须强调政府责任。

2. 城乡间的差距构成居民总体健康消费差距的主体；东、中、西部居民健康消费差异特点各异；人口变动在减缓健康消费差距扩大方面起到的作用微小；最近几年，农村内部健康消费不平等逐渐缩小，城镇内部健康消费不平等逐渐扩大。

我国卫生筹资增加了收入不平等，表现出了亲富人的再分配，主要的原因在于水平不平等和再排序效应，如果相同收入的人群进行相同的卫生支付，再分配效应将会降低64%，另一部分原因在于卫生筹资系统的累退性。在同为从穷人到富人的再分配中，农村卫生筹资亲富人的再分配程度高于城市；农村卫生筹资的累退程度大于城市；农村卫生筹资的水平不平等小于城市。

我国存在亲富人的健康不平等、医疗服务利用不平等，高收入人群的健康状况更好并使用了更多的医疗服务，收入因素对医疗服务利用不平等的贡献在0.13～0.2，医疗保险等因素也扩大了医疗服务利用不平等；农村健康不平等程度总体上高于城市，健康不平等程度城乡均在加深；1991～2006年，城、乡收入变动对城、乡健康不平等上升的平均贡献率分别为7.08%和13.38%。

3. 城乡私人健康投资、公共健康投资差距都不同程度地对城乡收入差距扩大起到了强化作用。发生灾难性卫生支出的城乡家庭比例较高，最穷群体的医疗费用超过收入的比例增加，医疗保险对减少收入不平等只起到微弱作用。医疗保险补偿后，城乡患病家庭的贫困并没有减少，医疗保险在减贫上的作用很小。关于贫困特征的

多元回归模型显示，家庭成员较多、教育程度低、抚养比率高、参保人数比率低是贫困的诱因，条件多元回归模型则显示，医疗保险对贫困的变动没有影响。由于大部分弱势群体没有被医疗保险覆盖、医疗保险基金节余率高、国家投资责任不到位等原因，使得我国过去的医疗保险制度在城乡反贫困方面作用微弱。

在平均健康水平下降且健康不平等增加的情况下，我国的健康绩效呈现下降态势。

新农村医疗合作社增加了医疗服务可及性，但却对净医疗费用影响甚微。城镇医疗保险改革对预防性储蓄没有挤出效应，医疗支出风险并没有随着改革的推进而降低，是我国城镇医疗保险改革对储蓄没有影响的重要原因。

4. 政府重城轻乡、忽视社会发展的战略及卫生财政偏差是城乡卫生医疗服务非均等的根本原因。医疗卫生支出是消费支出的构成部分，其基础是收入（生产率）。农民生产率低收入少，其中能用于医疗卫生的支出也少，城乡收入差距严重地抑制了农村居民对医疗卫生服务的需求，造成城乡卫生医疗服务支出上的不均等。再者，医疗保险的严重分割也是城乡卫生医疗服务不均等的原因。

5. 实现城乡卫生医疗服务均等化需要政府统筹城乡发展还农民国民待遇。改变政绩考核标准、健全卫生财政制度、缩小城乡收入差距是实现城乡卫生医疗服务均等化的着力点。可分三步进行城乡医疗保险整合。

关键词 城乡　卫生医疗服务　均等化　制度安排

ABSTRACT

Health and medical services show enormous differences between urban and rural areas in many ways, such as the difference between possession of medical resources, health financing, health consuming, medical insurance and so on. The disparities of the health care services in urban and rural areas not only affect the health condition of citizens but also cause a series of social problems. In showing the characteristics and causes of the equalization of the health and medical services in urban and rural areas, the existing researches at home and abroad have made some good attempts; however, on the whole they are still not comprehensive or in-depth. The researches have ignored a number of important issues, which are, for example, what's the scope of the equalization of the health and medical services in urban and rural areas? How to set standard of this equalization? What's the essence of this equalization? Are there any negative effect of the equalization, and if there are any, what are they? What roles do health system and other institutional arrangements play in causing the inequality of the hearth and medical services in rural and urban areas? The answers to these crucial questions are obviously of great importance in deeper understanding of the equalization of the health and medical services in urban and rural areas in our country. To this end, this paper is working at the equalization in China based on the result of the existing study, using the more advanced methods. This paper is ai-

ming at perfect the basic theory in the equalization of public services in urban and rural areas, and provides scientific policy recommendations in the practice of the reform in medical system.

There are eight chapters in this paper. Chapter 1 is the preface. And Chapter 2 – 4 is the basis and premise of the analysis: Chapter 2 is about the review. Chapter 3 is the mechanism analysis of the equalization of the health and medical services in urban and rural areas. Chapter 4 is the international experience of this equalization. What Chapter 5 to Chapter 8 study in include the equity of the health care in Chinese urban and rural areas, the effects of inequality in health and medical services in urban and rural areas, the reason why there is inequality in these areas and propose suggestions. Chapter 5 makes the disintegration analysis of the equality of health and medical services in the view of medical financing, health consuming, the usage of medical service and health equity. Chapter 6 analyzes the economic and social effects caused by the inequality of the health and medical services in urban and rural areas. Chapter 7 explore the inequality of these services in urban and rural areas from the side of government, the side of demand and the side of supply in medical services. Chapter 8 is the part of the policy recommendations in this paper.

Chapter 2 is a part of review. Firstly, this part sort out the western theory of equitable health care services, that is, public goods theory, welfare economics theory, super-welfare theory, mini-max theory and egalitarian theory, which are the basis of researching in the health and medical equalization in urban and rural areas. Secondly, this part reviews the empirical literature for the equalization of medical and health services. Chapter 3 makes the mechanism analysis of the equalization of health and medical services in urban and rural areas. This chapter firstly analyses the association and the operation mechanism in this equalization by the four of the government, the supply and demand sides and the third-party by making the connotation and essence of the equalization of

health and medical in urban and rural areas clear. And then designs an index system of this kind of equalization. Chapter 4 is a part of the experience drawing, from study the system arrangements of equalization of health and medical services in urban and rural areas in Japan, Korea and Taiwan in Asia and some countries in Europe and America, summarize the general law and enlightenment.

Chapter 5 makes the decomposition analysis in the equalization of the urban and rural health care. The method used in analyzing the health financing is similar to that used in the redistribution of tax revenue; in analyzing the utilization of medical service and equity of health, this paper uses a concentration factor decomposition method; and in analyzing the consumption inequality of civil health consumer, this paper utilizes the Thiele index, the Ginny coefficient and Atkinson index.

Chapter 6 analyses the non-equal effects of the health and medical services in urban and rural areas. This chapter firstly analyzes the effects in widening income gap of the non-equal health and medical services in urban and rural areas, by using panel data models. It is analyzed with respect to the two aspects which are consumption of public health and consumption of individual health. Secondly, it analyzes the economic and social effects caused by the development of medical insurance for urban and rural areas. It studies the welfare effects of the medical insurance reform in urban and rural areas by the use of method of difference in difference; and describes the relationship between the medical insurance reform and anti-poverty with the use of TIP poverty curves and PEN queue. Moreover, this chapter also calculates the balance of efficiency of health and equity of the health by using the health performance coefficient. Chapter 7 analyzes the reasons for non-equal of health and medical services in the urban and rural areas. Firstly, it analyzes the effects of the equalization in health and medical services in urban and rural areas which are caused by governmental actions, using space econometric methods

and panel data. Then, it analyzes the effects in the use of health service and the health funding caused by the urban-rural income gap.

Through the above-mentioned studies, this paper has drawn the main conclusions as follows.

1. The equalization of health and medical services in urban and rural areas refers to a process, which makes the urban and rural residents enjoy the same public health service, basic medical services and medical insurance services with the Government's participation. The essence of the equalization of urban and rural health and medical services is fairness, and what's more, it's the unification of fairness and efficiency. The goal of this equalization is to ensure the equality of starting point in the survival and development of urban and rural residents, to ensure the equality of the right to get the basic medical treatment of urban and rural residents, and to make equalization of the public health and basic medical services. The index system of equalization of urban and rural health and medical services is composed by three systems, which is the fair system, the efficient system and the system of government responsibility. The enlightenment of developed countries (regions) of the equalization of urban and rural health and medical services are that medical support model should be based on community-based health insurance, and we must emphasize the responsibility of the Government.

2. The gap between urban and rural residents constitutes the main body of the health consumption gap between urban and rural residents. And the differences among the eastern, central and western regions have their own characteristics. Population changes play a minor role in reducing the widening the health consumption gap. In recent years, the internal non-equality of health consumption in rural areas is gradually shrinking, however, the internal non-equality in urban areas is gradually expanding.

The health financing of China makes an increase of income inequality,

shows a redistribution of pro-rich. The main reason of this is because of the horizontal inequality and the re-order effect, for example, if the same income groups make the same hygiene payments, the redistribution effect will be reduced by 64%. Another reason is because that health financing system is regressive. In the same redistribution between the poor and the rich, the extent of pro-rich is higher in rural areas than that in urban, the regression in rural health financing is greater than that in urban, and the level of inequality in rural health financing is lower than that of urban areas.

The inequality of health and medical services in our country is pro-rich, and the high-income groups are in better health conditions and consume more medical services. Income factors make the contribution of 0.13 – 0.2 in the inequality of the usage of medical services, and other factors, just like medical insurance, also expand this inequality. The degree of this inequality is deeper in rural than that in urban in total, and in both areas, the degree of inequality is expanding. In the year 1991 – 2006, the average contribution rates in the inequality of health in urban and rural made by the income changes are separately 7.08% and 13.38%.

3. The gap between urban and rural private health investment and the gap of that in public health investment have played an enhanced role on the urban-rural income gap. There is a higher proportion of urban and rural households in catastrophic health expenditure, and the percentage of the poorest groups of medical expenses in excess of their income is increasing. The medical insurance has only play a weak role in reducing income inequality. After the medical insurance compensation, the number of home in poverty in urban and rural areas has not decreased, and medical insurance has a very small fluctuation in reducing poverty. The multivariate regression model about the poverty characteristics shows that more family members, lower levels of education, higher dependency ratio