

Providing Health Insurance in Rural China: From Research to Policy

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Abstract The focus of this case study is utilizing research to influence policy in a large developing country. Our experiences involve the lack of health insurance for China's rural populations and how our research helped shape China's recent policy attention and efforts on this issue. More than 80 percent of China's 700 million rural residents have no health insurance. This has been the case for the past thirty years, since the collapse of the once-successful Rural Cooperative Medical System after the economic reforms of the early 1980s. In 2002, the Chinese government announced a new rural health financing policy to provide health insurance for its rural populations, financed by a matching fund with contributions from central and local governments, as well as from individual households. This article documents the authors' experiences in addressing several critical questions for converting research results into policy actions, including the following: How are researchers to address policy relevant questions? How are they to acquire the attention of top policy makers to a specific problem? When is the issue at hand serious but not yet critical? And lastly, how are researchers to develop policy recommendations that stand a good chance of being accepted and enacted? Major lessons learned include the need to better understand the mandates and institutional constraints of the policy makers, the appropriateness of timing of both research result and policy efforts, how to use a country's cultural context to garner support of the government, how to enhance the policy's impact by combining formal and informal channels of communication for research dissemination, and the importance of following the policy process through the implementation phase to ensure the original objectives are achieved.

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Context

China is the largest country in the world with a total population of 1.29 billion. About 70 percent of the Chinese population live in rural areas and are engaged primarily in agriculture. During the second half of the twentieth century, China experienced two distinct development eras: the era of egalitarian society (1950s–1970s) and the era of economic liberalization (1980s–1990s). Since the collapse of the once successful Rural Cooperative Medical System (RCMS)¹ in the early 1980s, the majority of the rural populations remained uninsured. On October 29, 2002, however, the China National Rural Health Conference was held in Beijing (Yin 2002). This was the first rural health policy meeting held by the national government in China since 1949. At the conference, the Central Party Committee and the State Council jointly announced nine major national policies to support and strengthen the rural health care financing and delivery systems. These policies range from establishing new forms of the Rural Cooperative Medical System to upgrading rural township health center facilities. Financial support for each policy is provided by different levels of the government. China's most important new policy establishes a rural health insurance system for the currently uninsured 700 million rural residents. According to the new policy, the central government will provide medical assistance to the poorest of the poor. Moreover, China's lower-middle-income citizens will receive health insurance subsidies of more than 20 yuan (US\$2.50) with matching funds provided by central and local governments. To those unfamiliar with the Chinese health system, support of 20 yuan (US\$2.50) per capita from the government may seem insignificant. Indeed, this amount of money is by no means sufficient to purchase a comprehensive health benefit package for the rural populations in China. Nonetheless, it is the first step toward more progressive subsidy policies. It is important to note that for the past thirty years, the Chinese governments have provided no financial support to the purchase of health care services for rural farmers. Considering this context, China's new

1. The RCMS was an integrated part of the overall collective system for agricultural production and social services. Under RCMS, the financing of health care relied on a prepayment plan. Most villages funded their RCMS with three sources: (1) premiums—depending on the plan's benefit structure and the local community's economic status, 0.5 to 2 percent of a peasant family's annual income (4–8 yuan) was paid to the fund; (2) collective welfare fund—according to state guidelines, each village contributed a certain portion of its income from collective agricultural production or rural enterprises into a welfare fund; (3) subsidies from upper-level governments. In most cases, this subsidy was used to compensate health workers and purchase medical equipment.

policy represents a historic breakthrough and a fundamental shift toward a more equity-oriented social policy.

What is the government's new motivation to assist the rural poor in acquiring health insurance? This article tries to shed some light on the iterative process that led to this new policy in China. According to Nancy Milio's (1987) model of the complex process of public policy making, policy develops and is transformed on the basis of underlying beliefs of (1) the causes of a problem and (2) the potential effects of alternative interventions. This process occurs within the prevailing social, political, and cultural context. Therefore, research studies that vigorously analyze the causes of the problems and develop intervention strategies sensitive to the social, political, and cultural constraints are important for informing and influencing policy decisions. Furthermore, we highlight another critical element that relates to the uptake aspect of the policy process as described by Jonathan Lomas (1997). As a necessary condition for initiating the policy-making process in motion, the perceived seriousness of the problem and the urgency to solve it must exist among policy makers. This is especially important in authoritarian countries such as China, where public policies are rarely driven by opinion polls and where policy makers have powerful discretion with both policy focus and approach.

In this article we describe a research study that we conducted in 2001 (Liu, Rao, and Hu 2002). The study, which focused on China's rural health insurance, captured the attention of China's leaders. Major recommendations from that study were translated into the government's new policies. We would also like to note that some of our information was acquired through our access to insider stories, so the reader may want to keep this in mind as to our possible bias. In the Discussion section, we outline major lessons learned from our experiences in interacting with policy makers in China, including successful steps that we took as well as other important steps we should have taken. To begin, we first provide a brief discussion of the relevant research and policy background in China, creating a context from which this case study can be better understood.

Background: Health Equity Research

Before 1990, health equity was essentially a nonissue in China's public health and health-related research. In large part, the lack of research on health equity was due to the society's preoccupation with economic growth while paying little attention to distributive justice. China has no free and independent press, nor is there free and independent research. The major-

ity of Chinese universities and research institutes are owned and operated by the government, which molds their research interests. Domestic support for health and health services research mainly comes from government-controlled foundations, such as the China National Foundation for Natural Sciences and the Ministry of Health. The majority of research funding for health has gone to the clinical sciences and very few resources are allocated to health policy research, let alone on health equity. Meanwhile, the government's persecution of political dissidents before and after the Tiananmen demonstration in 1989 made many social scientists wary about undertaking equity studies, which points out problematic issues for the Chinese government.

This situation changed early in the 1990s, when studies on socioeconomic inequalities in health began to emerge. Most of these studies were either led by international scholars or funded by international resources. The World Bank conducted one of the earliest survey studies on health inequality (World Bank 1992). This survey, which was conducted in nine provinces in 1987 and 1992, showed that the percentage of stunted children in rural areas had actually increased, indicating increasing health disparities among the Chinese population. In 1993 and 1998, the Ministry of Health conducted two national health services surveys. Reports from these surveys, for the first time in China, documented health disparities among China's four different rural regions (grouped mainly by income level; Ministry of Health 1994, 1999). Before these reports were published, China had no national health statistics by socioeconomic groups. In a paper published in the *New England Journal of Medicine*, data on the growth of Chinese children (measured as height for age) again indicated increasing health disparities between urban and rural areas, despite overall improvement (Shen, Habicht, and Chang 1996). In 1998, the Rockefeller Foundation supported China's first systematic study on health equity. This study also showed increasing health inequalities during China's transition (Liu et al. 2001). Around this time the concept of *health equity* began to spring up within China's academic community (Rao 2000). However, study findings, by and large, had little impact in capturing the attention of China's policy makers. Instead, the Chinese government's top policy priorities during the 1980s and 1990s were economic system reforms and economic growth. Health improvement and access to health care were seen only as a by-product of economic growth. It was believed that if China's economy continued to grow, health improvement for all would eventually follow.

Since the late 1990s, other international agencies increased their sup-

port of equity-related research studies and interventions, with benefits targeted at China's poor. The United Nations Children's Fund (UNICEF) funded a seven-year health financing study on China's rural poor (Hu 2000). The World Bank and the British government jointly supported pilot projects to improve financing and delivery of health care in China's poor rural areas through their loans (Health Loan VIII) and aid programs. These studies stimulated discussions on health equity in China and raised questions about the government's lack of attention to equity. The World Health Organization (WHO) *Report 2000*, which ranked China's health system performance in terms of fairness of health care financing near the bottom of its list, also helped create momentum for China's health equity discussions within and beyond the academic circle. It should be noted that, with few exceptions, China's health equity studies tended to focus on problems related to access to health care, rather than on socioeconomic inequalities in health. This choice of focus may reflect the society's prevailing beliefs about health equity—China was not prepared to cope with health inequalities in a comprehensive way. Indeed, what was judged as inequitable and unacceptable by the Chinese policy makers was the lack of access to basic health services for low-income and vulnerable peoples; policies seemed to be consistent with this social sentiment. This issue will be further explored in the following section.

Policy Environment: The Paradigm Shift

The People's Republic of China was founded on the principles of an egalitarian society in 1949. Subsequent policy developments under Mao in the 1950s–1970s emphasized social equality, rather than economic efficiency. After the inception of the economic system reform programs in the early 1980s, however, China embarked on a development path through marketization. In this process, efficiency and economic growth were promoted as the country's top priority. Two major consequences on China's overall policy development process came from the Chinese Communist Party's (CCP's) emphasis on this growth-centered policy: First, inequalities were no longer considered to be necessarily negative. According to Deng Xiaoping, if increasing inequality could assist with poverty reduction and economic growth, why not “let some people get rich first” (Stanley 2001). Second, social policies, including health policies, have taken a backseat to other policy issues. China's leaders only found social policies relevant when they were perceived to affect social stability and economic development. Problems brought about by this *laissez-faire* attitude toward health

policy were further exacerbated by the fiscal system reforms of the 1980s when the role of the central government was significantly reduced. As part of the economic stimulation package, China's fiscal system was decentralized to give local governments more autonomy. Local governments are now responsible for health planning and supervision of health care markets. Not surprisingly, variation across regions increased regarding health inputs and outputs, according to the region's economic development and government policies. Besides a poverty alleviation fund, low-income regions received very little in payment transfers from the central government.

Rural Health Financing

It is important to note that unlike other socialist countries, China, even under Chairman Mao, never adopted a nationalized health system guaranteeing free access to health care for every citizen. Instead, China's experience with the urban and rural health systems differed with a strong urban bias regarding public resource allocation. Health care in the cities was mainly financed by the Government Insurance System (GIS) for the government employees and the Labor Insurance System (LIS) for the enterprise workers. (LIS is a self-insurance scheme subsidized by the government by tax expenditures.) By contrast, rural health financing was mainly based on community financing schemes called the Rural Cooperative Medical System (*He Zuo Yi Liao*; Zhang 1992). By the mid-1970s, about 90 percent of China's rural villages (called communes at the time) were covered by RCMS schemes. This community financing and organization model of health care was believed by many to have contributed significantly to China's success in accomplishing health improvement at a low income level (Sidel 1972, 1993; Hsiao and Liu 1996). From 1949 to 1973, the infant mortality rate was reduced from about 200 per 1,000 life births to 47 per 1,000 life births, while life expectancy was increased from thirty-five to approximately sixty-five years of age (Ministry of Health 1999; Hu 1995; Liu et al. 1996).

As China has moved away from a central planning toward a market economy, its health system has taken on a trend of marketization (Jamison 1984; Chen and Zhu 1984). Similar to the experience in the economic sector, health care access was increasingly dictated by the ability to pay. In rural areas, agricultural collectives transitioned to household responsibility systems and weakened the financial base of the cooperative medical system. This resulted in the collapse of RCMS schemes in the majority of

rural communities. By 1993, only about 13 percent of rural residents had insurance coverage (Ministry of Health 1994). Furthermore, while total health spending as a percentage of gross domestic product increased from 3.1 percent in 1980 to 4.82 percent in 1998, the government share of the total spending decreased from 36.4 percent in 1980 to 15.5 percent in 1998 (against international trends). Over the same time period, out-of-pocket spending as a share of total spending increased from 23.2 percent to 57.8 percent (Health Economics Institute 2002). Since the collapse of the once-successful RCMS in the early 1980s, many rural communities, especially the poor ones, faced several major problems. Currently 90 percent of the rural population is uninsured, paying out-of-pocket for any health service received. User charges and high direct costs effectively block access for many rural residents who lack adequate income to purchase basic health care when needed. Lost workdays and bedridden days are twice as high as the national rural average in poor rural areas (Liu et al. 1996). Therefore, rural residents usually do not see a doctor when they are ill, unless and until they are seriously ill. Then, medical expenses can cause financial impoverishment for the rural families (Liu, Rao, and Hu 2002).

Major Factors Affecting the Development of Rural Health Insurance

If the need for a rural health insurance system is so great, a question naturally arises: Why has no such system been vigorously developed in China? There may be several reasons for the government inaction in this area, including rural farmers' lack of political voice and the government's budget concerns. Although the majority of the Chinese population lives in rural areas, the rural sector is much less organized than the urban sector. Economic system reforms in China brought about the downfall of collective farming. In the 1980s, the agriculture sector in China was transformed from people communes into a household production responsibility system. This system functions as individual farm families work on their contracted plot of land on a long-term governmental lease. Except for limited small-sized rural production cooperatives, there have been very few social organizations in rural China. Rural farmers are underrepresented in the political process (Oi 1999). In contrast, urban workers have more channels for getting their concerns heard, either through unions or through organized strikes or protest (Saich 2001). Although there have been some published studies documenting problems associated with the lack of rural health insurance, most of these studies are limited to certain

regions of China, leaving it unclear as to how serious the problem is at the national level. Therefore, while serious efforts were made in urban health insurance reform since 1996 (Liu 2002), little progress has been made for rural health.

Lack of progress in rural health also reflected misjudgment of some policy makers. Given China's past success in community financing schemes, many government officials hoped that with economic growth, the demand for health insurance would increase. This increasing demand would automatically lead to community initiatives to address the health insurance issues. Should community initiatives be spread over the country, it was believed, then the government would not need to bear the heavy financial burden of financing the rural health insurance (which conceivably is quite large given the sheer size of China's rural population). In December 1996, the central government announced its policy direction of encouraging voluntary community insurance schemes (State Council 1997). Besides well-known problems with voluntary schemes, such as adverse selection, the lack of government financial backing prevents many rural communities from establishing the hoped-for local insurance schemes.

There are several reasons necessitating government support for rural health. First, increasing interregional inequalities in economic and social development imply that some communities will certainly be excluded, particularly if developing the rural health protection system is totally subject to the discretions of local communities. There are always communities where the stock of financial and social capital is too low for any meaningful health protection system to be formed. Second, establishing a rural health protection system in China, where the market for health insurance is yet to be developed, requires both that the institutions have sufficient authority and skills for fund collection and risk transfer and that the people trust these institutions. Except for coastal regions or those regions with well-developed township and village enterprises (TVE), many rural communities lack alternatives to government organizations for handling the complicated process of problem identification, benefit design, social marketing, fund collection, contracting and management, and so forth. This is especially the case for poor rural areas. These and other problems were vigorously analyzed by a collaborative study that helped trigger remarkable policy responses.

The Asian Development Bank Study and Its Impact

Our Team

In January 2001, the Asian Development Bank (ADB) commissioned Dr. Yuanli Liu of the Harvard School of Public Health to undertake a study on China's rural health security issues (the ADB study). This study was cosponsored by the State Development and Planning Commission (SDPC), China's leading ministry for establishing the country's major economic and social development goals and strategies. The ADB study was not the first large-scale study Dr. Liu undertook focusing on China's rural health care. Eight years earlier, a Harvard team led by William Hsiao and Yuanli Liu conducted a seven-year initiative of China's poorest counties (referred to from here on as *poverty counties*), performing first a survey study on 114 poverty counties (1993–1996) and then an intervention study in 10 of the poverty counties (1997–2000) to develop new forms of community financing schemes within the market economy. It was through these cooperative and policy-relevant activities that the Harvard team earned respect among the policy makers, as well as academics, in China.

To ensure a high-quality product and an effective dissemination process, Dr. Liu enlisted two leading experts in China, Dr. Keqin Rao and Dr. Shanlian Hu, as consultants. The two are also the coauthors of the final study report. Dr. Keqin Rao, director of the Center for Health Statistics and Information at the Ministry of Health, is an adjunct professor of social medicine at Beijing University. He led China's two national health surveys in 1993 and 1998, and he has been a key policy adviser to China's three different health ministers. Dr. Rao is also the co-principle investigator of the China Equity Gauge project, monitoring China's changes in socioeconomic inequalities in health. Dr. Shanlian Hu is one of China's leading health economists and is based at Fudan University. Performing an intensive data analysis and bringing their extensive working experiences from their respective fields to this project, Drs. Liu, Rao, and Hu sought to answer three major questions: (a) What are the major problems with lack of health insurance coverage for the rural populations? (b) What are the major reasons for the lack of a viable health insurance system in rural China? (c) What are some of the necessary and feasible policy recommendations to make such a system possible? The highlights of the study follow.

Major Problems from Lack of Insurance Coverage

In 1993, insurance coverage for rural residents was already quite low (12.8 percent). By 1998, only 9.5 percent of the rural population was insured (Ministry of Health 1999). Using the 1998 National Health Services Survey data, we estimated the impact of medical expenditure on the poverty head count for different rural regions.² The head count for the whole rural sample is 7.22 percent. Out-of-pocket spending on health care raised the head count by more than 3 percentage points. In other words, medical spending raised the number of rural households living below the poverty line by 44.3 percent. Similarly, the impact of medical expenditures on poverty gaps is also alarmingly large. For the total rural population as a whole, the poverty gap increased by 146 percent when accounting was done for poverty caused by medical expenditure. As it turned out, it was the magnitude of medical impoverishment that we discovered using the national survey data that caught the attention of China's policy makers and will be discussed in a later section.

Policy Recommendations: Three Models for the Three Worlds

What should be done then about China's rural health insurance? Given China's low-income level and the vast geographical and population size of the rural communities, we did not believe that a universal rural health insurance program, however desirable it may be, was immediately feasible. Furthermore, given China's decentralized fiscal system and diverse needs in different regions, many of China's recent economic and social policies have been developed and tailored to the special regional needs and institutional characteristics. Therefore, instead of developing a proposal

2. China's official poverty line for rural residents in 1998 was an annual per capita income of 635 yuan (US\$80). The poverty line in China, which is different for urban and rural residents, is based on the estimation of minimum costs for a subsistence living by taking into account basic needs such as minimum calorie intake (food consumption needs), shelter, clothing, and so forth. *Poverty head count* is the percentage of sampled households with reported per capita income below the poverty line. *Poverty gap* is defined as the total amount of money that would be needed to bring those people, whose income is below poverty line, out of poverty. Several cautionary notes are warranted in interpreting this statistic: (a) Income for the rural residents is not disposable income. It is defined as including farm produce people grow for their own consumption. (b) The aggregate statistics of poverty head count masks the significant variation among different rural regions in China. For example, in China's poorest regions, the poverty rate is as high as 25 percent.

for establishing a nationalized rural health insurance system, we recommended three different models of rural health insurance to address the unique needs and challenges in China's three different types of regions.

Different socioeconomic conditions and health care needs render a three-worlds characterization of China's vast rural areas: the coastal high-income region (the first world), the central middle-income region (the second world), and the western low-income region (the third world). Based on assessment of need, government responsibilities, and feasibility, three different models of rural health protection systems are proposed for the three worlds. These include a medical assistance system (Medicaid) for the low-income region, an enhanced RCMS system (RCMS-Plus) for the middle-income region, and a hospital insurance system (Insurance) for the high-income region.

People living in poor rural areas (e.g., in the poverty counties designated by the central government) experience difficulties accessing basic primary health care services. Moreover, due to limited income, a relatively small amount of medical expenses can cause financial hardship or even deepen poverty status. Therefore, at a minimum, health protection systems in low-income regions should ensure access to a basic set of cost-effective health care services, such as professional-assisted deliveries (at home or in the hospitals). In addition, the system should also provide a certain level of financial aid to families that are medically impoverished. In middle-income regions, access to primary health care services is less of a problem. But these middle-income regions (currently the majority of China's rural communities fall under this category) have the greatest variation in income levels and in levels of financial vulnerability to health care costs. Therefore, people often need and demand more comprehensive coverage of health care services, including outpatient visits, drugs, and inpatient care. By contrast, those in high-income regions do not experience serious problems with accessing primary health care services. Most households in this region can afford to purchase primary health care services on their own. Rather, what they most need from a rural health protection system is a mechanism to help protect themselves against catastrophic medical expenses often incurred as a result of episodes of hospitalization. Hence, we propose that the emphasis of health protection systems for high-income regions be hospital insurance.

Ideally, more than one source of funding is needed for all three models. Concerns for different financial needs and capabilities, however, led to a proposed major source of funding relative to other sources for each of the three models. The equity principle of a socialist market economy dic-

tates that governments, particularly the central government, should take a major responsibility in financing health protection systems for the poorest population of the society. The central government presently provides 30-yuan-per-capita subsidies for free care for Tibetan residents, matched by an almost equal contribution from the household. Due to political considerations, the central government has been providing generous subsidies to health and education sectors in Tibet. It would be hard to ask the central government to immediately treat every poverty county in China just like Tibet. We therefore recommended that the central government provide a 12-yuan-per-capita subsidy to create health protection systems for the nationally designated poverty counties. As for the middle-income regions, government financial support is still necessary both for the start-up costs and for stimulating private contributions for health protection. The majority of funding needs would have to be met by household contributions, due to local governments' limited revenue bases and few collective enterprises. High-income regions, with very few exceptions, are distinguished from other regions by their strong TVEs. Therefore, in these regions community-based collective funding possibilities can be tapped to help finance rural health protection systems that mainly cover low-probability events but that result in high financial loss. Relying on voluntary private contributions for insurance of this type would create problems of low effective demand (thus low contribution rate), and adverse selection. While government financial support is not necessary, it is still imperative that the government plays an active role in organizing the schemes under the market economy in China, where the social movement for risk sharing is not particularly strong.

The International Seminar in Beijing

After the ADB study was completed, resulting in a seventy-page research report, the State Development and Planning Commission organized an international seminar in Beijing in July 2001. The purpose of the seminar was to present and debate the study's major findings and recommendations among the leading experts and key advisers to China's top leadership. To ensure substantive exchange among participants and to help establish a sense of ownership of the report by major stakeholders, both English and Chinese versions of the study report were sent to the invited commentators before the meeting. Invited commentators included international experts from the World Health Organization and Harvard University, as well as senior officials (director-general-level officers) from China's major

ministries (including the State Council Research Office, State Council Office for Economic System Reforms, Ministry of Health, Ministry of Finance, and Ministry of Agriculture). Over seventy participants attended the seminar, including representatives of several line ministries of the central government, various provincial governments, leading economists, and other experts from China and the international community. After the seminar, the report's authors worked together with seminar organizers to revise the report, incorporating useful participant recommendations. A policy briefing paper was produced by Madame Hou Yan, division chief of health and social security of the SDPC, and her staff and was then sent to the office of Premier Zhu Rongji.

The Call from President Jiang Zemin

Premier Zhu Rongji, also known as China's reform-minded "Economic Tsar," has gained a reputation for his obsession with China's economic growth. Although it would be an unfounded accusation to state that he was not interested in health at all, health certainly was very low on his priority agenda. At one time, so the story goes, upon hearing of a Ministry of Health proposal to use an earmarked cigarette tax to finance health, he was prompt to state, "That's great—we can raise that much revenue from increasing the cigarette tax. That will help a great deal with our Three Gorges Dam Project!" Therefore, it was not surprising that no immediate reaction was heard from the premier's office after the SDPC's policy briefing paper had been sent. And had President Jiang Zemin not taken a personal interest in the issue, the situation in China today may have been completely different. The man responsible for motivating the president into action was none other than Dr. Zhang Wenkang, China's health minister.

For most of his life, Dr. Zhang had served in the army. Before coming to Beijing to work as the deputy commissioner of health in the Logistics Department of the Army, he worked for many years at the Number Two Military Medical University in Shanghai, first as an instructor in submarine medicine and then as vice president of the university. During his time in Shanghai, he befriended the then-mayor Jiang Zemin. Dr. Zhang was transferred from the army to the civilian sector to work as one of the vice ministers of health in 1993. Relatively inexperienced in the civilian sector, very few could have predicted Dr. Zhang becoming China's health minister only a few years later. But Minister Zhang is an intelligent man and learned quickly in this field. He is known for surrounding himself

with wise scholars, especially health policy analysts, and he is one of the very few ministers who can sit through lengthy senior policy seminars. Naturally, with his appropriate abilities, Minister Zhang became one of the first readers of our ADB study report. One day, after summoning Dr. Keqin Rao, one of the coauthors of the report, into his office, he stated, “Xiao Rao [*Little Rao*], I read your report three times. It is very good. Look.” He then showed Dr. Rao the many notes he made in the margins of the report pages, and continued: “I want you to do two things for me: first, make copies of this report for Chen Xiaohong [director-general of finance and planning] and Li Changming [director-general of primary care and maternal and child health]; secondly, I want you to reduce the seventy-page report to a report of no more than five pages; and lastly, I’d like to work with you to turn that five-page document into a personal letter from me to President Jiang Zemin.”³ Dr. Rao then spent the next two days and nights working on the letter, based on the major findings and recommendations of the ADB study. “This is perhaps the most exciting assignment in my life!” stated Dr. Rao. When it was personally revised and fine-tuned by Minister Zhang himself, the letter was then delivered by Minister Zhang’s special assistant to the office of President Jiang Zemin.

Knowing him as a statesman and personal friend, Minister Zhang was sure that President Jiang Zemin would find some time from his busy schedule to read his letter. What came as a total surprise, however, was the call Minister Zhang received from the president the very next day. “Wenkang,” the president said, “I am totally shocked by what you said about the rural situations. Are you sure that family bankruptcies due to medical expenses accounted for a third of the rural poverty?!” Minister Zhang told the president: “Mr. President, I was only quoting results of an independent study. You might want to send out researchers to further investigate the issues. But to be totally honest and frank, I don’t think the party, or the government, has done an adequate job caring for the rural population. They have been left behind by the current health system.” A few days later, Dr. Rao received two visitors from the Policy Research Office of the Central Committee of the Chinese Communist Party, asking him detailed questions about the study, the sources of the data, and the rationale of the study’s policy recommendations.⁴ The Policy Research

3. All stories and quotations in this section are from personal communications with Keqin Rao in November 2002.

4. To understand China’s policy-making process, it is critical to understand the role of the CCP. Even though other democratic parties exist, China is still ruled by one party. Except for the village heads, who are now elected by the villages, all government officials (ranging from

Office interviewed others responsible for the policy's recommendations as well. Two months later, the need for the government to do more in the area of rural health care started springing up in speeches of China's top leaders. Then, in November 2001, the State Council Office for Economic System Reforms was formally charged with the responsibility of coordinating the development of China's new rural health policies.

The First National Rural Health Policy Conference

The national policy-making process in China generally includes the following steps: First, relevant line ministries are urged by the Central Party Committee or the State Council to draft policy documents, with one national agency serving as coordinator. Second, draft policy documents are discussed during several rounds of politburo meetings. Third, when the policy documents are finalized, a national conference is scheduled to publicly announce the new policies. As an indication of insufficient policy attention focused on rural health, there had been no national conference on rural health since the founding of the People's Republic of China in 1949. But everything changed in 2002. Since the beginning of that year, the Ministry of Health, negotiating and fighting with other ministries (especially the Ministry of Finance), had begun working diligently to create and maintain the momentum for developing China's new rural health policies.

The timing of China's first conference on rural health was not an easy decision for Minister Zhang, who had been so instrumental in the whole process, to make. The year 2002 was marked as a historical year for modern China. Later that year, in November, the Chinese Communist Party would convene its Sixteenth Congress, during which a new generation of party leadership and (thus the new administration) would be formed. On the one hand, the central government was keen to hold the rural health policy conference right before the Party's Sixteenth Congress to demonstrate the Chinese Communist Party's commitment to the people and their needs. At the same time, however, for anyone who genuinely hoped for the implementation of the new policies, it made sense to hold the conference

mayors and governors to prime minister) are appointed by the CCP. The executive branch (including the line ministries) and the party apparatus (e.g., party secretaries at different levels of the administrative chain) jointly decide on major economic and social policies with the party holding the veto power.

after the Party's Sixteenth Congress so that the new administration would see this as its own initiative. This way the new administration would have a greater incentive to see the policy process through to implementation, rather than viewing the policy as some political hangover from the former administration. Minister Zhang was advised that holding the conference before the big party meeting should be conditional on the real resource commitment behind the new policies from the Ministry of Finance. The political negotiation was helped by the fact that the State Council person in charge of scheduling major national conferences, Gao Qiang, happened to be a former deputy finance minister who was very supportive of the idea that government should do more to help the rural populations improve their access to health care. Gao Qiang was able to assist in influencing and garnering the Ministry of Finance's attention and potential financial support, so the conference was scheduled with some real resource commitment.⁵ For the first time in China's modern history, a national conference on rural health care was held, with the attention and attendance of China's key leaders.

Discussion

The year 2002 was a monumental year for the hundreds of millions of rural Chinese, as the Chinese government finally decided to provide financial and organizational support for the establishment of new forms of the RCMS. This would provide insurance coverage for the currently uninsured rural population.⁶ This was extremely exciting because our study played a key role in this policy-making process. Although the ADB study was instrumental in drawing the leadership's attention to the health inequities experienced by China's rural populations, other important contributing factors include the government's increasing its financial capability to pay for social services as well as the publication of the *World Health Report 2000*, which shocked many within the central government by ranking China's

5. Interestingly, Gao Qiang later replaced Minister Zhang Wenkang during China's SARS crisis.

6. Recognizing that many rural communities cannot establish the needed rural health insurance schemes by themselves, the government changed its old policy of RCMS relying totally on local resources. While encouraging the high-income regions to develop hospital insurance schemes supported by the local governments, the new policy stipulates that for the 400 million rural residents who live in China's midland and western regions (China's lower-middle-income regions), the central government will provide 10-yuan (US\$1.25) premium subsidies per capita to be matched by at least 10-yuan contributions from the provincial and lower-level governments and at least 10-yuan contributions from the individual families.

fairness of health financing near the bottom of WHO's member countries. However, had the ADB research not been performed, the Chinese government may have delayed indefinitely the policy decision to assist the rural population with an improved health system (Lawrence 2002). Several valuable lessons can be drawn from our successful experience, and these lessons will be explored in the following section.

Undertaking Policy Relevant Study

There are two major points regarding the importance of determining a policy's relevance: the perceived urgency of a problem by the policy makers and the feasibility of solving the problem with the given economic and political constraints. Our first success was the ADB study's demonstration to China's policy makers that the problem associated with lack of health insurance coverage for the rural populations is a very serious one. Although there have been previous case studies in some regions and anecdotal stories as to the grave situation for rural populations needing health care, the ADB study was the most systematic in terms of empirically examining the impact of the problem and analyzing both the demand and the supply side of an equitable and efficient health system. The ADB study was the first to use national survey data to illustrate the scope of the problem at the national level. Moreover, in light of the political reality that economic development and poverty reduction, not health, are seen by most national government leaders as the most important policy focus, the ADB study estimated the poverty impact of out-of-pocket medical expenses, emphasizing dramatic increases in poverty among the rural populations due to lack of sufficient and affordable health care. As it turned out, it is the finding that rural families' financial bankruptcies due to high medical expenditures accounted for a significant portion (about one-third) of the rural impoverishment that shocked President Jiang Zemin into taking action. After all, China is most proud of its record in lifting over 200 million people out of poverty over the past thirty years. Many political leaders in China, not unlike many of their counterparts in other developing countries (Commission on Macroeconomics and Health 2002), believe that a rising economic tide can help raise everyone's economic standing. Namely, it had been believed that China would automatically outgrow many of its social problems (health included), without the need of developing specifically focused policies in the meantime. Surprisingly, the ADB study had a profound impact in transforming these previously rigidly held beliefs about development.

Crucial in drawing attention to and support for our findings, we analyzed the major causes of the problem and proposed sensible solutions. Frequently, scholars have enjoyed describing how bad the situations are, but stopped short of developing constructive solutions. At the same time, there are so-called international experts who like to transplant models from the industrialized world (e.g., private insurance) or from another developing country without carefully examining the suitability or appropriateness of the models for the country concerned. Careful to not make similar mistakes, we came up with constructive solutions that were flexible to the specific needs of each income region. Three models were developed (in terms of different financing sources and benefit packages) for China's three different rural regions, as we were cautious to not apply a one-size-fits-all model for all rural areas of the whole country. It is our belief that the modest amount of financial subsidies asked of the government combined with differential treatment of different regions (resulting from our efforts to carefully match recommendations to the specific needs of the various regions supported by the data) helped sell our recommendations to China's national policy makers.

Conducting Timely but Timed Information Dissemination

Upon finishing the first draft of the study report, we used the international seminar as an opportunity to seek wide consultation from many experts in the development community and government technocrats, branching outside of the health realm for criticism and advice. This exercise not only facilitated our improving the research product, but also helped establish a sense of collective ownership and support among the important stakeholders. Second, we utilized the momentum from the seminar and promptly worked with major government agencies such as the State Development and Planning Commission and the Ministry of Health to develop briefing papers for China's top leadership. At the same time, we did not publicly release our study results immediately. This turned out to be an important strategy considering the Chinese context. In a democratic society, mobilizing social movement for a cause and publicly embarrassing the government for lack of attention to crucial matters may be very effective in forcing them to take action. In China, however, a large country with one-party rule whose leaders are paranoid about social stability, a better approach was to allow the leaders to hear the bad news first, providing them time to prepare a response, while informing them of a later date for

publishing the study findings regarding the unfortunate rural health situation to the general public. This provided the government policy makers the ability, should they be confronted by the media or the public about the issue later on, to be in a better political position to state that they are fully aware of the problem and that they have already commenced appropriate actions to begin ameliorating the situation. Throughout the policy process, we worked with the policy makers as true partners. We utilized a team mentality to achieve our mutual goal of improving the health status for the rural population of China, while curbing the poverty rate increase resulting from medical bankruptcy. Because of this cooperative approach, we were able to create a constructive partnership with policy makers instead of experiencing the commonly held confrontational relationship that researchers and policy makers often possess with each other.

Several years have elapsed since the 2002 national health policy conference on rural health in China. After further analysis and examination of the progress since, we wondered what we could have done differently and if we relaxed our effort too early, claiming victory prematurely. The success we experienced in this process has been delineated in the steps listed above. We now would like to conclude this case study with some self-critical observations of our experience.

To begin, while the new policy certainly represents a momentous move forward on behalf of the rural populations and their improvement in equitable health financing, it is by no means the best the government can do. Judging by the significant amount of resources the government poured into fighting the SARS crisis, the 20-yuan-per-capita premium subsidy that was finally provided by all levels of the government appears to reflect a minimalist approach on the part of the government to support rural health insurance. Moreover, regardless of local economic conditions, every local government and household is asked to contribute the same amount to the insurance fund, which is then uniformly managed by the county government with little administrative transparency and accountability. This aspect of the rural health system in itself could be improved to be more efficient and effective in appropriately addressing the health needs while respecting the varying levels of financial ability to contribute to health.

Meanwhile, we did not involve ourselves in the process of developing detailed programs and policy guidelines, but basically allowed the bureaucratic process to take its own course. Bureaucrats are not reputed for being creative thinkers and visionaries. Instead, they tend to focus narrowly on issues and are able to devote limited attention to each issue. For

example, if reducing medical impoverishment is the major policy goal, cost containment and efficiency improvement in China's rural health sector should have been part of the solution. Instead, the new policy almost exclusively focused on insurance. Given the momentum we helped create and the respect we earned for our work, we could have been more active and effective in the policy design phase and worked to ensure the policy creation appropriately reflected the health inequities and needs our research found.

China has also been piloting the new RCMS schemes in many provinces since 2003. Preliminary experiences from some pilot sites indicate that the process of implementing a new policy was much more complicated than expected. To begin with, the very low level of premium contribution rate by the governments and households (30 yuan per capita) cannot be expected to significantly reduce medical impoverishment through the new RCMS schemes. Furthermore, this small amount of funding can be misused due to technical incompetence or political corruption at the local level. There is a significant need for technical assistance in the implementation phase, which we as technical experts could provide. The expression "the devil's in the details" rings true with regard to complexities arising in the design and implementation of adequate basic benefit packages that balance coverage of primary care services and catastrophic spending, the methods of contracting and paying providers to ensure quality and promote efficiency, and the manner in which deficits and financial insolvency of the locally run insurance funds are dealt with. Unless and until satisfactory and comprehensive answers to these important operational issues are generated, we cannot claim any new policy initiative truly successful, no matter how good the intentions may be. Looking back on this process, we expended great efforts to improve the health status of China's rural population and were effective in getting the policy makers' attention to this serious problem. And there are valuable lessons to learn from the steps we took in this process, steps that may facilitate one's policy objectives when working with a government. We failed, however, to go the extra mile regarding the implementation and design in efforts to realize the desired outcome of our work. Here, too, valuable lessons can be learned from the steps that we *did not* take in this process. Analyzing this overall experience, one should note that drawing policy makers' and government officials' attention to the greatest health needs of millions of people can enlighten their views, increasing their awareness and attention to such issues. But equally important is to follow the policy process through its implementation stages to ensure the overarching objectives are both met

and upheld. After all, it is following the process through that extra mile that is often critical in making a real difference.

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