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File

Non-State Actors and Public Health Policies

03 - 2010

France

History of the Health System in France

Pierre-Yves GUIHENEUF (IRG), with Béatrice LUMINET (Médecins du Monde) and the health team from ATD Quart Monde

In France, the health system is rooted in a long history in which religious organizations and the State have played an active role[1].

Private initiatives taken over by the public sector

The first hospitals can be traced back to the 6th century though they did not offer treatment: their purpose was to offer help to the pilgrims and the poor. At that time and throughout the Middle Ages, the treatment of the sick is conducted at home and falls to traditional practitioners, then to barbers become surgeons and trained on the job and finally medical practitioners who gradually develop a professional body on the basis of classical medical knowledge (from the Greeks and the Romans) enriched at a later stage with the Arab input. In 1220, the first university school of medical science is created in Montpellier, followed by another one a few years later in Toulouse where teaching gets formalized.

Hospitals still serve the purpose of assisting the poorest and isolating them from society at large but they start to dispense treatment with the advent of major epidemics in the 12th century. Hospitals are managed by religious orders set under royal authority. Their part in treating the sick really develops from the 18th century onwards.

The French Revolution oversees the nationalization of the hospitals by the State which turns them for good into care centers under the authority of physicians. With industrialization, in the 19th century, health remains the business of the State, notably under pressure from trade unions who demand the creation of occupational medicine services. In the 20th century, the two World Wars will lead further to mass medical care and to social welfare policies in which the State takes pride of place. From 1941, the hospital, hitherto assigned to the needs of the poorest becomes a mainstay of the health system, open to all. Yet, throughout this

period, private medicine continues to be the chief provider of healthcare at home and in some specialized institutions.

Today in France, the public health sector under the control of the state co-exists with a private sector whose professionals practice their profession independently and whose enterprises manage treatment centers.

The State as a key actor

The activity of this private sector is, however, regulated by government policies, specifically through agreement between the State and the Health Insurance system and through the refunding of care.

The leading part in the administration of the health system falls to the State, guarantor of public interest and of the improvement of the population's general health. The State may intervene in the production or the financing of care. It wields some control over the relations between funding institutions, professionals and patients in the name of health and broader economic imperatives.

Thus whether directly or via devolved services the State

- Meets the costs of general public health policies: mass prevention, health watch, fight against major diseases and blights (drug addiction, alcoholism).
- Answers for the training of health personnel, contributes to defining their approbation regulations, monitors standards of quality in care institutions as well as in pharmaceutical production
- Holds a supervisory role over the regional hospitalization agencies
- Ensures adequate health and prevention structures and regulates the size of care supply: staff, establishments, heavy duty equipment
- Holds a supervisory role in social welfare in the framework of target and management contracts and intervenes on its funding modalities (basis and rates of contributions), on the regulation of public welfare cover, on the relationship with healthcare producers, on meeting healthcare costs (tariffs and reimbursement rates). It works towards balancing social accounting.

Since 1996, Parliament has set annual health targets and determined the funding framework for social welfare cover.

Funding is mostly covered by the Health Insurance, a subsidiary to Social Security, an institution constituted in law and overseen by the State. A complementary protection is available from Mutualist organizations or private insurance.

The Health Insurance plays a dominant part in the funding of medical care. It meets the costs of 75.5% of health expenditure. However a growing number of people (87%) resort to complementary cover.

Currently the population is protected in its totality by the Health Insurance, for the most part on a professional or familial basis (workers and retirees along with their beneficiaries). The unemployed are also entitled to social cover for health purposes. Universal health cover allows for the most disadvantaged to access funding for their health costs.

(Endnotes)

1. Sources : L'hôpital public en France, bilan et perspectives. Rapport au Conseil économique et social présenté par Eric Molinié [State hospitals in France review and prospects], 2005. See also: the history of medicine, Wikipedia.

France
Funding Health

Pierre-Yves GUIHENEUF (IRG), with Béatrice LUMINET (Médecins du Monde) and the health team from ATD Quart Monde.

Altogether, France commits about 11% of its GDP to health (2006 figures[1]), one of the highest rates in Europe, below that of the USA (around 15%) and above that of China (around 5%)

General practitioners' remuneration

In France GP consultations are partly refunded by the Health Insurance. It offers those GPs who so wish to sign up to a convention setting the tariff that will be refunded by the Health Insurance. A GP signing this convention therefore commits in principle to charge the patient only the amount refunded by the Health Insurance. He thereby places himself in what is known as "sector 1".

GPs who do not wish to sign up to this convention are free to set their fee: they then fall into "sector 2". Only part of the amount they charge will be refunded to the patient.

In some cases, GPs may set a fee higher than that set by regulation, in which case the difference is not refunded to the person insured by the Health Insurance. This practice of extra-billing varies depending on whether the GP is in Sector 1 or Sector 2: extra-billing may thus be allowed exceptionally or consistently. GPs must, in all cases, according to their code of ethics, set their fee "with discretion and measure".

The way the Health Insurance works

All French people and persons residing permanently in France benefit from a partial or total cover of the costs of healthcare and drugs they may need. They have a social cover enabling them either to have the care and medicine expenditures they have paid for in advance refunded or to obtain that these costs be met directly in state establishments, as the case may be.

Beneficiaries from the different health insurance regimes
(in Millions)

General:	55.6
CMU[1]:	3.8
Others:	5.6

Source : Assurance maladie (French Health Insurance)

To that end and according to their profession, they must contribute a percentage of their income to bodies brought together under the Health Insurance system: employees contribute to the "general regime" (it will meet costs for them and their family and serves 85% of French people[2]), farmers and farm workers contribute to the "agricultural regime", shopkeepers, tradesmen and independent professions contribute to the "self-employed social regime" and a few specific professions contribute to "special regimes". These contributions are compulsory and are in essence solidarity and redistributive contributions.

The Health Insurance system is thus funded by these contributions, which make up 47% of it resources. Another major source of funding is supplied by a Generalized Social Levy or CSG1, a tax levied on work and property income (34% of resources). Finally other taxes such as those imposed on tobacco, alcohol and a contribution from the pharmaceutical industry bring in 9% of the resources and public bodies contribute up to 10%.

1. Contribution sociale généralisée

Specific provisions

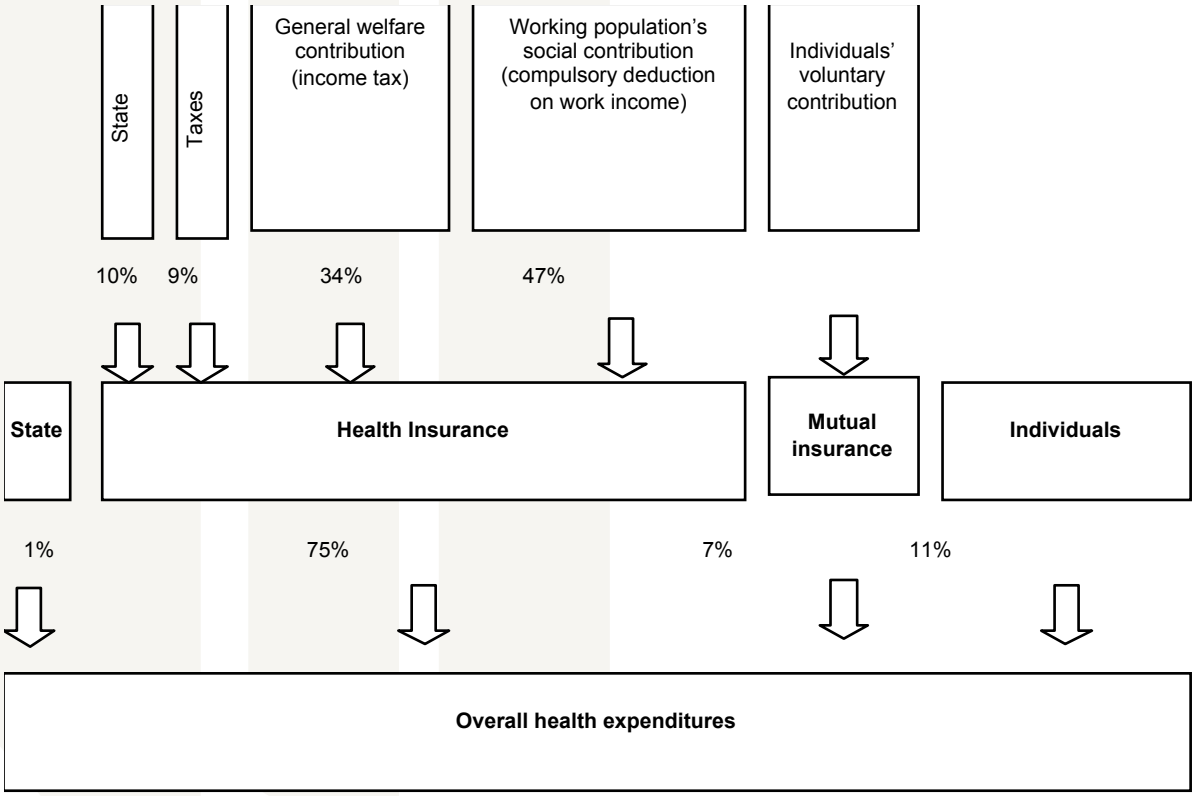
Two specific provisions are aimed at the disadvantaged:

- The CMU. Those who have lived in France for more than 3 months and-have a low income do not contribute to the Health insurance but have, since 2000, been granted social security membership thanks to the CMU (universal medical coverage) and to a complementary cover the CMUC.

- The AME. Illegal and destitute immigrants who have lived more than 3 months in the country in a settled way benefit from a State Medical Assistance (AME[2]), also brought in in 2002. it makes treatment free to them whether in the private or public sector.

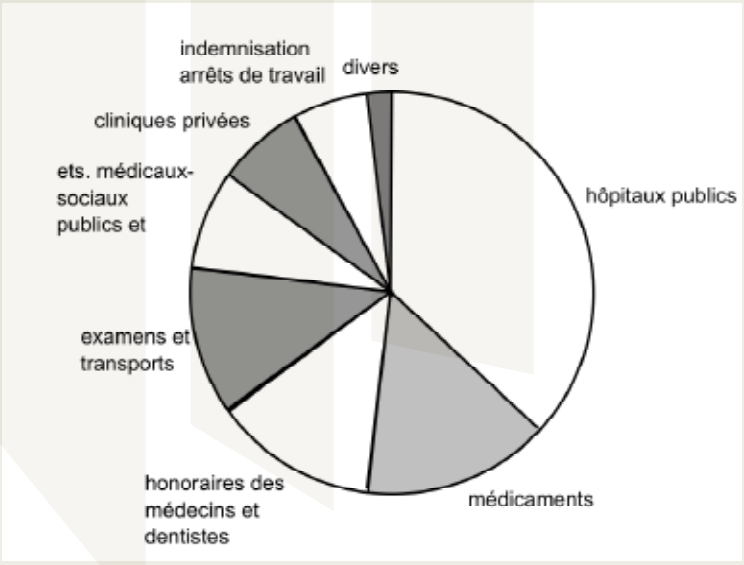
The Health Insurance does not refund health expenditures to the full: it only does this in the case of some illnesses (notably ongoing conditions). In the other cases, the Health insurance sets the cost of treatment and refunds 70% of that cost. The patient's mutual insurance will cover the remaining 30%.

In the case of some healthcare there is a discrepancy between funding and actual cost (glasses, hearing aids, dentures). Most persons insured also contribute to mutual insurances or – to a lesser extent – to private insurance, which top up the refunding for these costs. Such contributions are not compulsory. The subscribers can choose their mutual or other insurance as well as the amount they want to contribute, which will be reflected in the level of reimbursement. In some cases, the cost of the mutual or other insurance may be met by their employers.


State
Taxes
General welfare contribution (income tax)
Working population's social contribution (compulsory deduction on work income)
Individuals' voluntary contribution
10%
9%
34%
47%
State
Health Insurance
Mutual insurance
Individuals
1%
75%
7%
11%
Overall health expenditures

Health insurance outgoings

Source assurance maladie, 2007 [3]



Translation of items

clockwise starting at 12 o'clock:

- Diverse
- State Hospital
- Drugs
- GP's and dentist's fees
- Check-ups and transportation
- Public and private social welfare institutions
- Private hospitals
- loss of wages due to work related injury

In 2007, health insurance expenditures amounted to € 159 billion ($ 226 billion), that is an average of € 2446 euros per patient per year ($ 3424)

France's health expenditures have risen year after year, notably owing to population ageing and to some treatment costs. For many years, health insurance costs have exceeded revenue, the difference being met by the State. This deficit has contracted since 2004, indeed some years have seen the books balance. In 2007, the health insurance deficit stood at € 4.6 billion ($ 6.5 billion). To break even the Health Insurance system has undertaken a range of actions:

- Discourage excessive care and drug consumption
- Develop generic medicines
- Fight fraud
- Reduce reimbursements and increase excess charges

The 2004 reform notably pressed patients to choose a single "referring physician" (preferably a GP) who would ensure that the treatments given are consistent with one another and that individuals cannot consult a whole range of GPs at the same time for the same ailment. This measure has been seen in some places as a breach of civil liberties.

Negotiations were also undertaken with physicians' associations in order for them to regulate as best they can their professional structures and to prevent patients' over-consumption of treatment or drugs. The reimbursement rate of some treatments and drugs has also fallen. Excess has been set for the refund of standard care; the tariffs of X rays and lab analyses have fallen. Some so-called comfort drugs are less or no longer refunded. Prevention operations have been set up (vaccination, detection). Finally the pricing of services implemented in hospitals in the first decade of the century has motivated policies of control of expenditures but also led to a diminution of time-consuming treatments (care of underprivileged groups for instance), and the privileging of more "lucrative" activities.

(Footnotes)

1 Couverture maladie universelle = universal medical coverage

2 Aide médicale d'Etat

(Endnotes)

1 Source WHO

2 Source : assurance maladie.

3 Source http://www.ameli.fr/fileadmin/user_upload/documents/chiffres-reperes-2007.pdf

France

The Key Actors in the Health System

Pierre-Yves GUIHENEUF (IRG), with Béatrice LUMINET (Médecins du Monde) and the health team from ATD Quart Monde.

Distinctions can be drawn between several categories of actors intervening in the field of health in France. Distinctions will have to be drawn between public and private actors and, among the latter, between profit and non-profit making organizations.

Public actors

The two key decision makers are the State and the Health insurance system.

Central government

The Health ministry is chiefly involved with:

- Hospitals and public health centers (creation, renovation, equipment – or closure of public establishments, staff training and recruitment etc.)
- Health regulations
- Drug policies (authorizing sales, setting reimbursement rates…)
- Information, prevention, health watch, fighting drug addiction….
- Balancing the health insurance budget.

Local authorities

In France, where a decentralizing of government action has been under way since the eighties, the government has devolved some of its missions to the departments1 and regions. The nature of its intervention is subject to negotiations with local government. For their part Departments and regions sometimes take

1. A French department is an administrative unit about half way between the national and the local.

initiatives of their own in health and social matters. Local authorities have been associated with health and social care since 1982, the year the decentralization Law was passed.

The Conseil général (general council, an elected body running a Department) is responsible for mother and child welfare, local policies concerning the elderly, the disabled, children and exclusion. The state continues to co-finance and the Health insurance funds healthcare.

Town councils develop health policies in the framework of their urban policy and urban social cohesion contracts; these actions are contracted between central government and the town council. In this framework the "health and town workshops" are set up to help elicit improvement proposals from the citizens and the activists in the field. It is unusual for school-health to be taken up by local councils (only 15 towns have done so). Some have associated in a "WHO Towns" network; they must satisfy specifications in the field of health promotion, prevention and advancing access to health. The only duty of towns in the field of health is to keep the vaccination files up to date and to enforce compulsory hospitalization.

The Health Insurance system

Health Insurance is an outfit run by representatives from employers, the insured, mutual insurance companies and the State. It is funded by compulsory contributions and by the State.

It intervenes towards:

- Funding the health system (funding hospitals, setting the reimbursement rate of healthcare, drugs, check-ups, ambulance service, etc.)

- fixing the users' contribution rates according to their professional status and economic standing.

Private non-commercial actors

Associations managing health establishments and providing personal services. There are around 24000[1] private non-commercial organizations offering services in the field of health and social care (personal services and health care). These are essentially associations amalgamated within unions themselves members of a national federation (UNIOPSS).

☐UNA2 (National Union for Home Assistance, Care and Services) is one of these national unions affiliated to UNIOPSS. It federates around 1200 structures[2] that provide home care for the elderly, family support, assistance to the disabled, punctual and full nursing care in the home, health centers... UNA presses demands on the authorities to achieve a better recognition and funding for home assistance.

Health mutual insurance companies are non-profit organizations whose members pay up voluntary contributions and thus benefit from complementary reimbursement of their health care. There are 823 of them with around 38 million members[3]. They come together at national level under the Mutualité Française. They may also offer medical care in health establishments committed to their members only.

Associations bringing together health end-users. Extent in the health sector since the eighties, user associations have been recognized as essential actors in the health system with the Law 4 March 2002 relating to patients' rights and the quality of the health care system. Since 2007, some have been approved by the Health Ministry as partners in the bodies reflecting on government health policy and may sit in Regional health conferences, on hospital boards of directors and ethics committees.

They include, for instance:

- associations of people afflicted with a particular illness. The associations involved in the fight against AIDS and cancer are among the most significant.

☐ AIDES is the first French association for the fight against HIV/AIDS. Founded 1984, it spearheads operations of information, support, mobilization of individuals affected by HIV and hepatitis.

- Associations pressing for the recognition of alternative medicines (such as *Les Patients Impatients*[4]*, Santé Solidarité*[5], etc.)

- Associations with a broader scope, involved e.g. in the defense of family rights (viz. the *Union nationale des associations familiales*[6]) or consumer associations (e.g. the *Confédération de la consommation, du logement et du cadre de vie*[3]) are also implicated in health issues.

2. Union nationale de l'Aide, des Soins et des services aux domiciles
3. [Consumption, Housing, Life Environment Confederation]

- Solidarity organizations involved in the fight against poverty or exclusion that also operate in the field of health. Their action may target France but also foreign countries as the two sectors are generally bound in the same intervention principles. They lead operations assisting the most disadvantaged and frame proposals towards public policies regarding health or social issues. They may also operate in the provision of emergency health care but their particular sphere is support and connecting the institution, professionals and patients.

  ☐***ATD Quart Monde***/ATD Fourth World is a movement fighting extreme poverty that develops numerous activities in support of the poorest, towards the recognition of their rights and expertise. For instance, the groups for "access to fundamental rights" bring together people living in poverty and other citizens to investigate a theme (e.g. in 2009 towards a neighborhood healthcare for the poorest) and to rally around issues as close as possible to the facts on the ground. It sets up co-training programs for health professionals along with poor people in order to dissipate prejudices between the parties. *ATD Quart Monde* has obtained the Health Ministry's recognition as a user association. This administrative recognition is necessary (but not sufficient) in order to sit on some consultation bodies, notably the National Health Conference where *ADT* is currently the only non-health specialist association to be represented.

  ☐***Médecins du Monde*** is a solidarity organization founded in 1980 and whose objective is to care for the most vulnerable peoples and to advocate in their favor in France and the world over.

Beyond their demands, user associations have been able to show that they contributed expertise and experience complementary to that of professionals. They take part both at national and at local level in the dialogue with health professionals and the authorities on issues of health policies.

32 of them have associated within the *Collectif interassociatif sur la santé*[7]. (CISS) which brings together highly diverse associations: the sick, victims of medical mishaps, the disabled, family associations and consumer associations, etc. The CISS aims to represent users in health organizations and diverse working groups and commissions and to have a part in the evolution of the health system.

These associations:

- Offer the public at large information and individual or group support;
- Build up funds through fund-raising campaigns – notably towards research;
- Organize information campaigns aimed at the public at large and actions designed to bring pressure to bear on the authorities;
- Take part, at various levels, in dialogue on health policies with health professionals and the authorities;
- Stand for the recognition of patient rights and the necessity of their taking part in the definition of health policies, better cover for health costs, the further development of research.

Private profit-making sector

Health professional associations. General practitioners, nursing staff and other health professionals are organized in unions, they have the benefit of professional associations responsible for the observance of rules and Codes of Professional Ethics.

(Endnotes)

1 Source : /www.uniopss.asso.fr (association platform site)

2 Source UNA : www.una.fr/

3 Source : /www.mutualite.fr/

4 http://patients.impatients.online.fr/ [Impatient patients]

5 www.sante-solidarite.com [Health-Solidarity]

6 www.unaf.fr [the National Union of Family Associations]

7 http://www.leciss.org [Interactive Collective on health]

France

Interaction Models between Public and Non-State Actors

Pierre-Yves GUIHENEUF (IRG), with Béatrice LUMINET (Médecins du Monde) and the health team from ATD Quart Monde.

Forums set up by government

Forums have been created by diverse tiers of government (national, regional, departmental1). These temporary or ongoing consultation forums make it possible to collect non-state actors' proposals regarding health legislation or their opinions on some projects; they foster discussions with public actors and researchers.

- The National Health Conference (CNS[2]) is a consultation exercise focused on the directions of health policies bringing together representatives from patient associations, professionals or institutions, from the Health Insurance system, from research, from trade unions and businesses. It enables the system's stakeholders to state their viewpoint, conveys the population's requests and needs and favors dialogue between end-users, professionals and political decision-makers. The CNS advises the government in the devising of bills concerning public health; it issues recommendations and proposals towards the plans and programs proposed by the government; it contributes towards public debates on health issues[1]. The CNS has regional incarnations: The Regional Health Conferences.

- The National Bioethics Advisory Committee (CCNE[3]). Its 39 members nominated for a four-year term represent mainstream philosophical and religious thinkers, researchers and include major figures and personalities. Its president is nominated by the President of the Republic.

1. A French department is an administrative unit about half way between the national and the local.
2. Conférence nationale de santé
3. Comité consultatif national d'éthique pour les sciences de la vie et de la santé

- The National Council for AIDS (CNS[4]) is an independent body, though created by the government in 1989 to support health policies concerning AIDS. It counts 24 members including its president. They represent the main political and spiritual groupings and are nominated by the President of the Republic (four physicians and one philosopher); one member of the *Assemblée nationale*[5] and one member of the *Sénat*[6]; nine experts or representatives from associations nominated by the Prime Minister, seven major figures nominated by national institutions (the Economic and Social Council[7], the National Bioethics Advisory Committee, the National Union of Familial Associations, the Advisory Committee for Human Rights, the National Medical Association, the Conference of University Presidents and the National Commission for Information Technology and Civil Liberties). The government may ask the CNS for advice (analyses and proposals) or the latter may make recommendations of its own.

- The National Advisory Council for Disabled People brings together authorities, associations and diverse organizations. Since 2005, it has fallen to it to organize every three years a national conference on impairment and disability with a view to "discuss the direction and the means of the policies concerning the disabled".

Furthermore, some organizations have their own consultation set-ups aimed at directing their action or monitoring them. For instance:

- The National Solidarity Fund Towards Autonomy (CNSA[8]), has at its command a scientific council the committees of which are open to some association coalitions[2]. Its objectives: to identify needs in the field of home help, classify professional practices and their evaluation, etc.

- The INSERM, the French National Institute for Health and Medical Research, a State research establishment has created the "Mission Inserm-

4. Conseil national du Sida
5. Lower house
6. Upper House
7. Conseil Économique et Social
8. Caisse nationale de solidarité pour l'autonomie

Associations" and the "Group for Reflection with Patient Associations" (GRAM[9]) to work on research policies and protocols.

- The National Agency for the evaluation of social and medico-social policies (ANESM[10], created in 2007) has at its command a strategic policy council.

Initiatives from non-state actors

Non-state actors deploy numerous influencing strategies. For instance:

- Public information through methods ranging from the distribution of information newssheets to its members to the organization of shock actions designed to draw media attention.
- Creating working groups whose role is essentially to put proposals to the authorities and/or to health professionals.
- Setting up a rapid alert system alerting the press and public opinion when policy decisions have not been followed (e.g. people entitled to complementary universal medical coverage (CMUC) being refused specialist care)
- Creating national or regional federations aimed at weighing in more heavily on decision making and at opening coordination and knowledge exchange forums
- Implementing effective action (opening health centers, prevention or education campaigns, etc.), either to make up for the Health System's shortcomings or with a view to expose them.
- Etc...

(Endnotes)

1. http://www.sante-sports.gouv.fr/conference-nationale-de-sante-c-n-s.html

2. Source UNA (National Union for Home Assistance, Care and Services), Annual Report 2008, p. 69 onwards

9. Groupe de réflexion avec les associations de malades

10. Agence nationale d'évaluation des politiques sociales et médico-sociales

USA

How Public Health is organized and paid for in the United States

Extract from *Introduction to Public Health*, **Mary-Jane Schneider**, John and Bartlett Publishers, Second Edition, 2000

Local Public Health Agencies

The organization of public health at the local level varies from state to state and even within states. The most common local agency is the county health department. A large city may have its own municipal health department, and rural areas may be served by a multicounty health department. Some local areas have no public health department, leaving their residents to do without some services and to depend on state government for others.

Local health departments have the day-to-day responsibility for public health matters in their jurisdiction. These include collecting health statistics; conducting communicable disease control programs; providing screening and immunizations; providing health education services and chronic disease control programs; conducting sanitation, sanitary engineering, and inspection programs; running school health programs; and delivering maternal and child health services and public health nursing services. Mental health may or may not be the responsibility of a separate agency.

In many states, laws assign local public health agencies the responsibility for providing medical care to the poor. While this task may be considered part of the assurance function defined in *The Future of Public Health,*[1] the Institute of Medicine found that this role tends to consume excessive resources and distract local health departments from performing their assessment and policy development functions. The provision of medical services by public health clinics has often been a source of friction with the medical establishment [...].

The source of funds for local health department activities varies widely among states. Some states provide the bulk of funding for local health departments while others provide very little. The federal government may fund some local health

department activities directly, or federal funds may be passed on from the states. A portion of the local health budget usually comes from local property and sales taxes, and from fees that the department charges for some services. The extent to which local health departments are responsive to mandates from the state and federal government is likely to depend on how much of the local agency's budget is provided by these sources. When the bulk of a local health department's budget is determined by a city council or county legislature, the local agency's capacity to perform core functions may depend on its ability to educate the legislative body about public health and its importance.

State Health Departments

The states have the primary constitutional responsibility and authority for the protection of the health, safety, and general welfare of the population, and much of this responsibility falls on state health departments. The scope of this responsibility varies: some states have separate agencies for social services, aging, mental health, the environment, and so on. This may cause problems, for example, when the environmental agency makes decisions that impact the population's health without consulting the health agency, or - in one example described by the Institute of Medicine - when the Indian Health Service, the state health agency, and the state mental health agency argued about which was responsible for adult and aging services. Some state health departments are strongly centralized, while others delegate much of their authority to the local health departments. State health departments depend heavily on federal money for many programs, and their authority is thus limited by the strings attached to the federal funds.

State health departments define to varying degrees the activities of the local health departments. The state health department may set policies to be followed by the local agencies, and they generally provide significant funding, both from state sources and as channels for federal funds. The state health department coordinates activities of the local agencies and collects and analyzes the data provided by the local agencies. Laboratory services are often provided by state health departments.

State health departments are usually charged with licensing and certification of medical personnel, facilities, and services, with the purpose of maintaining standards of competence and quality of care. An organization chart of a typical state health department is shown in Figure 3-2.

People who lack private health insurance are generally the concern of state health departments, although many states pass this responsibility on to localities. Some of these people are covered by Medicaid, the joint federal-state program for the poor. States have significant—though not total—flexibility in how to administer the Medicaid program, determining eligibility rules for coverage as well as setting payment amounts for the doctors, hospitals, and other providers of medical care. Most states also provide some kind of funding to hospitals to reimburse them for treating uninsured patients who arrive in the emergency room and must be treated.

Funding for state health department activities comes mostly from state taxes and federal grants.

Federal Agencies Involved with Public Health

Most traditional public health activities at the federal level, other than environmental health, fall «under the jurisdiction of the Department of Health and Human Services (HHS). A list of HHS agencies is shown in Figure 3-3. The predominant agencies are the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the FDA. The Surgeon General is the nation's leading spokesperson on matters of public health. The position does not in itself carry much direct line authority, but it became very visible in the 1980s when C. Everett Koop spoke out with great courage and moral authority on the politically controversial subjects of AIDS and tobacco.

The CDC is the main assessment and epidemiologic agency for the nation. The mission of the CDC is, as its name implies, to control and prevent human diseases. Traditionally, the CDC focused on infectious diseases and was therefore crisis-oriented. In contrast, the NIH holds the longer view of a research agency. The CDC is staffed with epidemiologists who travel throughout the country and the world to detect outbreaks of disease, track down the causes of epidemics, and halt their spread. It also has laboratories at its headquarters in Atlanta, where biomedical scientists study the viruses and bacteria linked with the epidemics. One of the twelve centers, institute, and offices in the CDC is the National Center for Health Statistics, which is the national authority for collecting, analyzing, and disseminating health data for the United States.

The CDC has expanded its mission over recent decades to include chronic diseases, genetics, injury and violence, and environmental health. The CDC's change in focus is justified by the argument that infectious diseases no longer are the

leading causes of death and disability in the United States and that these other problems must be addressed in order to make further progress in preventing and controlling disease. However, the CDC's involvement in programs to prevent cancer and heart disease, injury, and violence is more controversial politically, in that it embroils the agency in discussions of the hazards of smoking and firearms, which may offend members of Congress who are supporters of those industries.

A list of CDC Centers, Institute, and Offices is shown in Figure 3-4. CDC issues a weekly publication called *Morbidity and Mortality Weekly Report (MMWR),* which is widely distributed in print and electronically via the Internet. *MMWR* reports on timely public health topics that the CDC deals with, such as outbreaks of infectious diseases and new environmental and behavioral health hazards. The first published report that heralded the onset of the AIDS epidemic appeared in *MMWR* on June 4, 198l.[9] The CDC's journal *Emerging Infectious Diseases,* published in print and online, discusses new infectious disease threats that occur naturally as well as potential bioterrorist threats.

The NIH is the greatest biomedical research complex in the world, with its own research laboratories, most of which are located in Bethesda, Maryland, as well as a program that provides grants to biomedical scientists at universities and research centers throughout the United States. NIH supports research ranging from basic cellular processes to the physiological errors that underly human diseases. NIH's Clinical Center in Bethesda is a research hospital where medical researchers test experimental therapies. NIH also includes the National Library of Medicine, which serves as a reference library for medical centers around the world. Its computerized bibliographic service can be accessed on the Internet. [...]

NIH has enjoyed strong Congressional support over the years. Research aimed at curing human diseases is a popular cause and, for the most part, is generally agreed to be a proper activity for the federal government. States and private companies could not afford to do biomedical research, except to a limited extent, and until recently the prospects for corporate profit in this field were not great. Even periodic budgetary constraints have usually spared NIH the worst of the ax.

Regulation of the food and drug industries has been difficult and controversial since Massachusetts passed the first American pure-food law in 1784. As recently as the late nineteenth century, milk was commonly watered down, then doctored with chalk or plaster of Paris to make it look normal. The Pure Food and Drugs Act of 1906 was opposed by the food canning industry, drug and patent medicine

manufacturers, whiskey interests, and, of course, the meat packing industry. That law was passed soon after the publication of Upton Sinclair's best selling novel, *The Jungle,* an exposé of brutal and filthy conditions in the Chicago stockyards.

The modem FDA was established in 1931, and the current law provides for the agency, in addition to ensuring that the food supply is safe and nutritious, to evaluate all new drugs, food additives and colorings, and certain medical devices, approving them only if they are proven safe and, in the case of drugs, effective. The agency also regulates vaccines and diagnostic tests, animal drugs, and cosmetics. The FDA is frequently under attack in the current anti-regulatory climate in Congress.

Other components of HHS include the Centers for Medicare and Medicaid Services and the Agency for Health Care Research and Quality, which supports research on health care quality and costs.. The Indian Health Service operates hospitals and health clinics for Native Americans.

Responsibility for environmental health is scattered throughout the federal government, including the CDC's Center for Environmental Health and the NIH's National Institute of Environmental Health Sciences. The prime agency for the environment is the Environmental Protection Agency (EPÀ), established in 1970 to carry out programs dealing with water pollution, air pollution, toxic substances control, and other issues of environmental contamination. The EPA is one of the most controversial federal public health agencies. It has often been attacked by Congress and, in recent years, its policies have been watered down by the White House.

Many other federal agencies have public health responsibilities. For example, although meat safety concerns were a major factor in the establishment of the FDA, standards of meat safety are the province of the Department of Agriculture. The Department of Agriculture also oversees food and nutrition programs, including food stamps and school lunches. The Department of Education oversees health education and school health and safety programs. The Department of Labor has OSHA, which is concerned with occupational health and prevention of occupational injury. The Department of Veterans Affairs administers its own health and medical services. The Department of Defense, which provides medical care for the armed forces, has long had to deal with public health concerns relating to threats from infectious diseases in foreign climates as well as health effects from toxic chemicals and radiation.

USA

Nongovernmental Role in Public Health

Extract from "Introduction to Public Health", Mary-Jane Schneider, John and Bartlett Publishers, Second Edition, 2000

While government bears the major responsibility for public health, many non-governmental organizations play important roles, especially in education, lobbying, and research. Organizations that focus on specific diseases, such as the American Heart Association, the American Cancer Society, the Alzheimer Disease and Related Disorders Association, and the American Diabetes Association, lobby Congress for resources and policies to benefit their causes. They also conduct campaigns to educate the public and may sponsor research concerned with their disease. Professional membership organizations, such as the American Public Health, the American Medical Association, and the American Nurses Association also are active in lobbying Congress in support of public health issues such as research related to the health effects of smoking. However, the American Medical Association is also known for its opposition to some public-health related programs such as President Clinton's universal health care proposal of 1994. Other organizations that will play an important role in defining the future of public health include the National Association of City and County Health officers, the Association of State and Territorial Health Officers, and the Association of School of Public Health.

Several major philanthropic foundations provide funding to support research or special projects related to public health. For example, the Rockfeller Foundation focuses on world population issues; the Robert Wood Johnson Foundation on providing health care to the poor as well as on AIDS, alcoholism, and drug abuse; the Pew Charitable Trusts on health and public policy; and the Commonwealth Fund also on health and public policy, especially concerning minorities, children, and elderly people. Bill Gates of Microsoft has endowed a new Bill and Melinda Gates Foundation, the mission of which is to improve global health.

Consumers groups organized around specific issues had a major impact on national or regional policy related to public health. For example, Ralph Nader's

traffic safety campaign in the 1960s forced Congress to pass legislation requiring the automobile industry to build safer cars. The Gay Men's Health Crisis played a political role in the 1980s in starting up community health services for AIDS victims in New York City.

One of the lessons of the Institute of Medicine report was that governments alone cannot achieve the objectives of public health. Organized community efforts to prevent disease and prolong life must involve all sectors of the community, including providers of health care services, local business, community organizations, the media, and the general public. In the words of one public health leader, "Public health, unlike virtually all other important social efforts, is dependant of its ability to obtain the participation of other agencies to solve its problems". Thus, public health leaders must be adept on negotiation and coalition building. Chapter 30 discusses some efforts – led by the federal government with the participation of other governmental and nongovernmental organizations – of the past decades to develop a framework for public health planning and action that involves all sectors of the community at the local, state and national level.

CONCLUSION

As an organized community effort, public health is primarily the responsibility of government although a successful public health enterprise must involve all sectors of the community. Because the U.S. Constitution does not mention health, the states have the primary legal responsibility for public health. In turn, local governments, as the level of government closest to the people, provide the bulk of public health services. Despite the lack of explicit constitutional authority, the federal government has established a significant presence in public health. Federal agencies establish and enforce laws and regulations on issues that need a national scope. Through its authority to tax and spend, the federal government leads and assists state and local governments in providing public health services.

A Case Study of Healthcare Reform

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■ Background

Since May 2009, we conducted a case study research of China's recent health care reform (2006-2009) to promote the understanding of the current Chinese central government's decision-making process. The study report includes an overview of the policy making process for heath care reform in past three years with an in-depth analysis of the changing decision-making mechanism, and some reflections on the relevant lessons. In particular, this research aimed to answer these questions:

☐ To what extent the central government's policy network in significant social issues has been expanded.

☐ How the key stake-holders with uneven resources act to pursue their goals within the existing institutions? And to what extent these interactions influence the final policy.

☐ How the Chinese policy-makers choose the decision path and keep the right policy orientation, especially when they want to reach a consensus in time and to make the decision effectively on the basis of taking opinions broadly?

☐ What are the main influences of the change in both "structure" and "process" on the decision-making mechanism and responsiveness of the central government?

☐ What are the policy implications for other policy domains or political system in general?

To answer these questions, it depends on a comprehensive analysis on the whole process of decision-making for the Chinese heath care reform – not only to examine the interactions of all agents participated the consultations and lobbying, explored the interests, goals and opinions regarding the new policy, and the

corresponding influence from the participants' perspective, but also to analyze how the decision-makers respond to the will of the people and make the decision effectively from the Central's perspective.

■ Research Methods

This project adopts the case study approach. To make clear of the whole policy making process of health care reform, and to assess objectively the actions and their influences of the main participants in policy making process, the research group collected a great deal of relevant materials and conducted some interviews. The information and data in this study were mainly gained from formal publications in China. Fortunately, many organizations in Beijing generously provided some complimentary information and data to fill in any missing gaps. The findings of this study are based on the analysis of Information and data obtained by:

☐ Referring a great number of official documents, reports and statistical data released by the government relevant to the health care reform.

☐ Referring some private materials provided by some individuals and organizations who takes part in the health care policy making process. The use of these materials in this report has been authorized.

☐ Reviewing more than one hundred review papers openly published in the media during the health care policy was making.

☐ Reviewing dozens of literatures of empirical research on public policy making in foreign countries.

☐ Reviewing more than ten literatures of empirical research on public policy making in China.

To ensure the observations are based on the best evidence, there was extensive consultation and interview with the representative persons from the key participant circles. From June 2009 to December 2009, we interviewed about 20 representative persons who took part in or were familiar with the policy making process. They are from:

☐ Policy making departments in the central government, including 6 representative persons from the General Office of the State Council, Ministry of Health, Ministry of Human Resources and Social Security.

☐ Policy research institutes affiliated with academic institutions, including 4 representative persons from Chinese Academy of Social Sciences (CASS), Peking University, People's University of China and Central University of Finance & Economics.

☐ Policy research institutes affiliated with Ministries in central government, including 3 representative persons they are from the Institute of Nutrition and Food Safety in Chinese Center for Disease Prevention and Control, and the Research Institute for Fiscal Science in Ministry of Finance.

☐ Policy research institutes affiliated with CCP central committee and the State Council, including the State Council Development Research Center (DRC), Counselors' Office of the State Council, Policy Research Office of the State Council, and Policy Research Office of the CPC Central Committee.

☐ Organized interests groups, including 4 representative persons from China Association of Pharmaceutical Commerce (CAPC), Chinese Pharmaceutical Enterprises Association (CPEA), and the R&D-based Pharmaceutical Association Committee (RDPAC).

■ Outputs

This project produces one main report submitted to the Central Policy Unit of Hong Kong Government, and the report contains nine parts: (1) Introduction; (2) Decision-Making Process and Involved Participants; (3) Common People's Participation and Influence; (4) Policy Research Agency's Participation and Influence; (5) Organized Interests Group's Participation and Influence;(6) Policy-Making Departments' Participation and Influence;(7) Inter-Departmental Coordination and Integration of the Plan;(8) The Role of Top Decision-Makers; and (9) Conclusions and Policy Implications.

■ Main Findings: Assessment of the Central Government's Decision-making Mechanism

This study shows that both the "structures" and the "processes" of the central government's policy making have undergone profound changes in current China. It lies on the fact that, the Chinese decision-making process has become increasingly consultative, participatory and interactive. When the "structures" and the "processes" changed, the inner dynamic and mechanism of policy making was changed accordingly, thus the democratic and scientific decision-making has reached a new level. As a result, the central government's capacity to coordinate, steer and make decision effectively based on the decentralized decision-making was strengthened, and the responsive capacity to meet the common people's immediate and long-term needs was improved too.

☐ Changes in the "Structures" of Policy Making

In contrast to 1980s or 1990s, not only leaders and cadres within the Party and government but also many more actors (including think tanks, NGOs, special interests, international organizations and general public at large) participate in the policy formation in China nowadays. To meet the demands from the society, Chinese decision makers positively open a door to straight advisers for soliciting opinions from all circles of the society in each period of policy making, and they care more about the consultation before making policy than before.

☐ Changes in the "Processes" of Policy Making

For leaders and officials of the Party and the government are no longer completely monopolize the power for policy making, compared to the traditional systems, the recent example of policy making in China has some new features:

The interactions occur among not only different departments, the central government and local government, bureaucracies and localities at different levels, but also common citizens, academic research agencies, organized interests groups.

The conventional wisdom on policy making process in China, which either regards decision-making in China as a dictatorial rule, or explains policy making process in China as a game of bargaining fragmented department within the government, are out of date.

● Changes in the Mechanism of Policy Making

The changes of both "structures" and "processes" exert great influences on the development and transformation of central government's decision-making mechanism in China.

Regarding the decision-making information, it has changed from depending on complete internal information to depending on both internal and external information.

Regarding the government investigation, it has changed from investigating by policy-makers to the combination of direct investigations by the government and indirect investigations by multiple-participants.

Regarding the decision-making type or mode, it has changed from the "personal decision-making" and "collective decision-making" to "public decision-making", and put the public policy on a more scientific and democratic basis.

☐ Improvement of the effectiveness and responsiveness of central government's decision-making

As the central government's decision-making mechanism has transformed, the mode of decision-making both in the departments and the central has also changed.

On the one hand, 1) setting of the national agenda, 2) the appearance of public debate around people concerned issues, and 3) the expansion of scope and channels for policy consultation, not only reinforced the policy deliberation/debate among different sectors, but also improved the responsiveness of policy makers to the public.

On the other hand, 4) the growth of information, 5) the change of investigations, and 6) the change of decision-making types and modes, greatly strengthened the capacity of the top leadership for decision making, including their capacity to formulate the clear policy preference, and to coordinate the departmental policy making and ending the dissension, which guarantee the top leaders were not misled by a few people but rather responded to the real will of the people through making the effective decision.

■ Policy Implications

Concerning the high complexity and uncertainty of the health care field and the unique nature of the reform plan, the case chosen in this research is a typical hard problem in the government policy making area. The various interests within the health care reform are difficult to coordinate since plenty of relevant public departments are involved on basis of conflicting ideological arguments. This is a lively illustration of general features of the current Chinese public policy making paradox.

China' experience of decision-making in health care reform, not only can be as the direct model for those governments in some countries and districts where they are facing the similar or same reform issues, but also, it has more universal values for building a democratic, scientific and effective decision-making mechanism and strengthening its responsive capacity to the will of the people and implement the idea of "for the people". These lessons can be summarized as:

☐ China's experience shows that, democracy can be realized through effective policy making. To implement the ideas and measures of "for the people" in decision-making process, is not only an important reflection for democracy, but also the very important resources for consolidating the legitimacy of the government.

To realize “for the people” in policy making and implement the reform measurement based on the responsibility, the Chinese government makes democratic, scientific, and effective decision-making as a ultimate target of institutional building.

☐ To facilitate the democratic decision-making, China’s experience shows that policy making should not be monopolized by decision makers within the government, but rather, the real democratic system should provide the common people with opportunities to participate in the whole process of policy making. To guarantee the common people’s opinions and advices can produce actual influences on policy formation, Chinese government encourages decision makers at different levels to open the information to its citizens, and go deep among the people to get to know what they are thinking and pool their wisdom through conversations meetings or investigations, and expanding the orderly participation of the common people in decision-making process.

☐ To facilitate the scientific decision-making, China’s experience is to encourage decision makers at all levels to make the best of “external brain” through creating the opportunities and channels as many as possible, expand the scope of the government consultation, and provide high level platform and institutionalized guarantee for consultation work. For fully using of the “external brain” and realize the transformation of the mode of investigation, China has provided direct experience with even can be copied.

☐ To facilitate the effective decision-making, China’s experience shows that, when permitting to explore and deliberate the possible solutions for any challenges based on the decentralized decision-making, it is very crucial for effective decision-making to play the roles of centralized decision-making mechanism for better coordination and plan. For this, the right governing philosophy, the clear preferences of the central leadership, and the existing centralized decision-making mechanism, are three very important variables which determine whether effective decision-making can be made.

The Economic, Political and Social Contexts for Changes in China's Medical and Health System

Ding Ningning

It was after Deng Xiaoping's speech made during his inspection tour in south China in 1992 that China began to pay attention to the social consequences of the economic system reform, and the main reason for that was the criticisms by foreign media on the widening gap among Chinese citizens' income. However the unexpected Asian financial crisis brought the whole nation's attention back to the economic field. The outbreak of SARS finally made the public understand how fragile China's medical and health system was, which put the public health service issue on the agenda of the government.

Various data of international organizations revealed that, in contrast with its great economic achievements, China' social sector has been left behind among developing countries in terms of some indicators from a good example for the developing world before the reform and opening up. To find out the root causes of various contradictions in the medical and health work, it is necessary to review the development of China's reform and opening carefully so as to make essential improvements in the future.

Although Chinese policymakers have raised the aim of social development on a par with that of economic development, the improvement of social development indicators and the reconstruction of the social policies and social service systems including the public health system is not a matter that can be accomplished in a short time. On one hand, the domestic academic circle has disagreement on how to coordinate the two aims of economic and social development; on the other hand, many current specific obstacles in system and policies also needed to be removed gradually in practice.

Ⅰ. China's Economic System and Medical and Health Sector before Reform and Opening to Outside World

Before the reform and opening up to the outside world, China's economy was at the stage of primitive accumulation for socialist industrialization. Over 80% of the population lived in the countryside; agricultural output accounted for more man 30% of GDP. The dual structure in both social and economic sectors was evident. Government controlled the prices of main agricultural and industrial products, and maintained the salaries of urban residents at a relatively low level but provided them with sufficient social security. Rural residents still mainly depended on self-reliant production and their actual income was much lower than that of urban residents. However, due to the existence of "collective" organizations, there existed a relationship of mutual assistance among members of the "collectives". Based on the relatively high accumulation rate produced by the collective system and the technical assistance provided by the former Soviet Union, new China laid the foundation for its own modern industry.

Comparing China's traditional economic system with the former Soviet Union system of planned economy, their similarity lay in the highly centralized policy making rights. But owing to the difference in the development stages of the economies of the two countries, especially the fact that self-reliant production still prevailed in our vast countryside, China's planned economy and the centralization degree for policymaking never reached the height as in former Soviet Union. After differences between the two ruling Parties of China and former Soviet Union were made public to the world, China once tried to break away from the Soviet mode. But for many reasons, China's economy could not walk out of the cycle of "becoming stagnant when regulation was strengthened and becoming chaotic when regulation was loosened. "Wartime economy" still remained: Government's strong ability for mobilization, low capacity of economic planning, and excessive emphasis on political responsibility instead of economic results.

The medical and health system in the planned economy was closely associated with the political aim and economic system at that time. Different from most of the developing countries that achieved independence after the Second World War, new China was born out of the workers' and peasants' revolution rather than the victory over Anti-Fascist War. Thus the concept of social equality was very strong. Secondly, China in modern times had never been totally subdued to become a colony of the West and, consequently, Chinese academia always kept its relatively independent perspectives while learning from the Western countries and felt free when creating new schemes. Furthermore, getting rid of the

humiliating history as “a sick man in East Asia” as soon as possible was the common desire of the leaders of new China and the people.

After the establishment of new China in 1949, the Central Government put forward four guidelines for the medical and health work: service for workers, peasants and soldiers; prevention first; combination of Chinese medicine with Western medicine and integration of health work with mass campaign. The government took advantage of its great mobilization ability and highly organized society at that time to set up gradually a relatively efficient public health and medical service system covering all urban and rural residents based on the system of planned economy where the government controlled the prices of medicine, medical equipments and basic medical services. In only 30 years (from 1949 to 1979), infant mortality rate and average life expectancy witnessed remarkable improvement. The system continued to function in spite of the great impact during the Cultural Revolution.

Due to the dual social and economic structure, there was a big difference in organizing method of the medical and health service systems in cities and the countryside. Medical and health system in cities was directly organized and almost totally funded by the government while a cooperative medical system with limited support from government and with low co-payment was practiced in the countryside.

Under the traditional economic system of “total government control over revenue and expenditure”, urban cadres and workers only needed to pay very limited expenses for their medical treatment such as “registration fee”. The system for the former, i.e. cadres in government departments or institutions, was financed by governments at various levels, and that for the latter, i.e. enterprise workers, came from welfare funds held by trade unions of individual enterprises where patients worked, which was also known as Enterprise Labor Medical Insurance. Since there was a unified budget for governments and enterprises, there was actually a social pool for health expenses among the nation, regions and industries.

The cooperative medical system in the countryside was based on the collective (commune- and brigade-based) economy. Collectives bore most of the medical expenses and the salaries (calculated in working points) of “barefoot doctors”, individuals paid a little fee for medical treatment, and government provided limited financial support (including low-priced medicine, some medical equipment, some funds for epidemic prevention and salaries for a small number of medi-

cal staff). At the end of the 1970s, the cooperative medical system covered the majority of the population in the countryside.

Although the economic development level during the period of planned economy was very low, the great achievements made in establishing medical and health system was undeniable. Though it was closely associated with the highly centralized economy at that time, such successful achievement was more attributable to the relentless pursuance of social aims. Moreover, contributions from various patriotic health campaigns and mass heath improvement movements mobilized cannot be ignored either, which were political mobilization in nature.

II. Basic Characteristics of China's Reform and Opening and Reform of its Medical and Health System

China's reform and opening to the outside world has two basic features. One is "centered on economic construction" and the other is "feeling the stones when crossing the river".

Since reform and opening to the outside world, the Chinese government has always focused on "economic construction" in the last 20 odd years. The Purposes of both economic system reform and opening to the outside world are for accelerating the development of the national economy. In fact, China has gained unprecedented achievements. The high-speed development of China's economy further boosted the overall reform of the economic system, creating a favorable interactive situation in which reform and opening to the outside world and the economic development helped promoting each other. However, excessive attention on economic development had led to the negligence of social problems, and the reform in the social sector was evidently lagging behind. At the beginning of the reform, the adjustment of social policies was subject to the requirements of the economic reform. After the mid-1990s, the problems of social policies gradually drew the attention of the policymakers as various problems emerged successively in the society. But to a large extent, reform of social policies used to serve the reform of the economic system or was for mitigating the negative effects arising from the reform of economic system.

Deng Xiaoping had a famous saying: "No matter whether it's a white cat or a black cat, it's a good cat so long as it catches rats"; and he repeatedly emphasized that people should not get involved in theoretic debate. The so-called "feeling stones while crossing the river" means there is not a clearly-set target beforehand for China's reform, and people have to feel their way forward through solving

problems existed in economic life. Hence the reform must be gradual and progressive, must rely on the enthusiasm of the masses and grass roots cadres and must depend more on political mobilization instead of expert planning. The advantage of doing so is: avoiding the negative effects caused by heated theoretical debates and violent political turmoil; giving cadres and the masses some time to gradually get adapted to the change of the systems in mind so as to keep the economy grow persistently and rapidly in the process of reform and opening to the outside world; While the "cake is made bigger", the life of most of the ordinary people should be improved, thus keeping the whole society stable.

Judging from the process of reform, the period from Deng Xiaoping's speech made during his inspection in south China in 1992 to the tax-sharing reform in 1994 could be regarded as an important turning point in the reform of China economic system. According to this timeline, reform of China's economic system can be divided into two stages.

The first stage of the reform and opening started from the implementation of the contracted household responsibility system linking remuneration to output in the countryside. The main measure was "administrative division of power" or "delegating powers and conceding profits to lower levels". The purpose of these reforms was to overcome the shortcoming of excessive centralization of power in the traditional economic system. The specific approach was "gaining experience through experimental units and spreading it in a gradual process". Meanwhile, reforms were tried in several other sectors. The government revenues and expenditures between central and local levels were divided through introducing different financial contracting systems. Different pilot schemes were carried out among state-owned enterprises to expand their independent operational rights The private sector was encouraged to develop including individually and privately owned enterprises and township and village enterprises and special economic zones and opening cities were established in coastal areas such as Guangdong and Fujian. The reform and opening to the outside world quickly achieved obvious results. The agricultural yield was increased rapidly and the people's life was improved considerably; proportion controlled by planning shrank and share by market adjustment increased; the proportion of non-state-owned economy expanded and external economic exchanges increased. However, reforms also created some problems, such as the lack of coordination among reform measures, severe regional protectionism, decrease of the central share in the government revenues and the corruption brought about by the double-track price system.

The speech made by Deng Xiaoping during his inspection tour in south China in 1992 unified the thinking in the Communist Party about the reform direction and made it clear that the target of the reform was the establishment of socialist market economy system, which further accelerated the reform of the economic system and opening to the outside world.

The second stage of the reform started from the reform of the tax regime in 1994. The purpose of the reform was to increase two proportions: one was the proportion of government revenues in national income, another was the share of central financial revenues in total government revenues, and to meet the needs of the Central Government to adjust the macro economy. Although the aim of the reform in this stage was clearly different from that in the previous stage, it did not completely break away from the influence of the reform mode in the previous stage. This was mainly because: The reform had not been well prepared in theory ever since it was started; the vested interests already gained prevented the reform from going further. Therefore, although the reform of the tax regime changed the situation of yearly decreasing of central revenues, responsibility was not divided clearly between local governments and Central Government. Consensus had not yet been reached on how to determine the proportion of public service expenses in the government budget. Besides, with China accelerating the pace of entering the WTO, the function of the market in terms of survival of the fittest through competition was becoming more and more apparent. Various social problems emerged gradually due to the ever-expanding difference in residents' income and the influence of the Asian financial crisis.

The above-mentioned characteristics and stages of economic system reform have produced a conspicuous influence on China's medical and health system since the reform and opening. First, as an important component of the social policies, the reform of China's medical and health system apparently lagged behind the economic system reform. In documents of the early period of the reform and opening, nothing was mentioned about the reform of the medical and health work. After the mid-1980s, this reform started and was quite passive, mainly serving the goals of the economic system reform instead of those of social development. For instance, social pooling was introduced in the urban employees' medical insurance system in order to push forward the reform of State-owned enterprises. Secondly, similar to the economic system reform, China's medical and health system was also reformed by "feeling the stones while crossing the river", i.e. walking one step and looking for the way for the next step, or patching the holes in the original plan. In respect of the reform of the medical and health system, China has

not found a clear direction up to now. Thirdly, the detailed contents and methods of the reform of the medical and health system were influenced too much by the economic system and many reform plans were simply subjected to the existing economic system without taking into consideration the rules of the medical and health work. Hence it was quite natural for various problems to arise during the development and reform of the medical and health work.

By now China's reform has eventually walked out of the period of decentralization, which focused on demolition of the traditional system, and has gradually shifted to the construction of the socialist market economy. Meanwhile, social contradictions, accumulated due to too much attention to economic growth for a long time, gradually came to the surface. Our thinking about reform and development also began to go through big adjustment. While stressing economic growth, the government began to pay attention to employment, the rights of workers and other social problems, and has put forward a new conceptual framework for economic and social coordinated development. It is exactly under such a condition that we can practically and realistically discuss the problems and deficiencies that have existed in our medical and health work since the reform and opening.

Declining Government Share in National Health Expenditures: Reasons and Consequences

—Influence of Economic System Reform on China's Medical and Health Work: Part One

There are many reasons for the decreasing utilization of China medical and health work on the whole since the reform and opening. One of the major reasons is the greatly reduced proportion of the government outlays on health and medical care. This changed the surviving environment of the medical and health work fundamentally and forced the medical and health system to adapt to the changes correspondingly.

Since the reform and opening, China's economy has kept growing at above 7% on average every year, but the proportion of government revenues in GDP decreased to less than 14% in the early 1990s from the 28% at the beginning of the reform. Although the reform of the tax regime reversed the trend of decreased financial revenues, the proportion of government revenues was only restored to around 15% of the GDP by 2000. Under such circumstances, although the proportion of the government outlays on health was not lowered remarkably, the proportion of government outlays on health in the GDP still was not restored to the level of

0.85% at the beginning of the reform in 2000 because the proportion of financial revenues was relatively low in GDP. At the same time, the national health expenditures increased from around 3% of GDP to 5.37% of GDP in 2000. Hence the proportion of the government outlays on health in national health expenditures decreased from 36% at the beginning of the reform to around 15% in 2000, i.e. a drop by 1% every year on average. The increments to health expenditures were certainly borne by the ordinary people.

An important reason for decreased share of government health spending in national health expenditure was "financial responsibility system. At the beginning of the reform, the State Council decided to practice on a trial basis the system of " dividing revenue and expenditure between the central and local governments and holding each responsible for balancing their budgets" from 1980 so as to arouse the enthusiasm of local governments. During actual implementation, the system evolved into various kinds of financial responsibility schemes such as allowing the local governments to keep the increased revenue without handing profits to the State, to keep the increased revenue apart from getting transfer payment from the Central Government, to keep the increased revenue while handing in fixed profits to the State, and fixed subsidies. The advantages of financial responsibility system are that it can encourage local governments to expand production, increase income and save expenses, while avoiding too much supervision and too much interference from the Central Government. The problem is that allowing local governments to have the "surplus claiming right" on increased profits for a long time would inevitably weaken the financial resources of the Central Government. This was not evident when the financial responsibility scheme was initially implemented, but the defects were soon brought to the surface after all State-owned enterprises started the practice in 1987, forcing the Central Government to start with centralized financial resources again and to implement the tax-sharing system in 1994.

In the context of financial responsibility system at different administrative levels, China's government spending on health mainly came from local financial budgets, and there was little central spending. With the widening gap in the development of local economies and in the financial resources of local governments, the difference between local governments in health outlays also expanded increasingly. The reduced proportion of local government in health outlays was regressive. In other words, the poorer a province (except Tibet) was, the quicker the outlays of its government on health decreased. The problem of the disparity between cities and the countryside became more serious. Before the reform and opening, although

government outlays also favored cities instead of the countryside, the actual difference shrank under the Central government guideline of placing emphasis of the health work on the countryside and the relevant polices and measures. After the reform and opening, the pressure from Central government disappeared and the difference in government outlays on health between urban and rural areas increased rapidly. Taking the year 1998 as an example, the national health expenditures were 377.6 billion yuan across the country that year. Therein 58.72 billion yuan came from governments, of which 9.25 billion yuan or only 15.9% were used for the countryside

The most immediate outcome of insufficient government inputs on health was the change of behavior of medical and health organizations. Under the traditional system, hospitals as well as cultural, educational, research units were all "public institutions" and all the outlays came from the government budget. Since the financial reform of "dividing revenue and expenditure between the central and local governments" in 1980, the method of "responsible for balancing one's budgets and keeping the surplus" was practiced in all government departments at various levels and public institutions related to research, education, culture and medicine. In practice, however, Government departments were not constrained by this rule, but all the public institutions were. In the 1980s when the economy grew rapidly, the practice of responsible for balancing one's budgets inevitably resulted in a smaller and smaller proportion of these institutions' funds in the government public funds. After the reform of the tax regime in 1994, although the proportion of the central financial revenues was enlarged, the situation of "outlays on health mainly coming from local financial revenues" did not change. Hence in many localities in the country, such institutions under the provincial level got an even smaller part from the government public funds.

The direct outcome of reduced government public funds was that public medical and health institutions lost a stable source of funds. After the 1990s, funds allocated to public hospitals by government were not only insufficient for basic salaries of medical staff, but even not enough for paying off water and electricity fees. Besides, many uncertain factors in the reform of medical insurance made the normal business incomes of many hospitals became very unstable. The situation of public health institutions was similar. The first two National Health Service surveys showed that the share of government funds to the sanitation anti-epidemic stations revenues decreased every year. The proportion from 1994 to 1997 declined from 46.2% to 38.8% in cities and from 40.2% to 34.8% in the country-

side. Therefore most public medical and health institutions had to maintain their operation through various means of "generating revenue".

In order to encourage "generating revenue", the internal allocation system of individual medical and health institutions must be adjusted correspondingly. The general practice was to link the incomes of teams and even individuals with their revenue generated. If early "generating revenue" was regarded as forced adaptation to changing situation, but it gradually became an active activity of medical institutions and staff as the attraction of financial interests increasingly intensified. The result was that the whole medical service system embarked on the commercialized and market-oriented road. The overall arrangement and organization of the medical service system as well as the focus of public health services and selection of technical approaches all deviated from public interests. This was the fundamental reason why the national health expenditures climbed incessantly, yet the utilization of medical and health services declined after the reform and opening.

After the reform and opening, although the standard of medical equipment had improved considerably and the provision ability of medical services had been enhanced greatly in China, they were not enough to alleviate the dissatisfaction of the ordinary people with the lowered service quality of hospitals and increased medical expenses. Facing the increasingly contradictions between hospitals and patients, the measures taken by the government were difficult to understand. The judicial explanation of "it is hospitals, not patients, who should provide evidence when hospitals are sued", promulgated by the Supreme Peoples' Court, did not relieved the contradictions between hospitals and patients but led to the negative effects of preventive medical measures.

Changes in Production and Circulation of Medicines and Supervisory System

—Influence of Economic System Reform on China's Medical and Health Work: Part Two

The over rapid increase, even loss of control, of national health expenditures is the biggest concern in the development of China's medical and health work and the root cause of many other problems. Although there are other reasons for the increase of medical expenses, such as the aging of the population structure, the enhanced medical technology and the change of the disease pattern, the more outstanding reason is the abnormal factors in the service process, among which

the most serious is the abuse of medicines and loss of control of their prices. In this respect, apart from the bad behavior of hospitals and medical staff, another important reason is the changes of the production, circulation and supervision systems of medicine.

In the traditional planned system, the production and circulation of medicine were taken charge by the Ministry of Chemical Industry and the Ministry of Commerce and the quality control of medicines by the Ministry of Health. In 1978, the China Medicinal Materials Co., China Pharmaceutical Co. under the previous Ministry of Commerce, the China Pharmaceutical Industrial Co. under the Ministry of Chemical Industry and the Medical Apparatus Co. under the Ministry of Health merged into the State General Drug Administration under the leadership of the Ministry of Health, which was renamed in 1982 as State Drug Administration and put under the administration of the State Economic Commission. In the following course of the reform, the State Economic Commission was disbanded and merged for several times and the higher authority of the State Drug Administration also changed, which weakened its functions. The quality control function of medicines had always been in the hands of the Ministry of Health but was taken over by the State Food and Drug Supervisory Administration in 1998. Although the organizations and functions are still there, quality control and industrial administration of production and circulation of medicines and medical apparatuses by the government only exist in name.

On the surface, China's drug administrative system after the reform and opening is similar to that of the US in many aspects, but in fact the actual situation is quite different. The US is a country with a federal system, but the licensing right of pharmaceutical production belongs to the FDA. China is a unitary country, but the licensing right of medicine production was delegated to provincial governments after the reform. Individual medicine quality control departments at the provincial level all have independent power to approve the production of medicines. Medicines approved can be produced and circulated in the respective provinces (including municipalities and autonomous regions). Due to the limitation of funds and technical capabilities, scattered approval inevitably leads to the loosing of licensing of medicine production. It was said that "if a medicine fails to get a state license, it will try the provincial one; if failing both, it will try to get a license for health care goods". Driven by the interests of developing local economies, several thousands of pharmaceutical factories emerged across the country. Medicines and health-protecting products in numerous names were advertised

on almost all TV channels, and it is very difficulty to tell the fake and shoddy medicine.

Before entering the WTO, the sales volume of State-owned and State-controlled medical wholesalers amounted to over 90% in China. But medicine-circulation was in extreme chaos. The State controlled the wholesale of medicines in name, but in the process of "delegating powers to lower levels and conceding profits", the former unified three-tier wholesaling system of medicines was dismantled into hundreds of medicine-wholesaling enterprises subject to local governments at different levels. The integration of economic interests between enterprises and local governments not only made government regulations exist in void, but also inevitably produced a reversed elimination through competition. Consequently, the number of medicine-wholesaling enterprises was increasing, and the average business scale of enterprises was getting smaller. In recent years medicine-wholesaling enterprises increased to over 16,000, but less than 400 of them have business revenue of 20 million yuan.

Due to the special nature of medicine and the existence of local protectionism, market competition did not bring about the improvement of efficiency and intensification of production and circulation. When government only controls service prices of medical and health institutions, the overheating competition among pharmaceutical enterprises provided a rare opportunity for medical and health institutions to "generate revenue". Currently, medicine in China is mainly sold in hospital pharmacies according to doctors' prescriptions. It is already an open secret that, in order to defeat competitors, individual medical enterprises price their medicine at a high rate to increase gross profits and then surrender most of them to hospital pharmacies as sales cost. It is also common for pharmaceutical manufacturers to give commissions to doctors under the table based on the volume of their prescriptions. This is not only an important factor for the increased medical fees but also gravely corrupts medical and health workers.

To tackle these problems, the government has adopted many methods such as setting price ceilings on medicine, group purchase of medicine through tendering, separation of dispensing from prescribing, and the third party payment system, all of which try to break the "conspiracy" between pharmaceutical plants and hospitals. However, no obvious results have been achieved so far. It needs further study and investigation on how to correctly handle the relationship between bringing the role of market mechanism into play and strengthening government regulations in respect of such a special industry as pharmaceuticals.

Review of Reform of Urban Medical Security System

—Influence of Economic System Reform on China's Medical and Health Work: Part Three

In the period of planned economy, China's urban medical insurance system was divided into two big parts: the free medical service system for the staff members of government organizations and institutions and the labor insurance medical system for enterprise workers. There was no big difference in the type of financial protection, the benefit level, financing method and administrative system between the two systems. There were two remarkable characteristics with the urban medical insurance system before the reform: First, apparently all units raised funds by themselves and provided benefits to their staff according to the benefit rate set by the State, but, in the context of overall control on revenue and expenditure, in fact there existed social pooling in both the free medical service system and labor insurance medical system and even between the two. Second, targets of the insurance system were only staff of State-owned units, but coverage for staff of collective economic units in cities followed the same pattern, , the system that only targeted public units actually covered almost all urban employees because there was basically no private economy at that time. Besides, since employees' family dependents could also enjoy part of medical benefits according to the related regulations, the urban medical security systems actually covered most of urban population at that time.

With the advancing of the reform and opening, the schematic foundation that traditional medical insurance system relied on had changed completely and constituted serious challenges to its operation and efficacy.

First of all, reform of enterprises required them to become independent both operationally and financially. Actual social pooling in the former labor insurance medical system of enterprises became enterprises insurance in its real sense. Since enterprises performed differently, problems such as the difference in the ability and standard in providing insurance, especially inability of some poor enterprises to pay medical expenses for employees, emerged quickly. This both affected employees' interests and social stability and posed obstacles to the reform of enterprises. Besides, due to the system of dividing revenue and expenditure between the central and local governments, governments departments and institutions were responsible for balancing their budgets,, the free medical service system were also changed into individual employer's liabilities, causing many problems similar to that of enterprises.

Another challenge came from the growth of the non-public economic sector. After the reform and opening, non-public economy and the number of workers in it increased rapidly. But the traditional medical insurance system was only designed to cover workers in public economy units. Apparently, if such discriminatory medical insurance system continued, it would not only deviate from the government policy to encourage the growth of non-public economy, but also affected adversely the equal development of economies of different ownerships and social equality and stability.

Apart from that, when both non-public economic sector and urban population grew rapidly, if medical insurance system still only covered workers of the public economic sector, the coverage rate of insurance system would definitely decrease and people outside the scheme would erode the medical resources in the system, and the problem would become more serious. The abuse of insurance funds, plus of the outrageous behaviour of medical service institutions above-mention, made the operation of the medical insurance system more and more difficult. Therefore there was increasing financial difficulties for both the free medical service system and the labor insurance medical system.

Confronting with all these challenges, the urban medical security system had to be reformed and adjusted. In the 1980s, when there was no dramatic change in the macro economic framework, many localities, enterprises, governmental and institutional units began to pilot many forms of reform on their own initiative for the purpose of controlling the growth of medical expenses. At the end of 1980s, they started probing for new medical insurance system. Till mid-1990s, various types of social pooling as a whole had been practiced. Afterwards, the pilot schemes were expanded on the basis of combining social pool with individual accounts. In 1998, the Central Government published the "State Council Decision on Establishing Basic Medical Insurance System for Urban Workers" and the system of combining social pooled funds with individual accounts was officially put into comprehensive practice.

Reviewing the past 20 years' medical insurance reform, it includes two basic elements. The first was to control the increase of medical expenses mainly through restricting the behavior of the insured (patients). All such measures as introducing co-payment, making a list of medicine for reimbursement or setting an individual account served the same purpose. The second was to push forward social pooling funds to solve the problem of unbalanced burdens among different institutions, especially enterprises. Although the reform has achieved some posi-

tive results, the effects are negligible. On the contrary, the negative outcomes are conspicuous.

The first reason for the failure is the deviation in guideline on the medical insurance system reform. In the establishment of medical insurance system, social goals should be the most important, i.e. realizing mutual aid on the basis of ensuring the basic rights of the public and providing institutionalized basic medical services for as many people as possible. With the rapid growth of the non-public economy and the increasingly accelerated process of urbanization, this goal appears even more important. But in the reform stated above, this issue did not draw the deserved attention. Almost all the considerations of reform aimed to control the growth of medical expenses. Even since the introduction of social pooled funds, pursuing the balance of funds has still been the most important target. Only those who were able to pay premiums can be insured. Obviously, the over pursuance of the balance of funds had already changed the attribute of social security to a great extent. The inevitable result is that the medical insurance system has become the "rich people's club".

The second reason is due to many problems in the choice of detailed measures. For instance, measures adopted to control the growth of expenses are basically only targeted at patients. But in actual practice, patients are much weaker than medical institutions in the determination of medical consumption. Besides, resources within the system are also seriously eroded by non-participants in the system. Yet new system did not form any effective restrictive measures against those and almost cannot contribute anything to contain the soaring of medical expenses. Another typical example of failure is the establishment of individual accounts. Medical insurance needs social mutual aid most. It is impossible to accumulate first and consume later in the raising and using of funds. The establishment of individual accounts does not accord with the general medical rule and the basic principle for designing a medical insurance system from any angle whatever.

The deviation of the guideline and a series of problems in the design of the specific system made the urban medical insurance system unable to play its expected role. With regard to the population covered by the insurance system, the urban medical insurance system only covers over 100 million people now, less than one fourth of the urban population. It covers less than half of the employed population even. In the absolute number, the population covered by the system is even less than that at the beginning of the reform. Most of the urban unemployed people, workers in the non-public sector and migrant employment represented by peasant-workers are excluded from the system. Besides, the medical insurance institutions are keen

on pursuing the financial balance between revenues and expenditures, but that fail to control the growth of medical expenses actually. Consequently, enterprises covered are charged a very high contribution rate, which makes the expansion of coverage of the medical insurance become even more difficult. The reform is basically a failure. It did neither realize the protection of the basic social rights of the overwhelming majority of citizens nor create fair competition among enterprises of different ownerships and promote the rational flow of labor.

As there have been great changes in the economic system, the urban medical insurance system must be continued to reform. But instead of making adaptive adjustments simply based on specific targets (especially the economic target only), the rule of the medial and health work must be fully understood and the overall target of the medical insurance system reform must be further clarified to establish a system which basically conforms to the basic requirements of the social development and suits the national situations of China.

Process and Cause of Collapse of Cooperative Medical System in Rural Areas

—Influence of Economic System Reform on China's Medical and Health Work: Part Four

In the period of the traditional planned system, the rural cooperative medical system of China was established on the basis of the collective economy. On one hand, a relatively sound three-tier (county, commune and production brigade) preventive and medical network was established with the efforts of governments at various levels and rural collective economy over many years. The most important of which was the clinic and barefoot doctors in every administrative village (production brigade) incorporating prevention and elementary medical services. This greatly enhanced the availability of health services. Moreover, medical service costs were strictly controlled through orientation of various service systems at various levels to public welfare and suitable technical selection. On the other hand, cooperative medical schemes (CMS) were also developed rapidly on the basis of the collective system for mutual aid in expenses. The CMS were available in around 90% of the administrative villages in China at the end of 1970s.

In 1979, Ministry of Health, Ministry of Agriculture, Ministry of Finance, State Medicine Administration and National Supply and Marketing Cooperative jointly publicized a document entitled the Regulations on Rural CMS (Tentative Draft) in an effort to further regulate and consolidate the CMS. But in the same year,

the reform of fixed output quotas for each household began in the countryside in China.

In 1983, the World Health Organization convened an international seminar on CMS in Shandong, China, praising China for having reached the health level of advanced countries on the basis of the economy of a backward country. But, unfortunately, the CMS started to collapse in China's countryside at that time. After the reform of fixed farm output quotas for each household, the collective economy in villages gradually deteriorated and most of the clinics in villages were contracted under the name of privatization. Their relationship with peasants simply became that between buyers and sellers. The collective economy and especially the collective medical system based on collective efforts collapsed rapidly and the collective medical system existed in less than 5% of the administrative villages by the end of 1980s.

In view of the achievements of the former CMS and the effects brought by its collapse on the medical and health work in the countryside, governments at various levels have been trying to restore and rebuild it since the mid-1980s. But the results were not satisfactory. Although the Ministry of Health put forward the plan for healthcare for everyone in the countryside in 2000, the second National Health Service survey conducted by the Ministry in 1998 showed that only 12.6% of the rural population had medical security to some extent nationwide and the participants in the CMS only accounted for 6.5% of the rural population.

In 2003, China made efforts again to build a "new cooperative medical system". The basic characteristics of the system are to protect financial protection for major diseases which is financed at a county level. Peasants can take insurance voluntarily and the government subsidizes the insured's contribution. However, the result is not satisfactory judging from practice and it is not attractive for most regions, in particular the central and western regions. And the technical design of the system itself had is open to debate. For example, taking insurance voluntarily will inevitably exclude the poorest and it will be an adverse redistribution if the government subsidizes the participants, which are relatively richer. Besides, it also opens to debate whether the rural medical insurance system should primarily target common and recurrent diseases or major diseases.

The reason for failing to restore smoothly the cooperative medical system on the basis of little support from the government was that the cause of the collapse of the rural cooperative medical system was not made really clear. of the success of traditional CMS depended on political mobilizations in the specific ideology and,

moreover, the rural collective ownership at that time and the strong power of the collective economy in distribution of income. Once this foundation disappeared, it is almost impossible to reorganize peasants. First of all it is a question of ideology. China's CMS are very different from the Western "cooperative" system. There was no tradition of "clubs", in a strict Western sense, in the Chinese history; and a patriarchal system was implemented even in secret associations, in which most members did not bear their own economic responsibility. The system of fixed farm output quotas for each household did mobilize peasants' enthusiasm for production, but it also awakened the farmers' narrow-minded family consciousness. No one is willing to take out money to pay others' medical expenses when oneself is not ill. Secondly, the quick transfer of property from collective ownership to family ownership increased substantially the cost of economic mobilization and administration. In other words, without the foundation of the collective economy, the rural CMS lost its economic support.

But only paying attention to the factor of the collective economy is far from enough. Another crucial factor for the popularity of the CMS in the period of planned economy was the support of the government. The CMS was not only a kind of simple and mutual aid among peasants, but also a system established jointly by the government, collectives and individuals. On the surface, the medical expenses were paid by collectives and individuals together, but they were only part of actual medical costs. Except clinics at the village level, two-tier medical service institutions at the county and commune levels were all set up directly by the government at that time and capital construction costs and salaries of medical staffs were all borne by the government. The government controlled the prices of medicines, diagnosis and treatment strictly and encouraged medical service institutions at various levels to adopt cheap and appropriate techniques and medicines, such as acupuncture and Chinese herbal medicines. All these greatly lowered the "threshold" for rural collectives and individuals to participate in the CMS. In other words, the financial support of the government and its control of the behaviors and prices of medical service institutions were the important causes for the practicability of the CMS.

What contrasts sharply with the period of planned economy is that the government inputs decreased enormously since reform and opening. Such a change, together with out-of-control on medical service institutions behavior and many other causes, push the costs of medical services to soar. Peasants can no longer enjoy government subsidies but have to pay medical institutions exorbitant profits when they buy medical services. Since 1990s, the income of peasants had not

increased for a long time and the prices of medical services in many parts of the country have exceeded the overall purchasing power of peasants. Even ignoring the factor of the disappearance of the collective economy, whether the CMS could be practiced is still uncertain in a changing context of medical services. The fact that many enterprises in cities and even some public departments of the government could not continue to participate in the insurance system due to soaring costs of medical services is probably a convincing evidence. The quick collapse of the rural collective medical system in 1980s proves that it is impracticable to totally rely on peasants' mutual aid. Under the situation that the medical system is in disorder and the costs of medicine and services cannot be controlled, it amounts to nothing for the government to subsidize peasants several yuan a year.

The medical financial protection of rural residents has attracted great attention from all walks of life. The current question is not whether the rural medical security system should be established or not, but what a system should be established. Due to changes of various conditions, the original cooperative medical system actually cannot be restored and re-established. If that is the case, maybe other approaches should be considered. For example, it may be a better choice for the government to provide rural residents with basic medical services free of charges or with a little co-payment.

Challenges Brought about by Widening Gap in Residents' Incomes

—Influence of Economic System Reform on China's Medical and Health Work: Part Five

Not only the change of the economic system itself has a great influence on the medical and health system, but the influence of its derivative results cannot be neglected. Among them the most noticeable is the difference in income distribution.

In the first stage of reform and opening, when the "cake" was made bigger, the income of most residents increased more or less. Although the gap in residents' income continued to increase, the social contradictions were not very conspicuous. After Deng Xiaoping made his speech during his inspection tour in south China, the reform and opening were further carried forward and the course of entering the WTO was restarted. Those, together with the adverse effects of the Asian financial crisis, had reduced considerably the income of peasants in the central and western regions and the laid-off in cities. Although the momentum

of the economic development was not bad, the contradictions in distribution of income became increasingly sharp. China's Gini Coefficient in the development report of the World Bank increased from around 0.3 in the early 1980s to 0.38 in 1988 and 0.415 in 1995. Although the Gini Coefficient published by the Chinese government was a little different from the estimates of international organizations and the academic circles, but they all agreed that the gap of income distribution was near the internationally recognized cordon. The most protruding in the gap was the difference between cities and the countryside and between regions. Certainly, the gap between different stratums in cities and the countryside was also quite big.

On one hand, the gap in residents' income was widened constantly, on the other hand, the medical services were gradually commercialized and market-oriented. The combination of the two forces resulted in the division of the medical service system and the differentiation of the satisfaction levels of residents' medical needs.

The high-income group requires high-quality medical services, which brought about marketable improvement in the technology of medical diagnosis and treatment and the hardware of some hospitals. After the reform and opening, color ultrasonic equipment, CT, nuclear and magnetic resonators and other advanced diagnostic equipment increased ceaselessly in big hospitals in cities. The wards of CCU and ICU were established widely and surgeries requiring higher techniques such as human organ transplants were more and more popularized. Besides, as private and overseas funds were introduced, some specialized and high standard wards were also built, which, together with profit-making hospitals and sanitariums, drew ordinary hospitals in an effort to change their wards according to the standard of star hotels. The popularization rate of high-grade medical instruments in many big Chinese cities is not only higher than that in middle-income countries, but also even higher than that in Western developed countries.

While medical resources concentrated in big cities and hospitals, the medical service system in the vast countryside and the central and western regions shrank inevitably, due to weak purchasing power of local residents. The difference between the medical service capabilities and standards in cities and the countryside and among different regions expanded gradually. Hospital beds increased by 135.3% from 832,000 in 1982 to 1.959 million in 2001 in hospitals in Chinese cities while decreased by 16.7% from 1.221 million in 1982 to 1.017 million in 2001 in hospital in the countryside. The beds in rural hospitals accounted for 34.2% in 2001 com-

pared to 60% in 1982, even lower than the 40.2% in 1965 when Chairman Mao criticized the Ministry of Health as a "ministry for urban bureaucrats".

Another noticeable point is the number of medical staff in institutions for providing the ordinary people with primary medical services decreased substantially. In the countryside, the number of rural doctors decreased from about 1.5 million in 1980 to about 1 million at present. The number of health workers in the countryside decreased from 2.36 million in 1980 to around 270,000 in 2001, less than the odd number of 1980. Besides, the number of midwives in the countryside also decreased by half from 615,000 in 1975 to 322,000 in 1997. The situation in many rural areas returned to that at the beginning of liberation, when medicines and doctors were generally insufficient. In cities, problems faced by health institutions in communities are also very serious, not only posing threat to the requirements of large numbers of urban residents for primary medical services, but also plunging the public health work into a situation of no one taking the responsibility.

The satisfaction levels of Chinese residents' medical needs differentiated to a disturbing degree. According to the statistics of the Ministry of Health, the national health expenditures were 476.397 billion yuan in China in 2000. Therein the health cost in the countryside was 107.36 million yuan, accounting for 22.5% of the total and that in cities was 369.02 million yuan, accounting for 77.5% of the total. That is to say, rural residents who accounted for two thirds of the national total population spent less than one third of the health expenses by urban residents. Even in cities, owing to the huge gap between different groups in incomes, the satisfaction levels of medical requirements are also vastly different. In other words, while some high-income groups pursue high technology and high-quality services, low-income groups and most rural residents have to lower their requirements for medical services due to lack of financial capacity. It can be seen clearly when comparing the two national health service surveys conducted in 1993 and 1998 respectively. The proportion of patients who could not afford to go to see a doctor or stopped treatment for economic difficulty and the proportion of patients who should have been hospitalized but were not hospitalized for economic reasons both increased remarkably. In some poverty-stricken countryside, 80% of the patients who should have been hospitalized were not hospitalized.

Table 1: Proportion of patients who do not go to see a doctor due to economic difficulty (%)

	Big cities	Medium cities	Small cities	Class I of countryside	Class II of countryside	Class III of countryside	Class IV of countryside
11993	3.21	2.40	9.58	15.10	21.36	19.55	24.42
11998	36.69	23.48	42.96	30.09	31.67	42.29	38.72

Table 2: Proportion of Patients Who Should Have Been but Are Not Hospitalized （%）

	Big cities	Medium cities	Small cities	Class I of countryside	Class II of countryside	Class III of countryside	Class IV of countryside
1993	34.09	33.87	53.47	47.95	63.15	61.14	67.72
1998	53.12	58.43	70.77	63.80	54.12	70.26	69.38

The underutilization of different groups, especially the dilemma faced by economically difficult groups has caught attention from many sides. Some local governments and related international organizations also began to probe the establishment of medical aid for poor people. But it should be seen that the overall gap of income cannot be narrowed down in a short time. Under this condition, if the medical and health system is not adjusted completely, aid to specific groups will not produce due effects. For example, when most people in the society cannot be protected by the institutional financial arrangements, only providing aid for the minority of the poor could neither prevent erosion of relevant medical resources, nor solve the problem of the "trap of poverty".

Consequences of Changes of Medical and Health System and Their Influence on Development

The reform of China's economic system has ultimately changed the foundation for the existence and development of the traditional medical and health system, therefore, medical and health system must be reformed. Nonetheless, according to the above analyses of various aspects of China's medical and health work, a medical and health system in line with the basic requirements of current economic and social development has not been formed yet due to the influence of many factors. Just as what has been generally recognized by all circles of the society, both the

equity in health financing and the utilization efficiency of medical resources are now worsening. But what is more noteworthy are the serious economic and social consequences of the changing health system.

First, the improvement of nationals' health status is impaired, according to the average life expectancy and infant mortality, the two indicators normally used in the world. The average life expectancy increased by 4 years in the world from 1980 to 1998. Therein it increased by 3 years in low-income countries, 5 years in medium-income countries and 4 years in high-income countries, whereas it only increased by 3.5 years in China from 1981 to 2000. In respect of infant mortality, it was 28.4‰ in China in 2000, lower than the world average of 44‰ and a little lower than the 30‰ in medium-income countries. However, from 1980 to 1988, it lowered by 29‰ in low-income countries, 23‰ in medium-income countries and 9‰ in high-income countries, i.e. it lowered by 23‰ on average in the world. But it only lowered by 6.3‰ in China from 1981 to 2000, even less than the reduction in high-income countries.

Besides, some upsetting signs appeared. First, the problem of epidemic diseases is becoming increasingly serious. Venereal disease that was basically wiped out in the mainland after liberation has become rampant again; there are nearly 1 million patients here infected with worldwide disease HIV/AIDS; incidence of tuberculosis originally under control begin to increase; the number of Hepatitis B virus carriers is the largest in the world (about 140 million) and the incidence is still increasing. Secondly, local diseases are not under effective control. Cases of schistosomiasis have reappeared in many southern provinces; people are poisoned with local fluorine (arsenic) in 1,289 counties (districts) and as many as 110 million people are threatened. The Kaschin-Beck disease ravages mainly the western region, threatening about 16 million people and the disability rate is as high as 33%. Thirdly, the problem of the disabled people is outstanding. Now there are about 60 million variously disabled people in China, and this number is increasing every year. There are currently 800,000 to 1.2 million disabled newborns every year.

Due to imbalanced development and income of residents, the difference in nationals' health levels between cities and the countryside, between regions and between groups has gradually become widened.

Secondly, social stability is directly affected. Many diseases and economic and mental pressure induced by the diseases are normally borne by individuals and their families. But if a considerable number of people in society cannot reduce

their disease risks due to economic difficulty, a series of social problems will inevitably arise, such as poverty, suicide, family breakups, increased rate of crimes, all of which have adverse influence on social stability. According to studies and reports from various sources, these problems apparently increased in China in recent years.

Apart from the threats that might be posed by individual social members to the society due to lack of medical protection, other social impacts should also been properly estimated such as the negative influence of ever-expanding difference in satisfaction levels of medical requirements between different groups on their relationship, and the consequent drop of the support rate of the public for the reform of systems and relevant policies of the government. Although most of the masses have truly benefited from the reform and opening, but many people still have a good memory of relatively equal social rights in basic medical treatment and education they ever enjoyed in the period of planned economy. After the reform and opening, part of their social rights of some or even most of the people have been neglected d and the resentment so caused can be felt.

Moreover, the current medical system has a great negative influence on social moral and the relationship between doctors and patients. Low-income groups in cities are unable to afford medical expenses, which greatly challenges the principle of hospitals to rescue the dying and to heal the wounded and the professional conscience of doctors. Under the traditional system, as the government would take the last responsibility, hospitals never hesitated to give emergency treatment and rescue people injured in accidents. But now based on the over pursuit of interests by medical institutions and the nonfeasance of the medical administrative departments under the government, the situation of only paying attention to money and deviating from the humanitarian tradition of healing the wounded and rescuing the dying is already very common and it sets up a negative example for many other industries. The contradictions between doctors and patients have been increased constantly.

Thirdly, the progress of the reform is affected. Promoting reform in other fields, especially in the economic field, through the reform of medical and health system is always one of the important driving force for the latter reform. But judging from the current situation, it not only failed to provide support for reform in other fields but also posed obstacles in many aspects. As the medical insurance system only covers a small number of social members and mainly those in the public sector, it is unfavorable for fair competition between different ownerships, and the flow of labor between different ownerships, different departments and between

cities and the rural areas. This is also a very harmful factor for the growth of non-public economy, the reform of State-owned enterprises and public departments and progress of urbanization.

Fourthly, it has negative impact on economic growth. The reason why the development of the medical and health work has not attracted enough attention for many years is because of the mere and over pursuit of economic growth. But, neglect of the medical and health work, on the contrary, produced severe negative effects on economic growth. The study of health economics proved long ago that if the basic medical requirements of a considerable number of members in a society can in no way be satisfied, it would not only pose threats to the patients and their families, but will also inevitably aggravate the burden of diseases for the whole society and even spread epidemic diseases. This would not only increase the medical and health expenses for that period, but also would bring loss on labor resources and have an unfavorable impact on long-term development. These problems have in fact appeared in China now. The great increase of medical expenses in the whole society is an evident example. The effects of "SARS" on the economy are probably an even more powerful piece of evidence.

Certainly the negative effects of the current medical and health system are not limited to the above. Since the coverage by the basic medical insurance is too small, the overwhelming majority of residents have to take the responsibility for health insurance themselves. Since the mid-1990s, banks lowered interest rates for seven consecutive times so as to ease deflation, but the saving rate of residents still didn't decline. One of the important reasons is the social expectancy is passive. The reform of social security and public service systems gave the ordinary people an impression that in the future, whether old-age pensions, medical treatment and schooling, government would no longer take care. Based on such understanding and, to may sense, a reality, they began to only cut down their current consumption to "prepare for the rainy days". The result was prolonged deflation.

IX. Learning Some Basic Knowledge of Modern Economics

China introduced various schools of academic concepts from abroad after the reform and opening, but the situation of "letting one hundred flowers blossom" we had expected did not appear. China's academic circle fell into the market omnipotence theory after breaking away from the rigid thinking of "politics could

govern everything". This is an important reason for the deviations in the medical and health reform and other social policy reforms.

In the mid-1990s, suddenly came a wave of commercialization of public affairs after target of system of socialist market economy was established. In a time when the gap in residents' income was already very wide, some beneficiaries of the reform, instead of prompting the government to shoulder the responsibility for maintaining social equality, requested it to quicken the pace to commercialize public services, so as to reap private interests for themselves. Driven by the market omnipotence theory, competition mechanism was not only introduced into production and circulation of medicines, but medical and health institutions e also accepted competition and established the so-called "reasonable compensation mechanism". Even the government also began to shift off responsibility for general services by the slogan that the State should not "take too much responsibilities", encouraging the medical and health institutions to "generate revenue" themselves. It seems that once market competition is introduced, medical and health resources will be distributed rationally and all problems in the medical and health sector (including social equality and general services) will be solved immediately. This kind of "theory" cannot withstand the test of practice. The reason is very simple. Different from general consumable goods and services, the purpose of medical and health services is to raise the health standard of all residents, enabling them not to contract diseases or contract fewer diseases. In comparison with that purpose, the economic results of medical and health institutions themselves are not important or even negligible. Since the simplest method for medical and health institutions to pursue their own economic results is to think of ways to make people contract diseases and contract major diseases, which, however, conflicts completely with the basic purpose of the medical and health work. In respect of competition, the Western economics proved long ago that because of the imbalance of information between hospitals and patients, the medical and health field is a typical field where the "market fails". Competition cannot raise the utilization efficiency of medical resources. On the contrary, if services are fully oriented to the market, problems such as less accessible, deviated technical route and service focus will arise.

Medical service requirements are also different from general consumer goods in nature. If medical and health expenses are mainly borne by individuals, the inequality in individual income and wealth will translate into inequality in medical and health services. The wealthy have money to enjoy high-quality medical and health services while the poor are excluded from the basic medical and health

services. Consequently, not only the health of the poor will deteriorate, but the health of all the people will also be adversely affected through the spreading of contagious diseases or the price and cost for the functioning of economy and society will be increased by other means. Hence many medical requirements have the nature of public or quasi-public products, which is also the basic knowledge in Western economics.

In many years' reform of the medical and health system, not only the basic knowledge of economics was violated on some fundamental issues, the design of some specific rules also apparently breached the basic knowledge of economics. For instance, the introduction of individual accounts into the urban medical insurance system and the design of the new rural cooperative medical system targeted at "major diseases" are obviously wrong.

It is exactly the specific characteristics of medical services that did not make medical and health services t fully commercialized in any Western countries with market economy. Government responsibilities are very prominent in terms of the provision of basic public and health products, financing and distribution in the general medical treatment field and interference in medical services. Some countries even adopt the planning method in many aspects. These practices really need our study and consideration.

The relationship between the medical and health work and economic growth is also the gray area where many people have misunderstandings at present. Many people think medical and health institutions are consuming departments. Developing medical and health work may affect economic growth, and strengthening government inputs will lay a bigger burden on finance. Apparently, all these do not tally with the basic knowledge of economics. We already analyzed that the deficiencies of China's medical and health system had already caused effect on the growth of macro economy. In fact, this is only one side of the coin. A bad medical and health system will certainly affect the growth of macro economy while a good system design will promote economic growth. For instance, if China can soon establish a medical insurance system that can cover a wide area and protect the basic health of all the ordinary people, firstly social equality and stability will be enhanced and the improvement of social environment will surely contribute to economic growth; secondly protecting national people basic health will inevitably raise the quality of the people and strengthen the competitiveness of the country; and thirdly it can dramatically improve residents' life expectancy which will stimulate consumption and drive the growth of macro economy.

Now many people are more concerned about the issue of financial capability, and are worried that developing medical and health work, especially strengthening the government role, will constitute a heavy financial burden or not. In respect of this question, we must realize that the current national health expenditures in China are already not so low. The problem is that health financing heavily depends out-of-pocket payment. If public power can be exercised through specific financing methods to centralize and redistribute the expenses currently mainly paid by individuals, the operation of other economic systems will not be affected and the medical expenses of the whole society could be even reduced under the premise of comprehensive improvement of the general health standard of masses, and more capital could be injected into economic construction. On the other hand, even if the increased spending on health may bring pressure upon public finance in a certain period, but more government health spending would means reduced household expenditures on health and increased money for current consumption and investment. Consequently, economic growth would sustain and so would the taxation revenue. Therefore, the entire economic cycle will be improved. Moreover, scaling up of government spending in medical and health work and especially in strengthening construction of the public health and basic medical service systems for the public, will have major impact on creating job opportunities.

Looking at the current situation of China, many problems impede economic growth and social development, such as the problem of increasingly widening income gap, and the issues of agriculture, rural areas and farmers. In spite of many measures taken, the situation has not changed. But if the thinking is changed slightly to actively promote the improvement of various social policies including medical and health policies, probably better results will be achieved than by improvement of general economic policies only. As for the distribution of income, for example, the medical insurance system is a very important means for redistribution. A rationale system will surely narrow down the gap in income and consumption. Regarding rural development, a basic health service system for all rural residents will probably be an approach more effective than the reduction and exemption of various taxes and charges, and will be more beneficial to peasants and more welcomed by them. In fact, good social policies should take into account not only citizen's civilian rights including political and social aspects, but also the relevant economic significance.

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