

---

# *Medical Financial Assistance in Rural China: Policy design and implementation*

Yuebin Xu, Xiulan Zhang and Xunke Zhu

## *Abstract*

This paper reviews the development of the Medical Financial Assistance program (MFA) in rural China, including design and implementation processes, and assesses major areas for improvement. Jointly financed by the central and local governments, MFA provides cash assistance to poor households for the purchase of medical services. Because policy design and implementation are decentralized to local governments, the schemes vary markedly across localities in terms of financing, benefit levels and payment methods. Constrained by limited financial resources, MFA benefits are granted only when recipients qualify by meeting a number of conditions. These conditions are disadvantageous to the poor, leading in general to low utilization of benefits by poor households. With increased financial input from central and local governments, the MFA schemes have been improved compared to their early design. However, additional institutionalized funding sources are needed in order to improve the policy further.

## *Introduction*

Since the latter half of the 1990s, social assistance has received increasing attention from the Chinese government as an integral part of its overall social protection system. A variety of means-test programs have been rolled out rapidly throughout the country. In the countryside, reforms in the economic and institutional structures that started in the early 1980s have markedly improved the livelihoods of millions of people. Combined with decades of development-based anti-poverty policies, rural poverty has been substantially reduced. However, rural economic and institutional reforms have also led to the dismantling of community-financed social protection programs, including those programs relating to access to the health care system. Therefore, at the same time as various social assistance schemes

supporting a subsistence-level standard of living among rural poor households have been implemented, poverty due to illness has increasingly become a significant social problem in rural China. This led to the formulation and establishment, early in the 21<sup>st</sup> century, of a new health program for the rural population, the New Rural Medical Cooperatives (NCMS). The NCMS is intended to work as a mutual assistance program covering a portion of the recipient's medical expenses. Meanwhile, a medical financial assistance program (MFA) was also implemented, based on the existing social assistance programs, in order to support the participation of rural poor households in NCMS and to give them direct support for receiving medical services. Jointly financed by central and local governments, MFA is a highly decentralized program, with local governments having discretion over both policy design and implementation based on local circumstances. As a result, marked variations are noted across localities. Although its goal has been defined as protecting rural poor households against the impoverishing impacts of major illness, both the implementation and effectiveness of MFA schemes depend on the performance of other social assistance programs and NCMS.

This paper reviews the implementation process associated with MFA, for the purpose of identifying areas for policy improvement. The paper briefly introduces the facts of rural poverty and the main features of corresponding social assistance programs currently operating in rural China, upon which MFA has been built. This is followed by a description of the dismantling and rebuilding processes of rural community-financed medical insurance programs, which both necessitates and is closely related to the implementation of MFA. Then the paper reviews the implementation processes of the MFA system and its policy design features across localities, focusing mainly on financing, benefit levels and methods of payment, and eligibility conditions. The paper concludes with a brief assessment of the problems and challenges China faces in providing an effective social protection system for the rural population.

## *The emergence of social assistance in rural China*

China has experienced a substantial reduction in the size of its rural poor population since reforms in the rural economic system began in the early 1980s. The numbers fell from 250 million in 1981 to 23.65 million in 2005, based on an annual per capita net income of 683 Yuan in 2005 as the official poverty line (China State Statistics Bureau 2006). Particularly in the early years of the reforms, the removal of tight state control over the economic activities of farmers certainly resulted in marked increases in their incomes, contributing directly to lifting the majority of the rural poor population out of poverty. Therefore, economic reforms are regarded as the most important factor in the reduction of the development-related poverty that characterized pre-reform China (Wang *et al.* 2004). Another major policy that has played an important role in bringing down the size of rural poverty has been the geographically targeted Development-based Approach to Poverty Alleviation projects which started in the mid-1980s. This has been an important tool for the government to use in addressing rural poverty since that time<sup>1</sup>.

However, in the second half of the 1990s rural poverty reduction slowed down, largely because an increasing proportion of the poverty was caused by disability or illness. This is in contrast to the early years of the reforms, when rural poverty was mainly a development-related phenomenon, and the poor population was mostly composed of people who were able to work but lacked the necessary means or opportunities to engage in income-earning activities. Since the mid 1990s, however, the distribution of the rural poor population has not been limited to the mountainous and ethnic minority areas, but has also occurred in many non-poor counties and even in the wealthy areas. The elderly, the sick and the disabled are becoming the major component of the rural poor population. Nationally, various estimates

---

<sup>1</sup>The project consists of a number of county-based programs, in which poor counties were chosen by either the national or local governments as targets for poverty reduction. The main focus was to create income-generating sources and improve living conditions for rural people, by such measures as improving rural infrastructure, providing employment opportunities through public works or enterprises funded by state poverty alleviation funds, and organizing the migration of poor people to well-off places.

have been made on the magnitude of rural poverty caused by illness<sup>2</sup>. A recent random sampling survey of 4,515 rural households in five provinces of China showed that 39 percent of poor households had at least one member who was either sick or disabled, 23 percent had at least one member who was 65 years old or older, and 17 percent had no members working full time (Xu *et al.* 2007). Obviously, many of the remaining poor households are unable to benefit from the development anti-poverty programs, which rely on the employability of their members to lift them out of poverty. Changes in the incidence and causes of rural poverty have led to increasing concern among both policymakers and researchers about whether geographically based approaches still have the capacity and effectiveness necessary to continue achieving their objectives. Thus, towards the turn of the century government paid increasing attention to setting up social assistance programs focusing on household-level interventions to support the rural poor, in addition to ongoing development anti-poverty programs.

By the end of 2007, major social assistance programs currently operating in the countryside in China included three schemes<sup>3</sup>: the Five Guarantee Program (Wubao), the Minimum Income Guarantee Scheme (Dibao), and Assistance for the Extremely Poor Households (Tekun). The Wubao program was first established in the early 1950s as a collective safety-net catering to the rural elderly and orphans without family caregivers and sources of income. For most of the time during the reform period Wubao has been the only social welfare program for the rural population. Recipients are provided with a locally defined rate of benefits in cash and in kind, which cover five categories of need, including food and fuel; clothing, bedding articles and pocket money; housing, along with the basic necessities; medical care; and funeral costs<sup>4</sup>. The Dibao program is a means-tested

---

<sup>2</sup> According to the information disclosed by the Deputy Minister of Health, Zhu Qingsheng, at a State Council's press conference on November 5, 2004, illness was the cause of poverty for 40 to 60 percent of the rural poor.

<sup>3</sup> Contributory rural old-age pension schemes were experimented in the early 1990s, but proved to be a non-viable tool to provide rural old-age security. The number of participants decreased from 82 million in 1997 to 53.74 million in 2006, with a total number of 3.55 million farmers receiving pensions, mostly in the well-off regions.

<sup>4</sup> According to the revised "Regulations on the Rural Five Guarantees" passed in 2006, benefit levels for Wubao recipients should be the equivalent of the average living standard of local residents.

benefit, which began in local trials in the mid-1990s in a few economically developed provinces and had been extended to most counties by the end of 2007. Before 2007, the schemes were almost exclusively financed by local governments, which often shared the funds among different administrative levels (e.g. provincial, prefecture, municipal, county and township governments) and village collectives. In 2007, for the first time, the central government allocated 3,000 million Yuan to subsidize local governments for the schemes, an amount that is expected to increase in the years to come. The design of the rural schemes is a modified version of the urban ones. In general practice, a poverty line or standard of benefits would first be determined by the county government. Households with a per capita income falling below the poverty line would be eligible for benefits, and they would receive the difference between the total eligible benefits (the local poverty line times the number of persons in the household) and the total household income.

Meanwhile, Tekun schemes have been promoted in economically less developed regions as an alternative to the Dibao system. This is mainly because only the regions that were developing rapidly economically were able to afford the Dibao schemes, due to the absence of financial transfers from the central government. In response to this situation, the State Council and the Ministry of Civil Affairs (MoCA), which is responsible for administering social assistance programs in China, issued new policy guidelines in 2003, cautioning local governments not to rush into the Dibao program. In particular, Dibao schemes were encouraged in places where local economic conditions would allow it, whereas in economically constrained localities the central government advised the adoption of the Tekun schemes, which provide temporary relief to households impoverished by major illness or loss of family labor. Consequently, the Dibao system came to be maintained only in the economically developed counties. Many counties in the less developed regions dropped out of the experiment and moved on to the alternative Tekun schemes. The attitudes of the central government toward the establishment of the Dibao schemes changed following the 2006 CCPC Sixth Plenary Session, which concluded that local governments should be encouraged to set up the schemes instead of exploring them based on local economic affordability. The decision to establish a rural Dibao system nationwide was restated in Premier Wen Jiabao's Government Work Report to the March 2007 National People's Congress, and was further announced

in the State Council Circular on Establishing a Rural Dibao System Nationwide in July 2007, which anticipated that the schemes would be established throughout the country by the end of 2007.

### *The dismantling and re-building of the rural medical cooperatives*

China's rural economic and institutional reforms have also been accompanied by the dismantling of the community-financed Co-operative Medical System (CMS). In brief, the abolition of the commune system not only led to difficulties in the financing of rural collective health care, but also removed its organizational basis (Hillier and Xiang 1994). Beginning in the early 1950s, the PRC government started to build a rural health care system based on the county, communes, and village collectives (e.g., production brigades and teams). The CMS schemes provided rural people with cheap and easy access to medical care, with the brigades taking on the responsibility for funding, administering and delivering the services. Funding came mainly from collective income and partly from individual farmers, who were required to pay a small registration fee in order to receive services. These schemes subsequently became an internationally recognized innovation for tackling the health care needs of rural populations. By the mid-1970s, when the rural Collectivization Movement reached its peak, the majority of China's rural population was covered under CMS. Shortly after the rural economic and institutional reforms, however, most of these schemes and facilities were abolished, and in most places the barefoot doctors<sup>5</sup> were replaced by private practitioners. By 1986 only 5.4 percent of the villages had CMS schemes (China Health Statistics Yearbook 1987). One investigation showed that in 1985 only 9.4 percent of the rural population was covered by such schemes (Hu 1994). Another source revealed that about 90 percent of the farmers were paying fees for treatment in 1986 (Shao 1988). For most of the rural population, free or cheap health care had become a thing of the distant past.

---

<sup>5</sup> The barefoot doctors were selected from among the local villagers and were often given a short practical training in either the county or township hospitals. They usually worked as both field laborers and doctors, and were paid with work-points, as were the rest of the villagers.

The collapse of the rural communal healthcare schemes has been accompanied since the early 1990s by nationwide privatization or market-oriented reforms in China's health system, which further exacerbated problems of access to health care for the rural population. For the government, several mutually related objectives were attached to the market-oriented reforms in the health sector. One was to make publicly owned hospitals compatible with the socialist market economy toward which China was moving. Others included cost containment and privatization<sup>6</sup> of social services, as well as providing incentives for hospitals, all of which were potential alternatives to government funding. A variety of reform policies first implemented in the restructuring of state-owned enterprises were adapted to the process of reforming hospitals. As a result, hospitals were increasingly given autonomy in financing, service delivery, and remuneration of their employees. Most hospitals, including township and county ones, were consequently turned into self-financing institutions, which relied increasingly on fees-for-service, leading to soaring prices for medicine and medical service in subsequent decades (Bloom 2001). This produced an increasing phenomenon nationwide of rural poverty stemming from chronic and major illness. According to the China Third National Health Service Survey, poverty due to illness increased from 21.6 percent in 1998 to 33.4 percent in 2003 (Ministry of Health 2004). Other research revealed that nationally about 41 percent of poor households fell into poverty because of illness-related factors, such as loss of family labor or high costs of medical care (Han and Luo 2005). In brief, since the mid-1990s both the media and academic research have frequently reported that rural families often borrow money, sell their productive assets, or cut short their children's education in order to pay their medical expenses, or simply do not go to see the doctor when falling ill due to their inability to pay<sup>7</sup>.

Indeed, market-oriented reforms in the health care system have produced some disastrous results on livelihoods within the general population. The impoverishing impact of catastrophic illness due to the combined effects of the collapse of rural CMS and rapid increases in the

---

<sup>6</sup> In Chinese term, privatization is called "societalization" .

<sup>7</sup> According to the Third National Health Service Survey by the Ministry of Health in 2003, nationally 48.9 percent of people did not go to see a doctor when falling ill, and 29.6 percent did not receive hospitalization service when they should.

prices of medicine and medical services have been well recognized by the government. Throughout the 1990s, a major concern of the central government was to explore new schemes for rural health financing<sup>8</sup>. Beginning in 1993, a number of provinces were selected to experiment with various forms of community-financed health insurance schemes, based on low annual premiums and voluntary enrolment. Due to the absence of financing from the central government, however, these efforts resulted in only sporadic improvements, and some localities even dropped out of the experiment later due to financial constraints. By 1997, only a small number of the schemes proved to be successful, mostly in wealthy areas such as coastal or suburban areas. More importantly, as the new schemes were primarily township or village-based, they were obviously non-viable solutions for the rural poor.

It was not until 2002 that the role of the central government was substantially expanded. In that year, the State Council issued the noted "Decision of the Central Government to Strengthen Rural Health Work." Labeled the "New Co-operative Medical System" (NCMS), the Decision announced that from 2003 onward, the central government would subsidize local governments in the middle and western regions for NCMS by providing 10 Yuan for each participant. Furthermore, in early 2003 the State Council approved the "Proposals on Establishing Rural New Co-operative Medical System" jointly prepared by the Ministries of Health (MoH), Finance (MoF), and Agriculture (MoA), in which the basic directions and principles for the implementation of the rural NCMS were outlined.

Compared with previous schemes, the Proposals incorporated three major changes: One, the requirement for NCMS was to focus on covering the expenses of catastrophic illness or inpatient services rather than minor illness or outpatient care, as was the case with most former schemes. Second, county-based pooling replaced the previous township or village-based pooling, allowing localities to start with township schemes and then move gradually onto county ones. Finally, the central government became one of the major sources of funding in the middle and western regions, in that local

---

<sup>8</sup> Between 1993 and 1997, the central government issued several documents concerning the reestablishment of rural medical cooperatives. Among them, the most important document was the State Council 1997 "Decision on Health Reform and Development," which emphasized the establishment of CMS as a major direction for China's rural health reform.

governments were required to jointly provide a minimum of 10 Yuan for each participant in 2003, which was the same rate subsidized by the central government<sup>9</sup>. Thus, funding responsibility in the less developed regions came to be shared equally between the central and local governments. Two other features in the previous schemes were maintained in NCMS: voluntary enrolment and co-payment by the participant, which was set at a minimum of 10 Yuan in 2003. With these changes, provincial governments were required to select at least two or three cities or counties for trials, anticipating that the schemes would be established nationwide in rural areas by 2010.

Central transfers had an immediate impact on the nationwide establishment of NCMS. By 2006, over half the counties across the country had set up the schemes, which varied considerably from place to place in both design and implementation. However, NCMS is not a pro-poor social policy by design, though its goal was defined in the State Council 2002 Decisions as protecting rural people against poverty due to catastrophic illness. Similar to MFA in design (described below), NCMS primarily provides coverage for expenses related to inpatient services. Benefits are paid based on the same rates for all participants, including poor households, mostly ranging from 20 to 50 percent of the total medical costs and varying according to the service provider; also, participants have varying floors for self-payment, above which reimbursement is payable. In addition, there are ceilings of maximum payments by the schemes. Across the schemes, differences are found only in the details of the benefit structure and benefit levels.

### *The implementation of rural Medical Financial Assistance (MFA)*

Local experiments with medical assistance schemes for rural poor households started in Shanghai and a few cities in Guangdong province in 2000 and 2002 respectively, where rural and urban residents were treated

---

<sup>9</sup> Since 2006 the total amount of government subsidies for each participant has increased to 20 Yuan for both the central and local governments (Department of Social Assistance, MoCA).

under the same package<sup>10</sup>. Among them, the schemes in Guangdong covered costs for both inpatient and outpatient services, and the benefit rates were also more generous. In early 2002, the provincial government of Guangdong issued "Notice on relieving the poor of the difficulties in seeking medical treatment," which called for the establishment of an urban-rural integrated medical assistance system with funding from local finance at different levels and a social donation component. Local finance at different levels was required in order to allocate an additional 14 percent of funds, based on the monthly Dibao benefit rates (300 Yuan per month per person in 2002). The provincial government was to arrange for an annual amount of 20 million Yuan to subsidize the funds. For the social donation portion, in addition to money from other forms of fundraising, governments at each level were required to set aside a maximum of 20 percent of their welfare lottery income for use in medical assistance funds starting in 2002.

The medical assistance schemes in Guangdong were administered jointly by the health and labor, and social security departments. The intended targets were Dibao recipients without medical insurance coverage, who were eligible for reimbursement of outpatient service costs up to 42 Yuan per person per month, usually on a quarterly basis. In addition, an emergency assistance fund was also established to support Dibao recipients and low income households (defined as households with incomes 20 percent above the 300 Yuan Dibao line) for receiving medical services for 14 types of catastrophic illness. A floor of 500 Yuan was set for self-payment, above which individual households would pay 20 percent of the costs, and the rest would be covered by the funds. However, there was a ceiling of 20,000 Yuan, which is the maximum amount of subsidies payable by the funds for each person per year. Finally, preferential policies were also made available for Dibao recipients to receive medical treatment. In Shunde and Foshan, for instance, Dibao recipients were exempted from registration fees for medical service, and they could also get a 20 percent discount in medical treatment costs or drug purchases.

In Shanghai, medical assistance schemes piloted in early 2001 covered poor households in both rural and urban areas. Financing was also shared by

---

<sup>10</sup>An earlier experiment of medical assistance programs in rural China was the World Bank-supported Health project, which started in 1998 and contained a special medical assistance component in its project areas.

the government at various levels, and the civil affairs department was put in charge of administering the schemes. Eligibility was defined as rural Dibao households with members having a major illness such as uremia, mental illness or cancer, and having difficulty paying their medical expenses. Similar to the schemes in Guangdong, a floor of 1,000 Yuan for self-payment by individual households was established, above which 25 percent of the costs could be reimbursed by the funds. An eligible person could be subsidized to a maximum amount of 5,000 Yuan each year.

Nationally, the decision to implement Medical Financial Assistance (MFA) for rural poor households was announced first in the State Council 2002 Decisions as an integral component of the new rural health system. While MoH was put in charge of designing and implementing NCMS, the mandate to implement MFA was given to MoCA. Thus, following the State Council 2002 Decisions, a special document, "Proposals on the Implementation of Rural MFA," was issued in 2003 by MoCA, jointly with MoF and MoH. The document set down basic principles for the program's implementation. In brief, the goal of MFA was broadly defined as protecting the rural poor households against poverty due to major illness. Therefore it provides assistance mainly for poor people to cover expenses for inpatient services or the treatment of major illnesses. Funds are used to support poor households' participation in NCMS and also to cover part of their medical expenses after reimbursement by NCMS. The program is financed jointly by the central and local governments. Funding from the central government has been used to subsidize provinces in the middle and west regions, and local governments at different levels were required to share funding. Starting from 2004, provincial governments were required to select two or three counties or cities as demonstration cases and then spread the schemes gradually to other localities. By the end of 2006, most counties and cities with rural population had established the schemes.

Faced with many constraints, particularly the lack of decision-making power over government funding sources and limited control over health service providers, MoCA has adopted a learning-from-practice approach to the task. The implementation is decentralized to county authorities, which have considerable discretion over both policy design and implementation - including financing, eligibility, types of illness or services to be covered, and levels of benefits and payment methods - leading to marked variations across localities.

## FINANCING

According to the 2003 Proposals by MoCA, the financing of MFA rests on a wide range of sources, including transfer payments from the central government, revenues of local governments, incomes from lottery funds administered by civil affairs at various levels, social donations and other funds available to the locality. Among them, money from the central government was used to subsidize local governments in the middle and western regions<sup>11</sup>, the amount of which increased from 300 million Yuan through 2003 and 2005 to 950 million Yuan in 2006 (including 600 million Yuan from welfare lottery funds) along with the schemes being extended nationwide. Accordingly, budgeted funds from local governments also increased, from around 755 million Yuan in 2004 to over 1,800 million Yuan in 2006. Table 1 provides information on the financing of rural MFA between 2003 and 2006.

**Table 1. Situation of financing of rural MFA, 2003-2006 (in million Yuan)**

	By central government	Budgeted funds by local governments
2003	300	
2004	300	754.57
2005	300	794.96
2006	950	1,812.65

Sources: Department of Social Assistance, the Ministry of Civil Affairs.

At the local levels, the financing situation of MFA is often confusing. Available data show that although multiple channels of financing are generally stated in MFA policy documents, government revenues and the welfare lottery funds have contributed the bulk of the funds, and funding through other channels has been negligible. Data from a survey of 32 provincial-level governments show that in 2004 provincial governments made a total contribution of 200 million Yuan, of which approximately 69 percent came from government revenues, 26 percent from welfare lottery

<sup>11</sup> Between 2003 and 2007, 22 out of the 31 provinces and cities directly under the State Council received subsidies from the central government in various amounts usually based on the numbers of eligible households reported by the local governments (Department of Social Assistance, Ministry of Civil Affairs 2007). The provinces and cities are responsible for further distribution of the funds to the lower level governments.

funds, and 6 percent from social donations; in the first half of 2005, total provincial contributions increased to more than 335.00 million, of which 71 percent was from government revenues, 27 from lottery funds, and 2 percent from other channels (Xu 2006). In 2006, budgeted funds by provincial governments increased further to 643 million Yuan (Department of Social Assistance, Ministry of Civil Affairs 2007). At the county level, county governments contributed over 300 million Yuan in 2004, 88 percent of which came from government revenues, 4 percent from the welfare lottery funds, and 8 percent from social donations; in the first half of 2005 the figures changed to 89, 2.4 and 8.2 percent respectively (Xu 2006). As social donations were primarily being raised from local enterprises, this channel of funding was available mainly in wealthy regions. For instance, in 2004 over 80 percent of the total social donations was raised by two provinces, Jiangsu and Zhejiang, which totaled approximately 120 million Yuan (Ibid). In terms of shared funding by governments at different levels, which is also stated in both central and local policy documents, counties tend to play the more important role in financing the schemes. This is particularly true in developed regions or wealthy counties, where subsidies from governments at higher levels (e.g., provincial and city governments) are usually available only for financially constrained counties. As a result, in many counties the schemes are based on funding from a single level of government, either the county itself or a higher level government<sup>12</sup>. In 2004, 45 percent of the counties funded their MFA schemes solely with money from government at higher levels, 8 percent solely with money from the counties themselves, and the rest had money from both counties and higher level governments; in the first half of 2005, 24 percent of the counties were financed solely by money from higher level governments, over one third had funding only from the counties, and the rest were able to use funds from both the counties and higher level governments (Ibid). It is calculated that in the first three months in 2006, in the eastern region where county or township economies are more developed, more than 60 percent of the funds came from county or district government revenues. In the middle and western regions, county and provincial governments often shared the bulk of the funding on an equal basis, varying slightly across individual localities (Department of Social

---

<sup>12</sup> In the statistics of counties, transfers from the central government are often included in the category of allocations by higher level governments.

Assistance, Ministry of Civil Affairs 2006).

Funding allocation for MFA is usually made on an annual basis. The county civil affairs department first submits a draft budget for the government to approve, which varies considerably across localities. In wealthy provinces and counties, where governments have additional money for the schemes, budgets would be established based on the agricultural population in the county. For instance, in Zhejiang the provincial government stipulated a minimum of 6 Yuan per person based on the local agricultural population figures; in Xiamen, the capital city of Fujian province, the municipal government set a minimum of 80 Yuan per person by the number of eligible households; in Gansu, the provincial government required lower level governments to allocate a minimum of 1 Yuan per person based on the number of the local agricultural population for rural MFA. Still, in a number of counties a certain percentage of funding from other existing social assistance programs is used to fund MFA, or alternatively, a lump sum was decided upon first and then allocated among various sources (Ministry of Civil Affairs 2007). In summary, variations in funding methods can be found across the schemes, shaping the funding of MFA mostly in the form of temporary arrangements, which are revised annually.

#### BENEFIT LEVELS AND METHODS OF PAYMENT

MFA benefits are paid out in two ways. One is to provide a premium for the poor households, e.g., the current social assistance recipients, to participate in NCMS in localities where the scheme has been implemented. The other method is to allocate direct cash assistance from the funds. For poor households who receive support for NCMS participation, direct cash assistance is also available after the reimbursement of medical costs by NCMS; this is often called a “second assistance.” For other, non-poor households that are eligible for assistance, only direct cash assistance is available. In localities where NCMS is yet to be established, all eligible households are paid in direct cash subsidies. A general feature of the MFA system is that it provides support for the cost of inpatient care or treatment for a major illness only and usually does not cover costs associated with outpatient care.

Apart from the fixed premium for NCMS enrolment, which is paid as a flat rate for all poor households (e.g. 10 Yuan), direct cash payments from

MFA funds are made on a reimbursement basis. The amount of money for which an applicant can be reimbursed is usually set as a percentage of the total medical costs, which vary with different categories of eligible households as well as the amount of medical expenses. Generally, recipients of Wubao are subsidized at a higher rate than other poor households, and non-poor households at a lower rate than poor ones. Reimbursement rates are usually designed based on a progressive structure. That is, the higher the medical costs, the larger the proportion to be reimbursed. In addition, most schemes have a fixed amount of floor money to be borne by the applicant, above which the costs are calculated for subsidizing. Nationally, the floor amount falls mostly between 400 and 800 Yuan, averaging 637 Yuan in the first quarter of 2006; in several provinces and counties the floor was set as high as 1,000 or more than 2,000 Yuan. Finally, most localities have set a maximum payment ceiling that the funds will cover, which usually falls between 2,000 and 5,000 Yuan, except in a few provinces in wealthy regions where it is over 10,000 Yuan (Department of Social Assistance, Ministry of Civil Affairs, 2006). Overall, provinces and counties in the east region tend to have a lower floor, a higher ceiling and larger reimbursement rate than those in the middle and west regions, and consequently can provide a higher rate of benefits for eligible households than the latter. Table 2 summarizes the benefit structure across regions for the first quarter of 2006.

**Table 2. Average floors and ceilings by regions in the first quarter of 2006**

Regions	Average floors (Yuan)	Average ceilings (Yuan)
Eastern region	600	9,000
Middle region	800	3,000
Western region	600	3,000

Sources: Department of Social Assistance, Ministry of Civil Affairs, 2006.

The benefit structure is the most complicated component of the MFA system and also accounts for the major differences among the schemes, which are otherwise similar in design. Across the counties, the reimbursement rates were generally very low, mostly ranging from 20 to 50 percent of the total costs reimbursable in 2005 (Xu and Song 2006). Some counties use a simplified payment method. For instance, in Jinmen City in Hubei province, a unified 30 percent benefit rate was applied to all eligible households with

medical costs in excess of 1,000 Yuan (Department of Social Assistance, Ministry of Civil Affairs 2004); in counties where MFA was designed to support medical expenses for a specifically defined category of major illness, a fixed amount of subsidies would be provided to an eligible household, varying with the type of illness and without reference to the actual expenses. Still, in some provinces and counties a fixed sum of cash assistance is paid to the household, which varies according to actual expenses. For instance, in Jinchang City in Gansu province, a fixed amount of assistance ranging from 500 to 1,000 Yuan is paid to a household if its actual expenses fall between 10,000 and 15,000 Yuan; 1,000 to 1,500 Yuan are reimbursed for expenses between 15,000 and 20,000 Yuan; and 2,500 to 3,000 Yuan are paid out when over 30,000 Yuan in expenses are incurred<sup>13</sup>.

Therefore, in most counties MFA may cover only a small fraction of actual medical costs, and poor households still bear the bulk of the costs even if they receive the support for which they are eligible. On the other hand, it is widely reported that poor households have limited opportunity for support from NCMS because of its stringent conditions for the receipt of benefits. Theoretically, poor households that are able to participate in NCMS are eligible for reimbursement from the schemes. However, the floors and co-payment in NCMS tend to present problems for poor households. While MFA can sometimes be very flexible in providing assistance to poor households, payment by NCMS is often based on a strict reimbursement basis requiring applicants to present evidence of costs, which is often impossible for poor households<sup>14</sup>. Therefore, for poor and destitute households, MFA tends to be the only possible source of support for medical costs. As benefits from other social assistance schemes do not cover expenses for medical costs, the standard of living for poor households will inevitably be affected if they have members falling ill and incurring any medical costs.

One major factor that has led to generally low levels of benefits and benefit payment methods that are disadvantageous towards poor households is that local civil affairs departments are concerned about the availability or sustainability of the funds. In spite of multiple funding sources for MFA, as described previously, funds allocated from both the counties and higher level

---

<sup>13</sup> Government of Jinchang County (2006), "Notice on Temporary methods on rural MFA".

<sup>14</sup> In fact, local civil affairs usually do not use the term "reimbursement" for MFA assistance. Instead, they use the word "subsidies" in policy documents.

authorities tend to be unstable and insufficient. Interviews with local officials reveal that, although funds for MFA are usually part of government budgets, the actual allocation of funds to the program is frequently delayed or reduced. This is particularly the case within less developed regions, where the removal of agricultural taxation has resulted in limited sources of revenue for county governments. Therefore local civil affairs officials tend to set policies with cost containment as their primary consideration, and various measures such as setting high floors, low reimbursement rates, and low ceilings are used to restrict the flow of benefits to the applicants. While they recognize that these methods are flawed, they cannot risk finding themselves in a situation where funds suddenly become unavailable, as this would likely result in social instability. In this way, less money tends to lead to more stringent conditions on the receipt of assistance. Priority for MFA funds in most counties is given to supporting the poor households' participation in NCMS, and direct support is strictly controlled to avoid funding deficits. The concern over the availability of funding also accounts for the contradictory phenomenon of huge funding surpluses in many counties while at the same time claiming fund insufficiency for the operation of the MFA system<sup>15</sup>. Nationally, surplus funds reached over 67 percent of the total funds raised in 2004 and 28 percent in 2005 (Xu 2006). In 2006, the total expenditure of the MFA system amounted to 1,500 million Yuan, which was about 55 percent of the total 2,750 million Yuan raised by the central and local governments in that year<sup>16</sup>.

Recently, a number of provinces have made attempts through financial incentives to encourage or force the counties to increase funds and spend money. For instance, one measure adopted in Chongqing was that the municipal government would increase its financial subsidies to counties where budgeted funds were allocated in a timely manner by the county government; however, the amount of transfers would be reduced if the county's surplus funds were found to be unacceptably large (Ministry of Civil Affairs 2007). In another example, early in 2007 the municipal civil affairs department in Zigong City of Sichuan province went so far as to specify the time span to be followed and a minimum amount of MFA spending to be

---

<sup>15</sup> Claims for increasing funds are present in most local reports (see Ministry of Civil Affairs, 2007).

<sup>16</sup> Calculated based on statistics from the Department of Social Relief, MoCA.

allocated by the counties. For most provinces and counties, attempts to reduce funding surpluses are primarily made by increasing benefits to the poor households by such means as abandoning floors, raising ceilings, expanding eligibility for outpatient services, and establishing more institutionalized funding sources.

#### TARGETS FOR ASSISTANCE AND CONDITIONS OF BENEFIT RECEIPT

In the 2003 Proposals by MoCA, the intended beneficiaries of MFA were primarily the Dibao, Tekun and Wubao recipients, who constitute the poor households in rural areas. However, local governments were given discretion to include other categories of people to receive assistance. Localities usually have several locally defined categories of eligible people, in addition to the poor households specified by the central government. These often include recipients of various preferential policies administered by civil affairs, such as families of servicemen or martyrs, people with disabilities in public posts or single-child households. In most localities, eligibility has been extended to all households whose livelihoods were severely affected by the unexpectedly high cost of medical services, even though they are not currently receiving social assistance. As such, all households are potential MFA beneficiaries. Research has shown that, while poor households constituted the major beneficiaries of MFA in that the scheme usually provided the premium for all of them to participate in NCMS, in most localities it was mainly the non-recipients of social assistance who tended to receive most of the direct cash assistance under MFA (Xu and Song 2006).

This phenomenon is largely due to the reimbursement methods that have been followed and the limited rate of benefits as described above, which make the receipt of MFA subsidies dependent on a variety of conditions that are met only with great difficulty by the poor households. Potential beneficiaries, including the poor households, are generally required to provide evidence of their medical expenses when they apply for assistance. That is, they have to pay their medical expenses before they can apply for support and then get the costs reimbursed. Combined with the fact that MFA covers only medical expenses for receiving inpatient services and that lump sum pre-payment for hospitalization is common practice in most hospitals, poor households usually have to spend a large sum of money to pay their costs before they qualify for assistance. This led to a rather ironic situation in the MFA system, namely that receipt of benefits depends on the

financial ability of eligible households to spend or borrow money in order to receive medical services. Poor households who cannot afford or manage to pay the costs first would not receive the support. Obviously, this is contrary to the goals of MFA, which aims to help the poor exactly because they cannot afford to pay the costs of medical care.

Since early 2007, the failure of the MFA system to reach the poorest of the poor due to high floors, low rates of reimbursement, and low ceilings has been increasingly recognized by both central and local governments. Along with the recent shift in emphasis from economic to social development in China and increased funding from the central government, local governments began to be less reluctant to engage in social spending and have generally increased funding for social programs. Similar to other social assistance schemes in China, the MFA system is basically a supply-led program in that policy design considers primarily resources available. Increased financial inputs are thus crucial for improvement in both policy design and implementation. As such, many provinces and counties have adjusted their schemes to increase the utilization of funds by the poor households. One major change is that basing the reimbursement method on evidence of medical expenses has been loosened and more flexible measures are used to enable poor households to receive medical services. Now, in most localities, poor households can apply for and receive cash support before they are hospitalized or during the hospitalization period. In fact, in many localities, civil affairs officials have never strictly adhered to the reimbursement procedures, particularly when the applicants are current recipients of social assistance. Instead, they simply provide them with a discretionary amount of assistance on a case-by-case basis, which differs little from other social assistance payments. Second, in most localities, eligibility for MFA assistance has been expanded to include outpatient service. For instance, in some counties in Zhejiang, Chongqing and Jiangxi, poor households living on Wubao and Dibao schemes are each given a medical care card and then a fixed amount of money is deposited in it for them to cover medical expenses related to outpatient care and buying medicine. This is partly in recognition of the fact that poor people tend to acquire major illnesses or often need to be hospitalized because they have neglected small illness. There is also more and more evidence that not only inpatient costs could lead to catastrophic expenditure, but also outpatient care. Finally, most localities have raised ceilings and reimbursement rates to varying

degrees, and in a number of localities the self-payment floors have also been removed for recipients of social assistance. However, these changes are limited only to the destitute, particularly the Wubao recipients. As for other poor households and non-poor eligible households, changes have been limited.

## *Conclusion*

Despite limitations in the operation of the rural MFA system, its implementation has provided an important source of support for the rural poor households. For most of the time, since the dismantling of the rural collective welfare apparatus following reforms in the early 1980s, alternative support for rural people in need other than from extended family has been scarce. Indeed, in the context of rural China today, while starvation is no longer an issue even for the most destitute, the general inability of rural households to access medical services has proved to be the most crucial factor in leading them into poverty and in preventing the poor from rising out of it.

To a large extent, the MFA's implementation process typifies the Chinese approach to delivering social protection programs. That is, experiment first and adjust policies later based on a learning-by-doing approach (Leung 2003 and 2006). The role of the central government has been limited for the most part to establishing broad guiding principles, while local governments are encouraged to experiment with different solutions or models based on local circumstances and financial capacity. The strength of this approach is that it encourages policy innovations and facilitates readjustments through feedback directly related to program implementation. Indeed, a unified method to provide social protection programs in the current context of China is neither possible nor desirable, given the vast disparity in social and economic development across regions. One shortcoming is that regional disparities can be substantial, leaving the needs of the poor households in less developed regions unattended by the government. Another problem with this approach is that decentralization without adequate governance at the grass-roots level may lead to abuse of the system in various forms, a phenomenon that is frequently reported in the media.

The role of the central government in financing local social programs has proved to be the most important factor in the establishment and improved functioning of the MFA system. In fact, the establishment of an effective social security system for the rural population has long figured on the agenda of the central government, and many attempts have been made to address this need since the mid-1980s. However, due to the practice of fiscal and welfare decentralization, most of the responsibility for financing social programs was transferred to local governments, particularly the counties – a factor which has contributed greatly to the scarcity or absence of social protection programs in rural areas. Indeed, over-reliance on local governments for financing social protection measures for the rural population has not only left vast unmet needs in the poor areas, but has increased regional and rural-urban disparity in social and economic development. The financing of rural social programs, with the counties assuming the major financing responsibility, means that there is an absence of transfers from urban to rural areas. This may make the establishment of rural social protection benefits almost an impossible task in less developed regions.

With the shift of China's developmental priorities from predominantly economic growth to social development, the central government has taken an increasing role and responsibility for the funding of rural social assistance programs through central transfers. This is a good indication of progress. Meanwhile, local governments are also becoming less reluctant to spend money on social programs. However, a more institutionalized funding mechanism needs to be established for the sustainability and sound functioning of the MFA system.

## References

Bloom G (2001). Primary health care meets the market: lessons from China and Vietnam. *IDS Working Paper 53*.

China State Statistics Bureau, China's rural poverty report (2006). [In Chinese].

China Health Statistics Yearbook (1987). [In Chinese].

Department of Social Relief, Ministry of Civil Affairs (2004). A compilation of MFA policy documents. Unpublicized document. [In Chinese].

Department of Social Assistance, Ministry of Civil Affairs (2006). *An analysis report of rural MFA*. Unpublicized document. [In Chinese].

Department of Social Assistance, Ministry of Civil Affairs (2007). Unpublished statistics. [In Chinese].

Han J and Luo D (2005). Report of medical care system in rural China ([www.cncms.org.cn/Content.asp?ID=2045&LClass\\_ID=139](http://www.cncms.org.cn/Content.asp?ID=2045&LClass_ID=139)). [In Chinese].

Hillier S and Xiang Z (1994). Health and rural health insurance in China in Krieg R & Schadler M (eds.) *Social security in the People's Republic of China, papers presented at the workshop on social security in the PRC*, Hamburg, February 5-7 : 159-177.

Hu Y (1994). Current conditions of the medical insurance system of China and directions for reforming, *Social Work Studies*, May 1994, Beijing: Social Work Studies Press : 39-42. [In Chinese].

Leung J (2003). Social security reforms in China: issues and prospects, *International Journal of Social Welfare*, 12, 2 : 73-85.

Leung J (2006). The emergence of social assistance in China, *International Journal of Social Welfare*, 15 : 188-198.

Ministry of Civil Affairs (2007). *A collection of documents for national urban and rural MFA work conference*. Unpublished documents. [In Chinese].

Ministry of Health (2004). *China health service survey: report of the third national health service survey*. Beijing: China Xiehe Medical University Press: 15. [In Chinese].

Shao Y (1988). *Health care in China*. London: Office of Health Economics.

Wang S, Li Z and Ren Y (2004). *China's eight-seven poverty alleviation project - the national plan and its impact*. paper presented in the 2004 Shanghai conference on poverty. [In Chinese].

Xu Y (2006). *A study of the financing and funds management of rural MFA schemes*. *Consultation report to the Ministry of Health*. [In Chinese].

Xu Y, Liu F and Zhang X (2007). *Revisiting China's rural anti-poverty policies*, *China Social Sciences*, 3 : 58-72. [In Chinese].

Xu Y and Xinming S (2006). *A study on the design and implementation of the rural medical financial assistance program in China*. *Consultation report to the Ministry of Health*. [In Chinese].