

Historical Changes, Realistic Difficulties, and Response Approaches for Rural Cooperative Medical System in China

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Abstract: Taking time as a dimension, the evolution of the rural cooperative medical system since the establishment of the People's Republic of China can be roughly divided into three stages: the exploration and advancement when the system was first created, the disorder and predicament during the economic transition, and the development and improvement after becoming the market economy, where the overall process has shown a zigzagging and positive trend, and has been accompanied by the profound changes of the age and social situation. While there have been considerable achievements in China's rural cooperative medical system, problems such as the uneven benefits to participants, the low level of medical reimbursement, the complicated procedures and the urgent need for improvement of rural medical services are also objective realities. To improve and strengthen the rural cooperative medical system as well as to make the system fully effective, it is reasonable to adopt such measures as increasing policy publicity, appropriately expanding the scope of medical reimbursement, simplifying medical reimbursement procedures, and improving the level of rural medical services.

China's rural cooperative medical system contains an integrated unity of theoretical and practical directions, as an important element of China's institutional structure, the rural cooperative medical system has its theoretical origins and historical evolution; as an important carrier of governance capacity, the rural cooperative medical system has its realistic efficacy, as well as countermeasures to the accompanying problems.

1. The evolution of China's rural cooperative medical system

The establishment of China's rural cooperative medical system did not happen instantly, and its development and improvement have had a tortuous and profound process, with different development characteristics during different times. From the vertical point of view, the evolution of China's rural cooperative medical system can be roughly divided into three stages: the exploration and advancement when the system was first created, the disorder and predicament during the economic transition, and the development and improvement after becoming the market economy, where the overall process has shown a zigzagging and positive trend, and has been accompanied by the profound

changes in the age and social situation.

1.1 Exploration and advancement in the initial period of the system

"At the time of the establishment of the People's Republic of China, the rural population reached 484.02 million, accounting for 89.4% of the country's total population."^[1] By that time, the rural population was hardly in a position to achieve the ideal state of "having medicines and medical treatment" when facing illnesses, and the costs incurred by medical care were basically entirely self-financed. The First China National Health Work Conference, held in August 1950, established the principles and policies of "facing the workers, peasants and soldiers" and the primary goal of transforming the rural areas from "no medical treatment and no medicine" to "having medicine and medical treatment". Under the impetus of the Chinese Central Government, the level and organization of medical services in rural areas in China had developed rapidly, and in 1955, at the climax of the cooperative movement in rural China. Under the impetus of the Chinese Central Government, the level and organization of medical services in rural areas in China had developed rapidly, and in 1955, at the climax of the cooperative movement in rural China, more than 50,000 townships and most of the agricultural cooperatives had built different forms of medical rooms and clinics between 1956 and 1957. Then in 1958, the vigorous communalization movement provided an institutional guarantee for the effective integration of the cooperative concept and rural medical services, and most communes began to implement the practice that members would pay a certain amount of medical fees and would not be charged separately for any subsequent medical services. The emergence and application of this model throughout the country were of great significance, and the prototype of rural cooperative medical treatment thus appeared.

In 1962, when the situation of the rural cooperative medical system was getting better, the Chinese Central Government began to carry out reforms of the national economy. During this reform, the cooperative medical system, which had originally benefited the peasants, was nearly halted, and it was advocated that a kind of collective doctors' medical institution, characterized by fee-charging and self-financing, should be implemented. This change greatly affected the development of the rural cooperative medical system, and the most obvious manifestation was that in 1964, less than 30% of the country's communities were still maintaining cooperative medical care. This situation attracted Mao Zedong's great attention, and he criticized the Ministry of Health's approach and indicated that "the focus of medical and health care should be put on the rural areas". In 1968, Mao Zedong also put forward the instruction that "more typical and fewer integrations", advocating that typicals should be used to promote the various works. As a result, the rural cooperative medical care system was once again brought to the forefront by the case of the "Barefoot Doctor", and the People's Daily even opened a column at that time to discuss the rural medical and health care system, which had again revitalized the rural cooperative medical system when it was once stagnant. By 1976, the rural cooperative medical system had been implemented in 93% of production teams, benefiting 85% of the country's rural population.

1.2 The disorder and predicament during the economic transition

In 1978, as China was gradually recovering from the turmoil, the Constitution of the People's Republic of China, adopted in the same year, identified cooperative medical care as a cause and a guarantee of the workers' health rights. In 1979, the Ministry of Health, in conjunction with the Ministry of Agriculture and other ministries jointly issued the "Regulations on Rural Cooperative Medical Care (Trial Draft)", which was the first time that governmental departments issued formal regulations and rules on cooperative medical care for rural areas, and marked the institutionalization of the cooperative medical system. This document defines cooperative medical care as "a medical

system of the socialist nature established by the members of people's communes relying on the collective strength and on the basis of voluntary mutual assistance, as a collective welfare business for the people", and promises that "in accordance with the Constitution, the country will actively support and develop the cause of cooperative medical care to make medical and health work better protect the people's health while developing agricultural production."^[2] However, the development of rural cooperative medical care has failed to keep pace with this series of positive signals and has instead fallen into a quagmire of stagnation.

On 23 June 1978, under Document No. 37 of the Chinese Central Government, it was forbidden to concentrate labor, financial, and material resources for unproductive constructions, and rural cooperative medical care was even regarded as increasing the people's burdens in some areas. Influenced by this, the proportion of production units implementing the cooperative medical system nationwide dropped from 92.8 % in 1976 to 52.8 % in 1982 and then to 11 % in 1983, a short period of seven years in which the positive momentum of the rural cooperative medical system was almost extinguished instantaneously. Most of the remaining cooperative medical organizations or institutions were confined to the more economically developed areas and the vast majority of rural health clinics were turned into private clinics. The reasons for such a drastic change in the situation of rural cooperative medical care were extremely profound:

(1) First of all, the economic conditions on which rural cooperative medical care used to be based had changed, with the implementation of the household contract responsibility system breaking down the institutional basis of the collective economy, and the important channel of fund-raising for rural cooperative medical care having been destroyed;

(2) Secondly, as the mainstay of the rural cooperative medical system, the identity of village doctors has changed in nature, their dual identity as land-dependent farmers and doctors being severed. "With the disintegration of the collective economy, most villages were unable to pay the barefoot doctors properly and had to sell or contract the medical clinics to individual doctors, which gave the doctors the incentive to pursue profits. At the same time, the contracting of land to individual farmers has made it no longer possible to gather, produce, and grow herbs collectively. Both of these changes had increased the cost of medical and health care."^[3] The use of health clinics and medicinal materials then became paid, and farmers naturally had to pay for the medical services they enjoyed;

(3) Finally, the view of the Cultural Revolution at the time affected people's and society's opinions about the rural cooperative medical system, which was regarded as a legacy of the Cultural Revolution, and the inertia of this kind of thinking broke the people's sentiments about the rural cooperative medical system.

As a result of all this, the development of the rural cooperative medical system in the early 1980s was difficult, and some documents even avoided the use of the expression "cooperative medical care", which showed the situation of the rural cooperative medical system at that time.

1.3 The development and improvement after becoming the market economy

In 1992, at the Communist Party of China's Fourteenth Congress, "Decisions on Several Issues Regarding the Establishment of the Socialist Market Economic System" was adopted, in which it was proposed that "the rural cooperative medical system should be developed and perfected", with the intention of helping to promote a rural cooperative medical system that would be adapted to, and constructed on, the new economic foundation. Although the Chinese central government intended to promote the construction of the system, due to the ambiguity of the government's financial responsibility for the funding of the rural cooperative medical system, as well as the discomfort between the value concepts of the emerging market economy and traditional thinking, the construction of the rural cooperative medical system has failed to achieve satisfactory results for some

time since then, and as of 1998, the proportion of the rural population that was covered by the medical insurance system was only 12.6 %, and only 6.5% of them had access to cooperative medical care.

"In 2002, the Central Committee of the Communist Party of China (CPC) and the State Council issued the 'Decision on Further Strengthening Rural Health Work', in which it was proposed to establish a 'new type of rural cooperative medical system that is mainly based on the integration of serious illnesses'. Governments were asked to actively organize and guide rural peasants to establish the new type of rural cooperative medical system (hereinafter referred to as the 'NRCMS'), with a focus on the integration of serious illnesses. In 2003, the 'NRCMS' was launched on as a pilot programme in the whole country."^[4] Although this new rural cooperative medical system, which was led by the government, participated voluntarily by farmers and was financed by individuals, collectives, and the government on multiple fronts, failed to fundamentally solve the problem of farmers' difficulties and high prices in seeking medical treatment, in the more than a decade it had been in operation, it greatly eased the pressure on farmers in the face of illnesses, especially serious illnesses, which provided important protection for the health care of the laboring people in general. "According to the 'Health and Family Planning Statistical Yearbook of China' of 2011, the number of people participating in the NRCMS had increased from 0.08 billion in 2004 to 840 million by 2010, with the participation rate reaching 96 %, and the policy goal of "basic coverage of rural residents" under the NRCMS was successfully achieved."^[5] Since the 18th National Congress of the Communist Party of China (CPC), with the rapid development of China's economy and society, the disparity in economic income between urban and rural areas as well as between regions has become a significant problem, and the resulting disparity between the NRCMS and the urban residents' medical insurance (hereinafter referred to as the "URMI") regarding the financial subsidies, service level, and the scope of insurance coverage is also becoming more evident day by day. In order to deal with this problem, the State Council issued the "Opinions of the State Council on the Integration of the Basic Medical Insurance System for Urban and Rural Residents" in 2016, which explicitly put forward to "integrate the two systems of URMI and the NRCMS, and establish a unified basic medical insurance system for urban and rural residents", and subsequently more than 20 provinces have issued relevant documents to promote the integration of urban and rural health insurance. "According to data from the National Health Insurance Bureau, as of the end of 2018, the overall number of participants in China's health insurance was at 1.345 billion, with coverage at upwards of 95 %, and the coverage rate of the NRCMS had reached 99 %, which had basically achieved full coverage. The regulation of per capita financial subsidies for residents' medical insurance increased by 30 RMB in 2019, so that the annual subsidy for each person will not be lower than 520 RMB, and these new subsidies are generally used to improve the protection capacity of the insurance for serious illnesses."^[6]

2. Realistic difficulties of the new rural cooperative medical system

2.1 The inappropriate awareness of participation of the peasant population

The problem of farmers' participation awareness is an important factor that affects the effectiveness of NRCMS and is mainly reflected in the problem of negative participation or non-participation caused by weak awareness or knowledge. In vast rural areas, the traditional awareness of raising children to protect them from old age still prevailed, and there was still a large market for feudal and superstitious thinking, the behavior of relying on children to pay for illnesses or seeking help from the so-called gods, while greatly reduced, had not been eradicated.

In addition, some peasants in underdeveloped areas have lower economic incomes, and they are more sensitive to expenses. In their self-consciousness, they confirm that they are in good health and will not suffer from serious illnesses or other contingencies. They have a weak sense of prevention and also a lack of awareness about the necessity for participating in the NRCMS, so that the sense of

non-participation dominates their thinking.

On the other hand, due to the bias in undertaking policy publicity or interpretation, the rural masses in some areas have a wrong understanding of the system. In addition, because of their lower level of knowledge, some rural people do not have a clear understanding of the NRCMS, and there are reasons for the distrust of the policy. Furthermore, the range of illnesses covered by the NRCMS is not comprehensive enough, and the rules for some chronic illnesses such as rheumatism or stroke are too harsh. There are strict restrictions on the level of the hospital or other conditions of medical treatment when it comes to reimbursement. As a result, the risks that are most probably to the general peasant population are not avoided by the NRCMS. In addition, China is facing the trend and the current transition of aging is also gradually becoming a challenge to the NRCMS, some of the elderly or poor health groups are more inclined to participate actively in the NRCMS, some of which "reverse choice" mentality in a certain sense exacerbate the financial burden, and even directly or indirectly affect the other people for the normal demand for medical resources or finances. "As a result of the participation of such 'vulnerable health groups' in the NRCMS, it will inevitably lead to an increase in government reimbursements, reducing the proportion of the total fund available for other participants, affecting the NRCMS fund benefits received by this group of participants when they suffer from illnesses, and to a certain extent undermining their right to health insurance." [7]

2.2 The reimbursement procedure is too complicated

Although the NRCMS upholds the principle of deepening "integration for serious illnesses and compensation for minor illnesses", and has begun to give a certain degree of financial support, however, the barriers of the organizational design have become a direct obstacle to the efficacy of the NRCMS. Since the reform and opening-up, the shift towards cities as the center of construction and development has brought about population movements, which in promoting urban construction has also posed certain challenges to the NRCMS, this problem is mainly reflected in the reimbursement procedures for groups of migrant workers, which are specifically the problem of the interface between local reimbursement and off-site reimbursement.

On the reimbursement procedure, it is basically impossible for migrant workers to achieve direct settlement of medical bills if they seek medical treatment in a different place, and they are required to pay the medical bills ahead of time, and the regulations on the time limit for reimbursement are relatively stricter, with as many as eight copies of the necessary documents required for reimbursement, so that they have to go back and forth from different institutions. This complicated procedure, which is time-consuming and laborious, is even more of a challenge for rural laborers, who are relatively uneducated. When reimbursing locally, they also need to go to designated hospitals to provide transfer certificates, which delays the arrival of reimbursements. The disparity in reimbursement proportions between local and off-site areas is also a promotional factor, as under the NRCMS, the reimbursement proportion for farmers attending hospitals in the participating areas can be around 75%, while farmers attending off-site hospitals can only be reimbursed around 40%. This means that if migrant workers are reimbursed in the city where they are working, they will have to bear most of the medical costs and face relatively greater financial pressure. The difference in reimbursement proportions between local and non-local areas is designed to relieve the pressure on medical care in economically developed areas or better medical areas and to organize the resources of medical services rationally, but it fails to take into reasonable consideration the problem of medical treatment for migrant workers.

2.3 Differences in the allocation of medical resources between urban and rural areas

The difference in the allocation of medical resources between urban and rural areas is shown in

two aspects: on the one hand, a large number of high-quality medical resources are concentrated in the cities, and on the other hand, the marginalization of the rural medical workers' group, which gradually widens the disparity between the medical level of the urban and rural areas. Since the reform and opening-up, with the development of science and technology, China's medical technology is improving day by day, and the precision and quantity of medical equipment have also improved rapidly compared with the early days of the establishment of the country. The constant changes in medical technology have also resulted in situations where medical resources are concentrated in urban areas, resulting in an "inverted pyramid" type of distribution for medical resources in China. Although the state has actively advocated a hierarchical diagnosis and treatment system in recent years, hoping to allocate medical resources rationally by referring patients to different levels of medical institutions in order to sink medical resources to the grass-roots unit, currently more than 90% of tertiary hospitals nationwide are located in large and medium-sized cities and economically developed areas, making it difficult to meet the demand for medical services in rural areas and farmers.

The advancement of medical technology requires a higher standard for medical workers in the new era, especially for rural medical workers: the requirement of academic qualifications has raised the barrier for rural medical workers to enter the profession, and the knowledge of the present rural medical workers has been relatively slow to be updated, and for the operation of the new equipment they are not skillful enough or are completely unfamiliar with it. The advancement of modern medical technology has weakened the reliance on human resources, and the trend toward marginalization of rural medical workers has become more obvious as a result. Because of the relative backwardness of medical workers and medical equipment resources, the powerlessness of rural medical conditions in the face of serious illnesses has become more and more obvious. In the long run, this has resulted in large-scale medical institutions actually receiving patients close to or exceeding their capacity, while the number of patients in primary medical clinics has been reduced to a mere handful, making it difficult to effectively safeguard the level and quality of the medical services available to the rural population.

3. Improved approach to the new rural cooperative medical system

3.1 Strengthening the policy and system publicity, breaking the ideological barriers

In the wider rural areas, the elimination of backwardness is a prerequisite for the effectiveness of the NRCMS, and it is also a necessity for the confrontation between modernization and tradition under the rapid development of the economy and society. Regarding the traditional idea of "raising children to prevent old age", the reasonable core of filial piety should be retained, and its performance should be reformed in accordance with the changes of the times so that the payment of NRCMS premiums for parents should be used as a breakthrough in publicity to organically combine the idea of "loving the elderly and caring for the elderly" with the situation of the times; as the popularisation of scientific knowledge and awareness in the rural areas is a long-standing task, the Government should step up its efforts to enhance the publicity of knowledge about health and safety for the rural population and to cultivate the long-term awareness of medical and health among the rural population in the vast rural areas.

As the most important and direct part of the policy propagandists and implementers, the Government departments and relevant staff should have professional knowledge and good quality, and their understanding of the policy and system should be thorough and clear. When they adopt appropriate publicity means and materials according to the actual situation of their regions, they can make the policy better popularised, such as setting up special or temporary NRCMS service points for solving and answering questions, so that peasants can have a more comprehensive and deeper understanding of the policy knowledge. In particular, the NRCMS should be popularised in terms of

its scope of coverage, scope of reimbursement, reimbursement procedures, and reimbursement proportions, so that the rural population can truly understand the beneficial nature of the NRCMS.

The medical workers, as the front line of the implementation of the NRCMS policy, it is necessary to continuously improve their own quality, firmly abide by professional ethics, enrich their skills quality, consider themselves in the situation of rural patients, and pursue excellence in service quality and professionalism. Whether the NRCMS can give full play to its effectiveness, is closely related to the main participants, so farmers, government agencies, personnel, and medical workers should continue to follow up on the awareness and establish the appropriate ideology.

3.2 Simplifying the process appropriately and matching the accurate poverty alleviation

The problem of overly cumbersome participation or reimbursement processes is very likely to lead to resistance among groups of farmers to the NRCMS in actual practice, which is counterproductive to the original intent of its establishment. To solve the problem of reimbursement for foreign labourers' off-site medical treatment, it is possible to consider online interconnections between the relevant units in the place where the insurance is enrolled and the medical institutions in the place where the treatment is received, so that the registration of rural patients can be completed online, and the materials and procedures required for medical treatment and reimbursement can be appropriately simplified. In addition, it should be appropriate to consider the issue of adjusting the reimbursement rates at the place of insurance and off-site, seeking a balance between the rational use of medical resources and the reimbursement rates for the rural population.

The Government should appropriately incline towards rural areas and less developed regions in terms of policy and finance, with the central and all levels of local finance increasing their financial support for the NRCMS within permissible limits. By using tax leverage and financial transfers to achieve, as far as possible, the relatively equitable development of medical services between urban and rural areas, and between developed and less developed areas, and to promote progress in the medical standards of rural areas, increasing the confidence of the rural population in the NRCMS.

The NRCMS plays an extremely important role in poverty alleviation. On the one hand, the NRCMS enriches and expands the path of poverty alleviation, and on the other hand, poverty alleviation effectively improves the quality and accuracy of the NRCMS. It is recommended that the database of farmers participating in the NRCMS is partially linked and shared with the database on accurate poverty alleviation and that the system be inclined towards patients suffering from serious illnesses, long-term medication users, the disabled, and the special poor, with tailored programs specifically designed for these groups of people, in order to prevent the emergence of the situation where "illnesses cause poverty and return to poverty".

3.3 Improving the legal system and promoting the development of the system

The legal system of the NRCMS should be improved and refined, with clearly defined objects and scope of the NRCMS, and ensuring its modern and feasible character. The National People's Congress and all local people's congresses should, in accordance with the actual situation in their respective administrative regions, improve the relevant legal system for the NRCMS, clearly define the scope of rights and responsibilities of participants and medical institutions, define the scope of medical reimbursement, and discuss whether or not to expand the content of medical reimbursement. In addition to the construction of the legal system, the relevant government units should, if appropriate, set up additional medical service and reimbursement points in more densely crowded areas, appropriately increasing the density of emerging NRCMS sites, so as to quantitatively resolve the problem of the rural population's "difficulty and distance in seeking medical treatment".

While ensuring the level of medical care, it should appropriately increase the number of rural

volunteers and strictly control the entry requirements for medical staff, reform the hospital talent management system, as well as consider the establishment of a system of temporary support for rural medical care by physicians from hospitals at or above the county level, and raise the level of treatment for those who devote themselves to the rural medical and health care endeavors. For rural medical workers who have been working for many years, a regular training and testing mechanism should be established to constantly update their medical and health knowledge, learn about leading-edge theoretical developments and professional competence, as well as to improve the level of medical services in rural areas, such that the NRCMS can provide a powerful boost from the viewpoint of human resources.

4. Conclusion

Reviewing the evolution of China's rural cooperative medical system, it has had its ups and downs according to the changes in social life, but on the whole, the trend has been favorable. As an important component of the modernization of China's governance capacity and system, China's new rural cooperative medical system is, to a certain extent, linked to the realization and completion of the overall goal for China's characteristic socialist cause, and is concerned with the people's immediate problems of food, clothing, housing, and transport. Although China's new rural cooperative medical system still faces many practical challenges and has not been able to fully overcome the "difficulties and expenses of seeking medical treatment" that have plagued the people for a long time, its effectiveness in greatly reducing the pressure on the people in the face of serious illnesses is an objective reality that should be positively acknowledged.

In the next phase, both the legal system and the basic infrastructure should be taken into account to improve the construction of China's new rural cooperative medical system from the perspective of the main participants, to achieve a better match between the construction of the system and the development of society.

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