NARRATIVE LITERATURE REVIEW

On Developing a Rural Healthcare System:

From Community Welfare to National Public Service-based Welfare

Qiufeng Zheng[1]

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Corresponding Author:
Qiufeng Zheng
Research Center on Social Work and Social Governance,
Henan Normal University,
Xinxiang, China
zhengqf1976@163.com

ABSTRACT

Background:
Healthcare related welfare is a matter of resource allocation. In modern market economies, redistribution in Western societies is accomplished through state welfare systems to balance the inequality of market resource allocation. However, resource allocation in socialist countries has its own peculiarities. And the relationship between market transformation (social transformation) and resource allocation methods in post-socialist countries is an important academic topic. This paper examines the changes in the rural cooperative medical system （RCMS） in China in order to explore the changes in rural cooperative healthcare governance mechanisms during recent social transformation.
Objectives:
The main purpose of this paper is to place the rural cooperative health care system （RCMS） in a macroeconomic-political context and to compare the changes in cooperative health care resource allocation mechanisms across time.
Methods:
The article undertakes a narrative literature review approach and method. The review used the following sources: Web of Science and PubMed. The search used the keywords" rural cooperative medical care system", "community benefits", " public service-based welfare" and "governance",and limited to articles published between January 2019 and June 2022. The selection of articles was based on the inclusion/exclusion criteria (keywords defined and time span of publication).
Results:
From collectivized cooperative medical care System （RCMS） to today's New Rural Cooperative Medical System （NRCMS), its governance mechanism has changed and the nature of welfare has changed with it. It has also changed from community welfare, where organized grassroots communities supply medical services, to government-led public service-based welfare.
Main Contribution to Evidence-Based Practice:
The paper shows the process of change in China's rural cooperative healthcare system, mainly analyzing the change of healthcare welfare governance mechanism. Thus, it provides a reference for governmental health policies development and for international researchers.

Authors' Affiliations:
[1] Research Center on Social Work and Social Governance, Henan Normal University, Xinxiang, China

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What do we already know about this topic?
The nature of China's rural medical welfare is changing from community welfare to national public service welfare, and the medical governance mechanism is changing.
What is the main contribution to Evidence-Based Practice from this article?
To clarify the transformation of cooperative medical care governance mechanism, analyze the problems existing in the current governance mechanism, and provide reference for the government's medical policy.
What are your research's implications towards theory, practice, or policy?
The article identified the need for further research on transformation of Rural Healthcare Governance.
Authors' Contributions Statement: Zheng conceptualized and drafted the article

The history of rural healthcare services has had 70 years since the founding of the country, from the exploration of what can be called cooperative medical care in various places in the early 1950s, to collective cooperative medical care based on agricultural cooperative model as defined in China.
The decline of cooperative medical care at the early stage of market-oriented reform, new rural cooperative medical care system and the current unified basic medical insurance system for urban and rural residents, the way of supplying and financing medical services are the core issues of cooperative medical care. During the transitions in the medical system, the way of organization and the connotation of the system have been seen important changes (Sun Shuyun and Ren Xuejiao,2020; Gao XinYu,2019). At each stage of the cooperative medical care experience, the rural social health and medical conditions and the priority medical problems to be solved were different. And the goals of the medical system were also different. In the 1950s, faced with the lack of medical care and epidemic and endemic diseases seriously endangering people's health, organizing local forces to rapidly change this situation became the main goal. In the early reform and opening-up period, the government under the market system and grassroots organizations lacked responsibility. The medical burden became an important reason for farmers to cause poverty and return to poverty. In the 21st century, national policies began to focus on livelihood issues including education and medical care. And the introduction of new cooperative medical care attempted to solve the problem of difficulty and valuableness access to medical care for farmers. Followed by further promotion of equity in urban and rural medical care, our country will establish a unified basic medical insurance system for urban and rural residents.
The reform of the rural medical system (RCMS) in the new century brought medical care for rural people into the national welfare system. As a result, scholars began to focus on the impact of the new cooperative medical system on rural poverty alleviation (Qin Li-jian et al., 2021; Ke Song et al., 2021) and on the enhancement of happiness (Wenhao Qi et al., 2022). Of course, some scholars have also reflected on the limitations of farmers' access to medical benefits. Leaving aside the effects and limitations of the health care system itself, changes in the governance mechanisms of rural cooperative health care in social transformation can be observed through changes in the sources of rural cooperative health care financing and in the way health care services are provided.
Methods:
The commentary utilizes the narrative literature review research method. The review used the following sources: Web of Science and PubMed. The search used the keywords" rural cooperative medical care system", "community benefits", " public service-based welfare" and "governance", and limited to articles published between January 2019 and June 2022 (except for classics). The reviewer to select articles based on the inclusion/exclusion criteria (keywords defined and time span of publications).
Results:
From collectivized cooperative medical care to today's new cooperative medical care, its governance mechanism has changed and the nature of welfare has changed with it. It has also changed from community welfare, where organized grassroots communities supply medical services, to government-led public service-based welfare.

A) Exploration and social mobilization of cooperative medical treatment

After the founding of the new China, faced with the lack of medical care and medicine in the most rural areas, the epidemic and endemic diseases endangered the health of the people. The exploration phase of cooperative medical care was carried out in various rural areas in conjunction with community conditions under the call of the Patriotic Health Movement of the Central Committee of the CPC. The first model for establishing cooperative medical care was the United Health Station in Mishan Township. The United Health Station was established in 1955 as a result of the development of a joint clinic founded in 1953 by a voluntary combination of private pharmacies and private doctors. Unlike the joint clinic, financing came from three parties: the agricultural production cooperatives, the peasant population and the doctors.

The Sun Village in Jishan County, Shanxi, is also a national model health village. From 1954 to 1956, during the agricultural cooperative period, the relevant county departments sent doctors to train more than 70 health workers and midwives for the village, As a result, each agricultural production cooperative was equipped with off-duty health workers and midwives. In 1956, the collective health care system （CMS）for community members was introduced. "The source of funding was a combination of paying ‘Health care fee' as well as village and community support. ‘Health care fee' of the community individuals is 50 cents for per person per year. The support was mainly to provide housing and subsidies to doctors for work points. Generally, the ‘six free' fees, including consultation fees, registration fees, treatment fees, injection fees, medical examination fees and preventive health care fees (including vaccination),were all free. The cost of medicine was still borne by individuals, but the profit on medicine dropped from 45% to 15% during the period of joint clinics, and the price of medicine in the production team's health room did not count as profit."(Zhang Zikuan， 2010: 11) After the people's communalization in 1959, the party branch decided to implement a medical cooperative system through the community assembly. It lowered expenditure and made access to medical services more convenient from the perspective of individual farmers. Members of the community were charged only 5 cents for a registration fee to see a doctor, and the consultation and medical fees were completely free (excluding nutritional tonic medicines or medicines purchased by themselves). Members who participate in cooperative medical care pay an annual medical cooperation fee of 2 yuan each (the five-guarantee households are paid by the social team). And the social team also arranges cooperative medical assistance funds from the public welfare fund. Members of the community do not need to register and wait for a doctor to see. Instead, the doctor delivers medicine and sees patients at home. When the farm is busy, the doctor goes to the field with labor tools, medicine kits and health textbooks. Without diseases, they participate in labor. When resting, they carry out health propaganda."（Zhang Zikuan，2010:13）

All over the country began to explore cooperative medical care, such as the "social cooperative medical system" of Wangdian Township Unity Agricultural Society of Zhengyang County, Henan Province. In 1955, the cooperative medical system started to be explored in Guicheng Township, Changshu County, Jiangsu Province, Xijiang Township, Yaojiang District, Zhuji County, Zhejiang Province, and Sun Village, Yingshan County, Shanxi Province.

There is no unified national specific policy implementation program about cooperative medical practice but only national heath work guidelines guidance. In 1950, the first national health work conference put forward the policy of "facing workers, peasants and soldiers, focusing on prevention and combining Chinese and Western medicine". And the second national health work conference added the content of "combining health work with mass movement". According to this guiding ideology, all localities carried out the actual exploration of cooperative medical treatment. In terms of financing and medical resource supply, the financial, material and human resources of local communities were fully mobilized. Thanks to the economic foundation and organizational support provided by collective cooperatives, the cooperative medical system was able to spread and develop rapidly throughout the country. During the collectivization period, cooperative medical care system was community welfare, instead of state welfare, and still had the color of local autonomy in terms of social mobilization and medical resource supply. But it was different from the village autonomy where the imperial power stopped at the county. Because the state power reached the grassroots of society through strong administrative power and tight organization, it strongly mobilized social participatory

mobilization.

B) Intervention of State Authoritative Forces

Due to the attention and active promotion of the central government ,the rapid change in the medical conditions and health status of the rural population after the founding of the new China. In the early 1950s, the Central Committee of the Communist Party of China (CPC) made epidemic prevention, sanitation, and general medical care an important political task.Cooperative medical care was conceived as a result of the patriotic health movement and national health policy guidelines. In view of the concentration of medical resources in the cities and the disparity between urban and rural medical conditions, Mao Zedong made the " Six Two and Six " instruction on June 26, 1965.It referred that the focus of medical and health work was in rural areas. In the process, not only did urban medical workers go to the countryside to treat the masses, but also trained a large number of rural health workers and barefoot doctors.These steps alleviated the shortage of medical services in rural areas.

The People's Daily, an important medium for conveying the spirit and instructions of the central government, continued to publish instructions from the central government affirming the positive role of cooperative medical care and "barefoot doctors". For example, in 1969, the People's Daily followed Chairman Mao Zedong's instructions on the rural cooperative medical system and organized 23 consecutive issues of "Discussion on the Rural Cooperative Medical System （RCMS） ".It affirmed the positive role of "half-medical and half-agricultural", "combined medical and agricultural" and "barefoot doctors" in rural medical care. This mode of mobilization was appropriate to the social development conditions at that time (Shang Huping and Huang Liuzhao, 2020). In addition, the state is good at using the governance method of setting up typical examples and modeling, and then promoting overall changes through the typical examples. For example, the "Mishan joint health care station" in Mishan Township, Shanxi Province, was first strongly publicized by provincial official media as a "Mishan medical model" .Subsequently, through the national media, the typical developmented in the whole country (Li Quanping and Xinglong, 2020). Of course, the implementation of national policies depends on grassroots government promotion and implementation. Rural health and farmers' health not only enter the macro-political sphere (Li, Quanping, 2020), but arguably are integrated into their unique governance model.

Community welfare: continuity and rupture of tradition

During the collectivization period, the rural cooperative medical system（RCMS） appears to be an entirely new system organized and mobilized by state administrative forces, but in fact there is a cultural continuity in this system. During the long history of the Chinese imperial period, the autonomy of the vast rural society relied mainly on the cultural network ties of blood and geography, and of course the intervention of state forces. As Du Zanqi's (2003) study shows in the rural society of northern China, during the late Qing and Republican periods the organization and conduct of local public affairs were supported by symbols and norms. And these cultural elements included clan concepts, religious beliefs, and local collective values, as well as popularized symbols of state power integrated into local culture. Cooperative medicine perpetuates the culture of cooperativism in local societies. There is also some continuity in terms of governance patterns. Huang (2008) points out that " the state-initiated governance model that combines the participation of village communities and local elites" is characterized by state minimalism. He refers to governance that "relies as much as possible on civil society mechanisms" and is semi-administrative as minimalist governance. And the legacy of minimalist governance in the Chinese empire has continued in part during the Republican period, the Maoist period, and the current reform era. Traditional cooperative health care governance is still characterized by minimalism. Cooperative medical care system in this period was community-based organization and mobilization, financed mainly by village collectives and individuals, and had the self-governance overtones of community-based welfare. The governance model, which was called and initiated by the state and combined mainly with the mobilization and participation of local communities and various social forces, still had the minimalist character of administration.

But the cooperative health care system（CMS） also has its own special political and economic system foundation. The totalitarian political system forms a totalitarian society in which the state controls almost all social resources . The state draws production surplus

from rural agriculture without providing public benefits to farmers in a redistributive way, and farmers rely on community cooperatives to provide rather limited medical resources and lower quality of care.

Gradually shift to national public service type benefits

The Weakening of the Cooperative Medical System

During the period between the disintegration of the rural collective economy and the implementation of the new cooperative medical system in 2003, the cooperative medical system weakened and even collapsed. One of the main reasons was the disintegration of the collective economic system on which cooperative medical care depended, thus losing the main source of financing.

Although the grassroots government and village organizations had public service responsibilities, under the "pressure-based system," the "hard" targets of grain collection and family planning were prioritized. However, the "soft" targets of education and health care were forced to be put on hold due to financial shortages. Second, the central government, through the "tax-sharing system," has taken over fiscal power.Nevertheless, requiring local governments, which lack financial resources, take on local public affairs such as education and health care. In the economically weak central and western regions, it is difficult to guarantee funding for education, and even more difficult to undertake cooperative medical care. Third, the state and all levels of government have not assumed responsibility for rural public health care. Pushing it to the market, the government's investment in public services, including health care, has been decreasing year by year. As a result, it is difficult and expensive for farmers to see a doctor. And the social problem of poverty caused by illness and return to poverty due to illness is serious.

New Rural Cooperative Medical System - national public service type welfare

As we entered the 21st century, the state began to rethink the developmentalist line and put forward a scientific concept of development for comprehensive economic and social development. In terms of policy, the central government began to address the systemic inequalities of the urban-rural dual welfare system by gradually incorporating rural education and medical care into the national welfare system.

In 2003, the General Office of the State Council forwarded the Opinions on the Establishment of a New Type of Rural Cooperative Medical Care System by the Ministry of Health, Finance, and Agriculture, and began a pilot program of new cooperative medical care. Since 2003, the central government has arranged cooperative medical subsidy funds at 10 yuan per capita per year for farmers participating in new cooperative medical care in central and western regions except urban areas. Local financial subsidies for farmers participating in new cooperative medical care at no less than 10 yuan per capita per year, with specific subsidy standards determined by provincial people's governments. In terms of medical service supply, the overall function of the rural health network should be fully played.

The government-run county-level health institutions are the business guidance center for rural preventive health care and medical services. Township (town) health centers mainly focus on public health services, provide comprehensive prevention, health care and basic medical care services. It was entrusted by the county-level health administrative departments to undertake the functions of public health management. In 2008, the country's rural areas have basically established a new rural cooperative medical system.However, the lack of supervision mechanism for medical institutions can generate moral risks of medical personnel and medical institutions by inducing patients to over-consume.Besides, the differences in financial capacity of local governments lead to regional differentiation of medical benefits. In response to the various shortcomings of the cooperative medical system, the central government has continuously pushed forward the reform of the medical system. In 2009, the State Council issued the Opinions on Deepening the Reform of the Medical and Health System, which clearly proposed the establishment of a government-led diversified health input mechanism. In 2016, the Opinions of the State Council on Integrating the Basic Medical Insurance System for Urban and Rural Residents was published. It proposed to integrate the basic medical insurance for urban residents and the new rural cooperative medical system, and establish a unified basic medical insurance system for urban and rural residents. This put an end to the split governance of health care for different groups in urban and rural areas.

The financing about the new cooperative medical care and the basic medical insurance for urban and rural residents are a system of mutual aid and assistance among the government, collectives and individuals.

This reflects the dominant position of the government. It is embodied in the formulation of medical policies, the government's assumption of primary responsibility for financing and the administrative, rule of law and uniformity of management. Rural cooperative medical care is integrated into the national section hierarchy and is gradually moving toward rationalized governance.

Conclusion

The formation of the rural cooperative medical system （RCMS） during the collectivization period was the result of the combined efforts of the central government's call, the grassroots government's promotion, and the community's exploration. It mobilized community resources and stimulated community autonomy in the supply, financing, and management of medical resources to achieve full community coverage of low-level medical services.

Since the 1980s, when China entered the era of reform and opening up, and until the beginning of the 21st century, China has continued the dualistic welfare system of urban and rural areas since the founding of the country, and the central government's financial support for the welfare of rural society, including medical care, has been lacking. The principle of financing cooperative medical care, which is based on "individual input, collective support, and appropriate government support," has turned medical care into a heavy burden for farmers and their families as the village collective economy disintegrates and local governments find it difficult to fulfill their financial support responsibilities. The heavy burden on farmers and the impoverishment of rural areas have led to a crisis of political legitimacy and social identity. The "three rural problems" gradually formed the "backward" pressure for the Party Central Committee to reflect on and promote rural health care reform in the 21st century (Zhang, Haizhu, 2020:174). In the 21st century, the state reflected on the developmentalist orientation of modernization and sought to address social problems such as unbalanced urban-rural development, rural poverty, and the heavy burden on farmers in terms of national policies, adhering to a scientific view of development, focusing on people's livelihood, and striving to address the equitable treatment of rural people in terms of education, medical care, and pension benefits. The new rural cooperative medical system （NRCMS）, and the subsequent implementation of the basic medical insurance system for urban and rural residents, emphasize the responsibility of financial support from the central government.

The new rural cooperative medical care （NRCMS）and the basic medical insurance for urban and rural residents were implemented from the top down, with the unity of the policy system and the statute of formal authority. As a result, rural medical care has shifted from community welfare to national public service welfare. And community autonomy in medical care has been gradually incorporated into the formal administration of the state hierarchy. There is complex interaction and cooperation between the community medical service supply with the color of autonomy, the state and society, i.e., the state's call, the establishment of models, the promotion of models, the grassroots society's exploration and mobilization of human, material, and organizational resources. They are gradually incorporated into the modern rational section management with the color of "technical governance ". However, it is difficult to say that farmers have become active citizens and that rural grassroots society has become a civil society as opposed to the modern state. It is worrying that folk cultural traditions and folk organizations that form community bonds are gradually weakening and disintegrating. However, new cooperative ideas and organizations have not yet been developed. In the face of this reality, we should attach importance to and explore the positive role of folk cultural tradition, guide and shape a positive citizenship guide the development and growth of civil organizations and foster a modern civil society. These are a proper part of the modern governance of the country.

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