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China: The Intersections between Poverty, Health Inequity, Reproductive health and HIV/AIDS

Joan Kaufman, August 2005

As the global development community begins the 21st Century, many are looking back with regret to a series of decisions made by global development institutions in the early 1990's that helped shape some of today's public health crises. The "Washington Consensus" espoused by the World Bank and other donors and governments in the 1990's emphasized investments in open markets, private sectors, and public sector contraction and economic management as the solution to poverty (Ruger, 2005, p.60). The resulting pressure on developing country governments to shift investments away from social sectors like health and education is coming home to roost. A recent report by the Global Learning Initiative, highlighted the crisis of health manpower shortages in the developing world and the impact this is having and will continue to have on the ability of health systems in developing countries to respond to the major health challenges or our era, such as AIDS and other emerging infectious diseases (Joint Learning Initiative, 2005).

This stark reality about global health access undermines the promises of "a woman's right to health", committed to by the international community at the ICPD in 1994 and the Beijing Women's Conference in 1995 (United Nations Population Fund 1996; United Nations, 1995). A decade ago at ICPD, global leaders and international civil society actors reached consensus on a woman's right to reproductive health care. Article 7.6 of the ICPD Platform for Action states that "All governments should strive to make accessible through the primary health care system reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015". But weakened public health systems are unable to deliver on these promises. In many countries those working to implement even the basic set of reproductive health services directly linked to women's mortality and morbidity (safe delivery services, access to

contraception, RTI and STD services) are struggling to have these services included in essential primary health care services prioritized by methodologies that give short shrift to problems affecting women and girls (Allotey and Reidpath, 2002).

While China's economic and development path was less directly guided by global institutions and their lending requirements in the 1990's, China's leadership adopted a similar path to health care financing, no doubt influenced by prevailing development wisdom at that time. As in other parts of the world, chronic and long term underinvestment in the health sector have created a public health crisis in China today that threatens its ability to maintain health gains for preventable causes of death and disease. This weakened health system is intersecting with poverty and gender inequity in China to erode women's right to basic health services in a country with a mixed record in the last twenty years that includes major gains in maternal mortality and morbidity but serious rights violations by the population policy. At the same time that a well funded family planning program begins to reform away from coercive practices, an under funded health system is increasingly unable to maintain basic access to preventable morbidity and mortality for women or respond to the new challenges for women's health posed by the expanding HIV/AIDS epidemic.

Twenty Years of Health Reform and Increasing Inequity

At the end of the 1970's as China began its transition to the booming economy that it is today, China's primary health care system was held up as the model for the call for "health for all by the year 2000" at WHO's 1978 Alma Ata conference. By 2000, China ranked 188 out of 191 countries in terms of fairness in financial contribution to health and in 2001, 21.6% of poor rural households fell below the poverty line from medical expenses (Li, 2002; Saich and Kaufman, 2005). Preventive health services and health education outreach have been seriously weakened by 20 years of reform and inequities between rich and poor and rural and urban have widened.

From 1949 to the late 1970's social investments in health and education were prioritized in China, as they were in many socialist countries. China's primary health care system was a target for Mao's "Cultural Revolution" from 1966-1976 that was launched with the phrase, "The Ministry of Health is an urban overlord! In medical and

health work put the stress on the rural areas!" (Peking Review, 1975). Reflecting an historical tension in China (as in many other countries) about the balance between investing in the urban hospital system versus a rural public health system, China's health spending pendulum shifted strongly towards the construction of an equity oriented public health approach for the rural poor. Because the rural economy was organized into large agricultural production units, "communes", it was possible to allocate a portion of the commune funds to support such an approach, including a rudimentary health insurance system. With basic services provided at the lowest level by barefoot doctors, minimally trained community health workers, and a "3 Tiered" health network of clinics and higher level health facilities and hospitals at township and county level, most rural citizens had access to medical care and financial coverage for serious illnesses. Since rural mobility was restricted and financial coverage dependant on referral up the chain, access to higher and more expensive, levels of health care, were controlled. The community level curative health system of basic care was supported by investments in preventive health through "patriotic health campaigns" consisting of public works (like mosquito control and clean water projects) and educating the public about the prevention of disease (hand-washing, prenatal care, etc).

While few wish for a return to the commune system, which was dismantled in the late 1970's as the country returned to family farming and a market economy, and few would glorify the sophistication and quality of China's rural medical care system in the 1970s, many long for a return to its equity and emphasis on prevention. The care, while basic, was available to all at little cost and was combined with health education and public investments in a healthy environment. In the late 1970s, over 90 percent of rural citizens were covered by a medical insurance system (CMS). (Li, 2002). After the breakup of the commune system in the late 1970s, the rural CMS was dismantled, and health-care financing was delegated to provinces and local areas, which turned to the market economy to provide the necessary money. As public finances decreased, the unregulated market (especially for drugs) steadily increased the price of care. Limited public finances were diverted to cover staff salaries at county- and township-level facilities. Rural citizens who could afford to do so bypassed expensive township facilities for county-level care, undermining the three-tiered referral chain and distorting the value

of manpower investments and training in rural health care. By 1992, only 10 percent of rural residents were still covered by rural health insurance (Li, 2002). The current system, with its focus on fee-based financing of curative care, has shifted attention and investments away from vital public health education and public works that prevent both chronic and infectious diseases. The level of curative care in rural China has greatly improved by contrast with earlier years and most essential drugs are available in the most remote parts of the country with staff trained in their use. But the cost of care and the breakdown in the government's preventive public health functions have created serious inequities and distortions in the rural health system and threaten the ability to control new emerging and common infectious diseases. China's current health minister, Gao Qiang, recently bemoaned the inequity and weakness of the rural health system blaming the 2003 SARS epidemic on its failings (China Daily, 2005). He cited an official national survey in 2003 that showed that nearly 49% of patients needing treatment did not go to a doctor and nearly 30% of patients needing hospitalization did not receive it because of cost. The minister noted that government contributions to hospital running costs have decreased from about 30% in the 1970's to under 8% in 2000, with the difference made up by patient fees. (China Daily, 2005). Of current total government health spending a full 25% occurs in four of China's wealthiest cities and provinces, Beijing, Shanghai, Zhejiang, and Jiangsu (Ministry of Health, 1999, pp 431-432). Fifty percent of all hospital beds and personnel are in urban areas and 80% of medical resources are spent in cities (Li, 2002).

Impact on Reproductive Health

This inequity and under investment has a disproportionate effect on health problems like reproductive health and critical disease threats such as HIV/AIDS that depend on public health prevention. Both require outreach and health education to vulnerable groups to change risk behaviors and adopt health promotion actions (prenatal care, contraceptive use, safe sex, screening for RTIs, attended delivery). The infant mortality rate and maternal mortality rate are closely correlated with the use of prenatal care and attended safe delivery, two preventive services that have been adversely affected by the privatization of health care in rural China. Our study in the mid 1990's in rural

Yunnan province documented the impact of changes in the rural health financing system on reproductive health service utilization for poor rural women. That study showed that poor health care service seeking for self-reported symptoms suggestive of serious reproductive conditions was directly related to the locality in which women lived (Kaufman and Fang, 2002). In poorer and more remote townships, women sought care less often, received less prenatal care, gave birth at home more frequently (94%). This was due not only to cost of service seeking but also perception of service quality and the impact of the breakdown of the health education system on women's understanding of the importance of health seeking for essential reproductive health services (like RTI screening and treatment, prenatal care and attended delivery). In an ongoing study to improve reproductive health service utilization in one poor county in rural Guizhou Province, we found service seeking for reproductive health problems improved between 1998 (when the interventions began) and 2003. In 1998 only 18.7 percent of women received prenatal checkups and 74 percent of women gave birth at home. Our intervention program, which provided both essential reproductive health education and financial subsidies for hospital deliveries, brought the prenatal check up rate to 87.4 percent and the hospital delivery rate to 67.6 percent (Kaufman, Fang, Liu, 2004).

Fang (2004) has noted national and rural/urban inequities in maternal mortality pointing out that rates in poorer western China are four times those of urban areas and double those of average rural areas in eastern China, reflecting the inequities in government health investments in those areas noted above. In relatively wealthy Zhejiang province infant mortality per 1000 live births was around 20, whereas in poor Guizhou it was 60. Similar findings emerge from a study of health conditions in 30 poor counties that found an infant mortality rate of 52.3 per 1000 live births compared to a national average for rural areas of 21.5. The rate of maternal death during childbirth was 216.8 per 100 000 as compared to a rural average of 114.9. (Meng and Hu, 2000). Liu and colleagues report similar findings with a rural infant mortality rate according to the 1990 census ranging from 29.3 to 72 and with Zhejiang having a maternal death rate of 23.74 per 100 000 and Qinghai at 215.37.(Liu, Hsiao, Eggleston, 1999).

The Family Planning Program

Financing shortages in rural maternal and child health services have been exacerbated by the separation of family planning services from maternal and child health care in the early 1980s. Prior to this time all reproductive health services, including family planning, were the responsibility of the Ministry of Public Health and its network of health bureau and institutions at the provincial, county, township and village levels. Subsequently a new system was set up under the Family Planning Commission (now National Population and Family Planning Commission) with its own network of offices and personnel at the various administrative levels. (Kaufman, Zhang, Qiao, Zhang, 1992). Since family planning is a state subsidized national program, resources for service provision are guaranteed from higher levels. The withdrawal of most family planning funds from the health system removed a guaranteed funding stream that helped subsidize related services such as gynecological care. The separation of family planning from maternal and child health and other women's health services fragmented the care that rural women receive and resulted in an increase of scarce resources at the local level going to family planning and a decrease in funding for maternal and child health provision. By 1990, national budgetary expenditure on family planning increased to 1345 million *yuan*, over five times the amount expended on maternal and child heath. (Zuo, 1997 p.90; Wong, Heady and Woo, 1995). Our study in Yunnan showed a big disparity in local government financing for MCH versus family planning services for poor rural women. Clients fees generated more than 50 percent of the cost of MCH care versus only 20 percent of the costs for family planning services in our surveyed counties in 1995 (Kaufman and Fang, 2002) Ironically, China's population policy is responsible for gains in Chinese women's health, even despite declining access to health care through the health system, by reducing pregnancies and the risks of child bearing. China's total fertility rate has dropped from about 7 births per woman in the late 1960's to under 2 births per woman today (Gu, Wang, Guo, Zhang, 2005) and with this drop in fertility has come significant overall improvements in rural maternal and infant mortality and morbidity from 58 per 1000 imr and 114.9 per 100,000 mmr in 1990 to 37 per 1000 imr and 69.6 per 100,000 mmr in 2000 (Li, 2002). However infant mortality rates are highly skewed by gender with a death rate for girls ten points above that for boys (41 versus 31 per 1000). The negative impacts of the Chinese family planning program on women's

reproductive rights and the gender ratio has been well documented (Greenhalgh, 1995; Greenhalgh 2001a; Greenhalgh 2001b). While efforts are underway to strengthen informed choice of contraceptives and reduce coercive practices, China's women still have limited reproductive freedom (Kaufman, Xie, Zhang, forthcoming).

The Threat of HIV/AIDS for Rural Women and Youth

The weakness of the health system for carrying out health education and prevention services, especially to rural women and youth, is worrisome for the escalating HIV/AIDS epidemic in China. China's AIDS epidemic is shifting to a sexually transmitted epidemic and the gender ratio is narrowing with more women becoming infected yearly. The deterioration in basic public health outreach, especially to rural women, will have serious implications for reaching rural women and large youth population with critical HIV prevention services. In Yunnan Province where China's AIDS epidemic began in the early 1990's among needle sharing injecting drug users, the proportion of sexually transmitted infections has increased in the last few years (Lu Lin, 2005). Sexually transmitted infections accounted for only 13 percent of all infections between 1989-2003 but in 2004, it had increased to 20.7 percent. Nationally, the gender ratio changed from 15.3% of infections among women between 1989-2003 to 39% by the end of 2004 (State Council AIDS Working Committee, 2004 p.4). Several factors have driven this shift to a sexually transmitted epidemic: the flourishing and ubiquitous illegal sex worker industry, high rates of untreated or poor quality treatment of sexually transmitted diseases, especially in China's southern provinces, large numbers of male economic migrants who spend many months away from home and family working in China's booming cities then return home to rural wives, high rates of reproductive tract infections among these rural women, the low social status of rural women with no self perception of risk and little power to resist sex or negotiate condom use.

China's has a huge youth population of 15-24 year olds, about 200 million in 2000; 10-24 year olds constitute 26% of China's 1.3 billion population (Ru Xiaomei, forthcoming) with little knowledge of safe sex because of traditional resistance about discussing sexual matters with unmarried youth, especially girls. There are many more young men than women as a result of long term differences in the sex ratio birth (SRB),

driven by sex selective abortion and son preference under China's restrictive family planning policy. The official SRB figure of 117 males to 100 females in the 2000 Census likely underestimates the true distortion (State Statistical Bureau of China, 2000). Many of China's youths, especially in urban areas, are already changing their sexual attitudes and behaviors and will require outreach, sex education and condoms if a larger epidemic is to be averted. Sadly, in Chinese provinces where HIV has been around the longest, youth aged 15-30 had the highest HIV rates (78 percent in Yunnan) (find reference: check Lu Lin) repeating similar trends from other countries in the world where HIV infections among youths or acquired as youths, constitute about half of all new adult infections (UNAIDS, 2004). "Surplus" males in China in the coming years may fuel the commercial sex industry and provide a new dynamic to the growing Chinese AIDS epidemic (Tucker et al, 2005).

High rates of untreated reproductive tract infections (RTIs) among China's rural women make them vulnerable to HIV infection from returning migrant husbands infected while working in cities. A community based study of over 2000 women in rural China in 1995 revealed high levels of RTIs among rural women (Kaufman, Yan, Wang, Faulkner 1999). Over 50 percent of women were diagnosed with an RTI and many women had two or more concurrent infections. These high rates of gynecological infections, especially trichomonas, put rural women at increased risk for HIV transmission. Epidemiological studies have estimated the increased risk of HIV transmission to women with trichomonas as four fold (Wasserheit, 1991). Less than 20 percent of women with symptoms of RTIs seek care for the symptoms at regular health facilities (Fang, 2001). Low service seeking for RTIs, prenatal care and attended deliveries in rural China will lead to many missed opportunities to prevent HIV infections in women and their children, through RTI and STD treatment (a proven HIV risk reduction measure) and the prevention of maternal to child transmission of HIV by prenatal screening of pregnant women and provision of anti retroviral medication to the newborn at birth, a major component today's HIV prevention programs.

In recent years, the National Population and Family Planning Commission has begun to utilize its extensive propaganda and information network to conduct HIV/AIDS education to rural women, rural migrants, and youth and to include RTI screening in

basic family planning check ups, still required for most women to insure that contraception is being used. There are few educational outreach systems in the world with as extensive a reach and message development experience as China's well funded family planning propaganda system. The separation of health and family planning financing and services in China, while counterproductive in many ways, may be a boon for some aspects of HIV prevention for rural women and help compensate for the weakness of rural health education services.

Rural Health Reform and Prospects for Change

Rural health reform has been on the government's agenda since 2000 and its importance was heightened by the 2003 SARS epidemic. The SARS epidemic put China's weakened rural health system in the global spotlight and was a wake up call for leaders that the control of infectious diseases is a critical component of global citizenship in an increasingly interconnected world. China also learned from the SARS epidemic that a combination of political will and adequate financing together with the mass mobilization techniques of the "Patriotic Health Campaigns" were successful in achieving what many thought was impossible: preventing SARS spread to China's rural areas. In recent years, newly appointed political leaders in China have been promoting a return to a "just society" ("xiaokang shehui"), and there appears to be a shift back towards social investment in health and education, or at least an acknowledgement of the problems that underinvestment has caused (Saich, forthcoming). The new Minister of Health's stark assessment of the problems of rural health inequity and the deterioration of the health system presages a new era of health investment and re-thinking about how to fix a very broken health system. But recent efforts to overhaul the health insurance system have focused on financing for curative care (catastrophic care) and most attention in health reform is focused on reigning in the "for profit" hospital system. The weaknesses in the public health system and prevention services have received much less attention. This does not bode well for addressing many of the health threats to poor rural Chinese women: the risks of dying in childbirth or of contracting HIV from their husbands. How rural Chinese women will fare in the health reform effort is anyone's guess.

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