

Social Security System in Rural China: An Overview¹

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I. Introduction

The rapid transformation from a planned to a market economy and from an agrarian society to an industrial society poses a great challenge to the traditional elderly care and healthcare system in the Chinese society. In the planned economic era, rural healthcare focused on preventive rather than curative healthcare measures. The communes, production brigades, and production teams had authority to mobilize the masses to engage in public health and infrastructure works. With large manpower input, the government could implement various public health campaigns, such as fighting against the four pests (rats, flies, mosquitoes, and bed bugs), expanding nationwide immunization, and training indigenous rural health workers (so called “bare-foot” doctors). In general, these public health measures were rather successful in controlling infectious and parasitic diseases (Zhang and Kanbur, 2005).

Following the rural economic reform in the 1970s, the communes were dissolved and households became the unit of decision-making, reducing the power of village collectives and directly affecting the provisions of education and healthcare. Not surprisingly, many rural health clinics have disappeared since the rural reform. To fill the vacuum, in 1984, the government authorized private medical practices in rural areas. Because private medical practitioners provide their services according to patients’ ability to pay, an increasing number of people have had to bear the full cost of medical care. Consequently, severe illness has become a major cause for people’s falling into poverty in the past several decades.

Not only does the rural healthcare system faces challenges, but also the traditional family-based elderly support system. According to the Chinese tradition “raising children to provide support for old age,” supporting the elderly has always been a family’s responsibility. In the past, on average each old person was supported by four to five children (even more). However, owing to the family planning policy put in place since the early 1980s, most families nowadays have only one child. This family planning policy, if effectively implementing for two generations, would lead to a “four-two-one” pyramid family structure, that is, four grandparents, two parents and one child. As population ages, the young generation will bear a heavier burden of family care for the elderly. Furthermore, in recent years, massive numbers of young people in rural areas migrate to cities to seek jobs. By living apart far away, it is difficult for young migrants to take care of their aging parents. As a result, the traditional family elderly support tradition is in jeopardy.

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Until recently China did not have a nationwide social security scheme, in large because of China's rather equal distribution of farm land. The household responsibility system introduced in 1978 allocated land user rights rather equally among rural residents. Even though in rural areas, non-agricultural income has increased dramatically in the past several decades, agricultural income still accounts for a larger share of family income in many parts of rural China. In essence, the rather equal ownership of agricultural land serves as an informal rural social security system. However, this land-based social security system is also threatened. With urbanization and industrialization, more arable land has been taken away. In addition, as the share of agricultural income goes down, so does its role in providing social security in rural areas.

In response to these challenges, the Chinese government has made tremendous effort to set up a new rural social security system to protect the poor and vulnerable. This paper reviews the evolution of major healthcare and elderly support policies in the past six decades. Section 2 focuses on the evolving patterns of rural healthcare system. Section 3 discusses policies related to elderly support, while section 4 describes other basic support programs in rural areas. Section 5 concludes.

II. Rural Healthcare System

Rural Healthcare during 1949-1980

After the establishment of the People's Republic of China, the public health sector developed tremendously in a very short period. A large number of urban medical workers went into the countryside to spread basic medical knowledge. Many villages set up clinics and hired *barefoot doctors*. One key innovation is the rural healthcare cooperatives. At the beginning, it was private-run and government-subsidized. The members paid "health care fee" and the cooperative covered the rest using charity fund. Since the system provided favorable medical care for the members, it improved accessibility of medical treatment for the locals and strengthened purchasing power of the sick. Owing to the active participation of the rural residents as well as support from governments, the number of rural health cooperatives had increased and replaced communal health centers in a number of counties during the recovery years from 1960 onwards. The development of such healthcare cooperatives accumulated experiences and provides examples for the construction of the cooperative health system across the rural areas of the country.

Along with the agricultural cooperative movement, health clinics built by the agricultural production cooperatives emerged in Shanxi, Henan, Hebei and Hubei province. The cooperative medical system was founded in such a way that medical funds were consisted of local people's health care fee and the production cooperative's charity subsidies. In the 1959 National Rural Working Conference held in Ji County, Shanxi Province, the cooperative medical policy was confirmed. In 1966, as a result of Chairman Mao's comment and instruction on the medical experience of Leyuan Cooperative in Changyang County, Hubei Province, the rural cooperative medical system had since widely expanded.

In 1978, the cooperative medical system was included in the *Constitution of the People's Republic of China* ratified by the Fifth National People's Congress (NPC). In 1979, the Ministry of Health, Ministry of Agriculture and Ministry of Finance issued the *Guidelines on Rural Cooperative Medical Care (draft)*. By 1980, rural areas had established a three-tier health care network with prevention, treatment and protection functions: county-level medical institution as the leading part, township-level medical institution as the main body and village clinics as the basic unit. About 90 percent of the administrative villages in rural China had carried out the cooperative medical system. There were 510 thousand licensed doctors, 1.46 million *barefoot doctors*, 2.36 million health workers and 630 thousand midwives (Zhang and Liu, 2007). Success of the rural public health attracted world's attention since the policy greatly resolved the shortage of medical resources under the planned economy at that time (Zheng 2002; Yang 2003; Lin 2002).

Rural Medical Health System during 1980-2008

During the early 1980s, as the collective system disintegrated, many public village clinics were either closed or privatized. Although the quality of medical care in the private village clinics was not as good as the county hospitals, the private village clinics were still the villagers' first choice when they were sick due to the low price and the availability of paying by credit. The villagers received treatment from the county or province level hospitals only when they had severe illnesses.

The existing rural cooperative medical system (RCMS) encountered severe funding shortage problems and by 1985, the proportion of the village that had functioning RCMS decreased dramatically from 90% to 5%. Although most of the remaining village RCMS are in name only, the government did not abandon this medical system because its origins were from the people. In 1993, Central Committee of the Chinese Communist Party proposed in the *Decisions on Establishing the System of Socialist Market Economy* to redevelop RCMS. In 1994, the State Council Research Department, the Ministry of Health and the World Health Organization jointly launched a pilot project "Chinese Rural Cooperative Medical System Reform" in seven provinces and fourteen counties. In 1997, the Central Committee of the Chinese Communist Party and the State Council recommended that "the growth rate in public health care expenditure should exceed growth rate in fiscal revenues," which provided policy assurance for the rural public health investment expansion sponsored by central and provincial governments. In October 2002, the Central Committee of the Chinese Communist Party and the State Council issued *the Decision on Further Strengthening the Rural Medical System* and decided to expand the pilot projects to several more provinces.

In 2003, the State Council General Office assigned the Ministry of Health, the Ministry of Finance and the Ministry of Agriculture to establish a new cooperative medical system (NCMS), requiring all provinces, autonomous regions and municipalities to launch pilot projects in at least two to three counties and to scale up gradually. The plan aimed to have all farmers to receive basic NCMS coverage by 2010. The NCMS is funded by individuals, local government and central government, and managed by county governments. Individual contribution should be at least ten RMB. Local governments in more developed regions were encouraged to provide more support for local NCMS. County governments were asked to define detailed standards of local

NCMS. In order to encourage individual and groups to participate in NCMS, local finance bureaus should subsidize no less than 10 RMB per capita. Since 2003, the Ministry of Finance has also subsidized 10 RMB to every NCMS participants in the central and western area.

On January 10th 2006, several ministries, including the Ministry of Health, the National Development and Reform Commission, jointly issued *Circular for Accelerating the Development of NCMS Pilot Projects*, to increase the government financial support for the program. The Ministry of Finance raised the subsidy to the participants of NCMS from 10 RMB to 20 RMB per person. Local government also increased the subsidy by 10 RMB per person accordingly. The *Circular* insists on that the additional local subsidy should be covered by finance bureaus at the provincial level in order not to aggravate the local fiscal burden. By 2008, nationwide NCMS basic coverage has been achieved, which was two years ahead of scheduled.

Current Status of the New Cooperative Medical System (NCMS): An Assessment

By 2009, the number of participants in the NCMS had reached 814 million, indicating a participation rate of 91.5 per cent. Several features of the NCMS are worth noting. Firstly, it is directed by government leaders, managed by the Ministry of Health, coordinated by related ministries, operated by associated institutions, and served by health organizations. Secondly, the participants can choose among any listed medical institutions in the county and use the insurance immediately after the treatment. The NCMS forms a compensation policy that is compatible with the conditions of the local areas. Thirdly, the government has established a supervision system over funding operations, auditing and reimbursement, with the participation of villagers and funding agents. Fourthly, a medical support system within the framework of the NCMS has been established. A policy framework that combined the medical service, medical supply and supervision management was formed (Project Team, 2008).

The Ministry of Health and the Ministry of Finance in 2007 raised the total contribution figure for an individual account from 50 RMB per year in 2007 to 100 RMB per year in 2008. The Central Government subsidized 40 RMB per participant in the central and western area. The local finance bureaus raised the matching contribution accordingly from 20 RMB to 40 RMB. Those areas with financial difficulty were given a two-year grace period to meet the above minimum requirement. Meanwhile, the contribution by individual participant was increased from 10 RMB per year to 20 RMB per year except for some poor areas where the target could be reached in two years.

Although the total contribution for an individual account has reached 100 RMB, the total coverage is apparently still very low. The Ministry of Health has indicated two proposals to increase the total budget of NCMS. The first proposal was to increase total contribution per participant to 150 RMB by 2010; the second one set a higher target of 200 RMB by 2010, among which 90 RMB was financed by the central government. With the higher contribution figure set by the central governments, there has been a large regional variation in the amount of local matching fund available due to different level of economic development. For example, Tongling City in Anhui Province set the total contribution to 130 RMB per participant in which 110 RMB was covered by the government and the remaining 20 RMB by individuals. In comparison, the much richer Haidian District in Beijing decided to raise contribution per participant to 600 RMB,

among which 80 RMB came from the Beijing Government budget, 400 RMB by the district budget, and 120 RMB from individuals or enterprises. Among the 600 RMB, 550 RMB was earmarked for inpatient fund, while 50 RMB was used for the outpatient reimbursement fund.

There are two major types of NCMS policy. The first type covers mainly severe illness reimbursement plus an outpatient family account. It sets up severe illness fund in order to reimburse most of the severe illness inpatient and in addition outpatient family account for covering treatments of certain diseases. The second type includes both inpatient and outpatient reimbursements. It reimburses the inpatient and outpatient expenditure separately with the NCMS fund.

The first type of NCMS policy started in 2003 when NCMS had just been introduced. This policy focused on guaranteeing the participants to receive treatment for severe illnesses. The NCMS funding were mainly used to subsidize the inpatient treatment. Part of the participation fee was used to set up a family account which covered the family members' outpatient reimbursement by different ratios for different expense ranges until the amount was used up. Minimum and maximum lines were set for the outpatient reimbursement. This type of NCMS was a huge success since it encouraged the active participation of the villagers. In the central and western areas, the participation rate for the family account even reached 80-90%. However, some disadvantages emerged over time. Some "cautious" and "thrift" villagers were still using their own money to pay for the outpatient treatment. As a result, a large proportion of the fund in the family account was not spent. Statistics showed that from 2003 to 2007, more than half of the fund in the family account was not used in Jiangxi Province. Statistics from the Bureau of Health in Anhui Province showed that by the end of 2007, 75% of the family medical accounts in the rural areas had virtually not made any claims and only 19% of the fund was spent. However, for the inpatient reimbursement, as some villagers could not afford the share of medical expenditures they had to pay, they often avoided using the NCMS and in many cases even gave up inpatient treatment. The implication is that the limited NCMS inpatient reimbursement was essentially benefiting rich villagers (Deng and Zhen, 2008). As a result, family accounts were gradually phased out of the market. Most provinces stopped setting family accounts in NCMS.

The second type of NCMS, a combination of inpatient reimbursement and outpatient reimbursement, is currently widely adopted. This type of policy focuses on ensuring the treatment for severe illnesses and at the same time taking care of common ailments. Thus villagers will be able to afford treatment for both severe illnesses and common ailments. This policy encouraged villagers to seek treatment for the illness before its aggravation and thus provided strong incentives for villagers to participate in. Although this policy can offset some of the disadvantages of the family account policy, some questions remain unanswered. For example, how to allocate funds between inpatient and outpatient treatments? Whether inpatient reimbursement should be based on a fixed ratio or progressive ratios according to the range of expenditures? Should there be a consistent standard with respect to the minimum and maximum cutting points for the first reimbursement and the second reimbursement? These problems are still under explorations in various pilot projects.

The major weaknesses and difficulties that the current NCMS faces include low accessibility, high cost of the medical treatment, and the occurrences of poverty caused by some

severe illnesses (Han and Luo 2005; Li and Zhang 2007). Financing is another big issue for the NCMS. In terms of the traditional Cooperative Medical System, the accounting unit was the village community which did not meet the “Law of Large Numbers”, and therefore the system could not spread the risk. In addition, since the scale was small and the funding resource was unitary, the traditional Cooperative Medical System was unstable (Liu, 2008). In contrast, the NCMS is currently operated at the county level. However, due to budget constraints, local governments cannot afford to support all rural medical expenditures. As a result, participation in the NCMS policy is currently voluntary. The central government and local governments offer matching funds separately from their fiscal budgets. However, the voluntary participation created adverse selection and moral hazard (Fang and Gu, 2006). As a result, in some areas, rich villagers do not have interest in the NCMS insurance scheme while the poor cannot afford the scheme (Liu, 2005). NCMS is based on a three-level medical health system, in which the provincial level medical institutes are the leaders; the county level hospitals are the main body and the village level clinics are the foundations. However, many county hospitals and most of the village clinics are facing financial problems (Project Team, 2008; He and Liu 2008). In addition, villagers often do not trust the quality of village clinics because of their rather weak background and insufficient training of the health personnel (Han and Luo 2005; Hu and Yang 2007).

There are a number of researches assessing the impact of the NCMS pilot program. For example, Wagstaff et al. (2009) conducted a following-up survey in 2005 in 10 counties that had implemented the NCMS during the 2003 wave of the National Health Service Survey. They compared the outcomes of these 10 counties with those of five other counties that had not implemented the NCMS pilot program. The study found that program enrollment was lower among poor households and higher among households with chronically sick members. They also found that the NCMS had increased overall utilization of inpatient and outpatient services. However, the increase in utilization was disproportionately higher among wealthier households, while the rate remained unchanged among poorer households.

Lei and Lin (2009) employed a longitudinal sample drawn from the China Health and Nutrition Survey (CHNS) to study the impact of the NCMS program. They found that participating in the NCMS significantly decreased the use of traditional Chinese folk doctors and increased the utilization of preventive care, particularly general physical examinations. However, the study did not find that the NCMS decreased out-of-pocket expenditure. Nor did they find it increased utilization of formal medical service or improved health status, as measured by self-reported health status and by sickness or injury in the past four weeks.

Yip et al. (2008) conducted a randomized experiment to evaluate the impact of Rural Mutual Health Care (RMHC) — one major policy design under the NCMS, on access to healthcare in rural China. RMHC provides first dollar coverage for both inpatient and outpatient services, and uses supply-side interventions to improve quality and reduce inefficiencies in health service delivery. They found that the RMHC had increased the probability of an outpatient visit by 70% and reduced the probability of self-medication by a similar percentage. Further, they found evidence of spillover effects in which non-enrollees of the RMHC sites increased the probability of village visits.

As the policy design of the NCMS varies across different areas, Brown et al. (2008) examined the level of satisfaction of participants under different policy designs. They found that households responded favorably to making emigrants eligible for coverage and lowering the expenditure threshold for reimbursement eligibility. However, they found that households were less likely to have received reimbursement in counties that require referrals, in part because households found reimbursement procedures in such counties to be cumbersome. Moreover, NCMS participants were less likely to receive reimbursement in counties that limit treatment to approved hospitals, suggesting such restrictions may be onerous. Finally, out-of-pocket expenditures associated with severe illness care might still be too high to facilitate treatment for the rural poor.

In sum, even though the coverage of the NCMS has been largely improved in recent years, there is still a large variation in its impact across regions and population groups. Therefore, policy designs suitable for local economic conditions are urgently called for.

III. Rural Elderly Support and Pension Schemes

In the era of the planned economy, most elderly were supported by their families, whereas those without a family lived in the homes for the aged provided by village collectives. After the reform of the planned economy, due to the lack of sustainable funding resource, the number of rural elderly support institutions dwindled. In 1986, the Ministry of Civil Affairs started to explore the Rural Elderly Support Insurance Policy. Pilot projects at the village level on rural elderly support insurance were launched in more than one thousand counties in relatively developed regions, including Shandong, Beijing and Shanghai, but the policy was not very effective.

In 1991, the State Council decided to select five counties in Shandong Province to experiment the county-level rural elderly support insurance policy. In 1992, the Ministry of Civil Affairs issued the Basic Guideline on Elderly Social Support Insurance at the County-Level (abbreviated as Basic Guideline thereafter), for which elderly support insurance policies at the county or township level were introduced. Pension fund was paid by individuals, subsidized by the collectives and supported by the local governments. Individual contribution accounted for more than 50% of the insurance premium and the rest was covered by local governments or by township and village enterprises (TVEs). Upon reaching the retirement age (60 years old), a villager could receive the pension based on the total amount in his account.

By the end of 1998, 2,123 counties in China and 65% of the townships had rolled out rural social elderly insurance with 80.25 million participants. In the same year, the State Council decided to hand the social insurance for elderly from the Ministry of Civil Affairs to the Ministry of Labor and Social Security. During that period, due to the rapid development of elderly insurance, the inherent problem of the policy, and the influence of the Asian economic crisis, the market value and balance of the elderly insurance account dropped sharply. As the foreseen benefit of the insurance decreased, the number of participants in most of the rural area diminished. The expansion of elderly support insurance program came to a halt. In July 1999, the State

Council decided that it was not ready yet to carry out the rural elderly insurance system. It recommended that qualified areas gradually transfer the policy into commercial insurance.

In 2006, the Ministry of Labor and Social Security released the first document of the year, listing the development of rural elderly support insurance as one of the most important tasks of the year. The document called for local governments to explore and establish new rural social support insurance for elderly program that is compatible with the local economic conditions. The new rural elderly support policy included individual accounts which were financed by individual contribution and matching fund from the local governments.

In 2009, the government prompted to actively explore and establish new rural social security system. There was a debate in whether a “pay as you go” model or an “individual account accumulation” model is more suitable (Yuan 2001; Cai and Meng 2003). He (2001) argued that the government should first implement the insurance scheme in relatively developed areas and postpone the implementation in less developed areas until conditions meet. Wang and Wang (2005) also reckoned that rural elderly support insurance policy should be developed gradually in the qualified areas first instead of rushing into action for the entire rural China. Zhao (2002) stated that the abilities for the families to support are diminishing quickly as a result of rapid economic transformation. Moreover, the rural “five-guarantee” support to elderly scheme can no longer support the elderly after the collapse of rural collectives. Furthermore, the looming problem of aging urges the establishment of the rural elderly support insurance system. A nationwide rural elderly support scheme is needed.

Since the New Rural Elderly Social Support (NRESS) scheme is still in its experimentation stage, detailed policy has not yet been set up. The social insurance policies for elderly vary across different areas. Some of the regions are still using the “payments from the individual, subsidy from the collective and support from the government” fund-raising policy as proposed in the Basic Guideline of 1992. On August 17th 2007, the Ministry of Labor and Social Security Audit Administration and the Ministry of Civil Affairs proposed to carry out a comprehensive audit on elderly social support insurance fund in 2007 in order to have an accurate estimation of its size and scale. On September 9th 2008, Dianguo Zhao, Director of the Rural Social Insurance Bureau of the Ministry of Human Resource and Social Security, proposed “Suggestions on the Development of New Rural Social Support for Elderly Schemes” based on a summary assessment of the local pilot projects. Nationwide NRESS pilot projects were expected to be launched after the authorization from the State Council in 2009 or 2010. On March 5th, Premier Wen Jiabao proposed in the Working Report of the Government at the Second Session of the 11th National People’s Congress that the NRESS pilot projects should cover about 10% of the counties in China.

Currently, there are three types of NRESS pilot projects. The first scheme is the individual account model. Payments from the individual, subsidy from the collective and support from the government would be directly deposited into an individual’s account. The pensionable amount was calculated using the total credit accumulated in the individual’s account. The second type is similar to the urban pension insurance system. Fund-raising is still based on payments from the individual, subsidy from the collective and support from the government. But the individual payments and collective subsidy is calculated into the individual account, and the government

support is counted into the social management fund. This type of policy incorporates both individual account and social management fund. Part of the basic pension is from the social management fund when the villagers start to claim their pension. The third type incorporates both individual account and basic pension directly provided by the government. Payments from the individual, subsidy from the collective and support from the government are incorporated into individual account. The basic pension is provided by the government directly.

Among the three types of NRESS policies, the third scheme has been most popular. For example, Beijing enacted NRESS Trial Law on January 1st 2008. According to the law, the paid-in amount per month to basic pension pool is 280 RMB. The portion paid in by an individual has flexible rates. The lowest rate is 10% of the previous year's average income in the district. The portion above the lowest rate is contributed voluntarily based on the individual's financial condition.

There are different academic opinions with regard to the roles of family support to elderly in the future. On the one hand, many scholars believe that elderly support in China should still depend primarily on family. For example, Yan (2000) argued that in a quite long period of time, the establishment of rural social support for the elderly should depend primarily on the family and partly on the society. Based on a household survey of 3,746 observations in Dongkou County, Hunan Province, Chen and Xiao (2007) find that family- and self-support tends to correlate negatively with the family size. Therefore, smaller family size as a result of one child policy does not necessarily imply less family support. Zimmer and Kwong (2003) also hold the same view that even though the number of children was an important determinant of family support, future reductions in family support may not be as dramatic as popularly anticipated.

On the other hand, several researchers argue that elderly support policy cannot count on family support, especially in the rural areas. Zeng and George (2001) stated that relying mainly on family support without social security would largely limit the independence of the elderly in decision making concerning their own lives. Family support plus social security would place the elderly in a much better position for happiness. Yang (2005) also argued that as rural population was large and economic development was uneven, it would be insufficient to merely depend on the society for the elderly support. The only way to solve this challenge was to combine family support, social insurance and community support together. Xu (2001) also suggested that family support was not a panacea for the elderly people in rural China. The operation of family support was often subject to the influence of idiosyncrasies and other social economic factors that were largely uncontrollable and unpredictable.

Some studies concern about the feasibility of social security programs. As the aging population is dramatically increasing in China, social security programs may put an unsustainable fiscal burden on the government. Lu (2003, 2006) proposed a policy called "land for security", which encouraged villagers, who already work full time in cities, to exchange their land user rights for social security benefit. They argued that this strategy would solve the resource constraint problem in the social security account. Through a simulation study, Jiang (1994) suggested that providing social security for the elderly was not financially implausible in rural China. Rather, if provisions targeted the needy elderly, the cost of an effective old-age assistance program could be remarkably low.

IV. Other Basic Support Programs

Rural “Five-Guarantee” Support Program

On June 30th, 1956, the First National People’s Congress (NPC) sanctioned the *Exemplary Charter for Advanced Rural Cooperatives*. The charter stated that “the agriculture production cooperative should make proper arrangements and take care of the elderly, the disabled and those who are disadvantaged in the labor market. The cooperative should guarantee the food, clothing and heating supply for those who qualified, the education for children and the interment for the elderly after they died.” In October 1964, the second NPC approved *The National Agriculture Development Guidelines for 1956-1976*, which stipulated that “the agriculture production cooperative should guarantee the food, clothing, fuel, education and interment supply for the widower, the widow, the orphan and the childless.” In the cooperatives period, the source of finance mainly came from cooperative public funds. The cooperative provided resources collectively to found “home for the aged” to take care of the elderly without child. In the planned economy era, the so called “five-guarantee” policy provided a regular supply of food, clothing, housing, medical care for those who did not have family support, including senior citizens, disabled, children under 16, and those who were unable to work.

Since the introduction of Household Responsibility System (HRS), households had replaced collectives as the basic production unit. Consequently, villages lost their revenue streams traditionally provided by the collectives to support neediest people under the five-guarantee system. The collapse of the collectives directly affected funding for the five-guarantee program.

In January 1994, the State Council promulgated the *Guidelines on Rural Five-guarantee Support Schemes*, which specified the procedures and operational details for the five-guarantee support scheme. However, funding had always been a problem because the Guidelines asked individual villages to cover the major cost of the five-guarantee program and many villages did not have much their own revenues.

In 2004, the Ministry of Civil Affairs (MCA), together with the Ministry of Finance and the National Development and Reform Commission, issued *The Circulars on Improving the Five-Guarantee Support Provisions*. The Circulars required all villages to allocate certain amount of funds for the five-guarantee support from extra agricultural tax income, after serving the normal expenditure of the village community. If a village had financial difficulty, the county and township governments should provide proper assistance. However, the problem has become worsened since China abolished agricultural taxes in 2006. Villages were no longer allowed to collect any fees after the tax reform in 2004, funding for five-guarantee support, which was originally, in a large part, covered by the agriculture surtax, had been shifted into the provincial and county level fiscal budget.

In 2006, the State Council issued new *Guidelines on Rural Five-guarantee Support Provisions (amendment)* (Abbreviated as *new Guidelines* hereafter). The *new Guidelines*

stipulated that funding for five-guarantee support should be included in the local government fiscal budget. Funding could be arranged using part of the rural collective operational income if applicable. Central finance would provide subsidy to areas with fiscal difficulties. The *new Guidelines* also prescribed that the standard for rural five-guarantee support should be higher than the average local living condition and the standard should keep in pace with the increase in local living standard. After issuing the *new Guidelines*, the MCA urged local governments to come up with a new five-guarantee support standard.

In January 2007, MCA announced the adjusted five-guarantee support standards for 31 provinces (including autonomous regions and municipalities directly under the central government). Basic summary statistics of rural five-guarantee support program from 2001 to 2008 is presented in Table 1. As shown in the table, since 2004, both the number of population covered by the program and the amount of coverage have seen a much faster pace of increase than before.

Table 1 Rural Five-Guarantee Support Program from 2001 to 2008

year	2001	2002	2003	2004	2005	2006	2007	2008
Support population (1,000)	3,959	3,121	3,050	3,280	3,540	5,033	5,311	5,310
Annual growth rate (%)	57.8	-21.2	-2.2	7.5	7.6	42.2	5.5	0.0
Annual support amount (yuan/person)	302	371	417	990	1,064	1,416	1,693	1,743

Data source: 2008 Chinese rural poverty survey report; MCA statistic data.

Rural Minimum Income Support (*Dibao* in Chinese)

China's *Dibo* program started in the cities. One key element of the economic reforms is to allow private-, individual-, and foreign-owned enterprises to compete with SOEs (state-owned enterprises). After two decades of reforms, the share of value-added produced by the non-state enterprises in the industrial and service sectors has increased significantly from almost zero to more than 50 per cent. The development of the non-state sector greatly augments economic growth and provides enormous job opportunities. However, on the other hand it also posed fierce competitions to the SOEs, which has been plagued with heavy burdens of social welfare provisions. To provide new impetus to the SOEs, the government launched an enterprise-restructuring program in 1996. The central theme of the SOE reforms is to transfer welfare-provision obligations such as healthcare and housing from enterprises to social insurance agencies and individuals.

These reforms have reduced workers' lifetime welfare ties to their employers, thereby providing them with a higher degree of freedom to change jobs and achieve higher earning potentials. The reforms allow market force to determine workers' pay that is more consistent with their ability. The efficiency gains from the urban reform are evidenced by the fact that per capita urban income has grown quite dramatically with an annual growth rate of about six percent in the 1990s.

On the other hand, the urban reforms and severe competition from other sectors have resulted in soaring financial losses of state- and collective-owned enterprises and a large number of urban workers had been laid off. As a social safety net was largely not in place, liberalization of the welfare system may have made some disadvantaged groups more vulnerable to shocks such as severe illnesses. Consequently both urban income inequality and urban poverty increased in the 1990s (Fang et al., 2002).

In order to help the new vulnerable groups in cities, the government started to set up *Dibo* system for the urban residents in 1993. However, it does not make sense if the same government provided *Dibo* to only urban residents but not to rural residents. Therefore, in 1996, the MCA issued *Suggestions on Accelerating the Development of Rural Social Security System*, calling for "wherever the rural social security system is developed, the focus should be placed in the improvement of the basic living allowance system; the policy should be set up even starting with low standard if necessary." At the same time, the government also formulated the *Guiding Methods to Establish Rural Social Security System*, asking local financial authorities and villages to share the cost. The exact sharing formula should depend on the circumstances specific to each area. In 2000, around 3 million villagers received *Dibo* (Hao and Dong, 2008).

Nevertheless, the exemption of agricultural taxation in the mid 2000s greatly reduced local funding for *Dibo*. In July 2007, the State Council issued the *Circulars on Establishing Rural Basic Living Allowance*, aiming to set up nationwide *Dibo*. On Aug 2nd, 2007, the Ministry of Finance and the MCA issued the *Notice Related to the Funding of Rural Dibaos*. The government earmarked three billion yuan to support local governments, especially those with fiscal difficulties. By the end of 2007, all the 31 provinces had produced *Dibo* policy documents. From 2005 to September, 2008, rural *Dibo* program took off (see Table 2).

Table 2 Rural Dibo from 2001 to 2008

Year	2001	2002	2003	2004	2005	2006	2007	2008
Support population (1,000)	3,046	4,078	3,671	4,880	8,250	15,931	35,663	38,577
Annual growth rate (%)	/	33.9	-10	32.9	69.1	93.1	123.9	8.2
Total subsidy (million yuan)	469	710	932	1,620	2,800	4,350	10,910	14,440
Subsidy per person-month (yuan)	12.8	14.5	21.2	27.7	28.0	34.5	38.8	43.0

Data source: 2008 Chinese rural poverty survey report; MCA statistic data.

V. Conclusions

The economic reform has altered the institutional foundations of rural social security provisions. As a consequence of increasing competition, income inequality has increased and many vulnerable people have lost their social security which was a part of the traditional employment arrangements. In response, Chinese governments have made various efforts to establish a new rural social security system. Because of the vast regional variation and complexity, China has followed a practical approach in carrying out social security reform. It also allowed different locations to experiment with various program designs. In fact, almost all the policies related to rural social security provisions started with some pilot projects. After being proven to be successful, the new systems were scaled up. Given the looming aging problem and concerns for rising inequality, China must continue its effort to set up a full-fledged rural social safety net program, although it is a long way to go.

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