



Original Article

How Health Workers Earn a Living in China

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Abstract

Health workers earned the same salary throughout China during the period of the command economy. Differences in earnings have grown substantially since then. Some health facilities supplement basic government salaries with substantial bonuses financed out of earned revenues, whilst others cannot pay basic salaries in full. Some health workers supplement their income through informal channels. The government's response depends on the kind of informal payment. It uses moral pressure and the threat of the loss of professional privileges to discourage acceptance of cash payments from patients. It treats those who accept kickbacks from drug suppliers or health facilities as criminals. The government faces very difficult challenges in facilitating the adaptation of the health system to a market economy. Its strategy has been to create a broad policy framework within which individuals and enterprises can develop individual adaptation strategies. It has enacted rules to regularise new relationships that emerge. The strategy of gradual institutional reform has enabled the health sector to adjust to major change. However, it has allowed people to profit from opportunistic behaviour and resulted in inefficiencies and problems with access. It could eventually change social attitudes about what constitutes ethical behaviour by health workers. The challenge is to create a regulatory framework that permits health workers to earn a reasonable income, whilst encouraging them to provide effective and affordable health services that meet the needs of the population.

Key words: Human resources, informal payments, China, provider behaviour, health system reform, transition

1. Introduction

Most analysts agree that health workers respond to economic incentives. Salaried employees tend to work less intensively, those earning a fee related to service provision tend to see more patients and recommend more tests and interventions and those paid a fixed amount per patient per year tend to minimise the time they spend on each consultation. However, immediate financial gain is only one of a number of influences (Figure 1).

The pursuit of a profession requires a substantial investment. Health professionals may trade immediate opportunities for gain against long-term career prospects. For example, British doctors work for many years for modest pay, hoping to achieve consultant status. Doctors and

nurses in other countries resist work in rural settings, if it will impede their professional progress. Systems for allocating training opportunities and selecting people for promotion in the public sector influence health worker behaviour.

Users of health services have little capacity to judge the quality of advice and services they receive. Societies have developed mechanisms for reducing the risk and transactions cost of selecting expert health services⁽¹⁾. One common strategy is for the state to limit the right to provide and/or charge for certain services to licensed practitioners. The aim is to protect users from dangerous practices and enable them to identify competent practitioners.



Figure 1 Influences on the behaviour of health workers.

The state gives practitioners a considerable amount of power by awarding them a monopoly right to sell certain services. Many countries have created mechanisms to limit the ability of health workers to use this power for personal gain. One mechanism for reducing their room for manoeuvre is for government to employ them. This places them under a contractual obligation to provide certain kinds of services in exchange for a salary. It is dangerous to generalise, nonetheless, the relative pay of health workers tends to be lower where government is their principal employer.

Many societies have established professional regulatory bodies. Some argue that these bodies give more weight to their members' interests than to the public. However, the long-term survival of health care professions depends on the public's perception of their integrity and they have a stake in limiting inappropriate behaviour. There is little knowledge about the performance of these bodies in low and middle-income countries.

Health worker behaviour is constrained by hard-to-define cultural factors.^(2,3) In some countries health workers internalise a set of medical ethics, in others they respond to political or religious factors. In exchange they have high social status as trusted advisors. The values of professional service have contributed to the preservation of the effectiveness of services in some countries, which experienced periods of admin-

istrative chaos.

This paper describes the response of Chinese health workers to radical changes during the transition to a market economy. It argues that transactions between health service users and providers now have many characteristics of a market. China is transforming almost every aspect of its social, economic and legal structures. It may eventually create a regulatory framework with rules of behaviour for providers of social services, but this will take time. The paper begins by describing the factors that influenced health worker behaviour during the period of the command economy. It then discusses how these factors changed during the transition to a market economy. It describes the legal and illegal livelihood strategies of health workers during the latter period and it discusses the blurred boundaries between the two in a society undergoing radical reforms.

2. Health Workers and the Command Economy

2.1 Organisation and finance of health services in the 1970s

Prior to the economic reforms of the 1970s, the state bureaucracy, rural communes and the Communist Party dominated the Chinese economy. The state bureaucracy was organised according to the principles of the command economy. The national government fixed prices

and pay, deployed workers and controlled investment. Lower levels of government and enterprises were expected to meet targets.

The rural areas were organised into communes, units of collective production. Communes allocated a portion of output to investment and local services and distributed the rest to their members, in proportion to the time they had spent on collective activities. The Communist Party played an important role in economic and social activities. Its cadres influenced decision-making in all institutions. The politicisation of economic life reached a high point during the late 1960s and early 1970s, when the Cultural Revolution put 'politics in command'.

By the early 1970s China had established a highly organised health service throughout the country. Its character reflected the society which created it⁽⁴⁾. Hospitals and work-based clinics served the urban population. The Ministry of Health (MoH) and state-owned enterprises, such as the railways, owned these facilities. The MoH paid the salaries of government health workers and financed some running costs of its facilities. Health facilities charged for drugs and services. Government employees and workers in state-owned enterprises were covered by health insurance, which paid most of these charges.

The so-called 'three-tier' health services covered most of the rural areas. Approximately 85% of villages had a health station staffed by one or more barefoot doctors, peasants who had been given a short training course. They provided curative and preventive services. The commune health centres provided referral services and supervised the barefoot doctors. All counties had a government hospital and specialised preventive institutes. The health bureau was responsible for planning and overseeing the management of the county's health services. A number of public health campaigns were organised under the technical leadership of the MoH and the political leadership of the Communist Party, which played an important role in mobilising the population⁽⁵⁾.

Both the government and communes contributed to rural health finance. The former paid salaries of its employees and covered some operating costs of county facilities and preventive programmes. The latter paid non-government health workers. Preventive services and consultations with barefoot doctors were supplied free or at very low cost, but patients paid for drugs and other consumable inputs. Local prepayment schemes, which derived revenue from individuals and communes, reimbursed a portion of these charges.

2.2 Influences on health worker behaviour in the command economy

Figure 2 summarises the influences on health worker behaviour during the 1970s. The health service was a tightly organised system, which combined what Moore calls 'hierarchical control' and 'solidarity'.⁽⁶⁾ The government and the Communist Party provided parallel mechanisms of hierarchical control. The government employed a large proportion of health workers. It transferred many to rural facilities during the late 1960s. Health workers were answerable to the facility that employed them. The communes paid the barefoot doctors and health workers in commune health facilities. The county health bureau was responsible for the quality of health work in the county and it supported supervisory visits and training sessions for grassroots personnel. The health centres supervised the barefoot doctors.

The Communist Party provided a second mechanism of hierarchical control through its network that extended to most villages. Political cadres directly influenced management decisions.⁽⁷⁾ The Communist Party was the primary route for implementing many government policies. For example, it led many public health campaigns, with technical support from the health sector. The slogan calling on people to 'put politics in command' highlighted the importance of non-bureaucratic and non-economic factors. Health workers were expected to serve the people

Figure 2 Influences on the behaviour of health workers in 1970s China

by leading these mass campaigns. They were answerable to local Communist Party structures and faced serious sanctions if they acted in a manner considered to be self-interested or counter-revolutionary.

Professional regulatory bodies were profoundly weakened during the Cultural Revolution of 1966-1976.⁽⁸⁾ The Communist Party led a reaction against a bureaucratic and intellectual elite whose interests were perceived to be divorced from those of the population.^(7,9) Between 1966-1969 medical universities and colleges were closed and through the mid-1970s training institutes only provided courses of practical orientation of no more than three years duration.⁽¹⁰⁾ Status and role differences among personnel with different levels of expertise were reduced in an attempt to diminish the power of physicians. Ranking by titles was opposed and promotion of any kind stopped for ten years. Revolutionary committees governed hospitals. Their members often had relatively little specialised training.

The health system of the 1970s provided almost universal access to basic preventive and curative health care, contributing to a dramatic improvement of health status.⁽¹¹⁾ However, there were problems. The high employment, low wage economy may have led to low effort and inefficient services. According to Feng et al, one reason why peasants were unwilling to contribute

to local health prepayment schemes after de-collectivisation, was that local elites had benefited disproportionately from them.⁽¹²⁾ It is impossible to assess the magnitude of these problems.

3. Health Workers and the Transition to a Market Economy

3.1 Organisation and finance of health services

China is transforming into a 'socialist market economy'. This involves changing from collective to household agricultural production, phasing out price controls, reforming state-owned enterprises, creating a labour market, and developing new forms of enterprise ownership. China has experienced rapid economic growth and its gross national product increased by 9.5% a year between 1978 and 1994.⁽¹³⁾

Government revenues have not kept pace with economic growth and they account for a diminishing share of gross national product. Government's contribution to total health expenditure (excluding health insurance for government employees) fell from 28% to 14% between 1981 and 1993.⁽¹¹⁾ The government has raised public sector pay several times and it also permits cost centre managers to pay bonuses out of revenues they earn from user charges.⁽¹⁴⁾ Earnings of personnel in profitable and unprofitable

enterprises, and rich and poor localities, have diverged increasingly. Local governments in the poorer parts of the country spend up to 80% of their budget on personnel.⁽¹⁵⁾ In spite of this, they can no longer afford even basic salaries. Many facilities in these areas can only generate small amounts of revenue to finance bonuses.

The so-called iron rice bowl, whereby trained personnel were assigned jobs and guaranteed employment for life, is ending. The changes have been slowest in the public sector. Local governments still assign new graduates to government facilities and facility managers have little power to dismiss personnel. On the other hand, workers can leave their post if they find a better job. Many rural health facilities have employed more staff but lost their most qualified personnel. Utilisation of these facilities has diminished.⁽⁸⁾ Hospitals in areas experiencing rapid economic growth have been able to increase their number of highly trained staff to meet the increasing demand for specialist services. Their employees have greater opportunities to earn bonuses.

Many local governments finance less than 15% of the budget of hospitals and health centres.⁽¹⁶⁾ Government grants often do not pay even basic salaries of health workers. Health facilities generate revenue from service charges, selling drugs and undertaking profit-making activities, such as manufacture of pharmaceuticals and so forth. They use some of this revenue to finance salary supplements. Government grants to public health programmes have not kept up with inflation. Preventive institutes have developed revenue-generating activities and charge for some preventive services.⁽¹⁷⁾

Cost centres now have a great deal of autonomy. Government bureaucrats and local politicians can no longer interfere with management decisions.⁽⁷⁾ The government is slowly replacing the command and control model of supervision with a functioning regulatory system.⁽¹⁸⁾ But the creation of alternative governance structures is proceeding slowly. Profes-

sional regulatory bodies are still weak. Alternative mechanisms of local public accountability, such as village representative bodies, are only now being established.⁽¹⁹⁾ This limits the degree to which local service providers are accountable to users.

3.2 Extra-legal payments for health services

Health workers employ a variety of strategies to augment government salaries. Health facilities are permitted to pay bonuses out of surplus earnings that can be as large as the basic salary. Patients may also give them gifts, called “red packages”, and suppliers of drugs, equipment and services may pay them “kickbacks”. These payments span a spectrum from fully acceptable to criminal. The boundary between categories is shifting as China creates a regulatory framework.^(20,21)

This section describes payments outside the ethical and/or legal norm. It is based on a review of academic literature, newspaper articles and government statements. These sources provide an impression of current thinking; they do not provide systematic data on the importance of formal and informal economic incentives.

3.2.1 Red Packages

During the period of the command economy people often had to wait a long time to gain hospital admission or access to specialised services and sophisticated drugs. Some gave gifts to a doctor or manager who allowed them to jump the queue or obtain special services. These gifts are called “red packages”, which were traditionally exchanged as an expression of mutual obligation. These practices were considered anti-social and red packages were infrequent and secret.⁽²²⁾

Red packages have become more common during the transition to a market economy. Xing reports that health workers in 190 hospitals recently turned 3.5 million yuan in such payments over to local government.⁽²³⁾ Feng and Feng found that over 50% of inpatients in Shengyang

had paid a red package averaging 260 yuan.⁽²⁴⁾ Li and Huang found that 74% of inpatients had made informal payments.⁽²⁵⁾ Most studies focus on urban health facilities, however, Jing et al report that health workers in rural Jiangxi also receive red packages.⁽²⁶⁾

Red packages mostly take the form of cash payments. Their size varies with the income of the local population, the degree of sophistication of the health facility, the seniority of the doctor and the field of specialisation.⁽²⁷⁾ Surgeons, obstetricians and anaesthesiologists do particularly well. Surveys of hospitals in several provinces report average payments between 140-320 yuan.⁽²⁸⁻³¹⁾ Studies of large referral hospitals have found averages of 400 yuan or more.^(32,33)

People pay red packages for a number of reasons. Some hope to encourage the doctor to give their case special attention. Uninsured patients may pay the doctor to refrain from recommending unnecessarily expensive items.⁽³⁴⁾ The payer may view the red package as a gift, which cements a reciprocal relationship. A newspaper article about a man who attacked his father's doctor who refused a red package illustrates the emotional significance of the transaction.⁽³⁵⁾

Health workers have ambivalent attitudes towards red packages. Zhou and Zhang report that 21% of doctors said they accepted them to compensate for unrealistically low pay, 59% refused them on ethical grounds and 15% turned them down for fear of punishment.⁽²⁷⁾ Another survey found that 31% of recent medical school graduates thought that red packages were normal.⁽³⁶⁾ It is impossible to assess whether these attitudes reflect actual practices of doctors.

3.2.2 Kickbacks

Health facilities are allowed to accept discounts of up to 5% from suppliers of drugs or equipment, as long as they record them in the accounts.⁽³⁷⁻³⁹⁾ All other payments are illegal. These commonly are in the form of cash, cars,

air-conditioners, mobile telephones, banquets, entertainment and travel.⁽⁴⁰⁻⁴³⁾ They are paid to health facilities and/or individuals. Wang reports that they typically amount to 8%-10% of the cost of common drugs and 30% of the cost of advanced ones.⁽⁴⁴⁾ Zhou estimates that a mid-scale hospital can earn as much from kickbacks as from the typical government grant.⁽⁴⁵⁾

Some health organisations or departments pay doctors "prescription fees" for ordering a particular investigation or drug, "introduction fees" for sending new patients, or "referral fees" for sending them patients for specialist care. These forms of informal payment emerged in the mid-1990s, reflecting the competitive nature of the health service market in urban areas.

There is little information on the extent of kickbacks. The government recently asked pharmaceutical companies and health facilities to carry out a self-audit. The 117,714 participating institutions reported 1.74 billion yuan in drug kickbacks over four years. The government also received 6103 complaints involving illegal payments of 664 million yuan.⁽⁴⁶⁾ Provincial audits have revealed substantial problems in Zhejiang, Hunan and Shanxi.^(31,45,47-49)

Policy analysts have identified several negative consequences of drug kickbacks including: loss of taxes, bypass of quality controls, and over-prescription of drugs.^(43,44,50) Some companies use kickbacks to promote expensive imported drugs or locally produced brand name products.⁽⁵¹⁻⁵⁴⁾ This has contributed to rapid rises in the cost of medical care.

3.3 Influences on health worker behaviour in the socialist market economy

Health workers are more influenced than previously by material incentives and, what Moore calls, 'dispersed competition'.⁽⁶⁾ However, many providers do not act as if their only motives are financial. Figure 3 identifies factors,

1 One US dollar was equivalent to approximately 8 yuan during the mid to late 1990s,

Figure 3 Influences on the behaviour of health workers in 1990s China

which explain this. Some are diminished versions of the influences on health workers during the 1970s and others are new. The discussion is complicated by the rapidly changing structure of the health sector. The government is reforming many aspects of health sector management, finance and regulation.

Health workers are mostly salaried employees of health facilities, which derive revenue from government grants and user charges. Village health workers are the major exception. Most of them receive very little money from the government. They earn most of their income from consultation fees, selling drugs and non-medical work.^(55,56) There is also a growing number of licensed private practitioners.⁽⁵⁷⁾ This section focuses on the employees.

3.3.1 Provider behaviour in a regulated market.

Chinese health facilities are neither public nor private, as understood in established market economies. They are mostly owned by local government, although some localities are experimenting with alternative forms of ownership. The government signs a contract with the facility manager and negotiates an annual grant. The facility raises the rest of its revenue (85% or more) by charging patients directly or billing the employer of insured workers. The facility manager can use surplus revenue to pay salary

enhancements or invest in improvements.

Weitzman and Xu call this kind of entity a 'vaguely defined cooperative'.⁽⁵⁸⁾ By this they mean that the manager is answerable to the employees and to local government. They argue that enterprises have been successful, in spite of the vaguely defined property rights, because the Chinese are used to limiting self-seeking behaviour in the interest of the community. Hsiao argues similarly that China may be able to create sustainable rural health prepayment schemes because its villagers are used to working cooperatively.⁽⁵⁹⁾ In this view, the performance of health facilities reflects a continuing negotiation between government, employees and users, moderated by poorly defined pressures for a socially acceptable outcome.

The regulatory bodies inherited from the command economy are modifying their roles. Until recently local managers had little control over hiring and firing. Health workers can now change jobs more easily than before. This has given skilled personnel greater negotiating power and the best trained have left facilities in poor localities.

Government price bureaus have kept charges for preventive services and routine consultations low, in order to keep services accessible. Many health facilities experienced serious financial problems during the 1980s and the

government responded by allowing them to earn a 15-20% mark-up on drugs and other consumables and to set high fees for services for relatively sophisticated equipment. This enabled health facilities to cope with a relative fall in government funding, but it created incentives to increase costs.

Health facilities reward revenue generation with salary bonuses. Tang describes rural health centres that pay larger bonuses to members of the more profitable clinical cost centres.⁽¹⁴⁾ One response of health workers has been to shift their activities from preventive programmes to curative services. Another response has been to sell more drugs.⁽⁶⁰⁾ This has contributed to a rapid rise in drug expenditure. The use of relatively new technologies such as ultrasound and CAT scanners has increased rapidly for similar reasons.

Local health departments play a diminished regulatory role. Officials control allocations to health facilities, but pay little attention to the quality or cost of services. This reflects the low priority local governments have given to health.⁽⁶¹⁾ The government issued a major health policy document in late 1997, which assigned to all levels of government responsibility for ensuring access to appropriate health services at an affordable price. This may stimulate greater political interest in health services.

Other reasons for the decline in regulation, particularly in poor localities, include low technical capacity of many local governments and lack of funding for supervisory visits or courses for health workers. The health facilities responsible for supervising grassroots providers depend on revenue generation and have little incentive to allocate resources to regulatory activities.

Health departments of higher levels of government provide almost no funding for facilities belonging to lower levels of government and they have almost no influence on their performance. They also spend very little on supervisory visits. In spite of this, Zhang et al describe how the Provincial Maternal and Child

Health Department in Yunnan influences the performance of local health facilities by paying performance-related bonuses to township health centres.⁽⁶²⁾ The authors report that the facilities improved their performance in response to a combination of peer pressure and small financial incentives.

Urban and rural insurance schemes also influence service providers. The schemes for urban workers generally reimburse health facilities on a fee-for-service basis. Since the early 1980s, claims on them have consistently risen faster than inflation.⁽¹¹⁾ The newly created Ministry of Labour and Social Security is reorganising the system of urban health finance. It plans to establish unified insurance bodies in each city. These bodies will exert a substantial influence on provider behaviour in future by monitoring their performance and altering the payment mechanism.

Most rural residents pay for their own health care. However, around 10% of villages have health prepayment schemes.⁽⁶³⁾ Recent policy statements strongly urge other localities to create such schemes. Most reimburse individuals for a proportion of treatment costs. However some have tried to influence health worker performance by monitoring drug prescription behaviour, auditing hospital costs, negotiating alternative forms of contract with health facilities, and so forth.⁽⁶⁴⁾ The new government policy recognises the potential influence of these schemes on the pattern of health services provision.

3.3.2 Redrawing the boundary between legal and illegal practices.

The government has become increasingly concerned with the use of extra-legal strategies by health workers to augment their income. Its response has depended on whether it perceived the strategy as criminal or merely undesirable. The government treats red packages as unethical and unprofessional.⁽⁶⁵⁻⁶⁷⁾ Health Departments take them into account in evaluating hospital performance.⁽⁶⁸⁻⁷²⁾ For example, Hunan down-

grades hospitals where more than 1% of employees accept red packages. Health facilities award prizes for “honest medical service” and rewards of up to 20% to health workers who refuse a red package or give it to the authorities. They punish offenders with fines, loss of bonuses, termination of employment, postponement of promotion, demotion and/or loss of the right to prescribe drugs. A recent strategy has been to ask patients and doctors to sign an agreement not to pay or receive a red package^(73,74).

One could attribute the growth in red packages to distortions in the health care market. Health facilities cannot charge economic fees for inputs of time by health workers. They have compensated by selling drugs and charging for the use of sophisticated equipment. However, they have not been able to match levels of pay of profitable enterprises. Health workers have sought additional income from informal sources to meet their aspirations. The different systems of health finance have created different markets for health services. People with health insurance, mostly in urban areas, can easily afford a relatively modest red package. The majority of the population, who are uninsured, have difficulty meeting formal hospital charges and have little capacity to make additional payments. Red packages are partly a response to rigidities in the health care pricing system and the widening differences in levels of pay. They have, in turn, increased inequalities in access to services between residents in rich and poor localities and the insured and uninsured and magnified the attraction of health workers away from poor areas. Their existence highlights difficult policy issues regarding health worker pay.

Government views kickbacks as a form of bribery.^(38,75,76) Several ministries are coordinating efforts to stop them.^(47,77) The MoH and Provincial Health Departments have carried out campaigns against kickbacks.⁽⁷⁸⁾ The punishments include fines and prosecution under the “Law Against Unfair Competition”. People found

guilty can be imprisoned for between 5 and 9 years.^(44,79) Zu documents 3363 cases of kickbacks, that went to court between October 1995 and October 1997.⁽⁴⁶⁾

3.3.3 The importance of non-economic influences. The attempt to explain the behaviour of health workers in terms of economic incentives ignores the influence of internalised moral, political and professional values. This may explain why many village health workers participate in preventive programmes and see poor patients in spite of the lack of financial incentives. It also explains why health facilities in Yunnan respond positively to small performance-related bonuses. It is hard to predict how long attitudes developed in command economy will persist as marketisation continues.

The influence of political cadres over health providers has weakened. This is partly because the former are more interested in economic development than health. It has been many years since the population has been mobilised for public health campaigns. This has reduced the pressure on health workers to take the interests of users into account. The government acknowledges the need to shift the balance in favour of the community. It hopes to achieve this through a combination of better regulation by government health departments and strengthening the capacity of civil society to influence provider performance.

The government is formulating a new law to establish criteria for registration as a professional.⁽⁸⁾ It is not clear how the regulatory bodies will monitor health worker performance and it is too early to assess the degree to which they will promote some form of professional ethic. The government is also beginning to establish elected village councils. It advocates “democratic supervision” of local health services. Most localities have not yet established mechanisms to improve accountability of health service providers.

4. The Changing Social Contract with Health Workers

China, in contrast to many other ex-command economies, has preserved an effective health sector during a time of great change. This is due, to a great extent, to its management of transition. China has not attempted a blueprint approach to reform. Most changes have taken place as a result of local initiatives, which other localities have emulated. The government has shifted policy to take into account the altered reality. This approach has enabled government to maintain relative stability during a period of rapid change. However, it has given a great deal of influence to local negotiations. Government has tolerated major distortions in the regulatory framework while waiting for new strategies to emerge.

The gradual approach to change is illustrated by the shift from administered prices to a market economy and from a managed labour system to a labour market. The government has had to balance the need to prevent excessively large geographic differences in health worker pay against the need to keep levels of pay in health comparable to other sectors. It has encouraged local governments, health facilities and health workers to find their own strategies for securing health worker incomes. Informal payments are one end of a continuum of adaptive activities. The government has responded to these adaptations, in turn, by modifying the regulatory framework (changing fee structures and so forth). It has also begun to define the boundary between legal and illegal activities.

The national government established a regulatory framework aimed at keeping the cost of basic services low. This arrangement was stable for over 15 years, but it created strains which have been expressed in movements of personnel to urban facilities, the shift in the balance of activities in favour of those which generate revenue and the increase in extra-legal payments. By the late 1990s, it was apparent that major institutional reforms would be necessary.

As long as there are substantial regional economic differences, the government will be unable to establish a unitary pay scale for health workers unless it makes large fiscal transfers to poor localities to maintain salaries at levels appropriate to richer areas. There are strong arguments for increasing subsidies to health services in poor areas, but there are also dangers in paying artificially high salaries to health workers. Governments have to address a number of difficult questions in formulating strategies for managing the emerging market for health workers:

- Can the objectives of providing access to health services for all social groups be reconciled with the need to pay competitive salaries to health workers?
- How should health worker pay be established? To whom should different categories of health workers be compared? Should health worker income vary between rich and poor localities? To what extent should the government intervene to reduce inter-regional inequalities in pay by controlling earnings in rich areas or subsidising health workers in poor localities?
- How can the willingness of richer social groups to pay more for health services be reconciled with the objective of ensuring access to skilled health workers for all? Can health workers earn additional income from fees without creating unacceptable inequalities? Should “private” patients be asked to pay the full cost of fees, rather than modest red packages?
- What are the relative roles of government, professional bodies and communities in supervising health worker performance?
- How can health workers be encouraged to maintain ethical standards during the transition to a market economy?

Government may be able to reduce the prevalence of informal payments by price reforms and more active enforcement of the law. However, as long as it tries to ensure equitable access to health services, it needs to find a way to balance the desire of health workers to earn incomes comparable to those in other sectors against the needs of poor patients.

The existence of informal payments is a sign of the increasing gap between the view of the health sector as a fully funded government service and reality. It also reflects a strain in the present contract between government and health workers. It is one aspect of a more general crisis in the performance of government services in many countries.⁽⁸⁰⁾ Nunberg and Lindauer put forward a number of reasons for this phenomenon including low levels of public sector pay, inadequate promotion structures, poor working conditions and the loss of the self-perception of civil servants as a socially responsible elite.⁽⁸¹⁾ The extent of informal payments provides a measure of the gap between the formal rules of the public sector and the emergence, in many countries, of an informal market for public services.⁽⁸²⁾

Governments have been unwilling or unable to either finance a health service, which meets the expectations of the richer members of society, or pay salaries, which meet the expectations of health workers with the most marketable skills. This has created a niche for legal and/or illegal markets for health services. In some cases health workers supplement basic government salaries with income earned (legally or illegally) from other sources. In other cases they leave public employment. The balance varies between countries.

Governments have to revisit basic questions about how they should make the best use of their limited financial and regulatory powers to influence health service providers. This may lead to a redrawing of the boundaries between public and private sectors and a re-negotiation of the social contract with health workers. The

relationship between health workers, governments, and civil society organisations are likely to change considerably in China and other low and middle income countries during the next few years.

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