Giving birth at a health-care facility in rural China: is it affordable for the poor?
Qian Long, a Yaoguang Zhang, a Joanna Raven, d Zhuochun Wu, d Lennart Bogg, e Shenglan Tang e & Elina Hemminki e

Objective To investigate changes in the expenditure of giving birth in health-care facilities in rural China during 1998–2007, to examine the financial burden on households, particularly poor ones, and to identify factors associated with out-of-pocket expenditure.

Methods Cross-sectional data on births between 1998 and 2007 were obtained from national household surveys conducted in 2003 and 2008. Descriptive statistics and log-linear models were used to identify factors associated with out-of-pocket expenditure on delivery.

Findings During 1998–2007, the proportion of facility-based deliveries increased from 55% to 90%. In 2007, 60% of births occurred at county-level or higher-level facilities. The Caesarean delivery rate increased from 6% to 26%. Total expenditure on a facility-based delivery increased by 152%, with a marked rise from 2002 onwards with the introduction of the New Cooperative Medical Scheme. In 2007, out-of-pocket expenditure on a facility-based delivery equalled 13% of the mean annual household income for low-income households. This proportion had decreased from 18% in 2002 and differences between income groups had narrowed. Regression models showed that Caesarean delivery and delivery at a higher-level facility were associated with higher expenditure in 2007. The New Cooperative Medical Scheme was associated with lower out-of-pocket expenditure on Caesarean delivery but not on vaginal delivery.

Conclusion Expenditure on facility-based delivery greatly increased in rural China over 1998–2007 because of greater use of higher-level facilities, more Caesarean deliveries and the introduction of the New Cooperative Medical Scheme. The financial burden on the rural poor remained high.

Introduction
In China, the number of women giving birth at a health-care facility is used as a target indicator for measuring progress towards improved maternal health. a The proportion of deliveries attended in health-care facilities varies across geographical areas and according to family wealth: in 2003, about 94% of urban women in China gave birth at a health-care facility. This is 1.4 times the proportion in an average rural area and 3 times that in poor rural areas. b In addition, giving birth at a health-care facility was four times more common among the richest 20% of women than among the poorest 20% (Z Wu, unpublished data, personal archive, 2010).

A limited ability to pay and high hospital costs have been identified as the major barriers for the rural poor wishing to access health care in China. a Following the demise of the rural Cooperative Medical Scheme in the 1980s, which occurred with the marketization of the rural economy, large sections of the rural population were left without health insurance cover. c In addition, China’s health-care system was decentralized in the 1980s and the central budget dropped to 10% of total expenditure. d, e Health-care facilities now rely on user fees to cover their running costs and the result has been a rapid increase in medical costs. d

Data from the Chinese Ministry of Health show that fee-for-service income accounted for 82% of the total revenue of maternal health-care institutions in rural China in 2002. f Delivery is the most costly part of maternal care, and expenditure can be especially high for emergency obstetric care. g Unexpectedly high expenditure on a delivery can push a family into poverty.

In 2003, a new rural health insurance programme, the New Cooperative Medical Scheme, was introduced with the aim of reducing the risk that health-care costs could become catastrophic for some individuals. The scheme operates on a voluntary basis and uses funds pooled from central and local government and from individual contributions. h The county (typical population: 0.5–1 million) forms the administrative unit of the scheme and the risks associated with illness are shared across the unit. The county government can decide the content, coverage and reimbursement model most appropriate for local conditions, although the Chinese Ministry of Health is responsible for developing overall strategies and policies. In 2008, 92% of the rural population were enrolled in the New Cooperative Medical Scheme. i

The New Cooperative Medical Scheme includes a maternal care benefit package that differs in design and implementation across counties. Usually this package provides reimbursement for delivery at a health-care facility, either as a fixed proportion of expenditure or as a fixed payment. Reimbursement may be the same or different for vaginal and Caesarean delivery.

The aims of this study were to investigate changes in expenditure on facility-based delivery in rural China between 1998 and 2007, to examine the financial burden on households, in particular on poor households, and to identify factors associated with out-of-pocket expenditure on facility-based delivery.

#Abstracts in العربية, 中文, Français, Русский and Español at the end of each article. #

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(Submitted: 6 May 2010 – Revised version received: 22 October 2010 – Accepted: 2 November 2010 – Published online: 2 December 2010)
Methods
The study was based on cross-sectional data from national household health service surveys conducted in 2003 and 2008 by the Centre for Health Statistics and Information of the Chinese Ministry of Health. For our analysis, only the rural component of the data set was used. Both surveys employed the same four-stage, stratified, random sampling procedure involving counties, townships, villages and households. Ten indicators of socioeconomic development were used to classify each county’s level of development as being in one of four categories: developed, relatively developed, less developed or poor. The probability proportional sampling method was used to randomly select counties for each development category; then, five townships were selected from each county and two villages from each township. Finally, 60 households were selected from each village. In total, 40,212 rural households were surveyed in 2003 and 39,654 were surveyed in 2008.

Data collection
The health service surveys involved trained township health-care workers carrying out interviews in the selected rural households using structured questionnaires. Each family member answered the questions individually. If one family member was not at home at the time of the survey, another answered the questions on his or her behalf. The questionnaires used in the two surveys had a similar structure and involved similar questions. The 2008 survey included questions about participation in the New Cooperative Medical Scheme and any reimbursement received.

To help identify changes in the women’s demographic and socioeconomic characteristics, the time period 1998–2007 was divided into four parts: 1998–1999, 2000–2002, 2003–2005 and 2006–2007. The χ² test was used to check for significant differences. The mean values of expenditure on all deliveries and, separately, on vaginal and Caesarean deliveries were compared between the two survey periods using the t-test. Out-of-pocket expenditure on delivery was defined as the birth attended at a health-care facility at a township or higher level. Births outside health-care facilities included delivery at home, in a village clinic or on the way to a health-care facility. Out-of-pocket expenditure on facility-based delivery was calculated as the total expenditure on the delivery minus any reimbursement reported by the women. Out-of-pocket expenditure was used as the main indicator for evaluating the financial burden on households.

The study also investigated the relationship between out-of-pocket expenditure and the following factors: maternal age; maternal educational level (i.e. illiterate, primary school, secondary school, high school or higher); health insurance cover; income category; parity, defined as the number of live births borne by a woman; and the location of the health-care facility (i.e. at a township, county or higher level). In China, education at secondary schools generally involves in the household and using the figure obtained to allocate the household to one of three categories: low-, medium- or high-income. Each category contained one-third of all households.

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Results
The number of women who gave birth in the time periods covered by the two surveys and their demographic and socioeconomic characteristics are listed in Table 1. The age and parity distributions were relatively similar in the four time periods considered. On average, the women’s educational level increased over time (P < 0.01). In addition, a substantial increase in the proportion of women with health insurance was observed in the time period 2003–2005. The great majority of those with insurance (i.e. 98%) had enrolled in the New Cooperative Medical Scheme.

Data analysis
The study examined total expenditure on delivery (i.e. reported medical expenditure) within or outside a health-care facility and according to the mode of delivery (i.e. vaginal or Caesarean). In the

Caesarean delivery than those with a low income (Fig. 1).

Expenditure on delivery

Expenditure on delivery outside a healthcare facility increased by 415% over the study period, from US$ 13 in 1998 to US$ 67 in 2007. In each year, facility-based delivery was more expensive than delivery outside a healthcare facility and, among facility-based deliveries, a Caesarean delivery was much more expensive than a vaginal delivery (Fig. 2). In 2007, expenditure on a Caesarean delivery was 3.5 times the expenditure on a vaginal delivery. Total expenditure on a facility-based delivery increased by 152% over the study period, from US$ 102 in 1998 to US$ 258 in 2007. Expenditure on a vaginal delivery increased by 226%, from US$ 45 to US$ 146, and on a Caesarean delivery, by 58%, from US$ 326 to US$ 515. For both vaginal and Caesarean deliveries, the greatest increase was seen from 2002 onwards (P < 0.01).

Since reimbursement data were not available for 2002 and since only around 11% of women had health insurance before 2003 (Table 1), we regarded out-of-pocket expenditure as being equal to total expenditure on delivery in 2002. Between 2002 and 2007, annual household income approximately doubled in all income groups. In these two years, both total and out-of-pocket expenditure on facility-based delivery were higher for medium- and high-income groups than for the low-income group. The increase in total expenditure on facility-based delivery between 2002 and 2007 was around 100% in medium- and high-income groups and 84% in the low-income group. Out-of-pocket expenditure on delivery also increased, but less substantially; the smallest increase was in the low-income group (Table 2). In 2007, out-of-pocket expenditure on delivery consumed 13.1% of annual household income in the low-income group, compared with 9.0% and 5.6% in medium- and high-income groups, respectively. Out-of-pocket expenditure as a percentage of annual household income had declined since 2002 on average, and differences between the income groups had become smaller.

For vaginal deliveries alone, the greatest increases in total and out-of-pocket expenditure between 2002 and 2007 were observed in the low-income group: 184% and 115%, respectively. However, in both these years, women in medium- and high-income groups spent more than women in the low-income group. Out-of-pocket expenditure on vaginal delivery as a percentage of annual household income did not change greatly in any income group. The highest

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**Table 1. Demographic and socioeconomic characteristics of women giving birth in rural China, 1998–2007**

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<tr>
<td></td>
<td>No. (%)</td>
<td>No. (%)</td>
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<td>No. (%)</td>
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<tr>
<td><strong>Age in years</strong>a</td>
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<td></td>
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<tr>
<td>15–24</td>
<td>969 (40.0)</td>
<td>1601 (42.4)</td>
<td>1169 (39.4)</td>
<td>1211 (45.1)</td>
</tr>
<tr>
<td>25–29</td>
<td>929 (38.3)</td>
<td>1295 (34.3)</td>
<td>914 (30.8)</td>
<td>705 (26.2)</td>
</tr>
<tr>
<td>30–49</td>
<td>525 (21.7)</td>
<td>881 (23.3)</td>
<td>822 (29.7)</td>
<td>772 (28.7)</td>
</tr>
<tr>
<td><strong>Educational level</strong>b</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Illiterate or primary school</td>
<td>1222 (50.4)</td>
<td>1640 (43.4)</td>
<td>1078 (36.3)</td>
<td>845 (31.4)</td>
</tr>
<tr>
<td>Secondary school</td>
<td>1058 (43.7)</td>
<td>1848 (48.9)</td>
<td>1613 (54.3)</td>
<td>1591 (59.2)</td>
</tr>
<tr>
<td>High school or higher</td>
<td>143 (5.9)</td>
<td>288 (7.6)</td>
<td>280 (9.4)</td>
<td>251 (9.3)</td>
</tr>
<tr>
<td><strong>With health insurance</strong>c</td>
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<tr>
<td>1</td>
<td>278 (11.5)</td>
<td>423 (11.2)</td>
<td>2764 (93.0)</td>
<td>2465 (91.7)</td>
</tr>
<tr>
<td>≥ 2</td>
<td>1186 (48.9)</td>
<td>1711 (45.3)</td>
<td>1505 (50.8)</td>
<td>1268 (47.4)</td>
</tr>
<tr>
<td><strong>Parity</strong>d</td>
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<tr>
<td>1</td>
<td>1237 (51.1)</td>
<td>2067 (54.7)</td>
<td>1458 (49.2)</td>
<td>1408 (52.6)</td>
</tr>
<tr>
<td>≥ 2</td>
<td>1186 (48.9)</td>
<td>1711 (45.3)</td>
<td>1505 (50.8)</td>
<td>1268 (47.4)</td>
</tr>
</tbody>
</table>

c Data were missing for seven women in 1998–1999 and nine in 2000–2002.
Affordability of facility-based delivery in China

We found that the proportion of women who gave birth at a health-care facility in rural China increased greatly in the period 1998–2007. Moreover, in 2007 the majority of births occurred at a county- or higher-level health-care facility. There was also a notable increase in the proportion of Caesarean deliveries in rural areas. Total expenditure on a facility-based delivery (both vaginal and Caesarean) increased markedly, particularly between 2002 and 2007, after the New Cooperative Medical Scheme was introduced. Out-of-pocket expenditure also increased, but less substantially. Having health insurance was associated with reduced out-of-pocket expenditure on a facility-based delivery, particularly on a Caesarean delivery. Out-of-pocket expenditure on a facility-based delivery as a percentage of annual household income decreased over the study period. However, the percentage remained high in the low-income group, even in 2007.

Factors affecting out-of-pocket expenditure

Factors affecting out-of-pocket expenditure on facility-based delivery in 2007 were investigated by linear regression analysis using the logarithmic value of expenditure. After adjusting for all variables simultaneously, we found that expenditure on delivery was significantly higher in women aged over 30 years, in those with a high school or higher education, in those with a medium or high household income and in those with a parity of one. In addition, expenditure on a Caesarean delivery was significantly higher than on a vaginal delivery and expenditure on delivery at a county- or higher-level health-care facility was significantly higher than at a township facility. Health insurance cover was associated with significantly lower out-of-pocket expenditure on facility-based delivery. The coefficients derived by the linear regression model are shown in Table 3.

The analysis was repeated for out-of-pocket expenditure on vaginal and Caesarean deliveries separately. Health insurance cover was not associated with lower out-of-pocket expenditure for vaginal delivery, but it was for Caesarean delivery (Table 3). The effects of age, household income, parity and the location of the health-care facility were similar to those found in the analysis of out-of-pocket expenditure on all deliveries.

Discussion

We found that the proportion of women who gave birth at a health-care facility in rural China increased greatly in the period 1998–2007. Moreover, in 2007 the majority of births occurred at a county- or higher-level health-care facility. There was also a notable increase in the proportion of Caesarean deliveries in rural areas. Total expenditure on a facility-based delivery (both vaginal and Caesarean) increased markedly, particularly between 2002 and 2007, after the New Cooperative Medical Scheme was introduced. Out-of-pocket expenditure also increased, but less substantially. Having health insurance was associated with reduced out-of-pocket expenditure on a facility-based delivery, particularly on a Caesarean delivery. Out-of-pocket expenditure on a facility-based delivery as a percentage of annual household income decreased over the study period. However, the percentage remained high in the low-income group, even in 2007.

Study limitations

The data collected in the two national household health service surveys has previously been shown to be of satisfactory quality in terms of the representativeness of the sample and reliability.16 Nevertheless, there are several limitations. First, interviewees had to recall information over a period of 1 to 5 years. However, most analyses were performed using data for the year immediately before the surveys (i.e. for 2002 and 2007), so that serious recall bias is unlikely. Moreover, any inaccuracies would probably be similar in the two time periods and should not have influenced the trend in expenditure reported in this paper. Second, out-of-pocket expenditure on delivery in 2002 may have been slightly overestimated because, although a small proportion of women had health insurance that year, expenditure was assumed to be equal to total expenditure on delivery owing to the unavailability of reimbursement data. In addition, since the level of reimbursement for a delivery under the New Cooperative Medical Scheme varied across counties and since data on these variations were not available, the study findings should be viewed as preliminary.

Location and type of delivery

The increase in expenditure on facility-based delivery was associated with an increase in the use of higher-level health-care facilities. This suggests that women were highly aware of and accepted the need for a safe delivery. Higher-level health-care facilities, such as those at county and city hospitals, are often regarded by the general population as providing good care, as a result of which they are often overloaded with patients.13 Conversely, township hospitals, particularly in poor areas, are often poorly equipped, have fewer qualified staff and have poor sanitary conditions and hygiene. Understandably, women may find them unattractive as a place of delivery. However, overuse of high-level health-care facilities has been found to affect the efficiency of service provision without increasing patient satisfaction or improving health.13 Moreover, the longer distance to

Fig. 2. Expenditure on delivery at or outside of a health-care facility in rural China, by type of delivery.2 1998–2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenditure on delivery (US$)</th>
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<tbody>
<tr>
<td>1998</td>
<td>Delivery outside a health-care facility</td>
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<td>2005</td>
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<tr>
<td>2006</td>
<td>Delivery outside a health-care facility</td>
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<tr>
<td>2007</td>
<td>Delivery outside a health-care facility</td>
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</tbody>
</table>

US$, United States dollar.

1 Expenditure was adjusted for inflation.

2 All deliveries outside a health-care facility were vaginal deliveries.
Expenditure on delivery

We found a marked increase in total expenditure on facility-based delivery and a relatively smaller increase in out-of-pocket expenditure around the period when the New Cooperative Medical Scheme was launched. Health insurance has been advocated as one way of moving closer to universal access to health care, as urged by the 58th World Health Assembly. In addition, the Chinese government is committed to increasing funding for the New Cooperative Medical Scheme. However, the health-care system has remained heavily dependent on user fees. The coexistence of fee-for-service financing and the government-run voluntary insurance programme may have contributed to the increased cost of delivery and higher expenditure for women. However, causality cannot be concluded from this study. Similar results have been reported in studies of community-based health insurance in other low-income countries, which suggests that such schemes can lead to higher revenues from fee-for-service care.

In addition, we found that the possession of health insurance, mainly New Cooperative Medical Scheme coverage,
was associated with lower out-of-pocket expenditure on Caesarean delivery but not on vaginal delivery. Generally the scheme provides a fixed payment for vaginal delivery. Consequently, while expenditure on vaginal delivery has increased dramatically, the level of reimbursement has remained low, resulting in high costs for women. On the other hand, the scheme views Caesarean delivery as necessitating hospitalization and reimbursements accordingly; the reimbursement may cover 40–50% of expenditure. In this way the New Cooperative Medical Scheme has helped reduce out-of-pocket expenditure on Caesarean delivery. However, as long as fee-for-service payment to health care providers continues, the scheme may not mitigate charges for women but may instead contribute to an increase in the income of health-care providers by encouraging Caesarean delivery, even in cases where there is no medical indication.14

Out-of-pocket expenditure on facility-based delivery as a percentage of annual household income decreased during the study period, mainly because rural household incomes increased. However, in 2007, expenditure on facility-based delivery equalled 13% of the mean annual income of low-income households. This is a heavy financial burden on families, as it is above the 10% of annual household income that serves as the threshold for catastrophic health-care spending.18

The burden was even higher for women from low-income households who had a Caesarean delivery, since one-third of the mean annual household income had to be spent on the delivery. Families are at great risk of health-care induced poverty19 and delivery care for the poorest households has become less affordable. In addition, many of the costs of prenatal and postnatal care are not usually covered by health insurance schemes. For example, for families who live some distance from a health-care facility, the costs of transportation, accommodation and food, and the cost in time for the women as well as for their accompanying family members, can be considerable.20

Conclusion

With the aim of enabling convenient access and improving cost-effectiveness,17 we recommend investing in and expanding the capacity of health-care facilities at the township level in rural China. The creators of financial mechanisms for funding health-care facilities and health-care providers should avoid introducing perverse financial incentives. The New Cooperative Medical Scheme should focus on women’s needs and should not encourage health-care providers to promote services that are not medically necessary.

In conclusion, the rise in the proportion of births taking place at higher-level health-care facilities, the increase in Caesarean deliveries and the introduction of the New Cooperative Medical Scheme have all contributed to a rise in expenditure on facility-based delivery. Although recent increases in rural household income have mitigated the financial burden of facility-based delivery for families in general, the burden remains high for the poor. ■

Funding: This study forms part of the CHIMACA project (015396), which is funded by the European Commission INCO Programme and co-ordinated by the National Institute for Health and Welfare, Helsinki. The Centre for Health Statistics and Information of the Chinese Ministry of Health funded data collection and management. Qian Long thanks the China Scholarship Council for supporting her study abroad.

Competing interests: None declared.
Malnutrition in rural China during the new millennium: Where is the hidden cost of poverty?

The issue of malnutrition in rural areas in China during the new millennium is examined. In 2002, the situation was assessed, with 15.4 million people identified as suffering from malnutrition. In 2007, this number had increased to 17.3 million. The proportion of people suffering from malnutrition increased from 12.5% in 2002 to 15.2% in 2007.

Methods

Data from the China Household Income and Expenditure Survey (CHIES) were used to analyze the changes in the prevalence of malnutrition in rural China. The survey collected information on household income, expenditure, and nutritional status. The sample included households from 28 provinces across China.

Results

The prevalence of malnutrition increased from 2002 to 2007, with the largest increase occurring in children aged 6-14 years. The proportion of children suffering from malnutrition increased from 19.1% in 2002 to 25.0% in 2007. The increase was most pronounced in rural areas, where the prevalence of malnutrition increased from 17.6% to 22.5%.

Conclusion

The increase in the prevalence of malnutrition in rural China is alarming. Effective interventions are needed to address this issue, with a focus on early childhood. Policy-makers should consider implementing strategies to improve nutrition education and access to nutritious foods in rural areas.

Résumé

Donner naissance dans un établissement médical en Chine rurale: les pauvres peuvent-ils le se permettre?

Objectif


Méthodes


Résultats


Conclusion

Affordability of facility-based delivery in China

Resumen

Dar a luz en un centro sanitario de una zona rural de China: ¿resulta asequible para los más pobres?

Objetivo

Investigar los cambios que ha experimentado el gasto económico que supone para las familias, especialmente para las más desfavorecidas, asociadas a los desembolsos efectuados.

Métodos

Se obtuvieron los datos de una muestra aleatoria y representativa de los nacimientos que tuvieron lugar en 2002 y 2007 a través de las encuestas llevadas a cabo en hogares entre 2003 y 2008. Se emplearon métodos estadísticos descriptivos y modelos logarítmicos lineales para identificar los factores asociados con los desembolsos efectuados.

Resultados

Durante el periodo comprendido entre 1998 y 2007, la proporción de partos en centros sanitarios aumentó de un 55% a un 90%. En 2007, el 60% de los nacimientos tuvieron lugar en centros sanitarios del condado o de un ámbito territorial más elevado. El porcentaje de partos por cesárea aumentó de un 6% a un 26%. El gasto total en partos asistidos en centros sanitarios aumentó en un 152%, especialmente entre 2002 y 2007. El Nuevo Sistema de Asistencia Médica Cooperativa de China costó el 5% del coste del seguro de salud, que superó el 12% del ingreso medio de un hogar de bajos ingresos en 2007. El Nuevo Sistema de Asistencia Médica Cooperativa asoció a un mayor gasto en los partos asistidos en centros sanitarios. Los modelos de regresión mostraron que el gasto por cesárea y por partos en centros sanitarios de un nivel superior estuvieron asociados a un mayor gasto en 2007. El Nuevo Sistema de Asistencia Médica Cooperativa asoció a un menor desembolso efectuado en los partos por cesárea; sin embargo, no en los partos vaginales.

Conclusión

El gasto en partos asistidos en centros sanitarios en China aumentó significativamente en 1998 y 2007 debido a un mayor uso de las instalaciones de un nivel más elevado, a un mayor número de partos por cesárea, y a la introducción del Nuevo Sistema de Asistencia Médica Cooperativa. La carga económica para las familias más desfavorecidas del entorno rural siguió siendo elevada.

References

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Affordability of facility-based delivery in China


