The conventional health care system in China is divided into a labor health care system targeting corporate workers from 1951, a public medical expense medical system covering civil servants from 1952, and a rural cooperative medical system in rural areas since 1952 It has been constructed as a center. However, in the latter half of the 1970s, when the People's Congregation was dismantled by the reform and open-door policy, the rural village contracting system was implemented, the collective farming work was put an end, and farmland management was left to individual farmers It was. As a result, China's rural cooperative medical system (old system) almost disintegrated, rural residents were excluded from the national health insurance system and became a serious social problem (Sha, 2005). Currently, in China, "nursing difficulty, nursing precious" (difficult to receive medical examination, medical expenses for examination is high) is becoming a social problem (Miura, 2009). In particular, disparity in income and medical security in urban and rural areas will not only make deterioration of unfairness and inequality in medical demand even worse (Luo, 2011) but also if medical costs increase but self-burden increases , Access to the medical services of the poor is restricted, medical inequality, and therefore health disparity will further expand (Miura, 2009). When Severe Acute Respiratory Syndrome (SARS) prevailed worldwide in 2003, rural people who accounted for 80% of the total population excluded from the public health system are extremely serious public He was exposed to sanitary risks. With the global outbreak of SARS in 2003, the Chinese government actively promoted the entry of rural residents into the new rural medical cooperation system. Introduction of the new rural cooperative medical system started in 2003 and social experiments were conducted in various regions since 2004, and it was spread and introduced in most rural areas throughout the country from 2006 to 2009. Many impact evaluations have been conducted on the medical system in urban areas of China, but most of the prior research focusing on rural areas has been limited to qualitative analysis. Regarding the new rural cooperative medical care system, Wang Yu (2009) reported that its main achievements were (1) the burden of medical expenses for farmers was reduced, (2) the medical resources were induced in rural areas, 2 points . Wang Feng Li (2008), on the other hand, because the benefits are small, the patient's own burden is still heavy, especially because a seriously ill patient must receive treatment at a department hospital or a city hospital, the self-burden reaches several times the annual income He points out that there are many cases. It also states that such phenomena are not only specific areas but also nationwide general phenomena. In addition, Wang Feng Li (2010) pointed out that Wang Yu (2009) that the burden of medical expenses for farmers was reduced, the farmers have various constraints such as high benefit start line, low benefit ratio, , The new medical system claims that it is hard to prevent falling into poverty or falling into poverty again due to illness or its treatment. Also, in view of the conclusion that medical resources were induced in rural areas, looking at the benefit status of the new rural cooperative medical system, small benefits are concentrated in the village clinic / hygiene room and Township and guardian clinic The high payment is concentrated in the hospital over the prefecture, the lag behind the village clinic / township guardians lives is that patients who need severe patients, precise examination and surgery are not familiar medical institutions , It is pointed out that there is a current situation that it is forced to receive treatment at hospitals over the prefecture. Based on the above background and problem awareness, in this research, we will compile aggregate data for each city in Henan Province (18 cities) and Anhui Province (17 cities) over 14 years from 1997 to 2010 (Urban versus rural: observation = 70 / year), the penetration of the new rural health care system in 2006 based on a specific financial subsidy policy is regarded as "natural experiment", which is a medical resource in rural areas And the effect on the burden of medical expenses per capita, we try quantitative evaluation by applying "difference difference" estimation (difference-in-difference) method. Based on the results of the analysis based on the "differential difference" in this study, the effect of introducing the specific financial aid policy in 2006 is the ratio of

the number of hospitals per 100,000, the number of doctors, medical health expenditure per capita, medical health expenditure in consumption expenditure / income , We obtained statistically significant negative results. In other words, since the introduction of the Specific Funding Assistance Policy in 2006, the number of hospitals and the number of doctors per 100,000 population in Henan Province / Anhui Province are rather decreasing, Wang Yi (2009) that medical resources were induced to rural areas It was a contradiction to the conclusion of. On the other hand, because the per capita medical expenses, the proportion of medical expenditure on consumption expenditure and income has decreased, the economic burden of individuals in rural areas has been relatively reduced compared to urban areas 崢, 2009) was quantitatively shown. Furthermore, compared to Henan Province, the policy effect of the number of hospital beds per 100,000 people and the number of physicians in Anhui Province was the result of the smaller decrease after policy introduction in 2006. The conclusion that this research that the burden of medical expenses of rural residents was reduced is the introduction of a new rural cooperative medical system in Henan Province and Anhui province and an empirical basis to justify the specific fiscal support policy in 2006 Respectively. However, it is suggested that government policy is still insufficient for guiding medical resources to rural areas. Going forward, the government will need to further tackle policies on the aspects such as introduction of medical institutions to rural facilities and welfare of medical staff.