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RECENT TRENDS IN HEALTH SECTOR REFORMS AND COMMERCIALISATION OF PUBLIC HOSPITALS IN CHINA

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Madhurima Nundy and Rama Baru

Abstract

This paper describes the commercialisation of public hospitals in China since the introduction of market reforms of the 1980s. It argues that the content of these reforms are similar to those seen in the developed and developing countries during the same period. It proceeds to examine the consequences of these reforms for the health service system and its comprehensiveness.

Introduction

Several scholars have commented on the content and process of reform as encompassing both developed and developing countries and acknowledge that it is a global process informed by the principles of new public management (NPM).[1] These principles include the introduction of "*managed competition/public competition or internal markets as means to implement the reforms*" (Tritter et al, 2010; p.33). Harding and Preker (2000) see three phases of public sector reforms. These are government divestiture of commercial activities which is the first wave of reforms; government applies these reforms to their public utility services in what is the 'second wave' of reforms and marketising reform modalities from other sectors to social sectors like health, education and pension is the third wave.

Tritter et al (2010) have elaborated the process and transformation of health sector reforms into three phases. The first phase focused on introduction of commercial principles in the public sector in order to reduce costs and improve efficiency. There was also emphasis on the separation of preventive and curative services. While the role of the state would be more prominent in the case of the former, markets would have an upper hand in the case of the latter. This phase was reforming the supply side of public provisioning. The second phase focussed on the private sector as a revenue earner for the economy and hence saw its productive role.

[1] Larbi (1999) observes that "NPM reforms shift the emphasis from traditional public administration to public management. Key elements include various forms of decentralizing management within public services (e.g., the creation of autonomous agencies and devolution of budgets and financial control), increasing use of markets and competition in the provision of public services (e.g., contracting out and other market-type mechanisms), and increasing emphasis on performance, outputs and customer orientation" (p. 4).

In most European countries the content of reforms is characterised by the first two phases. However, in several middle income countries[2], we would argue that there is a discernible third phase. During this phase of reforms there is a continuation of the commercialisation of public institutions[3] and simultaneously there is an expansion of the 'for-profit' sector. In this phase there is a concerted move to attract global finance in health services. These include hospitals, bio-technology, insurance, pharmaceutical and equipment industries thus giving rise to what Relman termed as the medical industrial complex (Relman: 1980).

This paper is examining the first two phases of reform in China by drawing on available studies and government reports. It analyses in some detail the process and content of these reforms and its implication for the health service system and public health. This paper is divided into three sections. The first section provides an overview of the levels of care and the referral linkages that existed during the pre-reform period. The second section addresses the process and content of reform in public hospitals during the reform period and the third analyses the implications of these reforms for the health service system and public health.

The health service system in pre-reform China

Soon after the revolution the focus of the communist party was on preventive care and for this purpose they set up epidemic stations to monitor and control communicable diseases. Institutional growth at the secondary and tertiary level was started in the 1960s. Existing public hospitals were strengthened and new ones were built. There was a referral linkage between the rural and urban areas. The cooperative medical scheme was integrated with the collectives and comprehensive structure was created at different levels.

The expansion of health services was only marginal between 1949 and 1957. The growth of hospitals was largely an urban phenomenon. The period between 1957 and 1965 registered a phenomenal increase. Around a third of the services were owned by the state and the remaining was collectively owned. Table 1 shows that until the late 1950s the emphasis was on building primary level services. There was a huge spurt in the growth of hospitals and health centres between the late 1950s and mid '60s.

As Liu observes: "*Before the economic system was reformed, the rural three-tier system (village health station, township health centre, and county hospital) was an integrated system with a formal bottom-up referral process for patients. Regular technical supervision was provided to the*

[2] This has been studied in the case of India, Brazil and China.

[3] Examples of this includes public-private partnerships; selling of public assets and NGOs managing public facilities.

lower-level health facilities by the upper-level facilities" (Liu: 2004, p. 536; World Bank: 2010). Thus, from the mid-1960s to 70s the health services were funded by the government with a well worked out three tiered network of primary, secondary and tertiary services that integrated preventive, curative and rehabilitative services. This model of a health service system influenced the primary health care approach at the global level during the latter half of the 1970s. However, with the de-collectivisation process during the 1980s this well worked out system collapsed leading to a crisis in China's public health services. The collapse of the primary level of care in rural areas meant that the referral system had been dismantled which had serious consequences for comprehensive health services.

Table 1- Number of health institutions and beds in China, 1949-65

	1949	**1957**	**1965**
Institutions			
Hospitals and health centres	2,600	4,179	42,711
Rehabilitating station	30	835	887
Outpatient department	769	1,02,262	1,70,430
Special treatment centre	11	626	822
Anti-epidemic station	-	1,626	2,912
MCH hospital	-	96	115
MCH centre	9	4,599	2,795
Drug test centre	1	28	131
Medical research facility	3	38	94
Others	247	8,665	3,782
Total	3,670	1,22,954	24,266
Beds			
Hospitals	80,000	29,47,337	65,558
Rehabilitating centre	3,900	68,860	93,388
Others	725	98,209	1,69,359

Total	84,625	4,61,802	10,33,305

(All hospitals in 1949 and 1957 were located at county or upper levels. 'Others' indicates health facilities below county level, mostly in district hospitals and township health centres.)
Source: Acharya, Baru and Nambissan, 2001

Public hospital reform

The commercialisation of Chinese health services coincided with the larger economic reform that was promoted by Deng Xiaoping for market socialism during the late 1970s. These reforms led to the dismantling of the co-operative medical services in rural areas and brought in structural changes in urban and rural health service provisioning. There was a fragmentation between hospitals and other institutions that were responsible for preventive and curative services. As Liu observes:

"*The problems associated with the commercialization of the health sector are most pronounced in China's rural areas…. In the two decades after reform, which were accompanied by the collapse of the rural Cooperative Medical System, China's rural health-care delivery system has become fragmented, with different health facilities competing for revenues from patients. Village health stations have largely been privatized. Although the national government has introduced a medical licensing system, whereby village medical practitioners have to be certified as "rural doctors"; these practitioners receive little supervision and professional training.*" (Liu: 2004; p. 536)

The focus of health sector reform during the late 1980s and '90s was on the secondary and tertiary hospitals. Several of these initiatives focused on introducing market principles in tertiary public medical institutions. The process of this reform led to the autonomisation of hospitals that was rationalised by the Bank. As the World Bank observes:

"In 1992, the Ministry of Health granted substantial financial autonomy to hospitals, allowing them to charge for their services and to sell drugs at a profit. They are now permitted to keep the surpluses that they generate, and they are responsible for their debts and operating losses. They can use their surpluses to invest in new facilities and services, or to finance salary enhancement systems. Prices for basic medical care are regulated. In general, medical services produce net losses, and drug revenues produce net gains. Hospitals have been given freedom to develop higher quality services for which they can charge prices above the levels reimbursed by social insurance. Public hospitals can also enter into joint ventures with the private sector. They are allowed to

raise "social capital" from medical staff and retirees, which can then be invested in private for-profit units within the public facilities."(World Bank: 2010; p. vii)

***Rationale and content of hospital reforms**:*

The rationale for these reforms was premised on the inability of the government to invest in health care. As the World Bank observes:

"*The main purpose of hospital reform has been to alleviate the government's financial burden. Reforms introduced market mechanisms and changed ownership to a State-owned enterprise (SOE) model…. Private capital was allowed to enter the health sector by encouraging retired medical staff to pool funds to launch medical institutions. Charging for services was permitted, thus moving medical prices toward actual market prices…. In 1989, State Council developed SOE reform by promoting various contracting systems for medical institutions. It also allowed public hospitals to earn profits from specialty medical services and to charge more for higher-quality services. This reform injected new funds for hospitals through the new means of funding."*(World Bank: 2010; p. 4)

As a result several market principles were introduced in order to make these hospitals financially self-sufficient. Newer organisational forms like the SOEs[4] were initiated in the health sector in order to augment financial revenues by introducing mechanisms like user fees, charging for drugs and diagnostics, contracting in, attracting private capital and opening tertiary care to markets. As a result, hospitals were now autonomous units within the health service system under the jurisdiction of local governments. They were individually responsible for their success or failure since the proportion of government funding started declining sharply in the 1990s. Government subsidies represented a mere 10 per cent of the total revenue of all public health facilities in the early 1990s (Yip and Hsiao, 2009).

The hospital reform process has broadly followed what Harding and Preker have postulated as the five organisational functions that create incentives shaping the ability of public hospitals and other healthcare providers to deliver on the government's policy objectives. Firstly, the authority or autonomy given to its managers; secondly, the market environment created by the provider payment mechanism and exposure to competition; thirdly, the extent to which the hospital keeps its surpluses and is responsible for its losses and debts; fourthly, accountability mechanisms; and lastly, the extent to which social functions of the hospital are explicit and fully funded (rather than

[4] SOE was an institutional arrangement created by the government in order to partake in commercial activities on its behalf.

being implicit or unfunded mandates) (Harding and Preker: 2000; World Bank: 2010). This process leads to what they term as autonomisation which is characterised by:

"First, ownership of service delivery is kept in the public sector. Second, hospitals are moved out of the core public service and transformed into more independent entities with greater control of management decisions. Third, hospitals are made responsible for the services they produce, often through contracts for service delivery." (World Bank: 2010; p. 51)

Autonomisation is a complex process and there are several aspects related to it. On the one hand the focus could only be on financial autonomy, in other cases it could combine finance and governance. Global evidence suggests that the idea of autonomy gained currency in middle and low income countries to reduce public spending. Financial autonomy would encourage individual hospitals to augment their finances through a variety of mechanisms like user fees, contracting out and in of supportive services.

Even in the case of China the process of autonomisation was premised on the understanding that public hospitals should put public interest in the first place and be better managed to increase efficiency and quality of services.

Phases in hospital reform in China

Broadly there have been three phases in the process of hospital reform in China up till now. The first phase includes the change in the status of government institutions to SOEs in the 1980s. In the second phase beginning in the early 90s, the Ministry of Health emphasised the principle of decentralisation of power and transfer of profits in the hospital sector. During this phase the emphasis was on incentivising hospitals and doctors in order to increase revenues there was no significant management improvements. By the late 1990s, there was a third phase when several local governments started to experiment with autonomisation giving rise to a plurality of management models, incentive and governance structures. The outcome of these experiments across different counties illustrated the complexity and plurality across different provinces during the 2000s. There was clear separation in governance structures – especially between management and supervision. There was variety of models in the financing structure and access to private finances across the provinces. Some of these have been described in the following segment.

In Shanghai, a pilot project is of particular importance for its structure of management and administration. Shenkang health management centre established in 2005 oversees three-fourths of all tertiary public hospitals. This institute is independent of the government's health bureau and its main functions include supervision of resource allocations to public hospitals in terms of

investments and loans, infrastructure building and mergers or acquisitions. It oversees the annual budgets and fiscal subsidies allocated to public hospitals. It also procures drugs, equipment and bargains against insurers collectively for public hospitals. Hospital managers are periodically evaluated and can be fired for poor performance. Therefore, the supervisory institute advices on all investments made; the role of the health bureau is reduced to regulating quality of services and entry of service providers and the managers have to monitor the functioning of personnel, incentives and compensation to personnel and organisational arrangement. Beijing has a similar model where an independent institute supervises all public hospitals. In both Shanghai and Beijing, the independent institutes report to the local government. There are similar models that are seen in Suzhou and Wuxi city and Jiangsu province that clearly show the separation of functions. Another interesting pilot is seen in Anhui Province where five hospitals merged into a single hospital group in 2008. The hospital group procures drugs for all five hospitals. In several other pilots, for example in Shandong Province, personnel system was transformed to a contractual system. (Qian: 2011)

Consequences of reforms for public hospitals

The trend towards autonomisation has created many distortions in the hospital sector. Firstly, the health managers have become important because they were vested with powers to garner financial resources. Often this meant that they were wooing investments that would produce high returns. For example, *"a hospital manager has very strong incentive to invest on high end service/equipment by which he can charge patients with unregulated prices or to procure high profit margin drugs given the price markup for drugs"* (Qian, 2011). Secondly, incentives were introduced into the hospital system and individual doctors were rewarded according to the number of patients they treated thereby generating profits for the SOE. This transformed the role of doctors from a lifelong, secure employment relationship with the government to a contractual one with the SOE. Thirdly, autonomisation led to unhealthy competition between enterprises and local governments leading to a great deal of variation in institutions in terms of quality and equity of access.

The reform of public hospitals raised many distortions regarding the administration, behaviour of institutions and their regional distribution. As Yip and Hsiao (2009) observe, these hospitals that were essentially publicly owned behaved more like for-profit private enterprises as a result of their autonomisation. At a deeper level it has led to fragmentation of governance; distorted human resource deployment; overuse of drugs and diagnosis for revenue generation; created regional and socio-economic inequalities.

Fragmentation in terms of governance and administration

The fragmentation of governance from administration is observed in the models that have been implemented in various provinces.

Qian lucidly observes: "*The agenda for hospital reform includes two "separations" regarding to governance structure of public hospitals: separation between administrative government and public hospitals and separation between the function of hospital management and regulation/supervision. Purpose of first "separation" is to give hospital managers discretionary power in personnel decisions while purpose of the second "separation" is to closely supervise hospital's investment behavior and financial conditions. The effect of these "two separations" may offset each other to some extent. Hospital managers are given more power to manage human resources while less power is granted for financial resources*. (Qian: 2011; p. 17)

Human Resources – Deployment and incentives

One of the most important policies of the public hospital reforms in China has been the shift from a centralised personnel system of employment to a contractual based one between the physician and the hospital. This is a clear shift from the pre-reforms where hospitals were public service units where personnel were closely controlled by government. Hospital managers are granted with more autonomy over hiring, firing and promoting physician. They can also offer incentive contracts based on their performance. (Qian: 2011)

There are consequences for training of human resources too. Guang Shi et al observe, "*Before the health reforms in China, public hospitals trained personnel for lower level hospitals without charges or for only a nominal charge. Secondary and tertiary hospitals also provided free training for medical students. Since the 1980s hospitals have charged trainees from primary hospitals, thereby weakening the social function and imposing an additional financial burden on lower level hospitals.*" (Guang Shi et al: 2003, p. 62)

Emphasis on high technology and drugs as a source of revenue generation

Guang Shi et al (2003) observe that with deregulation there are many private players in medical care in China. This has resulted in competition with the public sector that has to function in a market environment. Therefore, the supply side has introduced more high technology, medicines and procedures that are available at a price and this has resulted in irrational practices and rising costs.

Reduced government spending and dependence on out-of-pocket payments and private sources of funding

As a consequence of the market environment in which the public hospitals behave like the for-profit ones, costs of care have risen and so have inequities in access. According to the China Health Yearbook (2010), out-of-pocket expenditure accounts for 38% of total health expenditure. The average expenditure for health services and drugs for an urban hospital increased by more than 15% annually from 2002 to 2009.

Regional and socio-economic inequalities

There is enough evidence to show that there is variation in public hospitals across provinces in terms of facilities, equipment, and human resources. This is largely due to decentralisation and inequalities in finances. Therefore, in poorer areas there are severe shortages of government funding compounded with low capacities for revenue generation which further results in poor retention of human resources. This is well documented by Liu (2004) who observes:

"*Without appropriate mechanisms to transfer and equalize payments, decentralization naturally leads to increasing variations in investment by provinces, cities, towns and other entities in public health capacities, as well as to variations in the performance of health systems across China. So while some regions may be able to detect and control major epidemics in their area (e.g., Guangzhou and Beijing, which are among the best developed regions in China), others may simply be unprepared for major public health challenges. Particularly disquieting is the lack of an adequately functioning public health system in China's vast rural areas. Even though each county has an EPS, public health work at the township and village level has been weak due to under-funding and a lack of supervision and coordination among rural health-care providers*" (Liu, 2004).

The change in ownership of hospitals to an SOE and the subsequent reforms of decentralisation of power to local governments to generate revenues did not take into account goals of quality or equity. It has been observed that, "*Hospital autonomization by itself can reduce equity, reduce the less visible dimensions of clinical quality, and contribute to excessive intervention in profitable areas of treatment. Equity, clinical quality and cost-effective medical practice are not likely to be achieved without complementary reforms to strengthen accountability for these dimensions of hospital performance, and to use financing, contracting, and provider payment to create."* (World Bank, 2010)

Lack of a referral system

The referral system that was the strength of the health services system in the pre-reform period has completely broken down due to the move towards autonomisation. While pilots on creating a system of referral is on in some provinces it is too early to say whether these would be successful and be replicated to other provinces.

Brixi observes, "*The uneven capacities of public hospitals contribute to the flight of the sick toward specialists, which in turn, contributes to low utilization of hospitals and health centers at the lowest level, as well as overcrowding of the renowned specialized hospitals.*" (Brixi, 2006) This clearly shows the lack of a referral system that was one of the strengths in the past of the Chinese health services system.

Liu (2004) provides evidence from a 1998 survey which showed that apart from 5% of village health stations that were funded and supervised by the township health centres, the rest were operating independently and were disconnected to other levels of care regardless of ownership.

All the above consequences indirectly raise concerns for equity and comprehensiveness of health services. This found echo in the eleventh five year plan in 2006 that proposed increasing government efforts. Hu Jintao stressed on the welfare nature of public medical and health activities and advanced health system reforms. There was reassertion of role of public resources in hospitals; mobilising enthusiasm and innovation among medical staff; improving hospital management and quality of services; promoting efficiency utilisation of medicines and reducing patients' expenses; and strengthening pharma supervision to guarantee safety.

Consequences of autonomisation of hospitals for public health

The preceding section has discussed how the autonomisation of hospitals has led to the breakdown of the referral system in China. In a well-functioning public health system the role of the hospital is in relation to and dependent on the primary and secondary levels of care. The spirit of the Alma Ata declaration for primary health care had clearly enunciated this in their description of the health service system. Each level has its specific role and is graded in terms of clinical, technological, human resource and services. Within this perspective each level is dependent on the other for support and supervision, therefore cannot function effectively independently of one another. Thus, the hospital is not independent of the primary and secondary levels for curative, preventive, promotive and rehabilitative services. The process of autonomisation is antithetical to the idea of a health service system. In China, Brixi (2006) argues that autonomisation of hospitals has led to a situation where "*public hospitals are not explicitly linked to public health programs and public*

health institutions such as clinics, centres for disease control, and family planning centres function" (Brixi:2006). The adverse consequences of dismantling of the health service system were recognised with the outbreak of SARS in 2003. A study of the SARS outbreak and its management by the United Nations Health Partners Group in 2005 pointed out that the breakdown of the health service system resulted in lack of an effective strategy to control the spread of SARS. The report makes an important observation regarding the importance of a comprehensive health service system for controlling infectious diseases. They state that:

"Controlling infectious diseases, such as SARS, TB, and HIV/AIDS, requires cooperation between public health centers for disease control and clinical institutions, like hospitals. SARS showed the gap between these two institutions. There is limited communication between hospitals and the CDCs. There is more interaction at the lower levels of the health system, between county hospitals, township health centers, community health service centers, and the CDCs. For public health programs and health services to successfully combat disease, hospitals and other institutions, like clinics, must play apart. Hospitals, for instance, can boost disease prevention by encouraging people to get immunizations or to stop smoking. Or they can play a crucial role in stopping the spread of infectious diseases by reporting the number of cases they see in their wards and clinics. Since the SARS epidemics in 2003, the government has invested in a system for hospitals to report communicable disease information" (United Nations Health Partners Group in China, 2005).

After the SARS epidemic of 2003 the Chinese government became more proactive in strengthening health surveillance, prevention, cure and control of infectious diseases. However, the commercialisation of public hospitals has not been reversed. The government has used financial strategies like expanding public insurance schemes as a piecemeal effort to address control of infectious diseases. All these efforts do not address the breakdown of the health service system and its commercialisation during the last three decades. It is indeed ironic that the Chinese health care system that served as a model for primary health care during the 1970s, is grappling with the crisis of financing, governance and inequities as most other countries in the world.

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