7 China’s current health reform agenda

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Introduction

The People’s Republic of China (PRC), the world’s most populous nation, has undergone an unprecedented economic and social transformation since it was founded in 1949, as detailed in other chapters in this book. This has been accompanied by an increase in the standard of living, health status and life expectancy of its people (Meng 2007: 2). At the same time, as in many Western countries, problems that have an adverse impact on health outcomes of the population have also become more evident. These include issues related to affordability and quality of health care and the rising burden of chronic disease (cardiovascular and respiratory diseases, musculoskeletal conditions, mental illness and cancers). In this chapter we will discuss China’s current (2009 onward) health reforms, which represent a major departure from health and social policies of the preceding 20 years.

Globally, developing and developed countries alike face a looming epidemic of chronic disease, an outcome of the complex interplay of environmental, biological, social and economic factors. Obesity, high salt intake, high tobacco consumption, rapid industrialisation with high rates of urban migration and environmental pollution feature prominently when discussing the underlying causes of chronic disease in China.

In terms of sustainability of health systems, most countries today are faced with a similar set of dynamics, where the projected trajectories for population ageing, cost of health-care provision and the economic burden of chronic disease are not compatible with the future capacity to pay for health services and to provide the needed workforce (Coiera and Hovenga 2007: 28). Very simply, we are not able to continue indefinitely to deliver health care using existing models of care. There is a need for a profound rethink in our approaches to treatment and disease prevention. In recognition of this, most countries are engaged in ongoing health reforms aimed at strengthening primary health care, improving efficiency and effectiveness of health service delivery, moderating or re-directing demand for health services and improving the underlying health of the population as a whole. An additional concern for China is that its one child policy (which is very gradually and tentatively being relaxed) will exacerbate the
ageing demographic and will make it even more difficult to deal with the demand pressures on the health system.

In contrast to most Western countries China’s current health reforms are taking place against a backdrop of strong, albeit slowing, economic growth. This, in turn, gives the country a greater capacity than its Western counterparts to direct additional resources into the health sector. Furthermore, China’s major public hospitals currently receive less than 10 per cent of their funding directly from the government (World Bank 2010a). Undoubtedly, this needs to increase over time, either in terms of direct funding or indirectly through health insurance subsidies. By comparison, the Australian State and Federal Governments contribute close to 90 per cent of public hospital funding (AIHW 2012: 58), with public hospitals consuming some 40 per cent of total government health care expenditure (AIHW 2012: 25).

This means that the hospital sector, which typically absorbs the lion’s share of public health expenditure in Western countries and generally has a powerful vested interest in maintaining the status quo, potentially presents less of an obstacle in China to directing a high proportion of new funds into primary health care and secondary (county level) hospitals, rather than tertiary (urban) hospitals.

Key concepts

Before embarking on a discussion of health reforms, it is necessary to clarify some key concepts relevant to our understanding and analysis of China’s health reforms.

The terms health system and health care system have different meanings. The health system comprises all the elements that impact on the health of the population. It encompasses a myriad of biological, environmental and social factors. The health-care system forms part of the health system and is made up of health-care providers (health professionals and organisations) and public health services. The latter include health promotion, disease prevention and health protection and target the population as a whole or at-risk subgroups of the population.

Figueras and McKee (2012: 6) provide the following definition of a health system, which forms the basis of their Health Assessment Framework (HASF) for the purpose of making international comparisons of health system performance:

A health system includes, for practical purposes, the following three items:

1 The delivery of personal and population based health services, including primary and secondary prevention, treatment, care and rehabilitation.
2 The activities to enable the delivery of health services, specifically the functions of finance, resource generation and stewardship.
3 Stewardship activities aimed at influencing the health impact of ‘relevant’ interventions in other sectors, regardless of whether or not the primary purpose of those interventions is to improve health.

It is now recognised that the social determinants of health are largely responsible for inequalities in health status within a country and between countries. We are beginning to understand how the social determinants of health act, and some progress is being made in addressing health inequalities and inequities. Yet in both developing and developed countries (including China) the differential in health status and health outcomes across the socio-economic spectrum continues to increase relentlessly. The need to address the social determinants of health remains the greatest challenge for governments (and health systems) around the world (CSDH 2008).

An examination of the sustainability of a health system must include an evaluation of whether the system (as defined above) is able to address the social determinants of health and whether it contributes (directly or indirectly) to a reduction in inequalities and inequities in health. For those who feel that this is a subjective, values based argument, this statement can also be expressed in terms of the connection between health and the economic burden of disease, the productivity of the population and ultimately the political stability of a nation. However, we caution against seeing health merely as an enabler of economic productivity. We would argue that the health and well-being of the population should be seen as a primary societal goal and an inalienable human right.

In brief, any analysis of health policy or health reforms must look at the health system in its entirety and must take into consideration, as far as practicable, the many factors that impact on the health of the population.

China’s health system

China is a large country and there is marked geographic variation in health status and models of health-care delivery across the nation. Under a broad national health reform agenda, different health reforms are being piloted in different locations. Policies and directives emanating from the central government will, by virtue of distance from the centre and regional variability, be implemented in keeping with local needs and capabilities and in accordance with the interpretation by local government and Communist Party officials. Thus it is not useful to discuss China’s health system as if it were a monolithic system like, for example, the UK National Health Service.

At the same time it needs to be acknowledged that China’s central leadership plays a major and forceful role in setting reform agendas and provincial and local performance targets, using its ‘political dominance and fiscal muscle’ (Yang 2011: 21). Since the mid 1990s the central government’s share of budgetary revenue relative to the provinces has been above 50 per cent. Government ownership of large enterprises (including Asia’s largest tobacco manufacturer) and the
country’s four largest commercial banks further consolidate the fiscal (and hence policy setting) power of the central government.

China’s health system is separated into rural and urban health systems. The rural health system comprises village clinics, township and county (secondary level) hospitals. The urban system is made up of community health centres (each of which operates several community health stations), secondary and tertiary hospitals.

From 1959 to 1979 enormous progress was made in bringing public health problems such as cholera and schistosomiasis under control and improving the health of the population. Life expectancy at birth increased from 35 years in 1950 to 67 years in 1979 (Meng 2007: 2). From the mid 1950s, a Cooperative Insurance Scheme was established for rural people and Government Health Insurance and Labour Health Insurance schemes were set up for urban residents. As Meng (2007: 4) puts it, ‘China had used 2 per cent of the world’s health resources to provide 22 per cent of the global population with accessible basic health care’. This period is probably best known in the West as the era of the ‘barefoot doctor’. The success of this era has been attributed to: (i) the high priority placed on health and health care by the government; (ii) the emphasis placed on primary health care; (iii) the rapid expansion of the rural and urban insurance schemes; and (iv) intersectoral cooperation and participation (Bloom and Gu 1997).

During the 1980s and 1990s, as China opened up its economy, overall life expectancy continued to improve. Now, however, we are beginning to see greater differentials in wealth and health emerge within regions and between rich and poor regions across the nation. In 1998 catastrophic health care costs were the main cause of poverty for 4.4 per cent of urban families and 21.6 per cent of rural families who were living in poverty. By 2003 these figures had increased to 25.0 per cent and 33.4 per cent respectively (Meng 2007: 8). Infant mortality for 2000–2004 ranged from 26/1,000 live births in the most affluent parts of the country to 123/1,000 live births in the poorest remote western regions. Similarly mortality rates across the country for children under five ranged from 5/1,000 to 64/1,000 per year (Tang et al. 2008: 1496).

Over the same period government financing of health care was reduced. While total health expenditure (THE) from 1978–2004 grew at the rate of 17 per cent per annum (and GDP was growing at 9.4 per cent per annum), government expenditure on health care declined from 32 per cent in 1978 to 17 per cent of THE in 2004 (Meng 2007: 11).

Hospitals found themselves pursuing other sources of revenue, as government funding declined. With fee levels set by government price bureaus and fees often being well below the cost of service provision, they pursued lucrative medical investigations and tests and profit from drug sales to make ends meet. By 2006 drug sales alone accounted for 40 per cent of total health expenditure. This is substantially higher than most other countries (World Bank 2010b). There were perverse incentives (e.g. bonus payments to clinicians), leading to inappropriate utilisation of services and ever-increasing costs to the patient. The pervasive impact this has had on provider behaviour should not be underestimated. It will
take some time and perseverance with health reforms, before workplace cultures become less profit driven and more aligned with the social objectives of public hospitals.

While it is difficult to generalise about a health system as large and diversified as China’s, it became clear during the first decade of the twenty-first century that a number of serious and widespread problems had emerged:

1 Health care continued to be expensive and difficult to access. A popular saying was ‘to see a doctor is difficult; to see a doctor is expensive’ (kan bing nan; kan bing gui).

2 Rural residents, particularly in the poorer western regions, continued to have worse health outcomes and greater financial difficulties in accessing health services than urban residents. Rural doctors were often poorly qualified and it was difficult to attract qualified doctors to the poorer, remote regions of the country.

3 Migrant workers living in urban areas were particularly disadvantaged in terms of accessing health services and obtaining health insurance coverage.

4 There was an over-reliance on hospitals. As a result, primary health-care services were poorly developed. Consumers had little confidence in primary health care and attended hospital outpatient departments in large numbers, often for minor illnesses.

5 Hospitals relied heavily on profit from drug sales and hi-tech tests to generate income. One manifestation of this was the massive overuse of antibiotics and the frequent prescription of intravenous drugs (in community health centres as well as hospitals), which attract a higher fee than orally administered drugs.

6 Hospitals were primarily focused on pursuing revenue and market share. There were few incentives for achieving efficiency or ensuring the appropriateness and effectiveness of care.

7 The administration of public health-care services was, and continues to be, inefficient and fragmented with multiple central, provincial and local government agencies involved.

The 2009 health reforms

This chapter is about the initial implementation period (2009–2012) of China’s current health reform agenda. These far-reaching health reforms mark a major policy shift away from the market-based approach of the previous two decades, which treated health services as a consumer good traded in the market place. It was expected that market forces would ensure the supply of needed services at an efficient price. It is generally recognised that in health care information asymmetry and supplier driven demand commonly result in market failure. Most countries also accept that health services are a public good.

The SARS epidemic of 2003 brought home to the government and the Chinese people just how much public health institutions had declined and how
poorly prepared the country was to deal with a serious public health threat. There is little doubt that 2003 was the turning point in China’s approach to providing public health services. Even so, and not surprisingly given the size of the country and the inbuilt inertia of health systems, it took another five years to formulate and enunciate a comprehensive health reform policy.

With the introduction of the new reforms, the government has acknowledged the need to address major health system problems in order to maintain ‘social harmony’. It has also recognised that health services are a ‘public’ good. At the same time it is also trying to maintain a space for market forces and private enterprise to operate in the health sector.

By 2008 the government had begun to acknowledge publicly that market based health reforms were failing and a new approach was needed. As quoted by Tang et al. (2008: 1496), the government stated that ‘a wrong concept in the socialist market economy is that the health care system should be market-oriented depending on market forces to meet the medical care needs of the people’. After the 17th CCP Congress in 2008, the Ministry of Health released new policy directions for achieving a healthy China by 2020:

Health is the cornerstone of comprehensive human development ... assurance of health equity is now regarded as the key parameter for the social justice and fairness in the country.... Accessibility of basic medical and health care services is a basic right of the people.

(Tang et al. 2008: 1493)

Note, however, the emphasis on health-care services and the lack of public acknowledgement (and perhaps recognition) of the need to also address the social determinants of health. As Tang et al. so eloquently stated:

China must tackle three inter-related processes that create a perfect storm for health care: market failures and insufficient government stewardship, inequities in the social determinants of health, and erosion of public perceptions of fairness and trust of the health care system.

(Tang et al. 2008: 1496)

With respect to fairness and trust, it would also help if the widespread use of ‘informal payments’ made to doctors by patients seeking treatment and alleged kickbacks received by hospitals and their staff from pharmaceutical companies and equipment suppliers could be reduced.

In April 2009 China’s new health reform agenda was announced as well as additional expenditure on health of 850 billion RMB (US$125 billion) over three years. The far-reaching reforms covered five related initiatives (Yip et al. 2012: 833):

• increasing insurance coverage to reach more than 90 per cent of the population;
• creating a national essential medicines list with open tender purchase of pharmaceuticals and the retail price set (and subsidised) by central and regional governments;
• strengthening primary health-care services, creating a three-tier rural health system and dual referral pathways between urban hospitals and community health centres;
• developing equal public health services across rural and urban areas, by establishing uniform medical records, health screening and strengthened specialised institutions for mental health and maternal and child health services;
• public hospital reforms with piloting of alternative governance and payments arrangements and the gradual elimination of profits from drug sales.

It has been estimated that 46 per cent of the additional funds were allocated to medical insurance subsidies, 47 per cent to health care provision and 7 per cent to public health (IMS Health 2012).

In March 2012 the State Council issued the ‘Deepening Health Reform Plan and Implementation Action during the 12th Five-Year Plan’. It states that the government input in the following four years will be higher than for the 2009–2011 period, with the focus continuing to be on universal health insurance, consolidating the essential drug policy and public hospital reform (People’s REPUBLIC OF CHINA STATE COUNCIL, March 2012).

These reforms are indeed massive and are being implemented across the nation. In the remainder of this chapter we look at the progress of the reforms to date and ask the question whether China is on the way to developing a more sustainable health system. We emphasise that China is still in the early stages of the reform process, which has many years to run. The rationale for an evaluation at this stage is to assess the direction the reforms are taking in order to inform the next stages of implementation.

**Health care financing: insurance subsidies and investment in primary health care**

As reported by Meng *et al.* (2012), the National Health Services Surveys of 2003, 2008 and 2011 showed that from 2003 to 2011 insurance coverage for the entire population increased from 29.7 per cent to 95.5 per cent. Inpatient insurance re-imbursements increased from 14.4 per cent in 2003 to 46.9 per cent in 2011. Hospital admissions increased from 3.6 per cent to 8.8 per cent. Interestingly, the caesarean section rate went up from 19.2 per cent to 36.3 per cent. However, there has not been a reduction in the percentage of households experiencing catastrophic health expenditure. The figure stood at 12.9 per cent in 2011 (Meng *et al.* 2012: 813).

These are remarkable achievements. Of the three insurance schemes (UEBMI – Urban Employee Basic Medical Insurance, URBMI – Urban Resident Basic Medical Insurance – for children, elderly, students and, in some cities, migrant
workers; NRCMS – New Rural Cooperative Medical Scheme) the URBMI and NRCMS are subsidised by central and local governments. There is also a medical assistance programme, administered by the Civil Affairs Department, which covers some of the health care costs and insurance premiums of poor people.

In 2011 the subsidy levels reached as much as 200 CNY per person per year. In addition the government has introduced a subsidy (15 RMB per person in 2009, increasing to 25 RMB in 2011) to primary health-care providers to deliver a defined package of public health services. These include immunisation, maternal and child health care, folic acid supplementation for rural women, screening for breast cancer and cervical cancer, physical check-ups for the elderly and establishment of personal health records. By the end of 2010, 50 per cent of urban and township residents and 45 per cent of rural residents had health records, well ahead of expectations (Guo Yan 2011: 8).

The central government preferentially directs its share of these subsidies to the poorer western provinces, while provincial and local governments pick up the entire subsidy in the richer eastern regions like Shanghai and Shandong.

It must be stressed that the insurance schemes vary across the country. Generally the UEBMI offers a higher level of reimbursement than the URBMI. The NRCMS comes in several different forms, with local governments determining the insurance model and level of subsidies to be provided. Coverage for the NRCMS ranges from a limited range of inpatient services to a combination of inpatient and outpatient services. Outpatient services are generally reimbursed at a lower rate than inpatient services. The net effect has been an increase in the number of people seeking outpatient care at village clinics and inpatient services at township health centres, without a change in the overall number of patients being treated by these facilities (Babiarz et al. 2012). At the same time, county-level hospitals have seen a shift from outpatient to inpatient services in response to the new insurance arrangements. For a detailed discussion of the NRCMS see Ma Yuqin et al. (Ma et al. 2012).

At this stage, health insurance arrangements in China are fragmented and provide relatively shallow cover. The Lancet reported in March 2012 that in 2011 173 million Chinese incurred catastrophic medical expenses (Meng et al. 2012). For URBMI the cap for reimbursements is 150,000 RMB, while for the NRMCS the ceiling was recently increased from 30,000 to 50,000 RMB. The government objective is to bring co-payments for inpatient services down to 30 per cent. In many rural areas the costs of hospital delivery services are now almost fully covered by the NRCMS and government subsidies (Yip et al. 2012).

Individuals can lose part or all of their insurance cover if their employment status or place of residence changes. As noted in the World Bank Health Policy Notes (World Bank 2010c), ‘Further insurance reforms include regional level integration of UEBMI, URBMI and NCMS in order to establish transferability across systems and ensure individuals of continuous coverage and benefits’.

In August 2012 the National Development and Reform Commission (NDRC) issued ‘Guidance on Initiating Insurance Scheme for Catastrophic Illnesses for
Rural and Urban Residents’. According to this policy a new commercial insurance will be introduced with the aim that at least 50 per cent of out of pocket expenses (after NRCMS and URBMI payments) will be reimbursed (People’s Republic of China, National Development Reform Commission 2012).

In addition to health insurance subsidies, the central government is investing some 20 billion RMB per year in infrastructure building for 2,000 county hospitals and 4,700 local health-care facilities. An ambitious human resource capacity building programme is also under way. By the end of 2010 ‘72,000 health workers in township hospitals, 2,080,000 health workers in village hospitals and 420,000 health workers in community health care facilities had received training’ (Guo Yan 2011: 8).

Other initiatives directed at addressing the rural–urban imbalance include:

- waiving of tuition fees for medical students who are willing to work at township health centres for at least 3 years after graduation, recruiting to meet the target of one licensed physician per township health centre by the end of 2011, selecting physicians from county hospitals to receive on the job training in tertiary hospitals, and encouraging experienced physicians from tertiary hospitals to rotate to county hospitals to train staff. (Yip et al. 2012: 834)

In summary, major investments are being made in subsidising health care and in addressing urban–rural imbalances in the provision of access to affordable health care. From 2005 to 2009, the government share of THE increased from 17 per cent to 27 per cent, while the patients’ share fell from 52 per cent to 28 per cent. It will be sometime before the real impact of these recent investments and policy changes can be fully evaluated.

**Essential medicines**

As discussed above, there are numerous incentives for health-care providers in China to over-prescribe. It is estimated, for example, that antibiotics are prescribed at twice the rate recommend by the WHO and that the rate of intravenous administration of drugs, which attracts a higher fee and is considered by the general public to be more efficacious than oral administration, is three times higher than in other countries (Li Yongbin et al. 2012).

China had an essential drug list from 1996, which was revised every two years and used as the basis for urban medical insurance reimbursement of drug expenses. The list focused on low-cost generics and prices set were often not related to cost of production. Furthermore, prescribers had a strong preference for more expensive brand-name drugs that generated a higher profit margin. No pharmaceutical treatment guidelines were in place and doctors relied mainly on information supplied by drug companies for making prescribing decisions (World Bank 2010b).

In 2009 the government introduced a number of policies and regulations to reduce excessive drug use and to improve access to safe, effective and affordable
The cost of stocking and dispensing drugs is not covered. The measures have initially been targeted at primary health-care institutions. The intention is to extend these over time to private providers and hospitals. At the moment hospitals are restrained from marking up drug prices by more than 15 per cent above the purchase price.

The new National Essential Medicines list, introduced as part of the current health reforms, consists of 307 generic drugs, of which 102 are traditional Chinese herbal remedies. The essential drugs are subsidised by both the central and local governments. Disbursement of the central funds by the Ministry of Finance is linked to other health-care reform targets being met by local governments. Provincial governments purchase the drugs by open public tender via the internet and Community Health Centres have to supply the drugs to patients at cost. The central government monitors prices and sets price ceilings. Primary health-care organisations can only prescribe drugs from the National Essential Medicines list.

All 31 provinces had implemented (or were about to implement) the new drug policy by late 2011. Many local governments have added to the list. So far, 92 per cent of urban community health services have implemented the scheme. The drug list used by Community Health Centres comprises the National Essential Medicines list plus additional medicines added by provincial and local governments.

Not surprisingly, there have been problems and complaints:

- The cost of stocking and dispensing drugs is not covered.
- The list is too limited to effectively treat the spectrum of diseases seen in primary health care
- It has been necessary to refer patients to hospitals to gain access to necessary drugs that are not on the essential medicines list
- There are concerns, raised in Chinese blogs, but not otherwise documented, that the provincial level purchasing system is not transparent enough, that it is still possible for providers to receive kickbacks in one form or another and that in some cases retail prices are set well above production costs.
- Several community health centres have reported to us that the inability to generate profits from drug sales has undermined staff morale and productivity.

On the other hand, Guo reports that in the 27 provinces where the system has been in place for some time drug prices have dropped some 25 to 50 per cent on average (Guo Yan 2011: 8).

The real challenge still lies ahead, with the plan to reduce hospitals’ dependence on profit from drug sales. No doubt this will engender strong resistance from various influential interest groups. If there is a reduction in drug revenue for hospitals, it will be necessary to offset this with improved payment or pricing systems for hospital services. Payments should more accurately reflect the cost of service provision and have inbuilt incentives for efficiency and appropriateness of care.
Public hospital reforms

Public hospitals deliver 90 per cent of China’s inpatient and outpatient services and consume 2.9 per cent of GDP (Yip et al. 2012). In the absence of a strong primary health care system, let alone a ‘gate keeping’ function exercised by primary health care, there is significant over-utilisation of, and over-dependence on, the hospital sector.

In 2008 there were 2.2 hospital beds per 1,000 population and 1.2 township health centre beds per 1,000 rural population. Approximately 20 per cent of hospitals are privately owned for-profit organisations. They tend to be smaller and often cater for niche markets. It is estimated that collectively they handle about 5 per cent of all hospital outpatient and inpatient services (World Bank 2010a).

Hospitals have an archaic and complex governance structure. The Ministry of Health has responsibility for the population’s health, but various ministries have power to allocate public and insurance funds, to set prices and payment methods, and to decide on capital investment. Competing ministries often pursue their own bureaucratic interests and issue policies and regulations that contradict the socioeconomic purposes of public hospitals.

(Yip et al. 2012: 835)

Prices for hospital services, set by the Price Bureau, are often not related to the cost of service provision and encourage overuse of tests and drugs. Public service rules give staff permanent tenure and there is limited scope to address productivity issues. Hospital directors are appointed by the Organisation Department of the Chinese Communist Party.

The main focus of the 2009 reform agenda for hospitals has been on governance arrangements and the social responsibilities of hospitals. At the same time the government has acknowledged the need to reform hospital financing, payment and incentive systems, as well as human resource management practices. The reforms are being piloted in different forms and guises in 16 major cities across China. To date, little published information is available with regard the impact or effectiveness of these reform. Yip et al. (2012: 836) list the pilots for governance reform under the following headings:

- Clearly state the role and function of public hospitals.
- Achieved in 4 of the 16 pilot cities in terms of hospitals providing access to affordable basic health care, emergency service and medical rescue during disasters.
- Shift strategy to market competition and private ownership of public hospitals.
  - Kunming is trialling joint public-private ownership model;
  - Luoyang has ‘sold’ the ownership of some public hospitals to their staff.
• Address dispersion of responsibilities and power between various departments.
  • 10 cities have set up a central commissions to coordinate policies from various departments;
  • in four of these cities, the commission assumes responsibility for the day-to-day running of hospitals.
• Reorganise the responsibilities and powers of government departments.
  • Nine of the pilot cities have created agencies to manage and operate public hospitals;
  • in four cities the functions of policy, regulation and monitoring, on the one hand, and management on the other hand, were allocated to separate divisions within the health department.

(Yip et al. 2012: 837)

It needs to be said that apart from these, many different hospital reforms are being trialled in different localities in China. Some antedate the 2009 health reforms and many have been successfully implemented. From discussions with our China Master of Hospital Administration students over the past nine years we are, on an anecdotal basis, aware of many examples, including:

• trialling of a diagnosis related group (DRG) prospective payment system, claimed to have resulted in an average length of stay (ALOS) of the order of seven days;
• trusteeship arrangements, providing management oversight, and professional staff exchanges between tertiary urban hospitals and rural hospitals;
• trialling of two-way referral systems between community health centres and tertiary hospitals;
• use of shared hospital management services companies;
• separation of hospital facilities and asset management from operational management;
• outsourcing of non-core functions;
• performance monitoring of the senior management team;
• coordination, amalgamation or integration of hospitals;
• pilots with a small number of private insurance companies.

The World Bank 2010 policy notes on public hospital reforms also detail a number of pre-2009 initiatives being trialled in different locations (World Bank 2010a).

In June 2012 the Ministry of Health released a list of 311 county level hospitals that have been earmarked for pilot studies on hospital reform.

It is obviously not possible to discuss these initiatives as if they represent a single reform agenda. It may well be that the plurality of current reforms taking place is one of the strengths of China’s health system. Local governments and agencies find practical solutions that are feasible and, generally speaking, aligned
with central government policy directives. It is, of course, possible that some local governments achieve good results despite central policy directives. It is also conceivable that some local governments may not have the capacity to effectively implement central policies and may choose to resort to reporting results that may not necessarily have been fully achieved. In this context it should be noted that most performance targets for the current health reforms are related to inputs, rather than outputs or outcomes.

**What has been achieved?**

Given the short timeframe, the health reforms that have been implemented are remarkable and impressive in terms of scale and setting a new direction. It is far too early to assess the full impact of these initiatives.

Most significantly there has been a major policy shift from a market-based approach to a social justice (‘social harmony’) agenda. Moreover, health has also been given a higher priority than before, as evidenced by the fact that Executive Vice-Premier Li Keqiang oversees the health-care reform programme and ensures that there is continued high level political support for it.

We have some concerns regarding the future direction and effectiveness of the current health reforms:

1. Will China be able, and have the political will, to continue to grow government expenditure on health care, in the face of slowing economic growth? So far the signs are that China will push ahead with planned reforms, as evidenced, for example, by the 12th five year plan (KPMG China 2011).
2. Whilst the various insurance subsidies will have an impact on out-of-pocket expenses, they will not necessarily reduce the cost of health care or improve affordability.
3. Increased government financing will need to be accompanied by a payment system that promotes efficiency and ensures appropriateness and effectiveness of services. This in turn will require information systems and management capacity for service providers and payers alike.
4. Will the government be able to extend its drug policies to hospitals (and suppliers) in order to reduce the level of inappropriate and excessive prescribing, ensure efficient pricing and improve the quality of drug supply and distribution systems? We are aware that significant research is being undertaken in this area, but resistance from powerful vested interests is likely to be strong.
5. Will the general public have sufficient confidence in primary health-care providers, for them to start to function as ‘gate keepers’ to the hospital system? We believe that at present this will be difficult to achieve. However, with the high level of investment in developing the primary care sector and the use of financial levers (e.g. insurance payment arrangements) this will be achievable.
6. Will it be possible to create public hospital governance arrangements, not necessarily a single or uniform model for the entire country, which promotes
efficiency, accountability and social objectives? We believe that the many different governance and management models currently being piloted augur well for significant improvements in the hospital sector in this respect.

At the beginning of this chapter we made the point that health care and public health services are only parts, albeit very complex parts, of the health system. We made reference to the social determinants of health and stewardship functions of a health system. The emphasis in this chapter has been on health-care financing and delivery, as these are the focus of China’s current health reforms. It is important to remember that it is possible for the health-care sector to flourish, without the health of the population or differentials in health status across the nation being improved. We stated that for a health system to be sustainable, it not only needs to be resourced to carry out its essential functions and cover projected growth in demand, it also needs to address the social determinants of health and be able to undergo continuous innovation to stay ahead of what would otherwise be an overwhelming burden of disease. This is an important message, which policy makers in many countries have difficulty coming to grips with. As Thomson et al. state in their paper on financial sustainability of health systems: whilst the emphasis in discussing financial sustainability of health systems is on health care, ‘in many cases increasing spending on, or reallocating resources towards, public health interventions (within the health sector or other sectors) will maximize health gains and may therefore help to address sustainability challenges’ (Thomson et al. 2009: 2).

We believe that China has shown a genuine interest in addressing social inequalities (and thus the social determinants of health) across the board, not only in terms of health policy, but also in terms of investment in education, environmental policies, food policies, occupational health and safety policies and more generally in its overall social and economic policies. It is important to remember how fast the country has developed and how far it has come. The current health reforms are without a doubt a large step in the right direction. By introducing them China has demonstrated a willingness and capacity to tackle a difficult reform agenda. Even though we have identified shortcomings and potential obstacles in this chapter, we are of the opinion that in the longer term the necessary compromises will be made, solutions will be found and implemented, and China will continue to make remarkable progress towards a modern, equitable and effective health-care system. Inpatient outpatient

Bibliography


World Bank. (2010a) China Health Policy Notes 2: Fixing the Public Hospital System in
