

Health-care Provision and Health-care Reform in Post-Mao China

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Background

Throughout much of China's history, health care was seen largely as an individual responsibility, not a right. The attempts by Mao's regime to build a system of state-sponsored health care thus marked an important departure from the historical norm. The early 1950s saw the establishment of health insurance plans for government officials and state workers and the construction of state-owned hospitals and clinics at the county and district levels. By 1959, China had built a three-tiered health care system consisting of county hospitals, commune health-care centers, and brigade (village) clinics. This system delivered not only medical treatment, but also preventive care.

During the Cultural Revolution (1966-76), an unprecedented number of health personnel were sent to the countryside. "Barefoot doctors," farmers who were given informal medical training, became popular to treat common illnesses and promote preventive health care. At the same time, a community-based health insurance scheme called cooperative medical care also spread rapidly.

By 1976, China had more doctors, nurses, and hospital beds than virtually any other country at its level of economic development, and as a result, the general health of the Chinese people improved remarkably. Between 1949 and 1975, the average life expectancy increased from 35 years to 65 years.

The Urban-Rural Gap

Mao's death and the ensuing economic reform dramatically changed the landscape of health care in China. The demise of people's communes and the return to household farming in the early 1980s eliminated communal welfare funds, which had been the main source of financing for the Maoist rural health-care system. The number of barefoot doctors and villages implementing cooperative medical care dropped rapidly. Meanwhile, the rural economic reform increased the disposable income of peasants, who could now afford to bypass the village health-care stations or township health centers and seek medical care at urban hospitals. This development not only undermined the three-tiered referral chain in the countryside but also generated strong demand for more and better health care in cities.

When health-care institutions in the countryside started falling apart in the early 1980s, rather than take corrective action, the leaders of the Ministry of Health publicly called for their demise and promoted a policy of modernization to be implemented mostly in the cities.

As a result, the rural-urban gap in health care expanded. By the end of the Mao era, the health resources distribution actually favored rural areas in terms of the share of the hospital beds and health professionals. By the 1990s, the distribution had been reversed in the favor of urban residents; representing only 20 percent of China's population, urban areas had more than 50 percent of the country's hospital beds and health professionals. Compared with rural health units, urban health institutions have better educated health personnel as well as larger budgets for foreign or sophisticated equipment.

The growing demand for urban health-care services, coupled with the rapid urbanization—more than half of the population today live in the cities—created a vicious cycle that encouraged greater investment in the urban health-care sector. By 2004, nearly 80 percent of government health spending went to urban health-care institutions. Also, 80 percent of the urban health resources are concentrated in large hospitals, exacerbating the problem of access. Rural patients seeking inpatient care at large urban hospitals often had to wait for weeks, if not months to be assigned a hospital bed.

Governance Issues

China's miraculous economic growth is often viewed as an indication of its successful domestic governance. Yet if we use health as a yardstick for measuring governance, China's record has been far less impressive. Average life expectancy rose by only 6.9 years between 1981 and 2010, compared to the increase of 32.9 years during the pre-reform era (1949-80). Put it differently, three decades of post-Mao reform is associated with only 21 per cent of the improvement in people's health status in the six-decade history of the People's Republic of China.

Why did robust economic growth fail to translate into similar gains in the health-care sector? In my book *Governing Health in Contemporary China* (2013), I proposed that a polity shift from "bandwagoning" to "buck-passing" accounted for the content and form of health-care reform as well as the final reform outcome. Under Mao, the bandwagoning polity played a major if not the single most important role in health policy process. The concentration of political resources and the marginalized bureaucratic role led to quick cue taking, decline in strategic concerns, and more policy coordination. As a result, Mao was able to formulate and pursue his preferred health policy. While there were problems in the quality of services and the sustainability of the health-care institutions and programs, the unprecedented party-state intervention in health-care realm led to significant progress in reducing urban-rural gap and increasing access to health care.

Under the buck-passing polity, central party leaders, health bureaucrats, sub-national governments, even health-care units all had strong incentives to “pass the buck” – shirk their responsibilities in health-care provision. With the death of Mao, health ceased to be a sensitive political issue in elite politics. Single-minded pursuit of economic growth further marginalized public health and health care on government leaders’ agenda. In consequence, the party center shook off responsibilities to formulate health policy and finance public health.

As health policy process was no longer characterized by constant and concrete involvement of the political leaders, health bureaucrats were in a more secured position to pursue their own agenda. In fact, since the Maoist health model was premised on the minimized bureaucratic involvement, it was targeted for attack by health bureaucrats purged during the Cultural Revolution and rehabilitated in the post-Mao era. Shirking its responsibility in rural health care, the Ministry of Health chose to promote the modernization of China’s health sector. Fiscal and bureaucratic decentralization nevertheless made it almost impossible for the Ministry to mobilize sufficient resources to pursue its modernization agenda. This generated strong incentives for the health bureaucrats themselves to “pass the buck” – shifting the financial burden to other departments, health-care units, and users of health care.

Preoccupied by local economic growth, local governments, especially those at the grassroots level, had few incentives of earmarking significant amount of resources for health care. If there were any incentives, they were further reduced by the 1994 tax reform (in which the central government recentralized tax power while decentralized social responsibilities). Not surprisingly, government spending as a percentage of total health expenditures dropped precipitously in the post-Mao era, from 39 percent in 1986 to 16 percent in 2002.

Dwindling government support, in conjunction with market-oriented economic reform, also changed the behavior of health-care providers. Public hospitals began aggressively selling drugs and providing extra, often high-tech services in order to recoup losses caused by shrinking government support and fuel growth in revenues. Total health spending increased exponentially. And this occurred at a time when there was virtually no social safety net—the 1998 National Health Services Survey found that more than 87 percent of the rural population and more than 44 percent of urban residents had no health insurance of any kind. The cost of health care was ultimately borne by the users of health care, especially those living on the margin of the society (e.g., farmers, laid-off workers, migrant labor). By 1999, the private share of health-care spending exceeded 59 percent. In some cases, rising costs deterred the sick from seeing doctors; 60–80 percent of farmers who were seriously ill died at home because they could not afford care.

The Launch of Health-care Reform

Amid public outcry against problems of affordability and access, a new round of health-care reform was on the government agenda in 2005. Unlike the traditional pattern of decision making, which relies on bureaucratic agencies to come up with policy proposals, the government decided to solicit reform proposals from a diverse set of actors. Indeed, except for the proposal from a government think tank, all proposals came from non-governmental, external agencies such as universities and international government agencies.

The proposals, perspectives and positions of the experts involved in drafting the reform proposals nevertheless mirror those of vested bureaucratic interests. By September 2005, two reform approaches had emerged. A pro-government approach, inspired by the British model, proposed that government invest in public hospitals to maintain their “public benefit nature” and provide public health and basic health care for free. This approach received support from the Ministry of Health, which is the owner, operator, and regulator of public hospitals. By contrast, the pro-market approach, influenced by the Bismarck model, favors reduced government direct interference in health services provision and the use of the third party to purchase health services. This approach receives support from the Ministry of Labor and Social Security, which is in charge of the administration of

national labor and social security undertakings and has a strong interest in building a nationwide social health insurance system.

Since China's decision making emphasizes consensus, it is relatively easy for one involved policy actor to sabotage the adoption of important policies that it does not like. In the initial stage of the reform, the pro-government approach prevailed. Indeed, until May 2007 all the six proposals favored government dominance in the health sector. But apparently encouraged by the ministries supporting a pro-market approach, two additional proposals with different perspectives were later submitted. The crucial difference lies in whether government spending should mainly go to the "supply side" (i.e., public hospitals) or the "demand side" (i.e., the patients). While the first six proposals supported the idea of government financing of health-care providers toward establishing a free health-care system, the two new proposals emphasized the need for financing the demand side and achieving universal health coverage through the spread of social insurance. The latter two proposals were favored by the National Development and Reform Commission (NDRC), Ministry of Finance, and Ministry of Labor and Social Security. With support from powerful central ministries such as NDRC, the pro-government approach was no longer the favorite approach in the health-care reform. The pro-market approach received further support from the top level in July 2007 when the Office of the State Council issued a document endorsing the spread of social insurance in the urban areas. The pro-government approach nevertheless continued to have support from the Ministry of Health. By October 2007, there was a renewed emphasis on government intervention in the health sector. At the 17th Party Congress, President Hu Jintao reemphasized the "public benefit nature" of China's health-care undertakings, and explicated the need to "strengthen government responsibilities and investment."

The draft reform plan, completed in October 2007, reflected a compromise between the two approaches, with importance of government financing on both demand and supply sides written into the document. In part because of the influence of various interest groups, it would take an additional year to finally unveil the document to the public. In January 2009, the State Council approved the new health care reform plan.

An Assessment of the Health-care Reform

In 2009, the health-care reform was officially kicked off with an objective to provide "safe, effective, convenient and affordable" health-care services to everyone. There are five implementation priorities: health insurance coverage, public health, grassroots health-care institutions, essential drug system, and public hospitals. Between 2009 and 2012, the government invested more than \$371 billion, accounting for 5.7 percent total fiscal spending. This includes more than \$100 billion from the central government budget.

The immediate result of this increased government spending was expanded health insurance coverage. The percentage of people covered by health insurance surged from 30 percent in 2003 to 95 percent in 2011. As a result, the share of out-of-pocket spending dropped from 56 percent to 36 percent in that same period. The reform also generated increased demand for health care, with hospital bed utilization rate up from 36 percent to 88 percent. In addition, significant progress has been made in the equalization of the provision of public health services and improving the financial status of grassroots health-care institutions.

Yet contrary to the rosy picture portrayed by the government and some scholars, the reform has not been successful in addressing the problem of access and affordability. According to a survey released by the independent Horizon Research Consultancy Group in October 2013, Chinese people continue to have difficulty in accessing health care. About 81 percent of the survey respondents said it was difficult to see a doctor, and more than 57 percent said it was more difficult than it was four years earlier to see a doctor (compared to 20 percent who said it has become easier). On the affordability front, 95 percent of the respondents noted that it was expensive to seek care, with 87 percent saying that the cost was higher than it was four years earlier.

Despite the overall increase in utilizing health-care services, access and affordability problems have suppressed demand for health care unnecessarily. Of the respondents, 27 percent said that they opted out of hospitalization, with 74 percent attributing this to the high cost of inpatient care and 41 percent attributing it to the difficulty of being assigned a hospital bed.

Why and how did the well-intended health-care reform go awry? First of all, only one-third of the government investment went to the demand side (e.g., the patients). The irony is that even though two-thirds of the investment went to the supply side (i.e., health-care providers), the government contributes less than 10 percent of the revenues of public hospitals. As a result, not only is the overall benefit level of the health insurance quite low, but the government investment is also unable to leverage the behavior of public hospitals. Second, the essential drug list, with zero mark-up, is only implemented at the township level. Public hospitals at or above county levels are still allowed to sell drugs with 15-25 percent profit margin. Not surprisingly, 45 percent of total hospital revenues are collected from selling drugs, and total health-care cost continues to increase at an annual rate of 10 percent. Third, demand for services of the grassroots health-care institutions remains weak, despite the billions of dollars invested by the government. Both outpatient visits and inpatients received by the township health centers dropped, despite the growth in total number of outpatient visits and inpatients at the national level. Finally, significant progress has not been observed in reforming the public hospitals, widely considered the sine qua non of the health-care reform. Government health departments remain the owners, general managers and regulators of public hospitals, which still provide 90 percent of outpatient and inpatient services, even though 43 percent of the hospitals nationwide are owned by non-public entities. Among the non-public hospitals, 80 percent are controlled and owned by farmers in a small town in Fujian Province. .

China's Health-care Reform and U.S.-China Relations

China's health-care reform has generated demand for more and better health care, with opportunities for private and overseas investment. With sales of \$71 billion, China is the world's third largest pharmaceutical market, and, with an annual growth rate between 15 and 20 percent (twice that of the United States), is poised to become the second largest by 2015. Health spending in China is projected to almost triple, hitting \$900 billion by 2020. Given the U.S. advantage in pharmaceutical R&D as well as health-care management and service quality, China's health-care reform means tremendous business opportunities for U.S. biopharmaceutical firms, hospital groups, and insurance companies. In 2011, the top ten multinational pharmaceutical companies saw an average growth in sales of over 27 percent in China. In addition, the rapid population aging in China has also led to the growth of a new market: institution-based senior care. Currently, less than 2 percent of the senior population uses institution-based care, but more than 10 percent are willing to receive care in institutions. The number of elderly people who are able to afford senior housing will reach 22 million by 2020. In August 2013, Premier Li Keqiang convened a State Council meeting, signaling that China would relax restrictions on market entry and encourage overseas capital to invest in China's health-care industry, including senior care.

Demographic and epidemiological transitions, as well as movement toward affordable and quality health care, have also raised concerns regarding cost control. As shown in China's investigation of GlaxoSmithKline's involvement in commercial bribery last year, China's health-care reform has also led to stricter government regulation to rein in the unbridled health-care costs. This, in conjunction with population ageing and growing burden of non-communicable disease, has generated strong demand for affordable drugs and "self-developed" medicines. U.S. biopharmaceutical firms still enjoy a competitive edge in terms of size, technology, and R&D investment over their Chinese counterparts, and China still has strong incentives to create an environment attractive to foreign investment in its health-care and biopharmaceutical industry. Indeed, thus far China's protection and enforcement of pharmaceutical-related intellectual property rights has not been a major issue in Sino-American economic relations over the past decade. But China's efforts to develop a robust homegrown biopharmaceutical industry may lead to increased pressures for U.S. pharmaceutical firms doing business with

China to trade market access for technology transfers. In the future, we are probably going to see growing disputes between the two countries over issues such as market access, technology transfer and compulsory licensing. U.S. pharmaceutical firms will therefore face a much tougher and more complex business environment in the years to come.

An effective strategy to engage China's health-care sector requires U.S. government to continue promoting business opportunities for U.S. biopharmaceutical firms, hospital groups, and insurance companies. In the meantime, it is also important for the U.S. government and companies to demonstrate the willingness to work with China in addressing health issues of their immediate concern, including population aging, tackling NCDs and their risk factors, and access to effective and affordable medicines.