China's health care reform: A tentative assessment

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ABSTRACT

China has recently unveiled an ambitious new health-care reform plan, entailing a doubling of government health spending as well as a number of concrete reforms. While the details of the plan have not yet been completely announced, we offer a preliminary assessment of how well the reform is likely to achieve its stated goal of assuring every citizen equal access to affordable basic health care. The reform is based on three fundamental tenets: strong role of government in health, commitment to equity, and willingness to experiment with regulated market approaches. Within this framework, the reform offers a number of laudable changes to the health system, including an increase in public health financing, an expansion of primary health facilities and an increase in subsidies to achieve universal insurance coverage. However, it fails to address the root causes of the wastes and inefficiencies plaguing China's health care system, such as a fragmented delivery system and provider incentives to over-provide expensive tests and services. We conclude that China should consider changing the provider payment method from fee-for-service to a prospective payment method such as DRG or capitation with pay-for-performance, and to develop purchasing agencies that represent the interests of the population so as to enhance competition.

JEL Classification:
I11
I18
I38

Keywords:
Health Care
Health insurance
Income distribution
Asymmetric information
Incentive compatibility

1. Introduction

After years of intense discussion, deliberation and debate, in April, 2009 China finally unveiled its health-care reform plan (Anonymous, 2009a; Chen, 2009). President Hu clearly stated that the goal of the reform is to assure that every citizen has equal access to affordable basic health care by 2012. The announced policy explicitly states the government’s role of ensuring equity and providing public goods, while at the same time also encouraging the exploration of market mechanisms such as purchasing and competition to improve quality and efficiency. Implicitly, China is searching for the right mix of government and market, a fundamental question that countries around the world are still struggling to answer.

The Chinese government announced that it will spend an additional 850 billion RMB (USD 125 billion) over the next three years to invest in five specific areas: (1) expand insurance coverage with a target of achieving universal coverage by 2011, with significant demand subsidies for the rural population to enroll in the New Cooperative Medical Scheme (NCMS) and for the urban uninsured to enroll in the Urban Resident Basic Medical Insurance Scheme (URBMI); (2) increase government spending on public health services, especially in lower-income regions, with the goal of equalizing public health spending across regions; (3) establish primary-care facilities—community health centers in urban areas and township health centers in rural areas—which will serve as gatekeepers in the long run; (4) reform the pharmaceutical market; and (5) pilot test public hospital reforms (Anonymous, 2009a).

Can China's health care reform achieve its intended goals? Drawing on economic theories and existing empirical evidence from China and elsewhere, the primary objective of this paper is to provide a preliminary answer to this question. An assessment of
China's health care reform at this time is necessarily tentative and preliminary. As with any reform, the devil lies in the details. The details of China's health reform have yet to be announced, although a set of over twenty companion policies are expected to be published soon. This assessment therefore focuses on the fundamental principles underlying the reform. We first provide an overview of the root causes of the problems confronting China's health care system, then analyze the extent to which China's reform initiatives address these problems. We argue that while China's current reform provides some necessary changes to the health care system, these changes are not sufficient if China is to achieve its stated goal to provide affordable universal basic health care for its population of 1.3 billion.

2. Problems confronting China's health care system and their underlying causes

On the eve of China's health care reform, the greatest discontents voiced by the public are unaffordable access to health care, impoverishment due to heavy medical expenses (commonly known in Chinese as “kan bing nan, kan bing gui”), and huge inequalities across regions and between urban and rural areas (Hsiao, 2004). What are the underlying causes of these dismal conditions?

One commonly cited reason for unaffordable access and household impoverishment is the lack of insurance coverage. As recently as 2002, close to 90% of the rural population had no insurance coverage. In the urban areas, only around half of the population is covered, nearly all of whom are formal sector employees. Workers' dependents and migrant workers are not covered.

A more fundamental root cause of unaffordable access and high risk of medical impoverishment is often neglected in the literature, and is certainly less emphasized in the reform document. This is the rapidly rising cost of health care, which stems primarily from waste and inefficiency within the health care system itself, caused mainly by the providers' profit seeking behavior. This behavior, in turn, is the result of a combination of interrelated policies, including the under-funding of public facilities, distorted price schedules, and high drug mark-ups.

Although the majority of Chinese health facilities are publicly owned, they rely heavily on revenue-generating activities for financial survival. Consequently, while most health facilities are “public” in terms of ownership, they are really “private, for-profit” in terms of behavior. As of the early 1990s, government subsidies for public health facilities have represented a mere 10% of the facilities' total revenues. To keep health care affordable, the government sets prices for basic health care below cost. At the same time, the government wants facilities to survive financially, so it sets prices for new and high-tech diagnostic services above cost and allows a 15% profit margin on drugs. This price schedule has created perverse incentives for providers, who have to generate 90% of their budget from revenue-generating activities, and has turned hospitals, township health centers and village doctors all alike into profit seeking entities. Equally important, this price setting approach has created a leveraging effect whereby a provider has to dispense seven dollars' worth of drugs to earn just one dollar of profit.

Compounding the problem further is the collusion between providers and the pharmaceutical sector. Hospitals receive kickbacks from drug companies for prescribing their products, and doctors' bonuses are often tied to these kickbacks. In rural areas, village doctors buy expired and counterfeit drugs at low cost and sell them as valid products at higher prices.

These systemic distortions have created a health care system in which providers over-prescribe drugs and tests and hospitals race to introduce high-tech services and expensive imported drugs that give them higher profit margins. For example, 75% of patients suffering from a common cold are prescribed antibiotics, as are 79% of hospital patients—over twice the international average of 30% (Zhou, undated). Consequently, China's health care expenditure has been growing at 16% per year—7% faster than the growth of GDP—for the past two decades (Blumenthal & Hsiao, 2005). Empirical evidence around the world has generally found an income elasticity of health expenditure in the range of 0.9 and 1.1 (for a review, see Gerdtham and Jonsson (2000)). China's growth of health expenditure relative to its income growth has thus far exceeded that of international experience. In addition to the unnecessary costs this incurs, the wasteful treatment patterns behind such rapid health expenditure growth can also harm patients.

With limited insurance coverage, rapid health expenditure growth creates an additional force impinging on households' health-expenditure burdens. Out-of-pocket payments as a share of total health expenditure grew from 20% to almost 60% between 1978 and 2002 (Smith, Wong, & Zhao, 2005), leading China to have one of the highest ratios of out-of-pocket payments to total health expenditure in all of Asia, especially when compared to those countries that provide universal coverage through established national or social health insurance schemes (Yip & Hsiao, 2008). Studies found that over one-third of households have reduced their consumption or been impoverished by health-related expenditures (Hu et al., 2008).

Table 1 shows the financial burden of health care on rural and urban households. Between 1993 and 2003, health expenditure as a share of household income increased, on average, from 8.2% to 10.7% in rural areas and from 6.0% to 7.2% in urban areas. This shows that although income has been growing, health care spending has been growing even faster.

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Note: The table presents the per capita out-of-pocket health expenditure as a percentage of income for urban and rural areas in China for the years 1993 and 2003. The data are categorized by income quintile, with the lowest quintile representing the lowest income group and the highest quintile representing the highest income group. The data show a significant increase in health expenditure as a share of household income, particularly in rural areas, between 1993 and 2003.
Table 2 further illustrates rapid growth in health expenditure as a major contributor to individuals’ financial risk when they are faced with illnesses. Between 1993 and 2003, while real income per capita has less than doubled in both urban and rural areas, health expenditure per admission and/or per outpatient visit has more than quadrupled. Subsequently, while the cost of an episode of hospitalization was about 74% of a rural resident’s income and 80% of an urban resident’s income in 1993, the cost was twice as high as an individual’s annual income in 2003, for both the urban and rural samples.

Finally, China’s health care system is plagued with major inequalities. As Tables 1 and 2 show, even within the rural and urban areas there exist income disparities in the financial burden of health, with rural residents in the lowest income quintile spending the highest percent of their income on health care. Other studies have also documented significant inequalities in health care utilization and health outcomes in China (Tang et al., 2008; Yip & Mahal, 2008; Yip, 2009). One plausible explanation for these disparities is the heavy reliance on local public finance to fund health care. In 2003, 91.7% of the total government health appropriation came from local governments (Zhao et al., 2007). As a result, there is a wide variation in public spending on health across regions with different levels of economic development. For example, in 2003, per capita public spending on health for rural residents by region ranged from 32.36 RMB in Guizhou to 266.52 RMB in Zhejiang (Smith, Wong, & Zhao, 2004). A recent econometric study also empirically shows that provincial government budget deficits are a significant factor in explaining inequalities in public expenditures on health across regions (Chou & Wang, 2009).

In sum, China’s health care system suffers from a number of deeply rooted problems. A distorted pricing schedule, combined with a financing system that puts intense pressure on providers of all levels to bring in revenues, has led to an over-provision of high-tech diagnostic tests/services and expensive drugs at the expense of basic health care services. In addition to the potential harm this can cause patients, this has also led to a rapidly rising rate of health care expenditures, far outstripping the growth in national GDP. Moreover, limited financial risk protection means that individual patients bear the brunt of these high health care costs in the form of out-of-pocket spending. Finally, these problems are not distributed equally throughout the country—the poor and those living in rural areas are the hardest hit. Does the new health reform offer a solution to any of these problems?

### 3. China’s health care reform

The April, 2009 health care reform announcement represents a significant milestone in China’s path to establishing a strong national health care system. Following the guiding principle of building a harmonious society by balancing economic and social development, equity is given a high priority. Moreover, the reform announcement explicitly declares that the government has an important role to play in the health care sector and that this health care reform is government-led. This marks a major departure from the heavy reliance on the market that has been the hallmark of the financing and organization of China’s health care system for the past two decades. While the government acknowledges that there is still a role for the market in the new reform, especially in terms of improving efficiency and quality, the exact policies are vague, with only encouragements to explore various market mechanisms such as competition and purchasing, but no requirements that healthcare providers do so.

Importantly, the April reform announcement contains a concrete timetable for the injection of significant new government resources into the health sector. Over the next three years, the government will spend an additional 850 billion RMB (USD 125 billion) on healthcare. Since the early 2000s, government health spending has already risen significantly, reaching 240 billion RMB in 2008, compared to 112 billion RMB in 2003. The additional spending means that for the next three years, the government will double its current level of spending on healthcare.

The new funding will be allocated according to the following guiding principles. Priority will be given to public goods, including public health and health promotion activities, such as vaccination and immunization, safe motherhood, health education, and screening for chronic conditions. Government spending on public health will increase to 15 RMB per capita (many rural areas currently only spend 4–6 RMB per capita on public health), with the goal of increasing to 20 RMB in 2011. To improve efficiency in

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<th>Table 2</th>
<th>Growth in income relative to growth in health expenditure. Source: National Health Services Survey, 2003.</th>
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Note: All expressed in 1993 values.
resource allocation, funding will be directed towards building a healthcare delivery system with a focus on strong primary-care delivery, anchored on community health centers in urban areas and township health centers in rural areas. Once they are well established, these facilities are intended to serve a gatekeeping function, managing referrals to specialist care and hospital use. The government will invest heavily in infrastructure for these facilities, and, more importantly, will provide full funding for their staff, with the goal of alleviating the need for primary-care facilities to generate their own funding. By doing so, the government hopes that providers will shift their attention to patient care and begin thinking in terms of the patients’ needs rather than in terms of increasing their own income. To improve equity in resource allocation, more resources will be targeted to lower-income regions and rural areas. These additional resources will be used to build new health facilities and to improve public health service delivery facilities so that they are of comparable quality to those in more economically developed areas.

Limited insurance coverage is a fundamental cause of unaffordable health care. To address this issue, a significant share of the new government spending will be used to subsidize individuals’ enrollment in health insurance schemes—the New Cooperative Medical Scheme (NCMS) in rural areas and the Urban Resident Basic Medical Insurance (URBMI) Scheme in the urban areas—with a target goal of achieving universal coverage by 2013 (Anonymous, 2009b). The NCMS began as a pilot program in 2003, and enrollment has skyrocketed since that time, covering over 90% of the rural population by 2008. The per capita government subsidy towards NCMS has grown substantially from 20 RMB in the initial waves in 2003 to a target of 120 RMB in 2010.

The URBMI targets the 420 million urban residents not covered by BMI, including children, the elderly, the disabled, and other non-working urban residents. A large-scale pilot program for this scheme began in 2007. In 2008, nearly 41 million people had already enrolled, and the government announced its intention to roll the program out in half of China’s cities by the end of the year, with the goal of ultimately extending coverage to all Chinese cities by 2010 (Cheng, 2008; Lin, Liu, & Chen, 2009). Like NCMS, government subsidies for enrollment in URBMI are targeted to reach 120 RMB in 2010. However, since health expenditure is more expensive in urban areas, this means that the share of premium paid by individuals will be significantly higher in urban than in rural areas. (Lin et al., 2009).

In addition, funding will also be increased for the Medical Assistance program, a safety-net program introduced between 2003 and 2007 to provide financial assistance with health care payments for the poorest and most vulnerable residents in both rural and urban areas, especially those covered by the Wu Bao (Five Special Categories, including veterans, low-income individuals without children, etc.), Te Kun and Di Bao (Households falling below official poverty lines) social assistance programs (Wagstaff, Lindelow, Wang, & Zhang, 2009).

The new reform announcement is less specific on how to improve efficiency and quality within the health system, and how to control health expenditure growth. The announcement’s call for a “pilot” of public hospital reform is akin to an admission that more research must be done before more specific policy guidelines can be drawn up in this area. The government plans to examine the findings and experiences of these pilot experiments after three years.

4. A tentative assessment

In this section, we examine how well China’s latest health-care reform plan addresses the fundamental causes of the problems confronting China’s health care system, and in so doing analyze how likely it is that the reform will achieve its stated goals. In order for the large influx of new government health care spending to benefit the people, it is important for the Chinese leadership to acknowledge certain gaps in the reform plan. In our analysis, we identify these gaps and consider ways in which they can be addressed.

4.1. Affordable access to health care and financial risk protection

By focusing national energies towards achieving universal health insurance coverage, the Chinese health reform tackles one of the fundamental problems underlying unequal and unaffordable access to health care, as well as the major financial risk due to medical expenditures. Expanded health insurance coverage should reduce financial barriers to access. However, as discussed in section 2, another root cause of unaffordable access to care and impoverishment due to medical expenditures is the rapid growth in health expenditure stemming from waste and inefficiencies within the system. Both economic theory and international experience tell us that health insurance coverage coupled with a fee-for-service provider payment method will further exacerbate the problem of cost inflation. Because of information asymmetry, health care providers, especially those paid by fee-for-service, have an incentive to induce their patients to use clinically unnecessary services that increase provider income. When the patients are insured and do not face the full price of medical services, the incentive to induce demand is even stronger, a phenomenon known as supply-side moral hazard. In the long run, this type of provider behavior throws the sustainability of the insurance scheme into question.

Since the government has already committed a significant sum to expanding the NCMS in rural areas, it is helpful to review the evidence on how well NCMS has been able to improve access to care and reduce the financial burden due to medical expenses. NCMS was first rolled out in 2003, and some rigorously conducted evaluations are beginning to emerge. With some exceptions (e.g., Lei & Lin, 2009), the literature so far has found that NCMS increases the likelihood of outpatient visits and inpatient admission (e.g., Wagstaff, Yip, Lindelow, & Hsiao, 2009 and Wagstaff et al., 2009). However, the results of NCMS’s impact on reducing out-of-pocket spending and households’ financial burden are less promising. Most studies have found that NCMS has little or no impact on reducing households’ out-of-pocket spending, or reducing the incidence of poverty or catastrophic expenditure due to health care spending (measured as out-of-pocket expenditure on health greater than a threshold, for example, 30% of household’s
some studies have even found that out-of-pocket spending has increased (Wagstaff, Yip, et al., 2009). This is not surprising, and supports our prediction that insurance coverage alone will have only a limited effect on alleviating the problems of unaffordable access to health care and major financial risk due to medical expenditure. International experience has found that when countries expand health insurance coverage without appropriate supply-side controls, health care expenditure will grow as a result of demand-side moral hazard (patients using more services than necessary when they do not face the full price of medical services) and more importantly, supply-side moral hazard (providers recommending more services than clinically necessary when they know that patients do not have to bear the full cost of medical care).

What, then, needs to be put in place in order to maximize the benefit that the public obtains from the expanded insurance? The answer lies in establishing provider payment methods that give providers better incentives to improve efficiency and quality, and to create conditions that enhance competition.

4.1.1. Reforming provider payment methods

The method of provider payment determines the incentives faced by health care providers, and thus their treatment decisions. A fee-for-service (FFS) payment method encourages providers to provide too many services, since providers are reimbursed retroactively and therefore do not bear the full financial risk of over-provision. In the case of China, the incentive to over-provide is further compounded by the distorted price schedule and high drug mark-ups which lead to an over-reliance on high-tech diagnostic tests and expensive drugs. An alternative to FFS is a prospective payment method, which makes providers bear the financial risks of over-provision and thus provides incentives for them to reduce inefficient use of services. Two examples of prospective payment methods that could be suitable for China are the Diagnosis Related Group (DRG) payment method for hospitals and risk-adjusted capitation payment method for primary-care providers. Both of these payment methods reimburse providers a fixed amount depending on certain characteristics of their patients—the disease profile under DRG, and demographic characteristics under capitation. Physicians thus have an incentive to keep costs down so as not to exceed the fixed reimbursement amount. Positive experiences have been obtained in a number of countries, including the United States, the United Kingdom, and some transition economies (Schneider, 2008). Pay-for-performance could also be combined with DRG and/or capitation payment to improve quality (Eicher, 2006; Rosenthal, 2008). Under a pay for performance payment mechanism, providers are rewarded for improving the patients’ health outcome directly, or engaging in activities that have proven to be cost-effective in improving the patients’ health outcomes.

A recent review of provider payment methods in China suggests that a subset of localities have in fact moved towards prospective payment methods (Meng, 2008). Many of these were initiated by urban health insurance schemes, whose budgets have been feeling the strain of high health expenditure growth rates. To help reduce costs, the schemes have experimented with alternative payment methods. For example, in Hainan, the Social Insurance Bureau decided in the mid-1990s to introduce prospective payment methods in six hospitals, changing from FFS to a prospective budget. Yip and Eggleston (2001) evaluated the impact of the reform and found that, when compared with a similar set of hospitals that continued to be paid via FFS, these six hospitals saw slower rates of expenditure growth (about 50%) and lower co-payments per inpatient admission (about 40%) over the study period (1995–1997). In a companion paper, Yip and Eggleston (2004) found that Hainan’s payment reform was also associated with a slower increase in spending on high-margin services such as expensive drugs and high technology services.

4.1.2. Enhancing competition through effective purchasing

In the recent reform announcement, China announced a strong role for government in ensuring equity in health system development. At the same time, however, policymakers did not completely renounce the efficiency gains that can result from a market approach. In fact, the policy document mentions the use of purchasing and competition to improve efficiency but without specifying how such policies would be formed and implemented. By allocating a significant share (some estimate close to two-thirds) of the additional 850 billion RMB of government health spending to the demand side, China has in effect provided consumers/patients with the financial power to choose providers, and thus created a platform for using a regulated market approach to improve efficiency and quality. However, because of significant asymmetry of information in the health care market, consumers/patients need to rely on a third-party purchaser to represent their collective interests to make informed choices for them (Hsiao, 2007). The fundamental question that China faces now is, if competition is to be used to improve efficiency and quality, what type of organization would or could act as the patients’ best agent? Could the public insurance funds play the role of a purchaser? If not, how can such an organization be created?

While purchasing schemes are still in their infancy in China, some experimental efforts that use community participation to organize purchasing have produced promising results. For example, in a social experiment of rural health insurance conducted in the Western region, a fund board which included elected representatives from the villages, government officials, township health center directors and town financial auditors was created to act as a single purchaser of provider services. Purchasing decisions are based on provider performance and villagers’ rating. At the end of three years’ experimentation, the scheme demonstrated positive results of reduced expenditure and high public satisfaction (Hsiao, Yip, & Wang, 2008).

Another important determinant of effective purchasing is whether the purchaser has sufficient leverage over the providers to allow it to negotiate prices and quality of services with the providers. In general, the larger the share of provider revenue that the purchaser controls, the more likely it is that the purchaser can leverage desired performance from providers. As observed in the rural areas, purchasers in NCMS models which cover only the costs of hospitalization have no influence over the provision of outpatient care. Village doctors and township health centers continue to over-prescribe drugs. In contrast, purchasers in NCMS models which cover both inpatient and outpatient services are better placed to exercise selective contracting and change the
provider payment mechanism, as it represents a significant share of provider income. Furthermore, county hospitals receive revenue from both the NCMS and from the scheme covering urban workers, limiting the NCMS management office’s leverage over county hospitals (Yip & Hanson, in press).

4.2. Reducing inequality

China’s health care relies on joint funding by central and local governments. For example, of the 850 billion RMB of new financing, the central government is only responsible for 40%, while the local governments are responsible for 60%, or a total of 520 billion RMB (Tao, 2009). Although this represents an increase over the 27% previously provided by the central government, a 60% share can be a significant financial burden on local governments, especially in poor areas. Local governments tend to have fiscal capacities commensurate with the local economy, suggesting that the governments of poorer regions will have a harder time meeting their financial responsibilities than will the governments of more prosperous regions. This disparity in funding ability could create significant barriers in reducing inequality in China’s health care system.

5. Conclusions

Assessing China’s health care reform is a challenging task because China’s health care reform is just beginning, there is limited empirical evidence to draw upon in making conclusions about its efficacy. Moreover, because the details of the plan have yet to be revealed to the public, any assessment at this time is necessarily tentative and preliminary. Nevertheless, by relying on theory, international experience, and logical deduction, we are able to put forth a provisional appraisal of the reform.

With its significant new injection of government funding and a commitment to infrastructure building, we cannot deny that China’s current reform provides some important and necessary changes to the health care system. However, these changes are not sufficient if China is to achieve its stated goal of providing affordable universal basic health care for its 1.3 billion citizens. In particular, in order to ensure that the new funding brings tangible benefits to the people, China needs to adopt more policies aimed at improving efficiency and quality. More specifically, we recommend that China move away from the fee-for-service provider payment method towards a prospective payment method that will provide better incentives for providers. We also recommend that reform will be made more effective if purchasing agencies are established that will represent the best interest of the patients and select and contract providers based on cost and quality. As a matter of fact, some of these ideas are already being considered. For example, the Ministry of Health is actively developing a DRG-type payment method for public hospitals, although the details have not yet been published. Similarly, bulk purchasing for drugs by which a central agency purchases drugs on behalf of all the health facilities in a locality, and selects suppliers through competitive bidding is also being tested in many localities.

A few caveats are in order. First, although the proposed payment method can be an effective policy tool in changing provider behavior, no single provider payment method is perfect. International experience has taught us that any provider payment method that is effective at reducing expenditure tends to reduce quality as well. To safeguard quality of services, therefore, companion management strategies such as quality monitoring will be necessary. Moreover, adverse incentives built into fee-for-service provider payments are not the only culprit behind the waste and inefficiencies within China’s health care delivery system. China’s delivery system is extremely fragmented, with little coordination of care among providers. Tests are often repeated when patients move from one facility to another, and freestanding hospitals and clinics often hold onto patients when they should be referred elsewhere. Eliminating these inefficiencies requires a more comprehensive reform than has been proposed.

The second caveat is that while competition certainly has the potential to improve efficiency and quality, it is only feasible in areas that can support more than one provider. In rural areas, especially remote mountainous areas, competition is simply not a viable strategy. Other alternatives, such as bilateral negotiations between funders and providers, or direct management with improved information systems, should be explored in these regions.

Despite these critiques, China’s health care reform is impressive in both scale and scope. Under the broad direction of the national policy, many localities have already begun experimenting with innovative ways to improve their own local systems. Together with appropriate and objective evaluation, these experiments promise to generate valuable and important knowledge for guiding China’s health care reform into the future.

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