Fixing the Public Hospital System in China

Executive Summary

Overview of public hospital reform

Since the mid-1980s—with the collapse of the previous era's commune-based health system—the main impetus behind hospital reform in China has been to reduce the financial burden that hospital care places on government budgets. In 1992, the Ministry of Health granted substantial financial autonomy to hospitals, allowing them to charge for their services and to sell drugs at a profit. They are now permitted to keep the surpluses that they generate, and they are responsible for their debts and operating losses. They can use their surpluses to invest in new facilities and services, or to finance salary enhancement systems.

Prices for basic medical care are regulated. In general, medical services produce net losses, and drug revenues produce net gains. Hospitals have been given freedom to develop higher quality services for which they can charge prices above the levels reimbursed by social insurance. Public hospitals can also enter into joint ventures with the private sector. They are allowed to raise "social capital" from medical staff and retirees, which can then be invested in private for-profit units within the public facilities.

Reforms such as these have encouraged growth in the number of hospitals and the volume of their activity. Though still low by international standards, there were 19,712 hospitals nationwide by 2008, an average of 2.2 hospital beds per 1,000 population and 1.2 township health center beds per 1,000 rural population. About 20 percent of hospitals are private and for-profit (handling about 5 percent of total outpatient and inpatient services, though only about 1.5 percent of emergency cases).

The growth and character of the public hospital system has created additional scope for local reform initiatives. In some parts of the country, subnational governments and public hospitals have experimented with alternative management and governance models. There have been experiments with state-owned enterprise models, trustee models, contracting of hospital management, leasing of hospital assets, and creation of shared hospital management services company. Some local administrations have separated management of hospital facilities and assets from operational management of service delivery. Some subnational governments have reformed the regulations for appointing administrators and managers by introducing performance monitoring of the senior management team or "leaders group." Others have carried out reform of groups or networks of medical facilities. For example, they have integrated planning and management of groups of hospitals, sometimes including hospitals affiliated with non-health departments. They have strengthened cooperation between hospitals and other medical institutions, as well as between medical and family planning services institutions.

Some public hospitals have improved cost management by outsourcing support services such as hospital maintenance, administrative and information management. A range of
pharmaceutical cost-reduction initiatives and pharmacy management reforms have been carried out. To some extent, management has improved as a result. The pilots have generated important lessons for broader reforms in the future.

Social health insurance has expanded in parallel with hospital organizational reform. Mirroring international models, reforms in provider payment methods have complemented hospital reforms. Some of these initiatives have followed the general principle that "money follows patient choice."

The 2003 SARS outbreak spurred a review of public health functions of medical facilities. Since 2006, a series of "common sense" adjustments of hospital policy have been carried out—in particular, to address concerns about unintended effects of the self-financing policies. These adjustments included three key "separations"—separation of hospital management from operations; separation of medical services from drug sales; and separation of for-profit privately-financed from non-profit publicly-financed aspects of hospital operations.

**Issues facing public hospitals in China**

Policies regarding hospital organization face certain limitations and constraints. Although hospitals now enjoy considerable autonomy in their use of private revenues, governance continues to follow the traditional public-sector model. Hospital funds from government budgets are still allocated and controlled by the government hierarchy. Personnel management is still subject to central public sector controls over staffing structures and grades. Intervention from higher levels of government continues despite autonomous status. There is a lack of plurality in hospital provision; and in many areas, there is little competition among providers.

The reforms have had some unintended consequences—for example, the tendency for public hospitals to increase their private revenue by offering more-expensive and more-profitable services. Hospitals have expanded infrastructure and high-technology equipment in a chaotic way. There has been imbalance in the growth and distribution of hospital facilities. Especially in rural areas, county-level hospitals dominate at the expense of primary care and outpatient facilities.

Social capital investment in the private units of public hospitals has weakened management control over the staff who have invested and work in them. Self-financing has not created incentives for efficiency. Irrational over-provision of high-end services for more affluent patients and over-prescribing of drugs have led to uncontrolled growth in medical expenditure.

Patient dissatisfaction with hospital services has risen. The incentives introduced by self-financing have detracted from the essential social responsibilities of public hospitals—to ensure affordable access to quality medical services for the poor; to provide preventive health services and rehabilitation; to respond to public health emergencies; and to carry
out medical education and research. Social health insurance and price-regulation have not served to fully protect these core social functions.

The main causes underlying these issues are related to financing, provider payment policies, and the market environment in which public hospitals operate. The mix of limited government subsidies, dominance of the fee-for-services model, and increasing exposure to market competition has sent signals to hospital managers that are inconsistent with the Government’s social objectives for public hospitals. More generally, they have created incentives that work at odds with rational, cost-effective use of resources for health.

Government budget subsidies have been decreasing as a share of total hospital revenues since the mid-1980s. By the end of the 2000s, government subsidies accounted for only about 10 percent of average public hospital revenues. Fees for medical services and drug sales account for the remaining 90 percent.

New forms of public financing have gradually increased—for example, social health insurance reimbursement for medical services fees; compensation for developing capacity to respond to public health emergencies; and compensation for designated programs, teaching, and research. The effect of these new forms of financing is still relatively limited. Despite piloting of provider payment reforms, for example, social health insurance reimbursement is overwhelmingly based on fees-for-service. Out-of-pocket payments by patients and drug sales remain the largest sources of hospital revenue.

Given the financing sources upon which they continue to rely, hospitals are faced with strong incentives to increase the quantity and cost of their services and to increase the volume of prescribing and drug sales. By 2008, drug revenue accounted for an average of 40 percent of gross income of hospitals, far higher than the 15 to 25 percent common in most OECD countries. From a financial point of view, public hospitals have good reason to promote more-profitable higher-technology services and drug prescription oriented to patients who are able to pay. Similarly, they under-provide basic services that are loss-making, including services for patients who cannot afford extra or higher-quality services.

In this financing and provider-payment context, many public hospitals in large cities—especially in affluent areas—have been able to obtain capital investment finance from the private sector. This has enabled them to expand, improve infrastructure, update equipment, and attract the most popular doctors. By contrast, public capital investment financing has focused on smaller municipal-level and rural county-level hospitals, that is, those with less capacity to obtain credit or attract private financing. In the absence of control mechanisms or coordinated planning, the mix of private and social capital investment has been wasteful and duplicated capacity in urban areas. At the same time, there has been underinvestment in rural areas and in facilities providing basic services to poorer populations.

An international perspective on hospital reform
The problems described above are not unique to China. Public hospital reform has been advocated in every region of the world to address widely shared symptoms of inefficiency, waste, user dissatisfaction, brain drain to the private sector, emigration of professionals, failure to reach the poor, mismanagement, and often corruption. These problems are often associated with the nature of public hospitals as public, which is typically means without incentives for good performance and absence of managerial freedom to make change.

This paper uses a framework developed by Preker and Harding (2003) to look more closely at the nature of public hospitals and instruments of reforms. The framework decomposes the incentive regime a public hospital faces into, first, pressures originating from the external environment and, second, pressures originating from the hospital’s organizational structure. The pressures originating from the external environment derive from the relationship of the hospital to other actors in the health system. These come from four main sources—government oversight, organized purchasing, market pressures (from patient/consumer-driven purchasing), and governance from the owners of the hospital.

The instruments that allow hospitals to respond to the pressures of the incentive regime are managerial instruments. Preker and Harding posit five organizational attributes that create incentives shaping the ability of public hospitals and other healthcare providers to deliver on the Government's policy objectives—first, the authority or autonomy given to its managers; second, the market environment created by the provider payment mechanism and exposure to competition; third, the extent to which the hospital keeps its surpluses and is responsible for its losses and debts; fourth, accountability mechanisms; and fifth, the extent to which social functions of the hospital are explicit and fully funded (rather than being implicit or unfunded mandates).

Countries have adopted a range of approaches to hospital organizational reform. For example, the United Kingdom, Estonia, and Colombia have adopted a planned "whole systems" approach. Turkey has adopted phased reforms linked to constituency building. Uzbekistan has embraced an ad hoc problem-solving approach. The United Kingdom, the Philippines, and Macedonia have focused reforms on priorities in public health outcomes.

Reforms in some countries have succeeded with radical "big bang" approaches—for example, comprehensive public hospital autonomy plus provider payment reform in Singapore, Australia, and Estonia. More cautious, gradualist approaches have been successful in the United Kingdom and Tunisia. Whether big-bang or gradualist, a common feature of successful reforms is coherence and consistency in how reforms are designed. Successful countries have typically invested in capacity development (management, contracting and supervision capacity), and they have matched the pace of reform implementation to actual capacity. On a smaller scale, a range of countries have carried out successful reforms at the level of individual hospitals—for example, in Thailand and Indonesia.
Many less-successful reform experiences can be traced to conflicting incentives within systems where public budgets and private revenues are mixed. Many countries (other than China) have allowed public hospitals substantial freedom in charging fees, retaining income, and selling medicines at a profit—without corresponding controls on budget management and the financial behavior of personnel. Not only has supervision and accounting lagged. Reforms to address one set of policy objectives (for example, control of nonsustainable public expenditure) have often been implemented before effective mechanisms were in place to deal with another (for example, motivating public hospitals to treat those who cannot afford to pay). As social health insurance schemes later developed, hospitals were given undue autonomy in the use of social insurance reimbursements—in effect, reinforcing rather than correcting existing weaknesses in hospital financing.

In OECD countries, earlier reforms tended to focus on issues of efficiency and cost containment. More recently, reforms in OECD countries have tended to emphasize quality, safety, and evidence-based medicine. This trend is illustrated by the protocol guides for hospital practice in Spain and France, as well as the Healthcare Commission and National Institute for Clinical Excellence (NICE) in the United Kingdom. Countries such as France and the Philippines have implemented accreditation requirements that must be met before hospitals can receive social health insurance or other public funding for services.

**Implications of international experience for China**

The central government, subnational governments, and hospital groups have diverse interests in public hospital reform in China. A range of reforms are discussed in this paper, drawing heavily on international experience. Several lessons stand out: Public hospital reform is a complex undertaking requiring consistency and constancy over time. To succeed, government institutions must possess strong implementation capacity, as well as credibility among the many actors with whom they work.

Results of reform initiatives tend to be disappointing where some but not all of the five key Preker-Harding organizational dimensions are addressed—decision rights, market exposure, residual claimant status, accountability, and social functions.

Organizational reform requires close coordination between policy design and implementation. As ever, "the devil is in the detail"—especially the details in how operational policies are interpreted and implemented by managers and staff.

Public hospital reform is seldom successful in the absence of levers that constrain bad behaviour and promote good behaviour through hospital budgets.

There are few reform successes among governments with weak governance and poor stewardship (i.e., regulation, performance monitoring, and institutions the create accountability for public service providers). Similarly, there are few successes where hospitals have limited management capacity.
Strengthening management systems and management skills is essential for successful hospital autonomization. These are beneficial even without organizational reform.

The preconditions for reform success need to be clearly identified and addressed. These include management systems and capacity, contracting capacity, and supervision capacity. Assessment is needed to determine if these preconditions are in place. Piloting is appropriate where they are, and building the prerequisites is required where they are not.

In applying international models, it is important to recognize that public hospital reform in China has a much different starting point than that of upper-income countries such as the UK or Australia. China is facing rapid expenditure growth of both inpatient and outpatient care, as well as declining hospital efficiency. Although cost containment and efficiency were also important reform objectives in the UK and Australia, these countries financed hospital care predominantly from public sources. This gave government health authorities powerful financial leverage over hospitals. By contrast, many public hospitals in China function like private hospitals, and many public-hospital doctors function like private independent practitioners, because both hospitals and doctors obtain significant revenue from charging fees-for-services and earning profits from drug sales on a cost-plus basis.

**Continuing Challenges Facing China’s Hospital System**

In a country of the scale and complexity of China, there is not a single common set of problems or opportunities facing hospitals everywhere, nor is there likely to be a standard set of recommendations that are appropriate at all levels of the hospital system or in all parts of the country. China’s many subnational governments and a full gamut of hospital groups has undertaken a range of reforms employing a variety of models. Starting points for organizational reforms vary widely by place. Thus, while comparisons across may be useful across international and subnational lines, so too generalizations must be made with caution. Not all experience is easily transferable, and there has not yet been enough evaluation to assess the full range of local experiments and ongoing reform models.

Hospital expenditure is growing faster than income from public budgets and social insurance. Expenditure control and improved efficiency pose formidable challenges. Meeting these challenges will require consistent, coordinated approaches that span planning and investment, organization and governance, management, and provider payment. The need for more rational, evidence-based service provision is particularly crucial in China’s context of limited public and social health insurance financing, and substantial private out-of-pocket expenditure.

Building up a cadre of well-trained hospital managers is similarly important. This will take some years, and will require supportive policies to ensure that careers in hospital management are attractive for those with the necessary skills, aptitudes, and experience.
Finally, substantial investment is required in information systems for policy planning, performance monitoring and accountability, and evaluation. Both national and subnational investment is needed to steer the hospital system through the next phases of reform.