

# Chapter 2

## Challenges to Health Service System in China: Institutional and Financial Reforms

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### 2.1 Introduction

China witnessed a dramatic shift in the health sector from the 1980s when it ventured into the path of economic reforms. Since the late 1990s and 2000s, the Communist Party of China (CPC) has made attempts to improve access to health services and rectify the problems that emerged from the initial phase of reforms in the 1980s. China's health service systems face several challenges today which have implications for access and equity. The challenge it faces demands a need for a larger systemic correction than simply addressing the symptoms.<sup>1</sup>

This chapter will attempt to look at the transitions that China has made through the period of health reforms and the challenges it faces today. Health sector reforms can be divided into three phases in China. The first phase (1980s–1990s) was immediately after China ventured into market reforms. This phase witnessed the introduction of market principles in health services and focused on institutional reforms; the second phase (late 1990s–2009) was characterised by financial reforms to address the inequities arising from the first phase of reforms and more recently the third phase (2009 onwards) has emphasised the need to reorganise some aspects of the public health system and bring the focus to primary health care but it has also created a space for opening up to the markets in tertiary care. The last section will discuss the challenges the public health system faces today in China.

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Soon after the revolution the focus of the CPC was on preventive care and for this purpose they set up epidemic stations to monitor and control communicable diseases. From the early 1950s to the mid-60s there was more focus on preventive services and this took the form of patriotic health campaigns through mass mobilisation. Basic health services had still not developed for the rural population. The primary level of care was provided by private practitioners in rural areas and was not free while the urban residents were covered by public service medical scheme or labour insurance and had right to free services. So from the very beginning there was a distinct difference in the structure of rural and urban health services. The growth of hospitals was largely an urban phenomenon and the expansion of health services was only marginal during this time.

Though Mao reiterated the need to develop health services for the rural population, it was only with the socio-political changes during the Cultural Revolution that there was a systematic focus on developing health services. The Cooperative Medical Scheme (CMS) expanded during this time. It was a three tier referral network between primary, secondary and tertiary level of care from the rural to urban areas and integrated preventive, curative and rehabilitative services. The financing mechanism was akin to an insurance system linked to agricultural cooperatives and managed by the collectives in rural areas. The rural population made contributions based on their ability to pay. It was a comprehensive health service system that became a model for even the developed world and influenced the Primary Health Care approach at the global level in 1978 which was convened by the World Health Organisation (WHO) at Almaty.

While China's economy did very poorly during the Cultural Revolution, it made tremendous improvements in providing basic health care to all. Important indicators like the Infant mortality rate seemed to have reached almost at par with the developed world by the 1970s. Compared to China, India that started with similar socio-economic indicators in the 1950s lagged far behind.

## **2.2 First Phase of Reforms (1980s–1990s)**

China ventured into a path of economic reforms promoted by Deng Xiaoping in the late 1970s. The political context that led to the economic reforms in China was different from what was happening globally. While the idea and structure of reforms China undertook was different from the advanced capitalist world, the neoliberal policies on trade during the same time helped China to enter the world market. Special Economic Zones (SEZ) were established as part of the Chinese open door policy. These were pilots to attract foreign investments and to try out new management techniques to reform public institutions before replicating them across institutions, sectors and provinces.

The health sector reforms coincided with the economic reforms of the 80s and the first 20 years proved to be dramatic for the health service system and had a major impact on the organisation of health services.

The dismantling of the collectives had its impact on the CMS that collapsed in the 1980s. The insurance managed by the collectives stopped functioning. By the 1990s only 5 % of the villages had any CMS. At the primary level people had to resort to private practitioners and clinics. Secondly, much of the financing was decentralised to the provincial and local governments. Subsidies to public hospitals at the secondary and tertiary level considerably reduced and institutions were asked to generate their own revenues. Government subsidies represented a mere 10 % of the total revenue of all public health facilities in the early 1990s (Yip and Hsiao 2009, p. 614).

In 1989, State Council developed State Owned Enterprise (SOE) reform by promoting various contracting systems for medical institutions. Public hospitals were allowed to earn profits from specialty medical services. Several of these initiatives led to the introduction of market principles in secondary and tertiary public medical institutions in order to make them financially self-sufficient. The rationale for these reforms was premised on the inability of the government to invest in health care. Newer organisational forms like the SOE were initiated in the health sector in order to augment financial revenues by introducing mechanisms like user fees, charging for drugs and diagnostics, contracting in, attracting private capital and opening tertiary care to markets. Hence, the SOE was allowed to partake in commercial activities. This led to the 'autonomisation' of hospitals which meant that every institution was responsible for its success and failure. The hospitals now were competing with each other and the profits they made partly went back to the institution and also to doctors as incentives. In general, 60 % of surplus was used to develop the hospital and the rest 40 % was distributed as bonuses among the staff. Therefore, these perverse incentives made the doctors prescribe more medicines and diagnostic tests. This was the beginning of commercialisation of public health services in China.

The focus of health sector reform during the late 1980s and 1990s was on the secondary and tertiary hospitals. Several of these initiatives focused on introducing market principles in tertiary public medical institutions. As the World Bank observes:

In 1992, the Ministry of Health granted substantial financial autonomy to hospitals, allowing them to charge for their services and to sell drugs at a profit. They are now permitted to keep the surpluses that they generate, and they are responsible for their debts and operating losses. They can use their surpluses to invest in new facilities and services, or to finance salary enhancement systems. Prices for basic medical care are regulated. In general, medical services produce net losses, and drug revenues produce net gains. Hospitals have been given freedom to develop higher quality services for which they can charge prices above the levels reimbursed by social insurance. Public hospitals can also enter into joint ventures with the private sector. They are allowed to raise "social capital" from medical staff and retirees, which can then be invested in private for-profit units within the public facilities (World Bank 2010, p. vii).

By the late 1990s, several local governments started to experiment with autonomisation giving rise to a plurality of management models, incentive and governance structures (Qian 2011).

## 2.3 Consequences of Autonomisation of Public Hospitals

The trend towards autonomisation created many distortions in the hospital sector. Firstly, the health managers became important because they were vested with powers to garner financial resources. Often this meant that they were wooing investments that would produce high returns. For example, “a hospital manager has very strong incentive to invest on high end service/equipment by which he can charge patients with unregulated prices or to procure high profit margin drugs given the price markup for drugs” (Qian 2011, p. 16). Secondly, incentives were introduced into the hospital system and individual doctors were rewarded according to the number of patients they treated thereby generating profits for the SOE. This transformed the role of doctors from a lifelong, secure employment relationship with the government to a contractual one with the SOE. Thirdly, autonomisation led to unhealthy competition between enterprises and local governments leading to a great deal of variation in institutions in terms of quality and equity of access.

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

### 2.3.1 *Fragmentation in Terms of Governance and Administration*

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

Qian observes:

“The agenda for hospital reform includes two “separations” regarding governance structure of public hospitals: separation between administrative government and public hospitals and separation between the function of hospital management and regulation/supervision. Purpose of first “separation” is to give hospital managers discretionary power in personnel decisions while purpose of the second “separation” is to closely supervise hospital’s investment behaviour and financial conditions. The effect of these “two separations” may offset each other to some extent. Hospital managers are given more power to manage human resources while less power is granted for financial resources”

(Qian 2011, p. 17).

### ***2.3.2 Human Resources: Deployment and Incentives***

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

There are consequences for training of human resources too. Guang Shi et al. observe,

“Before the health reforms in China, public hospitals trained personnel for lower level hospitals without charges or for only a nominal charge. Secondary and tertiary hospitals also provided free training for medical students. Since the 1980s hospitals have charged trainees from primary hospitals, thereby weakening the social function and imposing an additional financial burden on lower level hospitals”

(Shi et al. 2003, p. 62).

### ***2.3.3 Emphasis on High Technology and Drugs as a Source of Revenue Generation***

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

### ***2.3.4 Reduced Government Spending and Dependence on Out-of-Pocket Payments and Private Sources of Funding***

As a consequence of the market environment in which the public hospitals started behaving like the for-profit, costs of care rose and so did inequities in access. Individual share in total health care expenditure became 60 % in 2001 which was as low as 20 % in 1978 (Korolev 2012, p. 48).

### ***2.3.5 Impact of Autonomisation on Equity***

The change in ownership of hospitals to an SOE and the subsequent reforms of decentralisation of power to local governments to generate revenues did not take into account goals of quality or equity. It has been observed that, “Hospital autonomization by itself can reduce equity, reduce the less visible dimensions of clinical quality, and contribute to excessive intervention in profitable areas of treatment. Equity, clinical quality and cost-effective medical practice are not likely to be achieved without complementary reforms to strengthen accountability for these dimensions of hospital performance, and to use financing, contracting, and provider payment to create” (World Bank 2010, p. 57).

### ***2.3.6 Lack of a Referral System***

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

Bixi observes, “The uneven capacities of public hospitals contribute to the flight of the sick toward specialists, which in turn, contributes to low utilisation of hospitals and health centres at the lowest level, as well as overcrowding of the renowned specialized hospitals” (Bixi 2006, p. 3). This clearly shows the lack of a referral system that was one of the strengths in the past of the Chinese health service system.

Liu (2004) provides evidence from a 1998 survey which showed that apart from 5 % of village health stations that were funded and supervised by the township health centres, the rest were operating independently and were disconnected to other levels of care regardless of ownership (Liu 2004, p. 536).

All the above consequences raised concerns for equity and comprehensiveness of health services. Hu Jintao in 2002 stressed on the welfare nature and social function of public hospitals that China had deviated from and advanced health system reforms. There was reassertion of the role of public resources in hospitals; mobilising enthusiasm and innovation among medical staff; improving hospital management and quality of services; promoting efficiency utilisation of medicines and reducing patients’ expenses; and strengthening pharma supervision to guarantee safety. This found echo in the 11th five year plan in 2006 that proposed increasing government efforts.

## 2.4 The Second Phase of Reforms (2000–2009): Financial Reforms

As discussed, the consequences of first two decades of reforms had severe repercussions on access and equity. Medical care had become inaccessible to many and was exemplified by the phrase *kanbing nan kanbinggui* (seeking medical care is difficult and costly). In 2002, the new leadership articulated the necessity of a balanced development in order to minimise the stark inequities in society. The SARS epidemic in 2003 also proved to be a global embarrassment for China and shed light on the unresponsive health system and the breakdown of the referral system which was in a sense the spine of the health service system in the pre-reforms period (Nundy 2014).

Financial reforms were introduced to increase access to health services and were seen as a way forward to make the system equitable. These reforms took the health insurance approach to universalise access. The first insurance scheme to be launched was that for urban employees in the formal sector called the Urban Employees Basic Medical Insurance Scheme (UEBMIS) that was started in 1997. This is an employer–employee contribution where 2 % of the income contribution is made by the employer and in general 6 % of the income is the contribution of the employee to the pool. The employee contribution varies from one city to the other. This was followed by the New Rural Cooperative Medical System (NRCMS) for rural residents that was launched in 2002. In this scheme there is a flat premium by the residents who are willing to participate and the government subsidises by paying two-thirds of the premium. Before the NRCMS was launched, there were a plethora of experiments on developing an insurance system for the rural population. Many of the provincial governments experimented on this. It is interesting to note that most rural families still wanted the CMS and many of these pilots did not survive (Wang 2009). Under the NRCMS, government subsidises the poor to get enrolled in the scheme and also provides additional reimbursement. The third major insurance was the Urban Residents Basic Medical Insurance Scheme (URBMIS) started in 2007 for urban residents who were unemployed and dependent. A large proportion of the insured are mostly the children and elderly and here too the government subsidises by paying two-thirds of the premium. NRCMS and URBMIS are voluntary schemes while UEBMIS is compulsory for employees where the organisation or enterprise has agreed to provide coverage. An enterprise can choose not to participate (Table 2.1).

The three insurance schemes function differently in terms of the way they are financed, in the way they operate and the range of services they provide. These insurance schemes were made to rapidly provide coverage across provinces. By 2008, NRCMS had covered 94 % and UEBMIS had covered 67 %. URBMIS had covered about 60 % of its target population (Barber and Yao 2010, p. 13). Despite these reforms in financing health care, cost of medical care was still high and people were still paying out-of-pocket. Having insurance did not translate to free or subsidised health care as the coverage was wide but benefits were shallow. The rural–

**Table 2.1** Summary of features of insurance schemes in China

Name of the insurance	Financing mechanism	Ministry	Reimbursement	Coverage
UEBMIS	Employee, employer contribution (not mandatory for enterprises to join)	Ministry of Health	70 % is reimbursed	220 million people covered in 2009 (employees and retirees)
URBMIS	Household contribution and subsidised by the government (not mandatory)	Ministry of Health	50 % reimbursed	182.1 million people covered at the end of 2009
NRCMS	Individuals, centre and local authorities (not mandatory)	Ministry of Social Security	40 % reimbursed	833 million covered by 2009 (enrolment rate of 94 %)
Medical assistance	Government funding and voluntary funding by social sector	Ministry of Civil Affairs	Cash transfer	47.4 million for all those covered under Wu Bao and Di Bao
Medical allowance for civil servants	Government funding	Ministry of Health		All government servants

Source Nundy 2014

urban disparities still existed and migrant workers did not fit into any insurance scheme. Cost of medical care had increased and the financial burden was still on individuals. Data also showed that life expectancy in the Eastern region was much higher than that of the Central region and life expectancy in Central region was much higher than the Western region (UNDP 2008, p. 140). Financial access was one of the major reasons for this gap where people did not access medical services in need due to costs. Lack of availability of health services due to poor infrastructure and lack of human resources in health institutions in the Central and Western provinces were some of the reasons for such disparities in health outcomes (Table 2.2).

## 2.5 The Third Phase (2009 to Present)

In 2009 several new policies were drawn for the health sector which were seen as the next set of reforms. This was in response to the high costs of care that still existed in spite of the financial reforms. The reform was based on three fundamental tenets: strong role of government in health, commitment to equity, and willingness to experiment with regulated market approaches (Hsiao and Yip 2009). The reforms



**Table 2.2** Total health expenditure by public and private

	1995	2000	2003	2005	2006	2007	2008	2009	2010	2011	2012
Total health expenditure (100 million yuan)	2155.1	4586.6	6584.1	8659.9	9843.3	11574.0	14535.4	17541.9	19980.4	24345.9	28119.0
<i>Public (%)</i>	50.5	38.3	36.2	38.8	40.7	46.9	49.9	52.5	54.3	55.9	56.0
General tax	18.0	15.5	17.0	17.9	18.1	22.3	24.7	27.5	28.7	30.7	30.0
Health plan premiums	28.1	17.7	14.8	16.0	17.5	21.3	22.5	22.6	23.2	23.6	24.5
<i>Private (%)</i>	49.5	61.7	63.8	61.2	59.3	53.1	50.1	47.5	45.7	44.1	44.0
PHI		0.6	3.7	3.5	3.8	3.3	4.0	3.3	3.4	2.8	3.1
OOP	46.4	59.0	55.9	52.2	49.3	44.1	40.4	37.5	35.3	34.8	34.3

Source Zhang Yuhui (2014), China National Health Development and Research Centre

were to accelerate the establishment of the basic medical security system; to set up the national essential medicine system; improve primary healthcare services system; gradually press ahead with the equalisation of basic public health services; push forward pilot projects for public hospital reform. While the CCP clearly spells out the need to focus on building the public health service system at all levels, these reforms also hint at greater private participation and many foreign investors see this as an opportunity to invest. Allowing for-profit investments in health care has to be seen in the context of a social transformation that is occurring in China. There is a demographic and epidemiological transition taking place and along with rapid urbanisation there are demands that have been created on the health services. The burden of non-communicable diseases is very high in China with cardiovascular diseases, diabetes and cancers at the top of the list. The demographic profile shows an increase in the percentage of population living above 60 years and there has also been an expanding middle class that is seeking alternatives to the public sector.

While there are innumerable for-profit clinics and institutions at the primary level, the growth of for-profit institutions at the secondary and tertiary levels is a recent phenomenon. The earliest for-profit hospital during the reforms period was an initiative by two American women who set up a company called Chindex, a supplier of medical equipment in the early 1980s. They diversified into provisioning of medical care in the late 1990s by successively opening a chain of hospitals under the name of United Health Group in the eastern and southern region of China—Beijing, Shanghai, Guangzhou and Tianjin.

Under the new leadership in 2013, the Party announced opening of Free Trade Zones that will allow Wholly Owned Foreign Medical Enterprises (WOFE) to be set up by investors from Hong Kong, Taiwan and Macau and foreign health insurance companies that will also operate within this zone. Cities around the Eastern Coast have created Medical Parks designed to attract foreign investors to invest in state-of-the-art hospitals.

## **2.6 Challenges Faced by the Health Service System Due to Financial Reforms**

There are several challenges to the health service system in China today. The distortions created by autonomisation of public hospitals still exist but the financial reforms have also created their own set of challenges.

### ***2.6.1 Lack of Depth in Coverage and Variation in the Schemes***

By 2012, over 95 % of the population was covered by a health insurance but the depth of coverage was still shallow. Out-of-pocket expenditure still accounts for

35 % of the total expenditure. In actual terms this amount is rather high. The three insurance schemes work very differently and do not provide uniform coverage. The UEBMIS is the better of the three in terms of coverage as it is linked to income and premiums are as high as 14 % of the income in Shanghai. So in a poor province the premium would be as low as 200 RMB per year while for an employee in Shanghai it would be as high as 4000 RMB per year.<sup>2</sup> The NRCMS is the weakest and coverage is shallow with people paying mostly out-of-pocket for out-patient services and they receive partial coverage for in-patient services. Much of the burden is on provincial and local governments and rich provinces fare better than the poorer ones in terms of providing better coverage. There are disparities across the three insurance schemes but there are disparities evident even within each insurance scheme across provinces. So the UEBMIS will vary from a city in the Eastern Coast to a city in Central China or Western China. The schemes are also handled by different Ministries. This has added to the complexity and further fragmentation of a comprehensive system.

### ***2.6.2 Insurance and the Rising Costs***

Addressing just the financing and not correcting the issues of provisioning has led to increasing costs. The insurance schemes in a system where institutions are autonomised behave like for-profit. The insurance schemes work on a reimbursement mechanism and many services are not covered. While people have to pay out-of-pocket for various services for which they do not get reimbursed, the rising costs are also a burden for the government as they need to subsidise further in response to the market. Out-of-pocket expenditure is still high. In a market economy it is always difficult to contain costs when there are multiple interests at play. In the health care market there are several players in China. The pharmaceutical sector and the medical devices industry have a significant presence in the health care market and have a major role in rising costs as they are driven by profits. This has an impact on the working of the insurance mechanism as premiums get expensive and the government has to further subsidise to keep up with the rising costs.

### ***2.6.3 Migrants and the Hukou***

The people who are most affected in terms of financial access and are left out of what should be a progressive insurance system are the growing number of migrants. While the *hukou* system may have been eased out in the 1980s and further in the

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<sup>2</sup>Interview with a public health scholar from Fudan School of Public Health.

2000s when rural to urban migration was allowed, there still exists discriminatory policies against the rural population. It results in unequal distribution of income, housing, food, education, medical services and so on in contemporary China.

In the case of health insurance, the migrants are enrolled in the NRCMS in the province where they have their *hukou*. In most cases the migrants are not enrolled in the UEBMIS as the premiums are very high and since they are not in any permanent or organised employment the enterprises they work with do not provide an insurance. Since they do not have an urban *hukou* the dependents cannot be part of the URBMIS either. The only option left for them is to either pay out-of-pocket or go back to their province to avail health services through NRCMS which becomes unrealistic as they have to travel long distances to access these services. While the NRCMS ideally should be providing coverage for the migrants, the insurance system reimburses progressively less as one moves upwards from a county level institution to an urban hospital. The reimbursement is highest at the home province. Rural migrants therefore rarely receive any reimbursement when seeking medical care in an urban hospital.

#### ***2.6.4 Impact of the Financial Reform on an Integrated System***

China has had a history of health insurance mechanism as the main source of financing but the financing structure that existed in pre-reforms period and that which exists now is very different. Apart from the different political and economic contexts within which the insurance systems were functioning, the former was an integrated structure where preventive and curative services were linked in a well-networked referral system. This is not so in the present context. The kind of insurance mechanism that exists today deals only with curative services. This has broken the link between the preventive and curative services and further fragmented the system. The burden of care is mostly on the tertiary level as the primary and secondary levels of care are weak. This has led to greater costs both for the government as well as the individual seeking care.

#### ***2.6.5 Regional and Socio-Economic Inequalities***

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

Without appropriate mechanisms to transfer and equalise payments, decentralisation naturally leads to increasing variations in investment by provinces, cities, towns and other entities in public health capacities, as well as to variations in the performance of health systems across China. So while some regions may be able to detect and control major epidemics in their area (e.g. Guangzhou and Beijing, which are among the best developed regions in China), others may simply be unprepared for major public health challenges. Particularly disquieting is the lack of an adequately functioning public health system in China's vast rural areas (Liu 2004, p. 534).

## 2.7 Conclusion

The health sector in China is extremely complex today. Access to health services as a consequence of autonomisation of public hospitals were addressed in the late 1990s and early 2000s by launching financial reforms but this has been unable to curb the rising costs. There is a growing realisation among policy makers and public health scholars that there needs to be further reforms to make corrections so as to make the system less complex.

One can discern several points of view that exist in China today in terms of the direction the reforms should take. While the markets are seen as a way to bring in more technology, drugs and capital, China has been extremely cautious about letting in the for-profit sector in health care provisioning at the secondary and tertiary level. It has only recently opened Free Trade Zones where it has allowed investors to set up wholly funded foreign hospitals. It is also slowly bringing in for-profits to partner with the public sector institutions in various ways. These are mostly seen in contracting models. Some public hospitals are managed by private management companies. There are also joint ventures between pharmaceutical companies, medical device companies (mostly domestic) and public hospitals. In the financial reforms, the government is making amends to make the insurance schemes efficient but commercial insurance has also been allowed space to grow in order to provide supplementary insurance and in many rural provinces manage the insurance schemes. While most of these partnerships have been initiated to raise capital and manage the system, in the long run this does not address the problems of rising costs.

It is widely agreed that public hospitals behave like the for-profit and must get back to their primary function of providing accessible services to all. Pharmaceutical sector has probably been the most important contributor to the profit-making behaviour of the public hospitals and the escalation of health care costs.

Qian and Blomqvist observe, "Attempts to counteract the problem of high drug prices through government regulation were ineffective, and in some cases may even have made the problem worse. Part of the reason they were ineffective is due to the fact that price regulation only covered drugs in common use; for newly introduced drugs, hospitals and clinics could set whatever prices they liked. Not surprisingly, this resulted in a bias towards prescription of new drugs even in cases where older, less costly drugs would have been equally appropriate" (Qian and Blomqvist 2014, p. 201).

One positive reform introduced in 2009 is the new essential medicine system that seeks to address the issue of drug costs by encouraging doctors to prescribe from the list of essential medicines and not allowing any markups and incentives. This system is still in its introductory phase.

Another point of view which is endorsed by many public health scholars is to make systemic corrections and rebuild the fragmented health service system. There are recommendations to merge the three insurance systems in order to make them equitable in terms of costs, coverage and benefits. Apart from the merging of the insurance systems, unifying the *hukou* would make the system inclusive especially for migrants who could access these services from anywhere. With increasing urbanisation which is also a mandate of the CPC, these would be important decisions to improve access not only to health care services but also education and housing.

The burden of care which is now on the tertiary level has led to the rising costs. There is a need to distribute access across primary, secondary and tertiary sector so that the load is lesser at the tertiary. It is interesting to note that there are several provinces that are experimenting with the family doctor model in the lines of the National Health Service of the UK. In this model, a community of 2000 people is contracted to a physician. Here, the first point of contact is the team headed by the physician at the community health centre at the primary level. If there are referrals needed then it is made by the family doctor. Hence the family doctor works like the gatekeeper of the system and network. The family health care model is a move towards diverting the flow of funds and patient load towards the primary level so as to balance out the top heavy system. This is another attempt towards making a correction in the system.

China has a very complex health service system and faces several challenges but the positive aspect is that reforms are not incremental but transformative. The 2009 reforms have in fact attempted to correct many of the distortions within the health service system as a result of the earlier phase of reforms. Providing accessible health care to people is a political mandate which is not so in the case of India which also has a complex set of issues to deal with in its health service system. It being a political mandate helps the system to continuously evolve while experimenting with various ways of making it equitable. These attempts are accompanied by continuous debates that go back and forth. The challenge lies in the equitable distribution of resources and in minimising the regional inequities that are still stark in order to provide access to health services for all.

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