Preface

China is undergoing a health revolution. As it becomes a more developed country, the disease profile of its increasingly urbanized, wealthy citizens is becoming less about infectious diseases, and more about the sorts of problems associated with wealthy countries - heart attacks, cancers and ailments associated with lifestyle.

It has long been known that China under these conditions is sitting on something akin to a health time bomb. Its population is aging, almost half its men smoke, and obesity is creeping up. Where the US spends 18 per cent of GDP on its health care system and Australian 9 per cent, China currently only uses five percent. It is certain this figure will need to rise drastically to address the country’s emerging health challenges.

This paper by Sam Hall is based on a close reading of government documents from China outlining new ways of attempting to fund and manage China’s healthcare system. It shows that officials are now trying to allow more diversity, and reform hospitals, pharmaceutical providers, and treatment methods. In any country this is a hugely complex area. For a place as large and fast changing as China, this is particularly the case. Chinese people expect more from their health providers, but are as unwilling to see costs burgeon as Americans or Europeans.

Hall offers a clear and lucid exposition of a dynamic, fast changing but crucial area of policy. And while the summary of this paper is broadly optimistic, it is also frank about the issues that will need to be faced in the years ahead if China is to achieve its goal of a universal, affordable and efficient national healthcare system.

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Urban hospital reform in China

By Samuel Hall

Executive Summary

New reforms to China’s urban hospitals are the latest among an array of concerted efforts to overhaul the nation’s healthcare system. Delinking hospital funding from pharmaceutical sales — as recent county-level reforms are also set to do — stands out as a particularly impactful measure. Over-prescription of expensive drugs is hoped to reduce drastically as drug mark-ups are replaced by a government subsidy system and higher service prices. Movement towards a performance based, rather than sales based, salary system for doctors is also slated, while insurance rebate caps on more diseases will further help control costs. Disproportionate pressures on top-tier hospitals are also addressed under plans for more cross-tier, regional IT platforms.

Alongside bolstered training and facilities, IT platforms will facilitate more efficient referrals, incentivising more visits to grassroots medical facilities. In addition, greater autonomy granted to hospitals in the form of hospital boards and presidents is designed to increase accountability to goals and costs. This full gamut of measures aims to make strong in-roads into increasing accessibility and quality of healthcare, while relieving pressure on public funds. Also to this end, future policy is likely to allow increasingly more private actors and capital to enter the Chinese healthcare market.
China is making concerted efforts to overhaul its healthcare system, and urban hospital reforms released on 17 May represent a key step in the healthcare reform drive. They go hand-in-hand with 8 May county-level hospital reform plans, and more broadly, healthcare reform targets for 2015, as well as the reform outline for 2020.

Current reforms focus on tackling a core set of unmanageable institutional incentives which threaten healthcare quality, accessibility, and affordability. A brief overview of these core issues is presented below.

A three-pronged reform approach
Policymakers and commentators identify a core tripartite of interconnected issues threatening the sustainability of China’s healthcare system, namely medical insurance (yibao, 医保), medicines (yiyao, 医药), and treatment (yiliao, 医疗). Because each of these issues shares the character yi (医), and since the successful reform of each is highly interdependent, current healthcare reform moves often seek to improve the three concurrently (san yi liandong, 三医联动). Understanding the problems underlying these issues and how they are interrelated, therefore, is useful in understanding the motivations and implications of current reform.

Medical insurance
While nominal medical insurance coverage rates are high in China (even for voluntary rural schemes), poor portability in practice often makes it difficult to lodge claims. A lack of institutional information sharing means cross-tier and cross-jurisdictional coverage is bureaucratically challenging, if not impossible. It is especially difficult for urban residents falling under the rural category of the Household Registration System. Many rurally-registered individuals working in cities are excluded from coverage, and lack the level of literacy necessary to make a successful claim. Urban registered residents also face issues of delayed compensation and opaque coverage rules; many are often burdened with large out-of-pocket expenses as a result. At the same time, over-prescription of expensive medicines is putting a fiscal squeeze on public medical insurance funds. Liability insurance for doctors and hospitals is also often fraught with payment issues and lacks proper supporting legal procedure. As a consequence, the relationship between medical staff and patients is often volatile, with practitioners being routinely attacked—physically and verbally. The issue is exacerbated by the fact that staff in lower-tier hospitals can often lack adequate training and expertise, their incompetence becoming a source of mistrust and anger.

Medicines
Because hospitals and doctors cannot sustain themselves on medical service fees and miserly government funding, public hospitals fund themselves primarily through medicine sales (known in Chinese as yiyao yangyi (以药养医)). Since medicines can be sold on to patients at a 15 percent mark-up on purchase price (provided they do not exceed price ceilings, which they rarely do), hospitals are incentivised to buy more expensive medicines from suppliers through the central bidding-procurement process. Pharmaceutical companies and their representatives respond by manufacturing and promoting expensive drugs over cheaper ones. The result is that consumers are prescribed drugs that are unnecessarily expensive and often not medically necessary. Notwithstanding concerns about good medical practice, this makes treatment expensive for both patients and insurance funds. Previous pilot attempts to eliminate mark-ups have been poorly designed and failed to incorporate necessary changes to accompanying insurance policies.

For example, patients receiving kidney dialysis through an infamous Chongqing pilot program were faced with astronomical fees, leading to street protests and a subsequent policy reversal only a few days later.

Treatment
In China’s three-tiered hospital system, the third or top-tier bears a highly disproportionate burden in treating patients. This is because bottom-tier or grassroots institutions—ideally the first port of call for most non-critical patients—lack the equipment and adequately trained personnel to provide comprehensive or reliable care. Low remuneration and poor conditions deter highly qualified staff, while funding for training is insufficient. A deep mistrust in these lower tier institutions means many patients prefer journeying to top-tier hospitals, even if their needs could in fact be met at lower levels. As noted above, insurance compatibility and portability issues complicate this issue, and cross-tier patient referrals are similarly dysfunctional.

**Urban hospital reform plan**

The Urban hospital reform plan is poised to make significant in-roads in tackling key healthcare reform issues. It is noted for its comprehensiveness, comparatively clear goals, as well as its ambitiousness. Building on 34 urban pilot hospitals initiated in 2014, as well as many more county-level pilots prior to that, the current urban plan seeks to implement reform by increasing the number of pilot hospitals to 100 by the end of 2015. This will expand to include all 6800 urban hospitals across the nation by 2017.

While the overriding impetus of this reform plan is ostensibly encapsulated by the slogan ‘ensuring public hospitals serve the public’, the real substance of this reform lies in its broad moves to overhaul the way hospitals are funded, managed and interconnected. Key reforms include:

**Funding reforms**

The centrepiece of reforms is the elimination of 15 percent markups on medicines (excluding traditional Chinese medicines). Hospitals and doctors will be forced to sell at cost price. Planned revenue replacement sources include increased service fees and central fiscal transfers, while savings will come from better management and accounting practices. Hospitals’ drug storage, management, and wastage will now be counted as operating costs and be given due compensation by the government.

Additional measures include allowing patients to buy drugs from third party pharmacies, and having expensive medical consumables purchased through central procurement bidding online, in order to encourage price competition.

Specific goals for 2017 are to:

- reduce proportion of hospital income coming from medicine sales to 30 percent of the total
- reduce the proportion of sales income from medical consumables to less than 20 percent of the total.

**Hospital management reforms**

Reforms to hospital management are crucial to ensuring the success of other reforms. While a number of well-intentioned moves are planned, they currently lack substance and clarity. Specific reforms will be gradually developed through a consultative process involving commentator recommendations and practitioners’ on-the-ground experience.

Allowing urban public hospitals to run autonomously is a key move which appears to reasonably delimit local government powers as a key funding source, and enables hospitals to develop management models best suited to their situation. Hospital presidents will be appointed with limited tenure periods as well as clear goals and accountability. Hospitals will also establish board-like councils to help oversee operations, while restrictions also prevent National Health and Family Planning Commission (NHFPC) administrators from becoming hospital heads. More general management goals will include better accounting practice, quality control, increased doctor liability insurance coverage, and appointment scheduling. Hospital performance will be made public and linked to funding.
Medical insurance reforms
Predefined, bulk-billable costs for certain diseases are the major insurance innovation, alongside broader serious illness insurance. This effectively cap insurance payouts and encourage hospitals to provide lower cost treatment so retain a margin on reimbursements.

Specific goals for 2015 include:
- implementing capped insurance payouts for 30 percent of all patient cases in pilot hospitals
- increasing the number of illnesses with predefined insurance coverage by tenfold to at least 100.

The specific goal for 2017 is to reduce personal out-of-pocket expenses to less than 30 percent of total medical costs, with the remainder to be covered by insurance.

Human resource and remuneration reforms
Where civil servants, SOE workers and service agency personnel have traditionally been permanently tied to their positions, reforms aim to decouple employees from their positions to increase the importance of employee performance in the retention of jobs. This change will also bring greater freedom of labour movement. When coupled with performance evaluated remuneration this is hoped to increase standards of professionalism, and allow private institutions to become a more competitive alternative in the employment market for medical professionals. Hospitals will also be allowed to hire non-payroll staff in addition to their set quota of payroll positions.

Coordination reforms
These reforms aim to increase cross-tier communication to better allocate resources and capacity, primarily by developing lower tier capacity and the role of private capital. While it is forbidden for public hospitals to borrow money to build or refurbish, reforms encourage second-tier hospitals (often seen as redundant by healthcare policy experts and commentators) to transition to community health centres, specialist hospitals or aged care centres. Moreover, cities with a wealth of public hospitals can invite private investment under the condition that ultimate ownership remains with the state.

Establishment of imaging and diagnostic clinics that hospitals of all tiers in a certain area can use collectively is also encouraged to help minimise resource replication and increase accessibility. Recent State Council meetings and a new privately invested imaging centre in Jiangxi Province indicate this is a key entry point for private investment.

Additionally, in-patient doctor training will be standardised and all new public hospitals staff will be required to have at least an undergraduate degree. More training for pediatrics, general practitioners and psychologists are also noted in reform plans.

The specific goal for 2015 is to limit ‘special services’ (usually chronic and difficult to treat diseases) to 10 percent of all services in urban public hospitals

Redistribution of burdens
A cross-tier referral system is at the core of the plan to encourage lower-tier hospitals to take on more work and resources. While the system allows for referral both upward and downward in the tiered system, the emphasis is on having lowest tier institutions be the first place of diagnosis for patients, after which they may be referred upwards if necessary. Downward referrals will carry treatment plans to guide lower-tier care. Training programs will also help lowest tier hospitals take on new capacity and function more effectively as general practices. Priority treatment for those referred up, as well as integration of insurance policies across tiers will support these initiatives.
The specific goal for 2015 is for 20 percent of all outpatients in urban public hospitals to come from appointments or referrals.

**Informatisation of healthcare reforms**
Regional information platforms containing electronic health profiles and medical histories are the central initiative here. The platforms aim to facilitate referrals, appointments, and medical insurance continuity across institutions and tiers. They will also help pharmaceutical companies and the Chinese Food and Drug Administration monitor and optimise medicine usage.

Specific goals for the end of 2015 are to:
- connect all middle- and top-tier, as well as 80 percent of bottom-tier public hospitals, on regional ICT platforms
- standardise information networks for middle- and top-tier pilot city hospitals
- establish remote medical ICT connections to higher level hospitals for 60 percent of grassroots institutions.

**Domestic response**
Reactions to this long slated plan largely applaud its boldness and relatively concrete array of reforms and goals. A common concern, however, is that large funding shortfalls will emerge following the elimination of drug markups. County-level pilots have on average resulted in a 26.52 percent funding gap, with local governments unprepared to adjust service fees and increase funding. Furthermore, current service fee price-setting and supervisory mechanisms are not sufficiently stringent to prevent hospitals from radically hiking service fees and passing on large costs to patients.

An element of concern also exists over whether hospital management committees will simply provide oversight; evidence from pilot schemes has already shown their frequent interference. Furthermore, many commentators also complain that the overarching goal of ‘public hospitals serving the public’ is too vague and will make it difficult to make changes and exercise responsibilities.

The call for more private capital involvement in managing existing and new medical institutions, on the other hand, has been broadly welcomed by reform commentators. The establishment of a third-party imaging centre in Jiangxi Province is the first of its kind, and may serve as model if there it gains initial success. A State Council meeting on 4 June, presided over by Chinese Premier Li Keqiang, also emphasised the need to give private capital a greater role in healthcare. Many prominent commentators, meanwhile, are calling for the number of public hospitals to be radically downsized, making way for more efficient private institutions.

**Conclusion**
Slated reforms are bold and promising, especially in the increasing space for private capital to flex its muscle. Key supporting policies include price negotiating mechanism pilots for patents and exclusive drugs, hospital hiring and salary reform policy and commercial insurance development policy.

But successful implementation remains heavily dependent on ministry-level cooperation. Of particular importance will be the NHFPC, which has been known to be reluctant to act on directives handed down from the National Development Reform Commission and other senior bodies. Commentators hope administrative and responsibility reshuffles will help realign NHFPC administrative interests with the central reform push. It may not be possible to iron out these administrative relationships in the short-term, but improving healthcare accessibility and affordability is increasingly becoming both a fiscal and demographic imperative. While the Chinese healthcare system may not yet be ready to open the floodgates to private capital,
there is now greater recognition that private actors will be pivotal in creating a more robust system.

References

This report was primarily based on the following State Council policy document:

*State Council General Office, Guiding opinions on comprehensive reform pilots for urban public hospitals, 17 May 2015* (国务院办公厅：《国务院办公厅关于城市公立医院综合改革试点的指导意见》),

[http://www.gov.cn/zhengce/content/2015-05/17/content_9776.htm](http://www.gov.cn/zhengce/content/2015-05/17/content_9776.htm), accessed 8 September 2015.

Analysis was based on a close reading of the policy text, and informed by China Policy internal research and knowledge.
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