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## Healthcare reform in China: making sense of a policy experiment?

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# Healthcare reform in China: making sense of a policy experiment?

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## Introduction

The ongoing transition of China from a planned to a market economy continues to fuel international interest. While China's rapid growth and economic expansion has led many to draw attention to its ascendancy as a global power, others have focused on the socio-economic problems and dilemmas that it currently faces. This latter perspective highlights how growing inequalities, urbanisation and an ageing population mean that China is seeking solutions for how best to manage ever increasing societal demands (Barber *et al.*, 2014).

Over recent years a raft of healthcare reforms has been introduced in response to these socio-economic changes in order to improve access and quality (Niuyun, forthcoming). Despite these efforts, a number of problems and failures with these reforms have been identified (Chen, 2009). Central to these criticisms have been concerns that the Chinese healthcare system is experiencing the negative effects of unbridled 'marketization' whereby successive pro-market policies have resulted in a decline in the quality of patient care and a rise in health inequalities (Hu *et al.*, 2008; Yi and Lanjuan, 2012). The increased autonomy given to hospitals represents a notable case in point as a reform that has been associated with escalating costs and a growing disparity in the quality and effectiveness of services (Yip and Hsaio, 2008).

The purpose of this Viewpoint is to explore how different scholars have sought to make sense of recent healthcare reform in China and recommend a promising theoretical lens for future research. We argue that while recent efforts to understand the impact of reform have brought significant understanding of key issues and processes, such interest tends to focus on the pragmatic evaluation of inputs, outputs and outcomes rather than pose wider theoretical and methodological questions about

the nature and pace of reform. Although perspectives are starting to emerge that seek to better understand the unique governance and public administration arrangements associated with China (e.g. Drechsler, 2013), we argue that greater attention needs to be paid to understanding the reform of healthcare in China as a public policy process. Our Viewpoint builds on others whom have sought to draw attention to the orientations, challenges and opportunities for enacting public policy within the “Asian Century” (Bice and Sullivan, 2014). In doing so, we argue that the lens of public policy is relevant and insightful given what has been documented elsewhere regarding China’s unique process characterised by ‘policy experimentation’ (Shi, 2012). We discuss how a policy experiment perspective may provide as a useful heuristic for understanding healthcare reform in China and conclude by outlining possible applications of this approach and look forward at the emerging research agenda in this area.

### **Mind the gap post 2009: the continuing challenge of healthcare reform in China**

The reform plan introduced by the Chinese government in 2009 set out the ambitious goal of achieving national comprehensive universal health insurance coverage by 2020 (Yip *et al.*, 2012). These healthcare reforms aimed to increase public finance investment and promote equity in healthcare, while also encouraging the use of pro-market mechanisms as a means to enhance quality and efficiency. The plan included a number of key strategic policies related to the introduction of a rural cooperative medical insurance scheme, a Medicaid system for the urban and the rural poor, and a national system for treatment and prevention of diseases. The reforms also included the division of primary and community care into a three tier network of county, town and village provision with community medicine centres and community “health gatekeeper” systems (see Figure 1).

**Figure 1. Summary of key national health care reform in China (adapted from Barber et al. 2013)**

<b>Area of reform</b>	<b>Key activities</b>
<b>Social security and insurance</b>	Large-scale increase in the number of people covered under formal insurance programs, from 294 million in 2003 to 1.28 billion by 2011 (21% to 93% coverage).
<b>Primary Care</b>	Reconstruction of the primary care system, including 2,200 county hospitals and 33,000 urban and rural primary care facilities.
<b>Public health</b>	The implementation of ten categories of basic public health services, through a per capita subsidy to primary care facilities.
<b>Secondary Care</b>	17 municipalities and 37 provincial cities designated to undertake hospital reform on a pilot basis. Activities include provider payment reform and clinical pathway redesign.
<b>Update Essential Medicines Lists (EML)</b>	The EML is composed of medicines, including traditional medicines, to be used by primary, secondary and tertiary providers. The selection of medicines should be based on clinical need, safety and efficacy, price, availability from suppliers, clinical treatment guidelines, and appropriateness for use.

These reform efforts have been associated with some notable successes, in particular the extension of insurance coverage to 93% of the population (Yip *et al.*, 2012; Parry, 2012; Yip and Hsiao, 2014). Yet implementation difficulties have also been highlighted. Parry (2012) notes a number of variations can be identified characterised by growing inequity across urban and rural areas, increasing costs of medical care, and the challenge of meeting growing insurance contributions. Parry also notes poor cooperation and integration among government departments, as well as a continuing imbalance between macro level central control and devolved market mechanisms.

Such trends have led some to suggest that the system remains underdeveloped and over-reliant on secondary care services which are largely concentrated in urban areas (Yi and Lan-juan, 2012). Hsiao (2007) classifies the problems facing China's health system into four key areas: under-funding and under-provision of public health and preventive services, the high cost of healthcare, unaffordable

access to healthcare and medical impoverishment. Yip et al (2012) suggest that further work is required in relation to providing more effective incentive structures, improving hospital governance, and developing better regulatory mechanisms.

These recurring problems have led to Yip and Hsiao (2014) to argue that fundamental change is needed in relation to how China implements its ambitious healthcare reforms. They suggest that an ‘alternative pathway’ is needed which shifts the focus from a profit driven public and private hospital-centred system to an integrated primary care-based system. Central to this alternative pathway would be the reform of public hospitals in order to enhance and tighten their accountability for quality and performance, and the introduction of new population-based capitation payments to promote coordinated care. Yip and Hsiao (2014) suggest such a pathway would be more cost effective and better able to respond to changing population needs.

## **Making sense of healthcare reform in China**

The various studies noted above have provided a number of valuable insights and suggestions as to how China might successfully achieve the ambition of high quality healthcare provision for its whole population. Much of this accumulated evidence is based on a variety of formative and summative evaluations of particular policies (e.g. Sang *et al.*, 2014). Yet, scholars have only recently started to explore the theoretical and methodological implications of these reforms.

One significant development has been the expanding body of research exploring the various multi-level governance structures that are nested within the Chinese healthcare system (Ramesh *et al.*, 2013; Allen *et al.*, 2014; Korolev, 2014). Ramesh et al (2013) for example argue that the contributing role of health governance in China remains poorly theorised and understood. These commentators suggest that to date debates about healthcare reform in China have been framed in binary terms - between market and government led health systems with little attention given to understanding the governance

relationships among policy makers, users, providers and insurers as well as the incentive structures which shape their preferences and behaviour.

In their review of governance in public hospitals in China, Allen et al (2014) conclude that while many of the reforms are still evolving, issues persist in the boundaries and dynamics of relationships between the different stakeholders charged with overseeing hospitals. The economic incentives for public hospitals also require attention as incentives to maximize the revenue of hospitals outweigh the need to maintain a balance between efficiency and public service orientation. In light of these findings, Allen et al (2014) call for more appropriate hospital remuneration arrangements and increased autonomy over hospital management. They also advocate the need for better designed regulations and institutions if competition is to be capable of promoting efficiency and improving quality.

Alongside governance, the perspective of political economy has been offered as a possible fruitful avenue for understanding healthcare reform in China. Hsiao (2007) notes that the choices facing China illustrate the importance of political economic analysis in examining the roles that the health bureaucracy and the medical profession play in shaping policy. Here, Hsiao argues that there has been a failure in the relationship between the top Chinese political leaders (the principal) and the health bureaucracy (the agent). In China the health bureaucracy, hospital directors, and physicians (what he collectively terms the ‘medical axis-of-power’) remains a tight alliance which is powerful enough to pursue largely its own interests rather than those of the principal, be that political leaders or the population. If China is to overhaul the dominance of the medical axis of power then Hsiao (2007: 247) argues that Chinese political leaders have to establish a new independent regulatory “check and balance” system which is better able to hold the bureaucracy to account for improving the efficiency and quality of care.

Zhang and Navarro (2014) also take a political economy perspective to argue that neoliberalism has been the driving ideology behind China’s healthcare reform programme. These authors argue that the central government’s primary purpose has been to use the healthcare reform programme to

accommodate political pressure generated by past implementation of neoliberal policies and to facilitate further neoliberal economic restructuring. They highlight that existing studies tend to focus narrowly on struggles *within* the health sector, while neglecting the social, political, economic, and historical roots of these struggles. This latter perspective argues that the failure of healthcare reform can be more accurately understood as the outcomes of China's neoliberal transformation of its political economy rather than the outcomes of health system restructuring. From this perspective, Zhang and Navarro (2014) suggest that improving the population's health may not have been the primary intention of the reform but rather the need to accommodate the wider political and economic goals. As a result, these neoliberal policies, if continued, are likely to undermine rather than improve the health of the population.

### **Making sense of reform as a 'policy experiment'**

The emerging perspectives of governance and political economy are providing valuable insights for making sense of healthcare reform in China. Yet there might well be other perspectives that scholars can draw on to explore these developments. This is particularly the case given that when we look at the governance and political economy perspectives we find notable limitations in their ability to tease out contextual variations both within and between the reform proposals. The governance perspective tends to focus solely on relationships and interactions while the political economy approach tends to focus on the macro structural trends underpinning the reform proposals.

Crucially, neither of these approaches specifically focus on the delivery of policy and how implementation processes may vary across geographical and institutional contexts. Such variation is exemplified in the point raised by Yip and Hsiao (2014: 815) who note that "no stand-alone policy" would be able to provide the "magic bullet" given the large and heterogeneous nature of China. These authors suggest that any policy recommendations should be "directional rather than operational" as localities need to be given sufficient space to modify and refine specific models based on particular contextual conditions. Continuing the theme of local implementation, recent research from Zhang et al

(2014) highlight how the introduction of the New Cooperative Medical Scheme in rural health systems has demonstrated great resilience because of its strong, centralized, and hierarchical administrative system interacting with existing local contexts. Zhang et al (2014: 7) describe how the Ministry of Health has played “a strong advocacy role in pushing for investment in facilities” but has also “promoted experimentation” by allowing health care workers and organizations to charge service fees without fully understanding the long-term impact of the emerging agent behaviour on the system goals. These authors note that the implementation of this policy in local contexts has stimulated a variety of responses in the form of resistance and adaptation, but has also created space to enable national policies to be interpreted by local management.

The case study by Zhang et al (2014) highlights the complex nature of implementation but also the role of government in setting health system objectives and supporting leadership for system change. This central-local dynamic draws similarities with the regional variation identified by Shi (2012) and Mei and Liu (2014) in their study of social policy initiatives. Reflecting on the development of urban pension reform, Shi (2012) argues that one of the defining features of the decentralised nature of policy in China is its asymmetric character: while central government retains tight control within the political sphere, it gives localities some degree of autonomy to seek out their own development. Heilmann (2008) develops this point further in suggesting that the pattern of governance in China has distinctive foundations with both a hierarchical state and models of decentralisation or federalism being combined. The approach is experiment based whereby the authority of a central leadership encourages broad-based local initiatives that aim to develop generalisable lessons to be applied in other areas. The term “experimentation under hierarchy” denotes the experimental efforts by local implementers under the patronage of senior leaders (Heilmann, 2008: 29).

Heilmann (2008) goes on to argue that the policy process in China is built on the assumption that central policy-makers can encourage local officials to try out new ways of problem-solving with these local experiences fed back into the formulation of national policy. The mode of experimentation is focussed on finding innovative policy instruments, rather than defining policy objectives, where local discrepancy serves to modify and adjust policies rather than challenge the centre. The author connects

this approach with the work of John Dewey who is seen as influential on political debates in China during the 1920s. Here, Heilmann summarises how a core theme of Dewey's work is the experimental method for generating and testing scientific knowledge which is “guided by intentional anticipation instead of being blind trial and error” (Heilmann, 2008: 18). The epistemology assumes that obtaining knowledge about the world and stimulating change can be achieved through a well-conceived process of practical experimentation. Heilmann also suggests that Chinese-style experimentation must not be mistaken as an attempt at “scientific”, “evidence-based” policy selection (Heilmann 2008: 28). Rather, in setting of policy objectives the selection of model experiments or identifying generalisable policy options is a distinctly political process which is driven by competing interests and ideologies and fuelled by personal rivalries, opportunism and ad hoc policy compromises.

### **Mapping out a research agenda**

Alongside the emerging perspectives of governance and political economy we argue that a policy perspective, particularly one in the tradition of policy experimentation outlined above might be used to explore and understand future healthcare reform in China. We suggest that such a perspective will be better able to take into account the high degree of decentralization which characterises the Chinese healthcare system. As Liu and Darimont (2013) suggest, the study of such contextual variation can be used to illuminate the discrepancies between rural and urban healthcare. Furthermore, the perspective can be used to explore ways in which the experimental nature of policy in China can be better enabled to facilitate the spread of best practice, improve transparency and accountability, and support the relationship and interactions between policy, practice and the population these reforms are intended to serve.

Following meetings in Beijing and Birmingham, the recently formed China-UK Health Policy Group aims to build on this perspective to provide further understanding into this vast reform programme. The aim of this group is to bring together academics and practitioners with an interest in healthcare

policy and practice from both countries. We believe that China provides unique insights into aspects of healthcare reform that are of international relevance.

In attempting to move the research agenda forward, group members are collaborating on a number of theoretically informed empirical research projects with the aim of generating insights into the policy experiments currently taking place in China: particularly in relation to the development of new integrated models of care, the relationship between governance and accountability at different levels of the healthcare system hierarchy and the dynamics of medical professionalism.

## **Conclusion**

The purpose of this Viewpoint has been to examine the nature and impact of healthcare reform in China from a variety of theoretical perspectives. We have outlined how different scholars have started to make sense of these developments and have argued that a new perspective is needed which better accounts for the unique characteristics of the policy process in China. In particular we suggest that the policy experiment perspective may provide a useful lens for understanding the nature and impact of past, current and future health care reforms in China.

## **References**

Allen, P. Cao, Q. and Wang, H. (2014), Public hospital autonomy in China in an international context, *International Journal of Health Planning and Management*, Vol.29 No. 2, pp. 141–159.

Barber, S.L. Borowitz, M. Bekedam, H. et al. (2014), The hospital of the future in China: China's reform of public hospitals and trends from industrialized countries, *Health Policy and Planning*, Vol.29 No.3, pp.367-378.

- Barber, S.L. Huang, B. Santoso, B. et al. (2013) The reform of the essential medicines system in China: a comprehensive approach to universal coverage, *Journal of Global Health*, Vol . 3 No.1, pp.1-9.
- Bice, S. and Sullivan, H. (2014) Public Policy Studies and the Asian Century, *Governance*, Vol. 27 No.4, pp. 539-544.
- Chen, Z. (2009) Launch of the health-care reform plan in China, *Lancet*, Vol. 373 No.9672, pp.1322-1324.
- Drechsler, W. (2013) Three Paradigms of Governance and Administration: Chinese, Western, and Islamic, *Society and Economy*, Vol. 35 No.3, pp. 319–342
- Heilmann, S. (2008), From Local Experiments to National Policy: The Origins of China's Distinctive Policy Process, *The China Journal*, Vol. 59, pp.1-30.
- Hsaio, W.C. (2007), The political economy of Chinese health reform. *Health Economics, Policy and Law*, Vol. 2 No.3, pp.241-249.
- Hu, S. Tang, S. Liu, Y. et al. (2008) Reform of how health care is paid for in China: challenges and opportunities, *Lancet*, Vol. 372 No.9652: 1846–53.
- Korolev A. (2014) Deliberative Democracy Nationwide?—Evaluating Deliberativeness of Healthcare Reform in China, *Journal of Chinese Political Science*, Vol.19, pp. 151–172.
- Liu, D. and Darimont, B. (2013) The health care system of the People's Republic of China: Between privatization and public health care. *International Social Security Review*, Vol.66 No.1, pp.91-116.
- Mei, C. and Liu, Z. (2014),Experiment-based policy making or conscious policy design? The case of urban housing reform in China, *Policy Sciences*, Vol. 47, pp. 321-337.
- Niuyun, S. (forthcoming), China. In Braithwaite, J. Matsuyama, Y. Mannion, R. and Johnson, J. (eds) (forthcoming) *Healthcare Reform, Quality and Safety: Perspectives, Participants, Partnerships and Prospects in 30 Countries*. Ashgate Publishers: Abingdon.

Parry, J. (2012), Nine in 10 Chinese are covered by medical insurance, but access to treatment remains a problem, *BMJ*, Vol.344, e248.

Ramesh, M. Wu, X. and He, A.J. (2013), Health governance and healthcare reforms in China, *Health Policy and Planning*, Vol. 29 No.6, pp. 663-672.

Sang, S. Wang, Z. and Yu, C. (2014) Evaluation of Health Care System Reform in Hubei Province, China. *International Journal of Environmental Research and Public Health*, Vol.11 No.2, pp. 2262-2277.

Shi, S-J. (2012), Social policy learning and diffusion in China: the rise of welfare regions?, *Policy & Politics*, Vol.40 No.3, pp.367-85.

Yi, Z. and Lan-juan, L. (2012), Transformation of the Chinese medical and health development: from the perspective of the public hospital reform. *Chinese Medical Journal*, Vol.125 No.16, pp.2933-2941.

Yip W, and Hsiao WC. (2008), The Chinese health system at a crossroads. *Health Affairs*, Vol.27 No.2, pp.460–468.

Yip W, and Hsiao WC. (2014), Harnessing the privatisation of China's fragmented health-care delivery, *Lancet*, 384: 805–18.

Yip, W. Hsiao, W.C. Chen, W. et al. (2012), Early appraisal of China's huge and complex health-care reforms, *Lancet*, Vol.379 No.9818: pp.833–42.

Zhang, W. and Navarro, V. (2014), Why hasn't China's high-profile health reform (2003–2012) delivered? An analysis of its neoliberal roots, *Critical Social Policy*, DOI: 10.1177/0261018313514805.

Zhang, X. Bloom, G. and Xu, X. (2014), Advancing the application of systems thinking in health: managing rural China health system development in complex and dynamic contexts, *Health Research Policy and Systems*, Vol. 12 No.44, pp. 1-9.