

Health Care System Reform in Contemporary P.R.China: Public Agenda, Private Interests and Global Interactions¹

Daniele Brombal (daniele.brombal@unive.it)
PhD Candidate
Department of Asian and North African Studies
Ca' Foscari University of Venice

*Threaten a reduction on the profit of their money
and the beast in them awakes with a snarl.
They become ruthless as savages, brutal as madmen,
remorseless as executioners.*

Dr. Norman Bethune (1939)²

1. Introduction

Contemporary China observers tend to agree over the positive role played by post-maoist market-oriented reforms in shaping a political system increasingly open to interactions between private interests and state authorities. Recent works exploring these interactions describe a context where “pursuit of economic expansion has led to the emergence of an interest-based social order” (Zheng 2002: 64) and a polity where “largest and most active interest groups are economically driven and have a great impact on . . . political and social affairs” (Yang 2007: 2).

In the last thirty years, Chinese public health care system has experienced a pervasive restructuring process, whose trajectory has been defined by the State coherently with national development priorities. As reforms in the health sector deepens, private interests are emerging. Despite the deep influence of market-oriented reforms in the sector, however, scarce attention has been devoted in investigating policy inputs conveyed by economically driven interests—in particular those of medical providers and pharmaceutical producers—to the political power, either in the form of resistance to regulatory pressures or through the articulation of specific demands. This paper will attempt to investigate the processes which lead to the constitution of economically driven interests in post-Mao China's health care sector, how they exerted their influence on the commitments taken by the Hu-Wen leadership towards a more “harmonious” pattern of socio-economic development and which avenues they might follow in articulating demands upon the political system. Finally, recent developments in health policies and the relevant debate involving major stakeholders will be introduced.

2. Health care sector reforms 1980s - 2000s

The health care system developed in China during the sixties and the seventies has long been considered by the international community an ‘outstanding example’ in terms of primary health care (WHO 1983: 11). Between 1952 and 1982, average life expectancy rose from 35 to 68 years, while infant mortality was reduced from 250 to 40 deaths every 1,000 live births (Hsiao 1995: 1047). These achievements were possible thanks to a health care system focusing on prevention, financed through public resources and guaranteeing universal access to primary healthcare.

Economic reforms initiated in the early 1980s had a major impact over the health care sector. The abolition of communes caused the collapse of the Cooperative Medical Scheme (CMS) (*nongcun yiliao hezuo zhidu*), a community based mutual insurance scheme financed and operated at brigade and commune level. Between 1978 and 1985, the percentage of insured rural population dropped from 90 percent to 5 percent (Yip, Hsiao 2008: 461). In the 1990s, due to the curtailment of workplace benefits, coverage declined also in the cities. In 1998, 56 percent of the urban population were insured, against 73 percent of five years before (MoH 1998: 23). In the mid-1980s, public financing of health providers' current expenditures—salaries, maintenance, equipments—declined from an approximate 50 percent to 5-10 percent of total hospital budgets (WHO 1983: 66-67, Sun *et al.* 2008: 1046). Due to the lack of public financing, providers turned to user fees, largely paid out-of-pocket by patients. In 1985, hospitals were attributed financial autonomy, being allowed to retain the surplus generated through the sale of services (Meng 2006: 17). Although the government retained ownership of the majority of health providers, reliance on user fees and the attribution of financial autonomy resulted in a *de-facto* privatization of health care³.

Scarce insurance coverage and rising costs caused huge difficulties in accessing health care, a phenomenon which in Chinese goes by the expression of *kan bing nan, kan bing gui*, “seeking care is difficult and expensive”. In 1993, over 40 percent of rural residents didn't have access to hospital treatment when in need, in most cases due to unaffordability. Impoverishment due to medical expenditures became common: in 1998, they were causing 45 percent of the cases of impoverishment in the countryside (MoH 2009a: 46; Liu, Rao, Hsiao 2003: 219).

Throughout the 1980s and most of the 1990s, Chinese leaders seemed convinced that in the long run market reforms would play its magic, ‘slowly raising all boats’, despite warnings repeatedly launched by the Ministry of Health (MoH) (MoH 1993: 64-64; MoH 1998: 132-135). In those years, the shift towards market mechanisms was not uncommon among developing countries. The assumption that only market could ensure a proper allocation of the ‘health good’ was consistent with the neoliberal recipe then advocated on global scale by international financial institutions such as World Bank (WB) and International Monetary Fund (IMF), with social concerns subordinated to economic performance. An example of this subordination can be found in the words of former prime minister Zhu Rongji⁴, who upon hearing of a MoH proposal to use an earmarked cigarette tax to finance health, stated: “That’s great—we can raise that much revenue from increasing the cigarette tax. That will help a great deal with our Three Gorges Dam Project!” (Liu, Rao 2006: 83).

In the long run, however, the crisis of the health care sector couldn’t be ignored. Impoverishment due to medical expenditures hampered economic development in the rural hinterland, while difficulties in accessing health care fueled dissatisfaction among the populace. In late 2002, at the eve of the the XVI Congress of the Communist Party of China (CPC) which was to designate Hu Jintao as general secretary, CPC Central Committee and State Council issued the “Decision on Further Strengthening Rural Health Care”. This document redefined the rationale of the state’s health intervention in rural areas as “promoting agricultural economy, protecting the development and stability of the rural society” (*CPC Central Committee, State Council* 2002: Preamble). The reform process of the health care system was accelerated by the SARS crisis, which clearly demonstrated how the shortcomings of the medical system could result in economic disaster (Saich 2011: 316; Gu 2004: 154)⁵.

The health reform initiated by the Hu-Wen administration has been inspired to the goal of delivering tangible benefit to the most vulnerable part of the population, coherently with the outline for the construction of a “harmonious society”, as well as with the need of ensuring the long-term legitimacy of the régime. As ambassador Wang Xuexian stated in his keynote speech during the ASEM Development Conference 2009: “Employment and social security are the key elements to maintain social stability” (Statement # 0422, 2009). Developing a relatively efficient welfare safety net is seen by authorities also as a tool to foster internal consumption, so far limited by high rates of precautionary saving, especially in the rural hinterland. This has been a priority for Chinese leaders since the financial and economic crisis of 2008-2009, which reduced demand for Chinese goods in Western markets. During the 2010 Davos World Economic Forum, vice premier Li Keqiang—a strong advocate for the health reform—recognized that China had been “excessively reliant on investment and export”, stressing the need to boost internal demand (*BBC News* 2010).

In public statements made by proponents of the health reform, a renewed faith in the role of the public institutions as guarantor of the common good can be found, sometimes along with a “nostalgia” for the time when the Chinese health care system was considered a model. As Peking University’s economist Li Ling—among the most visible advisors to the government for health care reform—put it in an editorial published on MoH’s *Health News*, “we must rethink development targets [. . .] and focus on people’s happiness: our final goal must be that of ensuring to the people the pursuit of happiness [. . .] and well-being”. In her editorial, prof. Li also calls for a renewed effort to reform China’s health care system, which should become “a model for the entire world” (Li 2010).

Rhetoric aside, in the last few years the share of China’s total health expenditure covered with public resources has increased, reaching 47 percent in 2008 (WHO 2011: 128). Additional resources were utilized to a large extent to strengthen health insurance: in 2007, 66 percent of government health expenditure was used to subsidize government run insurance schemes (WHO 2009: Table A). In 2008, the portion of insured population accounted for the 87 percent of the total, up from 22 percent in 2003. Wider insurance coverage was achieved largely thanks to the introduction in 2002 of the New Rural Cooperative Medical Scheme (NRCMS) (*xinxing nongcun hezuo yiliao zhidu*), which by 2008 was covering 93 percent of rural residents, or 800 million people (MoH 2009a: 14). According to Dr. Rao Keqin, head of the Center for Health Statistics and Information of the MoH, “So far, the most important achievement in the health care reform process has been the establishment of the NRCMS” (Statement # 1202, 2009). In urban areas, the Urban Workers Basic Medical Insurance (UWBMI) (*chengzhen zhigong jiben yiliao baoxian*) was complemented in 2007 by the Urban Residents Basic Medical Insurance (URBMI) (*chengzhen jumin jiben yiliao baoxian*), targeting children, elderly, unemployed and workers of the informal sector⁶. By 2008, UWBMI and URBMI covered 57 percent of urban population (MoH 2009a: 14).

3. Economically driven interests in the health sector

Payment of health services in China is commonly based on a “fee-for-service” (FFS) mechanism, i.e., patients are charged for each item they consume, regardless of their diagnosis⁷. Chinese medical price schedule is heavily distorted: tentatives made over the years by the National Development and Reform Commission (NDRC)—in charge for price regulation—to curb medical costs resulted in a situation where most prices for medical services are set at a level below cost, while providers are free to generate profits from the mark-up on drugs and from the provision of hi-tech diagnostic procedures. As a result, service provision is largely skewed towards the

prescription of items ensuring high revenues, with special reference to drugs, which constitute on average the 40-50 percent of hospital revenues (Sun et al. 2008: 1046). To incentive service provision, hospitals provide monetary bonuses to physicians on the basis of prescriptions' value and amount. The more a doctor prescribes, the higher will be his/her salary. In a county hospital surveyed by the author in 2008, bonuses allowed doctors to double the basic salary—RMB 2,500/month for a clinical physician—provided by the government⁸ (Interview File # 0418, 2008).

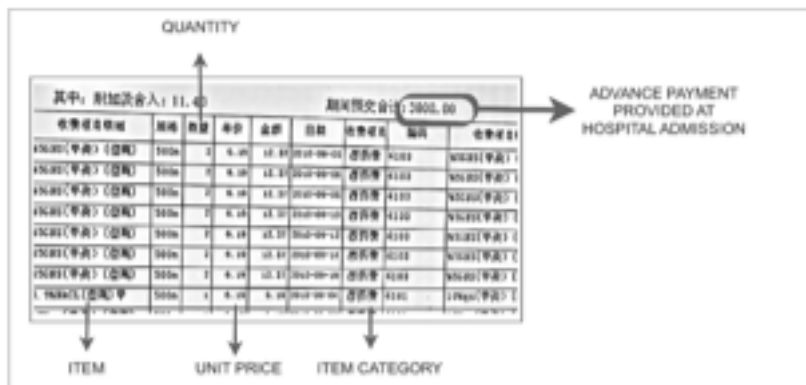


Figure 1 (Above): Screenshot from a digital Hospital Information System (HIS), showing prescriptions made to a patient receiving IP treatment in a rural hospital. Near the the top-right margin the value of the advance payment provided by the patient—RMB 3,800—can be seen (Author’s picture, Central China, 2010).

The incentives towards provision of curative services and the distorted price schedule heavily influence clinical practice. Over-provision of services in China—for those who can afford them—is well documented. A study conducted in 1998-99 in four township health centres (THCs) and eight village clinics concluded that less than two percent of drug prescriptions were reasonable on medical grounds (Zhang et al. 2003, in Eggleston et al. 2006: 1). According conservative estimates published in 2001, 20-30 percent of China’s overall health care expenditure was spent on services and drugs whose prescription was either unreasonable or unnecessary (Zhong 2001, in Yu et al. 2010: 12).

According to Chinese regulation, medical personnel is forbidden to “deny emergency treatment” (NPC 1998: Art. 24). However, in Chinese hospitals treatment is often denied, delayed or withheld if patients are incapable of providing an advance payment, which is required at the moment of IP admission. In the case of Mr. Feng⁹, a farmer living in Inner Mongolia, the amount of the advance payment was ten times the local average per capita one-year income: “Last year [in 2007] my brother was hit by a car on his way to work. He was badly injured. When we arrived to the hospital, they first visited him, then asked for an advance payment of 30,000 yuan. Luckily, we were able to put together the money, and he was treated” (Interview File # 0715, 2008). According to an expatriate medical professional operating in China, “hospitals often put up a facade of formal compliance with regulations when patients aren’t able to pay the deposit. They do provide some sort of treatment, but this is in most cases inappropriate and useless, generally consisting in glucose infusions” (Interview File # 1013, 2011). Similar situations occur also after the patient has been admitted: once the advance payment is exhausted, medical personnel require patient’s relatives to fill in the deposit, according to an amount generally indicated by a clinical physician. The problem is so pervasive that in 2009 MoH issued specific regulations over the issue, specifying the principle of *xian jishi qiuzhi, hou bujiao feiyong* “first timely treat, then pay the fee” (MoH 2009b, Art. 23).

Interests of public health providers are closely tied with those of the pharmaceutical industry, since hospitals account for more than 4/5 of all retail pharmaceutical sales (Sun et al. 2008: 1046). Since the 1980s, when economic reforms allowed drug factories to adjust production plans according to market demand, the pharmaceutical sector has been developing at a rapid pace. In 2005 pharmaceutical manufacturers operating in China were 4,600, up from 839 in the early 1980s. The total value of domestic pharmaceutical production rose from 10 billions yuan in 1985 to over 446 billion in 2005 (Tang et al.: 3). Once distributed exclusively trough wholesalers controlled by the government, drugs can now be sold also directly to health providers. Sales agents often contact hospital managers and physicians, providing incentives—commissions, kickbacks, gifts—to incentive them to purchase or prescribe their products (Yu et al. 2010, pp. 10-11).

4. Impact of economically driven interests on the Hu-Wen policies

Despite the increase in insurance coverage, results of the health care reform launched by the Hu-Wen administration in terms of enhanced accessibility of health care services and financial protection against medical

expenditures have been scarce. According to a study conducted by the Italian Development Cooperation and the Chinese Ministry of Health in 2008, involving 11,000 individuals in Central and Western rural China, over 46 percent of those who had been prescribed hospitalization in the 12 months previous to the survey had not been able to access treatment. In most cases, the reason was the lack of money to purchase the treatment (89 percent) (HCU-MoH 2009: 27)¹⁰.

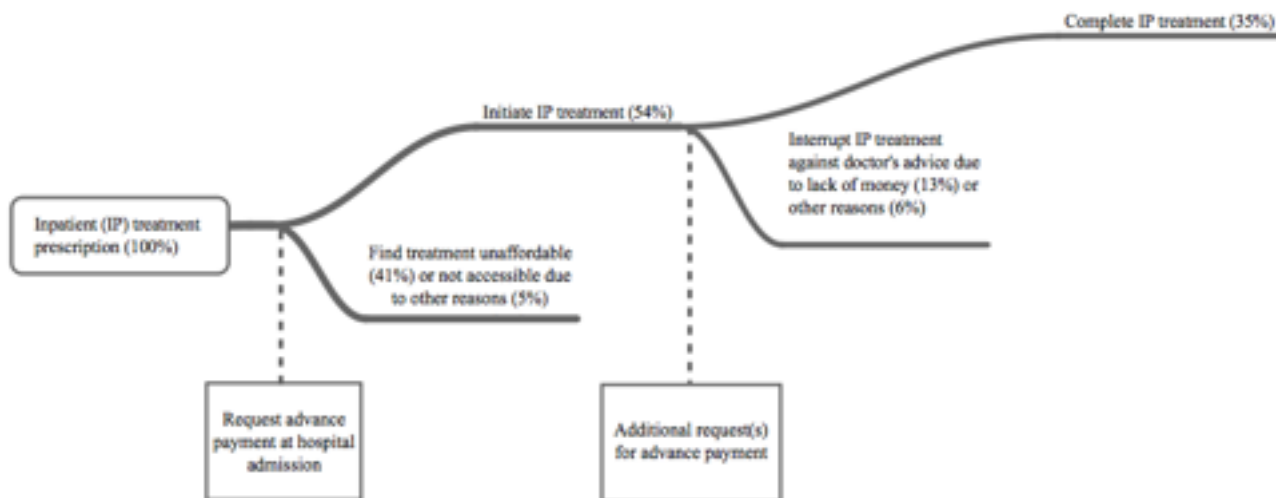


Figure 2 (Above): Inpatient (IP) services prescription and provision in rural Central and Western China, 2008. Only 35 percent of those who have been prescribed by a doctor IP treatment are able to complete the treatment. Other patients in most cases are forced to either renounce to IP treatment (46 percent of the total) or interrupt it against medical advice (19 percent), in most cases due to unaffordability (HCU-MoH 2009: 25-34).



Picture 1 (Above left). Ms. Wang¹¹ says: “My son has diabetes and hepatitis. Doctors tell me I should bring him to the hospital to get some treatment. We can’t do that: I am a poor old woman and he can’t work on the fields. How could we possibly go to the hospital?” (Author’s picture, Central China, 2008. Interview File # 0420, 2008).

Picture 2 (Above right). Patient undergoing dialysis session in a rural hospital. At the time of the author’s visit, cost of the treatment was equal to RMB 240 for each session. With an average of two session per week—in case of chronic kidney failure—this means a cost of RMB 25,000 per year. When the author visited the area, local one year per capita average income was equal to RMB 5,000. (Author’s picture, Central China, 2010; Interview File # 0917, 2010)

Interestingly, according to the same study, being insured or not didn’t make much of a difference: no significant differences in levels of unmet health care need between the insured and the uninsured were found. Where being insured *did* make a difference, however, was in the amount of out-of-pocket expenditures. Curiously, NRCMS insured patients were more likely to spend in IP treatments a considerable amount of money (≥ 10 percent of the household one-year income) than the uninsured ones, although no evidence of adverse selection was found (HCU-MoH 2009: 20-40). These findings are consistent with the results of a WB research in

urban areas, which found a significant higher probability to incur in catastrophic expenditures among insured patients than among uninsured ones (Wagstaff, Lindelow 2008: 10). A study conducted in Guangdong province produced similar evidence, finding that the insured had spent on average 60 percent more than the uninsured, largely due to higher costs and quantity of medicine prescribed to them (Pan *et al.* 2009: 1146). As a senior MoH official put it, health reform so far hasn't changed the fact that "health providers are public only by name. In fact, they operate as private institutions", i.e., pursuing their economic interests (Statement File # 0619, 2009).

Reforms have been a good opportunity for pharmaceutical companies to boost their revenues. The value of the Chinese pharmaceutical market increased threefold between 2004 and 2009, with growth forecasts around 20 percent/year (Partnering News 2011). According to estimates, public resources allocated under the health reform plan 2009-2011—whose characteristics we'll introduce in paragraph six—produced in 2010 an eight percent growth of the pharmaceutical market, for an estimated 53 billion yuan (Shen 2009:3).

Chinese citizens are keenly aware of the contradiction between Beijing's commitments and the economic interests of the health industry. In a comment posted in the web forum launched by NDRC in 2008 to collect public opinions over the health reform, a netizen wrote: "Doctors don't think about the actual condition and needs of their patients, but rather about how to make more money"¹². Significantly, frustration of patients and their families doesn't take the form of organized demonstrations directed towards local authorities—as it is increasingly common with other issues of public interest—but rather is revealed by incidents of violence against medical personnel. In 2006 10,000 cases of aggressions were reported, with 5,500 wounded (Xinhua News Agency 2007). To deal with episodes of violence, in 2010 police officers were invited to be the vice-presidents of 27 hospitals in Shenyang, a large city in north eastern China (The Lancet 2010: 657). Hospital admission departments, as well as offices of both clinical physicians and administrative personnel, are often protected with metal bars.



Picture 3. (Left) Admission office of a county hospital. In Chinese hospitals, violent disputes between patients and medical personnel are common. Metal bars often protect administrative offices (Author's picture, Central China, 2010).

Picture 4. (Right) Department of internal medicine in a county hospital central China, 2010. Mr. Wang¹³ complains: "I've been here since this morning, already paid a 2,000 yuan, but up to now I still don't know what's wrong with me. You're a doctor, right? So why don't you come here and tell me?" (Author's picture, Central China, 2010).

5. Resistance to regulatory pressures and platforms for interest articulation

The capacity of single individuals and institutions to resist policy and regulatory pressures has been widely documented in communist polities and China in particular (Skilling 1966: 436; Burns 1988: 32; Hook 1996: 4). Selective provision of services and selective compliance with regulations among Chinese health care providers, illustrated in the third paragraph, are a clear example of this resistance(s), expressing an orientation opposed to the policies inspiring the role of the state in terms of health care provision under the Hu-Wen leadership.

Building on the existing literature analyzing the interactions between private interests and public authorities in other areas of China's economic, social and political life, it is possible to outline platforms for interest articulation in the health care sector¹⁴. At this regard, based on different structure and constituencies, we can distinguish between institutional, associational and corporate interest groups¹⁵.

The major institutional group comprises of managers and physicians working in public hospitals. Hospitals are, in fact, part of a bureaucratic apparatus attached to government and party authorities. Hospital managers are effective in lobbying government departments to gain access to financial resources, often acting outside any kind of formal coordination by local health authorities. On a broader perspective, hospitals have influenced the policy dialogue nationwide, mainly through MoH's institutional channels. Complaints of physicians about poor working conditions and low salaries have been consistent throughout the years, acquiring a relevant position in the current debate on health care reform (Pye 1996: 38; Qiu 2009: 11). According to a well-informed source, "doctors and

hospitals are MoH's constituency, the basis of its power. When Zhang Wenkang [ex minister of health, sacked for the mismanagement of the SARS crisis] declared 'I'm not the CEO in charge of public hospitals, I'm the CEO in charge for the well-being of 1.3 billion people!' he was harshly criticised, and forced a few months later to correct his statement. This demonstrate how MoH must be careful dealing with doctors' interests" (Interview File # 0730, 2011).

Key actors of Chinese health industry are grouped in various organizations, such as the Chinese Hospital Association, the China Insurance Association, the China Pharmaceutical Commerce Association. These groupings mostly fit into the description of state-corporatist organizations, working as a consultative arm of the government (Unger, Chan 1995: 37-51; Thompson 2009: 64). Associations, however, at times can convey upwards requests and opinions, formulated either by their own constituencies or by actors affected by decisions being taken at higher levels. According to a senior pharmaceutical marketing manager, "Associations are very important channels of communication between the government and businesses. In many cases, their leadership is chosen directly by the associates, effectively representing the interests of businesses included in the association" (Interview File # 1130, 2011).

Other than into institutional and associational groups, interests can coalesce into corporate interests groups. Corporate pressures, through either legal or illegal avenues—lobbying, kickbacks, bribes—have been widely documented with reference to the pharmaceutical industry. In 2007 Zheng Xiaoyu, director of the Chinese State Food and Drug Administration (SFDA), was executed after being found guilty of receiving bribes to smoothen approval of drugs not complying with mandatory quality and safety standards (*BBC News* 2007). Dynamics of interest articulation in other key regulatory areas, such as the definition of indicative retail prices for drugs—responsibility of NDRC—and the inclusion of drugs into the formularies of items reimbursable by the government health insurances—NRCMS, URBMI and UWBMI, for which are in charge respectively the Ministry of Health (MoH) and the Ministry of Human Resources and Social Security (MoHRSS)—are more difficult to ascertain. However, while new measures of drug pricing reform were being discussed by top leaders in 2009, "intense discussions" reportedly went on behind the scene (Shen 2009: 3). It must be noted that, due to the considerable fragmentation of the Chinese pharmaceutical market—where none of the top ten pharmaceutical companies controls more than 2.5 percent of the market—neither international MNCs or biggest domestic firms are in a monopolistic or quasi-monopolistic position, a condition which in other sectors allows major enterprises to articulate successfully their interests (KPMG 2011: 20, 28; Naughton 2009: 7-8; Yang 2007: 2-5). This said, market's structure will probably evolve towards an increased concentration in the near future, as major mergers and acquisitions are occurring at a rapid pace (PWC 2009: 22). In the first half of 2011, various collaborations were established between domestic producers and foreign MNCs, including Pfizer, Novartis, Daichi Sankyo, Takeda.

In the Chinese context, direct contact between interested parties and their regulators has been documented to be one of the most common forms of interest articulation (Kennedy 2005: 3). Considering the almost symbiotic ties often existing between government and business, strengthened after Jiang Zemin opened party ranks to entrepreneurs a decade ago, this finding is not surprising. Interest articulation through personal connections and elite representation—i.e., presence of a group member in the policy making structure or sympathetic representation by an elite figure (Almond, Powell 1966: 83)—seems to be likely patterns for putting demands upon the political system in the health sector. With special reference to the pharmaceutical sector, personal connections are fostered also through departments for governmental affairs—which inside pharmaceutical companies are specifically entrusted with smoothing relations with authorities—whose operations are considered necessary prerequisites to run a profitable business. "Without such departments", says a well-informed source, "there is no way to close good deals" (Interview File # 1130, 2011).

6. The 2009-2011 health reform plan: Contents, debate and resistance

In 2009 Beijing launched a new phase of the health reform. Priority has been once again attributed to the government-run health insurance sector, which received 2/3 of the 850 billion yuan earmarked for the plan in the period 2009-2011. Besides additional resources for the insurance sector, the plan also envisages the establishment of a new set of regulations pertinent to drugs prescription and hospital management (State Council 2009). By late 2010, over 300 "essential drugs" were listed by MoH. According to the new regulation, physicians employed in the lowest tiers of the health care provision network—village clinics (*cun weishengshi*), township health centres (*xiang weishengyuan*), community health centres (*shequ weisheng fuwu zhongxin*)—should exclusively prescribe drugs included in the list. New measures also require the gradual abolition of the mark-up on the price of drugs. To compensate losses, local authorities have been required to gradually increase subsidies to cover current expenditures of hospitals. As for hospital management, the plan focuses on curbing the rise in medical expenditures and avoiding over-prescription. MoH has developed 112 clinical protocols, which are being piloted in over 100 public providers, showing encouraging results in reducing average costs for IP treatments (Jiankang Bao 2010).

Not surprisingly, the reaction of the pharmaceutical industry and medical providers hasn't been enthusiastic. Short before reform measures were disclosed in early 2009, Pharma China—a business media based

in the US, tied to the consulting firm Wicon International—published a long editorial, whose central paragraph read “Top priority of Chinese healthcare reform should *not* be cost containment” (Shen 2009: 2). In the first months of 2010, debate previously kept behind the scenes went public: Commenting on the health reform plan during the Chinese People’s Political Consultative Conference (CPPCC) in March 2010, the delegate Zong Licheng, manager of a pharmaceutical company, openly criticized the measures aimed at curbing medical costs (Nanfang Zhoumo 2010a). Also public hospitals expressed discomfort. According to a hospital director named Hu Siming, “even if the prescription of certain treatments isn’t ethically justifiable, hospital and doctors must find some way to survive” (Nanfang Zhoumo 2010b). While discussing with the author, the director of a prefecture hospital located in central China defined the reform plan as “idealistic” (Interview File # 0520, 2010). Local authorities seem to share this attitude. A representative of a provincial health department repeatedly expressed to the author skepticism over the economic sustainability of hospital operations under the new restrictive framework regulating drugs’ prescription and clinical procedures (Interview File # 0925, 2009).

Passive resistance to regulations seems likely to continue along the usual patterns. According to an ex pharmaceutical marketing manager, “hospital will try to avoid restrictions, continuing to prescribe unnecessary treatments and items not yet subject to strict government regulation” (Interview File # 0221, 2011). According to another medical source, “the proposed measures [on the abolition of mark up on drugs] could lead to illegal arrangements between drugs manufacturers and hospitals: the wholesale price of drugs could be artificially increased, so as to make up at least partially for the financial losses caused by the ban of mark up” (Interview File # 1014, 2009).

7. Conclusions

In February, 2011, while addressing a national meeting on health reform, Chinese vice-premier Li Keqiang said that in 2011 “the country would fight the toughest battle to reform the health care system” (People’s Daily Online 2011). Li’s words seem to confirm the difficulties encountered by Beijing in pushing ahead the most controversial elements of the health reform, with special reference to the hospital management reform, whose progress has been so far reportedly slow.

China faces enormous challenges with respect to health care, likely to become even more daunting in the coming years due to the rapid aging of the population. The capacity of its health care system to ensure equitable access to safe and effective health services will largely depend upon the interactions between social needs, political power and economic interests. The latter—which developed during the 1980s and 1990s—in the Hu-Wen era have considerably curtailed the space of maneuver of state’s authorities, resisting the implementation of policies which they perceived as detrimental to their economic interests. Should these interests achieve considerable influence over the current health care reform process, the outcome of China’s transition—at least in this area—could be different from the one advocated by many China scholars and observers: policy making could become responsive to powerful private interests, rather than accountable to society at large.

Disclaimer: Views and opinions expressed un this paper are those of the author alone

Notes

¹ This work partially reproduce materials included in the paper “Health Sector Reforms in Contemporary P.R.China: A Political Perspective”, prepared by the author for the conference *Globalization and Public Sector Reforms in China and India*, held at Copenhagen Business School (CBS) on September 23-24, 2011,

² See Hannant (1998: 327). Known in China by the name of *bai qiuen*, Norman Bethune was a Canadian medical doctor and communist political activist. In 1938-1939 he was stationed in the Communist stronghold of Yan’An. He died in November 1939 of septicemia, probably contracted performing surgery on a wounded Chinese soldier. He is still remembered and celebrated in China among revolutionary heroes

³ Village—the lowest tier of the Chinese health care system—is the only layer of the health care provision network where a considerable portion of providers privatization went to its full extent. By 1998, 40 percent of village clinics were independent and private practices (Liu et al. 2006: 241).

⁴ Chinese premier between 1998 and 2003.

⁵ According to WHO, between November 2002—when first cases were detected in Guangdong province—and August 2003, SARS cases worldwide were 8,422, with 916 deaths (WHO 2003). The ‘People’s War to SARS’ declared by President Hu Jintao in early 2003 (Perry 2007: 15) is often considered the ridge between the ‘old’, market-oriented health policies and the ‘new’ course initiated with the ‘fourth generation of leaders’.

⁶ While NRCMS and URBMI premiums are heavily subsidized by the government, with a flat rate contribution paid by the single enrollee, UWBMI is financed by the worker and the employer. On average, UWBMI insurance premiums amount to 8 percent of the annual salary, 2 percent provided by the worker and 6 percent by the employer.

⁷ In most western countries ‘fee-for-service’ (FFS) mechanisms have been replaced by per-case based, forfeit payment systems. Among these systems, the most widely used to determine cost for inpatient (IP) services is based on Diagnosis Related Groups (DRGs). DRGs classify patients into major diagnostic categories. Each of these categories groups together diagnoses whose treatment should consume a similar amount of resources. The introduction of DRGs is typically intended as a mechanism to incentive providers to economize, and have proven to a large extent effective. Since the actual costs incurred by the hospital are not taken into

account, DRGs requires the adoption of well-defined treatment protocols. Per-case payment mechanisms have been tested in many Chinese hospitals in the last few years, as MoH called for the experimentation of payment mechanism based on patients' diagnoses.

⁸ In October 2011, 1RMB = US\$ 0.16; EUR 0.11. In the same area, average income for peasants was around RMB 3,000 per capita per year.

⁹ Fictitious name.

¹⁰ The author took part in the study, providing operative, scientific and field coordination on behalf of the Italian counterpart. The results of the study have been published in 2009 at <http://saluteinternazionale.info/2009/09/riforma-sanitaria-in-cina-lo-stato-dellarte/> [Italian language].

¹¹ Fictitious name.

¹² In October, 2011 the comment was still accessible at http://www.sdpc.gov.cn/ygyj/ygyj_detail.jsp?comId=31240.

¹³ Fictitious name.

¹⁴ See Kennedy 2005: 1-24, Yang 2007: 2-5.

¹⁵ To describe the concept of "interest group", we refer to the definition given by Gabriel Almond and Bingham Powell: "group of individuals who are linked by particular bonds of concern or advantage, and who have some awareness of these bonds" (Almond, Powell 1966: 75).

References

Almond, A. Gabriel and Bingham, Powell. *Comparative Politics: A Developmental Approach*. Boston: Little Brown and Company, 1966.

BBC NEWS. "Death Penalty for China Official", 2007, <http://news.bbc.co.uk/2/hi/6699441.stm>.

BBC NEWS. "China Says Domestic Demand 'Key'", 2010, <http://news.bbc.co.uk/2/hi/8485779.stm> Davos2010.

Burns, John. *Political Participation in Rural China*. Berkeley: University of California Press, 1988.

Central Committee of the Communist Party of China (CCCPC) - State Council. "Guanyu jin yi bu jiaqiang nongcun weisheng gongzuo de jue ding, zhongfa, 2002 nian, 6 hao" [Decision of the CPC Central Committee and of the State Council of further strengthening rural health], *Central Committee of the Communist Party of China*, 2002, http://www.gov.cn/gongbao/content/2002/content_61818.htm.

Central Committee of the Communist Party of China (CCCPC) - State Council. 'Zhonggong zhongyang, guowuyuan guanyu shenhua yiyao weisheng tizhi gaige de yijian, zhongfa, 2009 nian, 6 hao' [Suggestions of the Central committee of the Communist Party of China and State council on further strengthening health care system reform], *Central Committee of the Communist Party of China*, 2009, [http:// gov.hzrb.cn/system/2009/04/06/010019487.shtml](http://gov.hzrb.cn/system/2009/04/06/010019487.shtml).

Eggleston, Karen and others. "Health Service Delivery in China: A Literature Review." *World Bank Policy Research*, Working Paper no. 3978 (2006): 1-19.

Gu, Xin. "Health Care Regime Change and the SARS Outbreak in China." In *The SARS Epidemic. Challenges to China's Health Management*, edited by Yongnian Zheng and John Wong, 123-155. Singapore: World Scientific Publishing, 2004.

Hannant, Larry. *The Politics of Passion: Norman Bethune's Writing and Art*, Toronto: University of Toronto Press, 1998.

Health Coordination Unit in Beijing - Italian Development Cooperation, Health Human Resources Development Center - Ministry of Health of People's Republic of China (HCU-MoH). *Impact of the New Rural Cooperative Medical Scheme on Health Care Services Accessibility in Central and Western China*. Paper presented at the seminar 'The Chinese Health Care System at a Crossroads: The Issue of Accessibility and Reform Perspectives', Beijing, 19 June 2009.

Hook, Brian. *The Individual and the State in China*. Oxford: Clarendon Press, 1996.

Hsiao, William. C.L.. 'The Chinese Health Care System: Lessons for Other Nations.' *Social Science and Medicine* 41, no. 8 (1995): 1047-1055.

Jiangkang Bao, "Linchuang lujing shidian chujian chengxiao." [Experimentation of clinical protocols achieves first results], 26 October 2010.

Kennedy, Scott. *The Business of Lobbying in China*. Cambridge MA: Harvard University Press, 2005.

KMPG Advisory (China) Limited. "China's Pharmaceutical Industry - Poised for the Giant Leap", http://www.kpmg.de/docs/China_pharmaceutical_May_2011.pdf.

Lampton, David M. *The Politics of Medicine in China: The Policy Process, 1949-1977*. London: Dawson & Sons, 1977.

- Li, Ling. "Yigai You Wang Chengwei Zhongguo Moshi Zou Xiang Shijie de Xiansheng" [Chinese Health Reform Can Become the Vanguard of the Advancement of the Chinese Model in the World]. *Jiangkang Bao* [Health News], August 09, 2010, p.6.
- Liu, Xingzhu and Anne Mills. "Evaluating payment mechanisms: how can we measure unnecessary care?" *Health Policy and Planning* 14, no. 4 (1999): 409-13.
- Liu, Yuanli and Keqing Rao. "Providing Health Insurance in Rural China: From Research to Policy." *Journal of Health Policy and Law* 31, no. 1 (2006): 71-92.
- Liu, Yuanli and others. "Health Care in China: The Role of Non-Government Providers." *Health Policy* 77, no. 2 (2006): 212-220.
- Liu, Yuanli, Keqin Rao and William Hsiao. "Medical Expenditure and Rural Impoverishment in China." *Journal of Health, Population and Nutrition* 21, no. 3 (2003): 216-222.
- Liu, Yuanli. *Reforming China's Health Care System: The Balancing Act*. Paper presented at the seminar 'Where Is China Headed?', Boston, 8 December 2008.
- Meng, Qingyue. *Health Care Pricing and Payment Reforms in China: The Implications for Health Service Delivery and Cost Containment*, Stockholm: Karolinska University Press, 2006.
- Ministry of Health of P.R. China (MoH). "1993 nian di yi ci guojia weisheng fuwu diaocha fenxi baogao" [Research on national health services - An analysis report of the first national health services survey in 1993], *Ministry of Health of P.R. China (MoH)*, 1993, <http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohwsbwstjxxzx/s8560/201009/49159.htm>.
- Ministry of Health of P.R. China (MoH). "Guojia weisheng fuwu yanjiu - 1998 nian di'er ci guojia weisheng fuwu diaocha fenxi baogao" [Research on national health services - An analysis report of the second national health services survey in 1998], *Ministry of Health of P.R. China (MoH)*, 1998, <http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohwsbwstjxxzx/s8560/201009/49160.htm>.
- Ministry of Health of P.R. China (MoH). "Guojia weisheng fuwu yanjiu - 2008 nian di si ci guojia weisheng fuwu diaocha fenxi baogao" [Research on national health services - An analysis report of the second national health services survey in 2008]. Document presented at the conference 'The Senior Level Seminar on National Health Services Survey and Health Reform Monitoring and Evaluation of China', 02-03 December 2009, 2009a, Beijing.
- Ministry of Health of P.R. China (MoH). "Jizhenke jianshe yu guanli zhinan (shixing)" [Instructions on establishment and management of emergency departments], *Ministry of Health of P.R. China (MoH)*, 2009b, <http://www.moh.gov.cn/publicfiles/business/htmlfiles/mohyzs/s3578/200906/41146.htm>.
- National People's Congress of the People's Republic of China (NPC). "Zhonghua renmin gongheguo zhiye yishi fa" [Law on licensed doctors of the People's Republic of China], *National People's Congress of the People's Republic of China (NPC)*, 1998, http://www.gov.cn/banshi/2005-08/01/content_18970.htm.
- Nanfang Zhoumo, "Yao yang de yiyuan." [Hospitals depending on drugs sales], 11 March 2010.
- Nanfang Zhoumo, "Liang hui shi da bianlun" [Ten debates from the two congresses], 18 March 2010.
- Naughton, Barry. "Sasac and Rising Corporate Power in China." *China Leadership Monitor*, no. 24 (2008): 1-9.
- Pan, Xilong and others. "Absence of Appropriate Hospitalization Cost Control for Patients with Medical Insurance: A Comparative Analysis Study." *Health Economics* 18, no. 10 (2009): 1146-1162.
- Partnering News. "Big Pharma Increases Activity in China", 2011, <http://ebdgroup.com/partneringnews/2011/05/big-pharma-increases-activity-in-china/>.
- People's Daily Online. "China to Fight Toughest Battle to Reform Health Care System: Vice Premier", *People's Daily Online*, 2011, <http://english.peopledaily.com.cn/90001/90776/90785/7290240.html>.
- Perry, Elizabeth J. "Studying Chinese Politics: Bidding Farewell to Revolution?" *The China Journal*, no. 57 (2007): 1-22.
- PricewaterhouseCoopers (PWC). "Investing in China's Pharmaceutical Industry-Second Edition", 2009, <http://www.pwc.com/gx/en/pharma-life-sciences/investing-china>.
- Pye, W. Lucian. "The State and the Individual: An Overview Interpretation." In *The Individual and the State in China*, edited by Brian Hook, 16-42. Oxford: Clarendon Press, 1996.

- Qiu, Zexi. "Towards a Harmonious Relationship Between Yi and Huan." Report presented at the conference 'The Senior Level Seminar on National Health Services Survey and Health Reform Monitoring and Evaluation of China', 02-03 December 2009, Beijing.
- Saich, Tony. *Governance and Politics of China*. Houndmills: Palgrave & MacMillan, 2011.
- Saich, Tony. *Providing Public Goods in Transitional China*. New York: Palgrave & MacMillan, 2008.
- Shen, James J. "Wheels of Healthcare Reform Begins to Roll." *PharmaChina*, no. 35 (2009): 2-4.
- Skilling, Gordon H. "Interest Groups and Communist Politics." *World Politics* 18, no. 3 (1966): 435-451.
- State Council. "Guowuyuan bangongting zhuanfa fazhan gaige weiyuanhui weishengbu beng bumen guanyu jin yi bu guli he yindao shehui ziben juban yiliao jigou yijian de tongzhi, 2010 nian 58 hao" [Circular of the General Office of the State Council forwarding the opinions of NDRC, MoH and other ministries on further encouraging and guiding medical facilities established by social capitals], *State Council*, 2010, http://www.gov.cn/zwgk/2010-12/03/content_1759091.htm.
- State Council. "Guowuyuan guanyu yinfa yiyao weisheng tizhi gaige jinqi zhongdian shishi fang'an 2009-2011 nian de tongzhiguofa, 2009 nian 12 hao" [Circular of the State Council on the Implementation Plan for the Recent Priorities of the Health Care System Reform 2009-2011], *State Council*, 2009, http://www.gov.cn/zwgk/2009-04/07/content_1279256.htm.
- Sun Qiang and others. "Pharmaceutical Policy In China." *Health Affairs* 27, no. 4 (2008): 1042-1050.
- Tang, Shenglan and others. "Pharmaceutical Policy in China: Issues and Problems." WHO, http://archives.who.int/tbs/ChinesePharmaceuticalPolicy/English_Background_Documents/summarypapers/PPChinaIssuesProblemsShenglan.doc.
- The Lancet, "Chinese doctors are under threat", no. 376 (2010): 657.
- Thompson, Drew. *China's Health Care Redux*. Washington: Center for the National Interest, 2009, <http://www.cftni.org/Thompson-China-Health-Care-Reform-Redux2009>.
- Unger, Jonathan and Anita Chan. "China, Corporatism and the East Asian Model." *The Australian Journal of Chinese Affairs*, no. 33 (1995): 29-53.
- Wagstaff, Adam and Magnus Lindell. "Can Insurance Increase Financial Risk? The Curious Case of Health Insurance in China." *Journal of Health Economics* 27, no. 4 (2008): 990-1005.
- World Health Organization (WHO). *Primary Health Care: The Chinese Experience*. Geneva: WHO, 1983.
- World Health Organization (WHO). "Summary Table of SARS Cases by Country, 1 November 2002 - 7 August 2003", 2003, http://www.who.int/csr/sars/country/2003_08_15/en/index.html.
- World Health Organization (WHO). "National Health Accounts Series - March 2009", 2009, <http://www.who.int/nha/en/>.
- World Health Organization (WHO). "World Health Statistics 2011", 2011, <http://www.who.int/whosis/whostat/2011/en/index.html>.
- Xinhua News Agency. "Doctor Face Growing Risks of Violent Medical Disputes", 2007, <http://www.chinagate.cn/english/medicare/50839.htm>.
- Yang, Guangbin. "Interest Groups in China's Politics and Governance." *East Asian Institute Background Brief*, no. 361 (2007).
- Yip, Winnie and William Hsiao. "The Chinese Health System at a Crossroads." *Health Affairs* 27, no. 2 (2008):460-468.
- Yu, Xuan and others. "Pharmaceutical Supply Chain in China: Current Issues and Implications for Health System Reform." *Health Policy* 97, no. 1 (2010): 8-15.
- Zheng, Yongnian. "Interest Representation and the Transformation of the Chinese Communist Party." *Copenhagen Journal of Asian Studies*, no. 16 (2002): 57-85.