

**GOVERNING THE HEALTHCARE MARKET:
REGULATORY CHALLENGES AND OPTIONS
IN THE TRANSITIONAL CHINA**

Submitted by

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LIST OF ABBREVIATIONS

CCTV	China Central Television
CEE	Central and East Europe
CEO	Chief Executive Officer
CHEI	China Health Economics Institute
CHI	Commission for Health Improvement
CHMAA	China Hospital Management Accreditation Association
CIS	Commonwealth of Independent States
CLEAR	Consolidated Licensure of Entities Assuming Risk
CMA	China Medical Association
CMS	Cooperative Medical Scheme
CMS	Centres for Medicare and Medicaid Services
CCP	China Communist Party
DRG	Diagnosis Related Group
EFQM	European Foundation for Quality Management
FDA	Food and Drug Administration
FFS	Fee-For-Services
FP	For-Profit
GDP	Gross Domestic Product
GP	General Practitioner
GIS	Government Insurance Scheme
HCFA	Healthcare Financing Administration
HEDIS	Health Plan Employer Data and Information Set
HPEDIS	Health Plan Employer Data and Information Set
HIC	Health Inspection Centre
HMA	Hospital Management Association
HMO	Health Maintenance Organization
IHM	Institute of Hospital Management
ISO	International Organization for Standardization
JCAHO	Joint Commission of Accreditation of Healthcare Organization
LIS	Labour Insurance Scheme
MATO	Medical Accidents Treatment Ordinance
MIMOIA	Medical Institutions Management Ordinance Implementation Article
MOC	Ministry of Construction
MOCA	Ministry of Civil Affairs
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MOLSS	Ministry of Labour and Social Security
MOP	Ministry of Personnel
MQSA	Medical Quality Supervision Agency
MSA	Medical Savings Account
NAT	National Administration of Taxation
NBS	National Bureau of Statistics

NCQA	National Commission of Quality Assurance
NDRC	National Development and Reform Commission (new name for SDPC)
NETC	National Economic and Trade Commission
NFP	Not-For-Profit
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NIH	National Institute of Health
NLHI	National Library of Healthcare Indicators
NPC	National People's Congress
NPFPC	National Population and Family Planning Commission
OECD	Organization of Economic Cooperation and Development
ORYX	(A core performance measurement set identified by JCAHO)
PMA	Physician Management Association
PPO	Preferred Providers' Organization
PRO	Professional Review Organization
PRC	People's Republic of China
RBRVS	Relativity Based Relative Value Scale
RMB	Renminbi (Chinese monetary currency. 1 USA = 8.2 RMB)
SAA	State Administration of Audit
SAIC	State Administration of Industry and Commerce
SOE	State-Owned Enterprise
SPB	State Price Bureau
SDPC	State Development and Planning Commission (now NDRC)
SATCM	State Administration of Traditional Chinese Medicine
WTO	World Trade Organization
yuan	unit of Chinese monetary currency (also RMB)

TERMS AND DEFINITIONS

Accreditation: Professional self-regulation on performance of facilities.

Audit: Either internal or external evaluative intervention in the form of monitoring, review, supervision, site inspection and reporting.

Certification: Professional self-regulation on performance of personnel.

Clinical governance: To have hospital CEO, manager and clinicians responsible for service outcome.

Corporate governance: To keep corporate actions directed at the corporate objectives established by the corporation's shareholders and to follow statutory laws.

Cost-quality compromise: The provider tends to increase and/or decrease service volume depending on the service payment method, which implies an increase in cost and/or decrease in quality.

Cost-quality regulation: Aims to regulate cost-quality compromise.

Dynamic efficiency: To refer to innovations made by the provider in technological advancement and economic sustainability (in contrast to static efficiency).

Economic regulation: Regulating marketisation that includes economic steering on market structure and competition.

Effectiveness: In term of regulation, it refers to the extent to reach the regulatory objective.

Enforced self-regulation: Aims to impose regulation by external agency either by state or by civil groups.

Entrepreneurial state: The state pushes marketisation by creating contestability and transforming public hospitals into business operated public firms.

Extensive accountability: balance multiple missions claimed by constituencies.

Governance: All sorts of organizations, public, private, semi-public, that contribute to the pursuit of the public interest

Guanxi (connection or association): Two meanings: Reciprocity between individuals and/or organizations, and rent seeking.

Healthcare regulation: Any social action exerting an influence, directly or indirectly, on the behavior and functioning of healthcare personnel and/or organizations.

Informal regulatory system: System of norms.

Institutional cost: Payments made by market participants to institutions to allow them to operate in the market (status costs), and to encourage favorable institutional action (influence costs).

Intensive accountability: Demands to embrace a spectrum of values.

Formal regulatory system: Combination of state and civic regulatory systems.

Licensure: Minimum legal requirements set by a state agency for market entry.

Local governance: Formal and informal rules by which local stakeholders collectively solve their problems.

Local state corporatism: Means state and/or collective institutions have been turned into quasi-corporate entities. Local governments regard such entities within their administrative purview as components of a larger corporate whole. Public employees serve on behalf of board of directors. Control has been made by monopoly of property rights that local governments retain.

Managed market: Refers to the U.K. NHS where internal market reform is halfway, and that managerial cooperation prevails instead of purchase between NHS Trusts and Health Authorities.

Mandated self-regulation: See enforced self-regulation.

Marketisation: Use market mechanisms to finance and provide health services.

Market-based governance: That civil society groups are to undertake increasing role previously played by state, and that civil society groups mandate market agents to act on their behalf.

Management-based regulation: Regulation aims at integrating public objective into institutional management practice, and that public objective translated at planning and operating stage of production at the institution.

Market-driven consumers: Unorganized privately financed healthcare consumption, or organized commercial health insurance consumption.

Market socialism: Combination of market mechanisms with socialism.

Market state: Without use of public employee (such as entrepreneurial state) and public money (such as networked state), to use government power to create market that fulfills public value.

Managerial mechanism: Regulatory tools in state and civil regulatory systems.

Multi-power centered: Pluralist relationships between society and state

Network state: Policies implemented by NGOs through contracting-out and financing.

Open systems governance model: NFP hospitals are detached from health departments and are in the marketplace exposed to market risk and benefit.

Performance-based regulation: Regulating on selected measurements of service outputs and/or process throughputs

Planned market: State purchases the health service, on behalf of principal (taxpayers). As the purchase is equity-oriented, it is therefore the policy or planned purchaser. The planned market in OECD is planner-dominated that differs from multi-purchasers-dominated regulated market in the U.S.

Planning system culture: There is no accountability at cascading administration levels and no merit based performance incentive, only to follow the orders from the top.

Policy purchaser: State purchases the health service, on behalf of principal (taxpayers).

Rational goal governance model: State policy purchaser purchases healthcare in accordance to the level of economy, e.g. the rational approach instead of social entitlement for healthcare.

Regulated market: Extensive use of private contracts, multi-purchasers and strong regulation, as in the U.S.

Social agreement: a) norms are accepted by individuals cognitively; b) norms have become a social capital that is shared among a growing number of people; and c) eventually, the norms have become a social routine that forms mainstream behavior.

Social efficiency: measured by the level of provision of unnecessary services.

Social insurance-based policy purchaser: Socially organized and socially financed purchase of healthcare.

Self-governance model: Hospitals are under autonomous after fiscal decentralisation, and regulated by the surrogate regulator with internal rules.

Self-regulation: Actors themselves impose restrictions on their actions.

Semashko model: Healthcare system under planned economy, where finance, provision and management of health service are all under a state monopoly.

Social capital: Value or norm shared to allow cooperation among people.

Social market: Firms prefer social objective as well as economic objectives.

Social ownership: Public ownership with private operation, and collective claims on dividend (residual value of operation).

Social regulation: Aims at social control such as standard settings.

Surrogate regulator: The same as the agent that is on behalf of the principal to regulate.

Stakeholders: Those people may affect policy-making and implementation.

State-society: That there is a unitary and homogeneous society without social groups, with state as a monopoly for social life.

Technical regulatory tools (or technical regulation): Regulatory tools included in social and economic regulations.

Technology-based regulation (contract-based regulation): Regulation that emphasizes the use of (information) technology and/or a contract to regulate technical quality.

Voluntary self-regulation: Self-initiated and self-disciplined regulation.

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ABSTRACT

During the transition from a planned economy to a decentralized, market socialist economy, the Chinese healthcare system has evolved from a centralized, egalitarian public system (1949-1979) to one which is largely self-governed and can be characterized as ‘public identity, private behavior’ healthcare system (1980-1999). With blurring of the distinction between public and private governing systems, and a shift in norms towards profit orientation, major concern has arisen about the extent of high cost, high volume services being offered through excessive entrepreneurial practices.

This thesis is concerned with the regulatory strategies and options to reach 2010 health reform objectives of equity and efficiency under a mixed public/private market. While possible lessons can be drawn from established economies and transitional economies, China faces some unique challenges, given the diverse market structures and fragmented healthcare system across the country, and the underdeveloped framework for the rule of law. The thesis reviews policy documents from 1949 to 2004 and draws from interviews with senior health policy-makers and hospital directors in three different locations, in order to explore the role of the state in market regulation, the effectiveness of technical and social regulations, and how policy implementation and regulatory compliance occur.

The research has found that the dynamics of the healthcare system are shaped by the financing arrangements for healthcare and the absence of arms-length governance of hospitals by health departments. Without an effective state health financing tool, nor mature market institutions, China is not able to use neither performance-based regulation nor technology-based regulation. China has adopted a management-based regulatory strategy but the absence of effective governance structure hinders effective regulation.

If the reform objectives of improving healthcare quality while costs are to be attained, China will need to develop purchasing tools to alter the current perverse incentives for provider behavior. Government will also need to work with civil society organizations to develop tools for clinical governance, such as clinical audit for risk management and hospital accreditation programs. To do so requires establishing arms-length governance mechanisms between health departments and hospitals, and appropriate corporate governance structures within hospitals. Specifically, MOH needs to establish a technical policy think tank to investigate all the policy issues arising from the announcement of the 1997 health reform, including coordination with other line ministries and provincial authorities, and formulation and implementation of a policy research agenda, in order to attain a market-based governance system for health by 2010.

STATEMENT OF AUTHORSHIP

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person's work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

The Ethics Committee of the Faculty of Health Sciences, La Trobe University, approved all research procedures reported in the thesis.

CHAPTER ONE

CONCEPTUALISATION OF THE RESEARCH

In contemporary history, three historical events have brought about fundamental social change in the People's Republic of China (PRC): the declaration of socialism by Mao Zedong in 1949, the 'economic reform program' announced by Deng Xiaoping in 1979, and 'market socialism'¹ adopted by Jiang Zemin in 1992. In 2003, Hu Jintao, the new General Secretary of the China Communist Party (CCP), continued the momentum of change, by calling for 'maintaining the authority of the Constitution' and building a 'people-centered, well-off society'² (Xinhua News Agency, 2003c). In the transition from a planned economy to a market economy, the change of policy, policy practice and management practice over the past two decades suggests that, implicitly or explicitly, the system of social governance is evolving gradually from 'rule of man' towards 'rule of law' (Peerenboom, 2002; Xinhua News Agency, 2004b).

The healthcare system in China has evolved from a planned system (1949–1979), to a decentralised self-governed system under the first stage health reform (1980–1999), and towards the mixed public/private market system under the second stage health reform (2000–2010). With decentralised self-governed system, the healthcare system drifted into the healthcare market as the overall economic system adopted market socialism. Regulating the emerging healthcare market has come to the fore of the policy agenda as result of perverse provider behavior brought about by market incentives. To build a mixed public/private market system, regulating 'public identity, private behavior' health provider brought about by the first stage health reform is a policy challenge for China (see chapter two), for market-based regulation involves the interplay of three forces which are still taking shape: the state, the market and civil society. Furthermore, the market and civil society in China are in essence state-led market and state-led civil society (Frolic, 1997, pp. 46–67; Zhang, 1997, pp. 124–148; Oi, 1999, pp. 97–98). Therefore, it is worthwhile to explore the understanding of this transition: how do Chinese health policy makers conceive the regulatory issues under the emerging healthcare market? What are the possible policy options that will lead to a successful transition for China?

¹ Market socialism is a combination of market mechanisms with socialism (Yu, 2003a and b).

² 'Yi ren wei ben, xiao kang she hui' in Chinese.

This chapter first describes China's economic transition, that is, from planning to market, and the consequences for the healthcare system. From this, it defines the research objective and research question. The conceptualisation of the health regulation and regulation analysis framework in the research is then discussed. Finally, the organization of the thesis is described.

Macro perspective: From planning to market

The profound governance challenge brought about by economic reform is to redefine the relationships between individuals, institutions and state in the transition from planning institutions to market institutions. China's entry into the World Trade Organization (WTO) in 2001 has pointed to another set of relationships and rules that China has to accommodate with respect to policy and management practices in the global context. Governing the newly developed relationships among newly defined individuals, institutions and the state requires adjustment from traditional instruction-based policy practice and administrative practices to rule-based policy and management practices – that is, the shift to market-based governance³ practices in civil society. The concept of governance in a transitional context therefore implies a change in the nature of social institutions (see chapter four).

Such policy and management practice adjustment requires abolition of the planning system culture, characterised by a lack of accountability at different administrative levels, no merit based performance incentives, and obeying orders from the top (Figure 1-1, arrows in the diagram indicate the linear relationship between the health department and the hospital). A planning system culture is inherently a vertical governing system rather than a horizontal one, as required by market exchange. Such a culture hinders the consolidation of achievements of economic reform, the promotion of social institution advancement and progressive cultural change (see chapter four). Worldwide, a positive correlation is seen in the relationship between economic development and social institutional change (Harrison and Huntington, 2000, p. xxviii). Within China, evidence suggests that the differentiated stage of economic transition in the coastal region, central region and western inland areas⁴ correlates with what Deng Xiaoping referred as 'thought

³ Market-based governance refers that public is to undertake increasing role previously played by state, and that public mandates market agents to act on their behalf (Donahue, J., 2002). Market-based governance is observed where there are mature market institutions and civil institutions, and that civil institutions play increasing role complementary to the role traditionally delegated by state.

⁴ In the early 1980s, the central government has classified all provinces into three economic belts

liberation' (Li, 1999; Zhang and Lin, 2001; Lu, 2002; Shan, 2002; Appendix A1). While much of the course of social transition relates to what Harrison calls underdevelopment as a state of mind (Harrison, 1985), the evolution of policy practice and management practice in the health sector is multidimensional rather than merely the advancement of the norms and ethics of healthcare professionals.

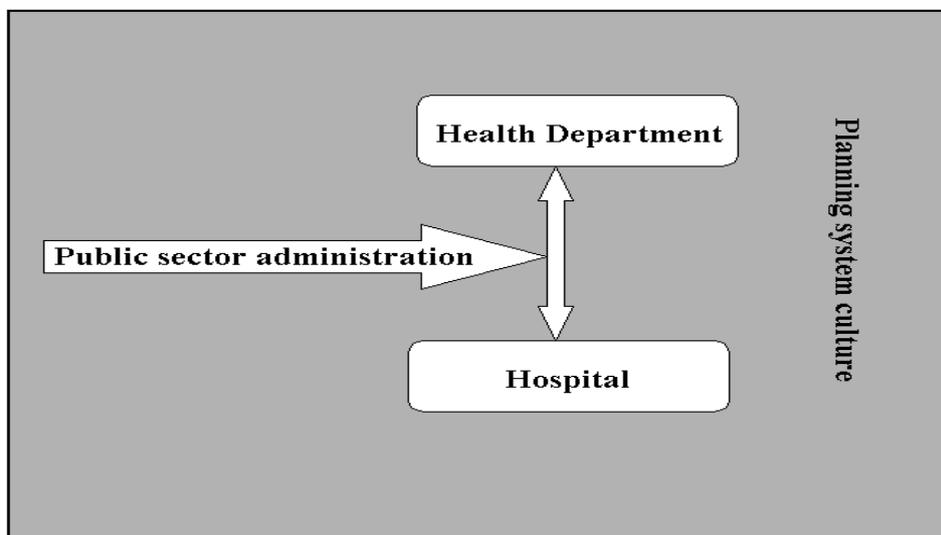


Figure 1-1 Administrative Practice in a Planned Economy

In China's centrally planned healthcare system (1949-1979) consistent with a planned economy, the prevailing social norm deemed healthcare provision and financing as a free public good in an egalitarian society, where a cost accounting concept for salaried doctors did not exist, and egalitarian medical behaviour constituted the basic element of a professional ethic of 'serving the people'⁵. In a decentralised and market-oriented healthcare system (1980-1999), the medical profession drifted into a business. The incentive structure changed when a self-managed and self-financed hospital works for revenue generation. The doctor's utility maximising behaviour led to inducing medical demand in order to earn additional bonus payment. These market incentives led to either overuse or misuse of health services (i.e. poor quality). In aggregate terms, it triggered medical cost escalation at the system level as a whole. International practice reveals that, to improve service delivery efficiency by applying a market-oriented mechanism, an effective regulatory system needs to be instituted to counteract the perverse influence the market brings to the supplier with respect to cost-quality

according to geographic distribution: coastal, central and western economic belts.

⁵ Advocated by Mao Zedong in his "6.26 Instruction" on June 26, 1965, in which Mao complained that 'MOH officials were urban gentlemen' who were not reaching out to the people.

compromise⁶. Competition needs to occur within the framework of sound management and financial systems.

This thesis argues that transition to market-based governance for China's healthcare system in urban area requires that:

- a) An hierarchical administration structure be transformed into a flat market structure where four new entities emerge - health departments, hospitals, consumers⁷ and social insurance-based purchasers⁸;
- b) The new relationships between the four entities be guided by a new governing system and, these relationships include, labour market, drug market and relationship between health departments and hospitals; product market and payment method between hospitals and purchasers; coverage management between uninsured and insured, and medical disputes handling between consumers and hospitals; and
- c) A social agreement⁹ be put in place to allow new relationships and new procedures to operate (Figure 1-2, arrows in the diagram indicate the relationships between the entities).

⁶ Cost-quality compromise: Economists hold that, in a for-profit market for any product, supplier tends to reduce volume but with high price. For a healthcare market where there is no hard budget constraint, the provider tends to increase service volume that implies to increase cost and/or decrease quality, particularly at time management system is not effective (Maynard, 1998).

⁷ These involved in unorganized privately financed healthcare consumption, or organized commercial health insurance consumption.

⁸ Social insurance-based purchaser refers to socially financed purchase for healthcare. In China, the newly reformed Ministry of Labour & Social Security (MOLSS) organizes social insurance.

⁹ Social agreement means: a) the norms are accepted by individuals cognitively; b) the norms have become a social capital that is shared among growing number of people; and c) eventually, the norms have become a social routine that forms mainstream behaviour.

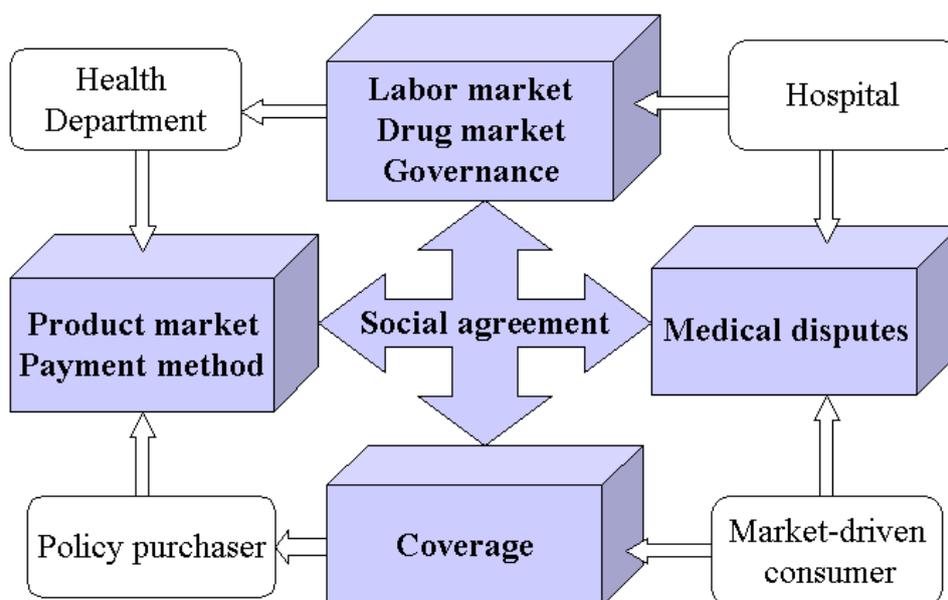


Figure 1-2 Market-based Governance System

In the transition from an instruction-based administration to market-based governance, a hierarchical relationship needs to evolve into multiple rule-based relationships, and the planning system culture should evolve into a social agreement that governs exchange relationships among four legally defined entities. Theoretically, such transition can take place by resort to new rules, for the role of rules is both the origin and consequence of orderly change (Salamon, 1983, pp. 150-151), embracing civil institutions can enhance rule compliance (Fukuyama, 2000, p. 99), and application of rules for institution change has been observed in transitional economies (Murrell, 2001). The next section briefly describes the key issues China must face in the transition from planning institutions to market institutions.

Defining the research question

To develop a mixed public/private market, a reform policy program must address four issues: balancing equity and efficiency at the system level; an effective management and financial system at the institutional level (management process); accountability of the governing system (structure); and social agreement to obtain compliance.

With two decades of decentralization, the traditional Government Insurance Scheme (GIS) and Labor Insurance Scheme (LIS) had become dysfunctional, and public hospitals

and health departments evolved into cooperative local state corporatism¹⁰. While the public insurance system no longer exists, the provider system increasingly uses market incentives to stimulate demand as compensation for reduced public financing support. The consumers are sandwiched between the collapsed health financing system and increased market incentives to provide high volume services. Equity and efficiency are not appropriately traded off at the system level. Financing inequity triggers high cost, high volume competition – this is the first fundamental problem in China (WHO, 2000b, pp. 152-155; Appendix A2).

The decentralisation program called for local fiscal responsibility and local innovation in managing cost recovery, as the centre was no longer responsible for budgetary allocation for public hospitals. Local governments have therefore focused more on economic activities than on social responsibility. In the late 1980s, there were emerging fee services among public hospitals (Appendix D, Policy 4). Coming into the 1990s, increasing user charges and diminishing benefits of traditional health insurance were widely observed (Xinhua News Agency, 1996). The decentralised, self-governing healthcare system created the phenomenon of ‘public identity, private behaviour’ amongst hospitals under the first stage health reform. Without regulatory constraint, the self-managed and financed hospitals have spurred the escalation of total health expenditures to almost 5.6% of GDP by 2001, with the annual medical price index inflating by over 10% over the past decade (CHEI, 1999; Rao, 2002). The market-based management and financial systems have created high cost, high volume competition at the institutional level. It has triggered a top-down health reform in 1997, which is the foundation for the second stage health reform (Appendix D, Policy 12).

The official start of the second stage health reform was 2000, marked by a series of bold and broad-based policy documents issued by various central ministries, including the Ministry of Health (MOH) and the Ministry of Finance (MOF) (Appendix D and E). The major reform objective was to provide quality service at a cheaper cost at the time. According to these policy statements, the healthcare system is to be restructured towards a mixed public/private market. Most importantly, the policy involved:

¹⁰ Local state corporatism means state and/or collective institutions have been turned into quasi-corporate entities. Local governments regard such entities within their administrative purview as components of a larger corporate whole. Public employees serve on behalf of boards of directors. Control has been made by monopoly of property rights that local governments retain (Oi, 1999, pp. 97-98).

- a) Separation of health provision from financing by creating a purchasing agency, the Ministry of Labour and Social Security (MOLSS);
- b) Detachment of hospitals from direct government affiliation by creating a Non-For-Profit (NFP) hospital sector, a new concept for PRC;
- c) Transformation of some public hospitals into For-Profit (FP) hospitals or private hospitals, as part of a mixed public/private market; and
- d) Defining the role of the state to steer health development in accordance with the administrative law.

In essence, the reform was aimed at remedying the ‘public identity, private behaviour’ of the state corporatist practice, by creating independent legal entities under a market-based governance system.

Internationally, regulating providers’ excessively perverse entrepreneurial behaviour has been a central aspect of the policy framework for achieving order to achieve high-performing healthcare systems (Saltman, Busse et al., 2001; OECD, 2004). Yet for China, the compliance with the regulation was an issue as the system of norms is evolving and social agreement was not in place (Ding, 2004). Therefore the social institutions necessary to institute regulation remain a key issue in relation to policy implementation.

Given that the two fundamental issues – the financing role of the purchaser and the developing governing system for the provider - are still evolving, the research aim of the present study is to identify the optimal regulatory mechanisms to manage the transition in order to contain the excessive entrepreneurial behaviour that has emerged during the market-oriented reform, so that cost, quality and equity could be reasonably balanced in the market-based Chinese healthcare system. The development of effective regulation needs to consider both formal rules and cultural norms, and how they converge towards social agreement. Social agreement requires the establishment of formal institutional rules (that is, regulatory system design) as well as compliance among key actors in the system (that is, policy implementation). Effective regulation must therefore take into consideration how those key actors perceive these rules. In this regard, this study explores the development of formal rules and stakeholders’ perception of these formal rules as signposts of convergence towards social agreement. Broadly, social agreement relates to the development stage of a market and civil society. Specifically, the study attempts to explore the views of key stakeholders on the following questions:

- a) What are the drivers and consequences of excessive entrepreneurial behavior in the transition to a market-based governance system?
- b) What are the technical regulatory tools required to regulate the behaviour?
- c) What are the institutional and structural issues that may conversely limit the effectiveness of the technical regulatory tools?
- d) What are the optimal means to achieve cost containment, quality, and equity in the transition towards a mixed market by 2010?

This study uses a qualitative research methodology. The key analytical methods used are a combination of health reform policy; stakeholder analysis of the structure of policy implementation; economic analysis of the market structure and function; institutional analysis of the response of policies with respect to the governing system; social analysis to understand changing society; and complex social adaptation analysis to explain the social transition. The data collection is conducted through: a) a review of key national health policies from 1980-2004; b) in-depth interviews of key; and c) a field study to observe emerging healthcare markets and governing approaches in Shenzhen, Shenyang and Jining cities (see Chapter Five).

The next section describes the concept of regulation in healthcare, from historically individual-based medical practice (generally private in nature) to contemporary healthcare delivered both publicly and privately and in an organized system. The importance of viewing regulation from an historical and social institutional perspective is revealed, and understanding of health regulation evolution in a market-oriented system. That the institutional aspects of management and governing structures need to be in place if technical regulation is to deliver policy objectives at an operational level are also made evident.

Concept of regulation and adaptation for market-oriented healthcare

Regulation is about rules and norms

The concept of regulation is older than concept of the state. For example, the Code of Hammurabi and codification of Roman law evolved into the modern common law system (Harlow and Rawlings, 1997). The concept of early administrative regulation originated from 1688 Glorious Revolution resulted in executive, legislative and judicial branches of governments (World Bank, 2001, p. 100). The concept of regulation in modern time is generally understood as sustained control exercised by government agencies over

activities valued by the public (Selznick, 1985, pp. 363-368). Such a concept of regulation has the meaning of state stewardship, which is similar to the concept of governance¹¹, defined as system of control and authority¹² (Institute On Governance, 2003).

Baldwin considers three categories of regulation: state mandatory rule; economic steering; and a mechanism of social control by creating or reinforcing societal norms and values (Baldwin, Scott et al., 1998; Baldwin and Cave, 1999). Such broad concept of regulations refers to regulation as rules and norms, and the source of regulation is not only from the state but also from para-state agency in influencing norms. State regulation therefore means much “the same thing as governance or Foucauldian governmentality” in rule setting (Braithwaite, 2003, p.1); while para-state agency, civil groups for example, takes up increasingly the role of ‘regulating’ norms (Lewis, 2001).

Such rule- and norm-based definition of regulation is also referred as ‘meta-regulation’ (Grabosky, 1995). Regulation is to be pro-active and reactive to risks deemed harmful to the public (Garland, 2002), and to promote competition so to increase the level of welfare – the so-called Pareto improvement (see Chapter Seven). Regulatory policy making and implementation emphasize rule setting: to identify and monitor risks so to learn how to respond to risks (Braithwaite, 2003, pp. 3-16), and influencing norms: to promote market institutions and civil society so to enable the alternative governing bodies to be effective, apart from the traditional regulation provided by the state (World Bank, 2001). Regulatory process is inclusive of management at the institution level, and implementation of law and policy (Chinitz, 2001, p. 58).

Evolving concept of regulation for market-oriented healthcare system

Traditionally, healthcare regulation was based on professional self-regulation¹³ that could be implemented through either enforced self-regulation or volunteer self-regulation¹⁴ (Gunningham and Grabosky, 1998). The concept of regulation in contemporary healthcare was incorporated from social control (or social regulation)

¹¹ Governance, in its broad term, cannot mean just state but all sorts of organizations, public, private, semi-public, that somehow contributes to the pursuit of the public interest (Kamarck, 2002, pp. 227-263).

¹² The concept of governance includes public governance, corporate governance, and arms-length governance that links the public governance with corporate governance.

¹³ In a self-regulation, “the actors themselves impose restrictions on their actions. Self-regulation may be initiated and organized by, for example, an industry association in order to avoid government intervention” (Arvidsson, 1995, p. 66).

¹⁴ Enforced self-regulation refers regulation imposed by external agency either by a state or by civil groups; volunteer self-regulation refers to self-initiated and self-disciplined self-governance arrangement (Gunningham and Grabosky, 1998; Coglianese and Lazer, 2002, pp. 201-226; Newman, 2003, pp. 83-100).

through standard settings (quality) to regulation of marketisation¹⁵, including economic steering of market structure and competition (or economic regulation; Kumaranayake and Lake, 2002, p. 82-83). Regulatory effectiveness depended on the degree of the self-regulatory entity's influence on its affiliated members (Arvidsson, 1995, p. 66). Self-regulation aims to reduce social harm by setting standards and promote professional ethics (Wolper, 1995).

In the past century, however, the individual-based medical practice has evolved into healthcare system-based practice (WHO, 2000b, p. xiii). As a healthcare system becomes market-oriented, economic regulation becomes important. Together, social and economic regulation can be referred to as technical regulation. The health regulation evolved into a mix of common law system, state regulation and self-regulation (Merry, 2003; Figure 1-3).

<u>Genealogy of Regulatory System</u>	<u>Management of Healthcare Practice</u>
Hammurabi (Code of conduct)	
Roman legal system (Common law system)	Hippocrates Oath on medical ethics
State board/college system (Entry regulation)	
JCAHO (Performance-based self-regulation)	Codman on service standardization
PRO/NCQA (State enforced self-regulation)	Donabedian on structure and process
HEDIS/ORYX (Technology-based regulation)	Disease outcome management
Reporting card (Market information disclosure)	Cochrane on evidence-based medicine
Clinical governance (Management-based regulation)	Clinical pathway/practice guidelines

Figure 1-3 Health Regulation Evolution (adapted from Merry, 2003)

Figure 1-3 depicts the evolution of practice of health regulation- including the Hippocrates Oath on medical ethics, service standardization through process and

¹⁵ Marketisation refers to use market mechanisms and incentives to finance and provide health services (Hsiao, 1994).

structure¹⁶, disease outcome management, evidence-based medicine, clinical pathway and practice guideline, and clinical governance¹⁷. In particular, the society's approach to healthcare management is paralleled by the development of tools at the institutional and clinical practice levels. Health regulation in this study is defined as "any social action exerting an influence, directly or indirectly, on the behavior and functioning of healthcare personnel and/or organizations" (Hafez, 1997, p. 1).

Health regulation under marketisation differs between developing economies and established economies. For developing economies with more mature markets, regulation usually focuses on inputs and entry variables (Kumaranayake and Lake, 1998). For established economies, regulation takes a comprehensive approach, regulating on target variables, such as entry, quality, price, distribution; institutional variables, such as organization and market; and professional ethics, such as code of conduct and incentive (Harding, 2001; Saltman, Busse et al., 2001; Kumaranayake and Lake, 2002). Saltman refers to these technical regulatory tools (either social regulatory tools or economic regulatory tools) as managerial mechanism¹⁸ (Saltman, Busse et al., 2001).

The application of technical regulatory tools relates to norms, the management and financial systems and existing governing structure (Donabedian, 1980; Hafez, 1997, p. 5; Medicare Payment Advisory Commission, 2002). Regulation theory suggests that an institutional foundation is a precondition to institute technical regulation and management and financial systems (Hafez, 1997, p. 1-3). The effectiveness of policy implementation depends on design of technical regulation; delivery of technical regulations through management and financial systems (process); and existing governing structure.

In the present study, broadly, the regulatory system refers the making and design of regulation and compliance system refers the enforcement and/or implementation of regulation. The regulatory system (Formula 1-1) consists of both a state regulatory system and civil system¹⁹ (Scott, 1995, p. 52). The compliance system (Formula 1-2) consists of a system of norms (voluntary compliance system) and the compulsory compliance

¹⁶ Ernest Codman developed the idea of standardizing medical services (JCAHO, 2004). Donabedian developed structure, process and outcome theory to evaluate healthcare (Donabedian, 1980).

¹⁷ Cochrane developed the idea of looking for evidence for medical treatment (www.cochrane.org). Clinical governance means to have hospital CEO responsible for service outcome; performance-based regulation, technology-based regulation and management-based regulation are explained in Chapter Five (Coglianese and Lazer, 2002, pp. 201-226).

¹⁸ Managerial mechanism is viewed as regulatory tool (Harlow and Rawlings, 1997; Lewis, 2001).

¹⁹ Parsons refers to regulatory system and civil system as government mix and sector mix.

system²⁰ (Parsons, 1995, pp. 491-532; Fukuyama, 2000, p. 106; Braithwaite, 2003). The governing structure and compliance system are part of the social institutions that is informed by path-dependent development of history and culture (Scott, 1995, p. 52).

Formula 1-1 Regulatory system = State regulatory system + Civil system

Formula 1-2 Compliance system = Compulsory compliance system + System of norms

Analysis framework for regulation design and implementation

A view of the issues arising from the first stage health reform suggests that high cost, high volume competition was related to the ‘public identity, private behavior’ that was systemic, along with the market-oriented managerial system and lopsided equity-efficiency market structure. The strategy to realize the objectives of the second stage health reform suggests that MOH/MOLSS are attempting to remedy the state corporatist behavior by instituting an open systems governance model²¹ at the supply-side and a rational goal governance model²² at the demand-side: the so-called detachment of hospitals from government affiliation and splitting of financing from provision. Thus the ‘public identity, private behavior’ healthcare system is to be reformed into a mix of newly defined public, social and private entities that operate in the open market. To develop a mixed public/private market, the role of the state will become a service quality regulator (MOH) and a rational purchaser (MOLSS) for essential healthcare. For regulation design, the question is how to regulate the relationships of these newly developed market entities to promote efficiency and how to develop the role of the state to assure equity and safety. For regulatory implementation, the key issue is how to make regulatory tools effective, when health professionals drift into business.

Broadly, this thesis is concerned with how to balance healthcare equity, efficiency and effectiveness in the transition from planning to market. It will be argued that effective public governance is required for instituting technical regulatory tools to deal with equity

²⁰ Parsons refers norm system and enforcement system as value mix and enforcement mix.

²¹ In the open systems governance model, NFP hospitals are detached from health departments and are in the marketplace.

²² In the rational goal governance model, a state policy purchaser rationally purchases healthcare in accordance to the level of economy. Healthcare is therefore not a social entitlement.

and efficiency at the market and the institutional levels. It will also be argued that good corporate governance is the premise for effective internal and external regulation, and compliance is to harmonise between norms and rules in order to reach social agreement.

The design of regulation is explored from three perspectives in this thesis:

- a) The implications of three stages of healthcare system development – the ‘public identity, egalitarian behavior’ healthcare system under the planning stage (1949-1979), the ‘public identity, private behavior’ healthcare system under the first stage health reform (1980-1999), and towards mixed public/private healthcare market under the second stage health reform (2000-2010);
- b) Clinical and management practices, and policy practice at three levels – the individual level, the institutional level and the system level; and
- c) Effectiveness of regulatory tools in relation to evolving institutional changes.

The implementation of regulation is explored from the compliance perspective – the extent of social agreement between systems of norms and rules and their acceptance by the key actors. In another word, in order to have effective regulatory and compliance systems, the relationships between norms, rules, and compliance are explored in the particular social context (see Chapter Ten).

Globally, regulatory systems exist to sustain a competitive healthcare market while assuring equity. For example, in a regulated market²³, technology-based regulation is to regulate multiple purchasers through contracts, the role of the state is to maintain market function and to purchase care for the needy population through Medicare and Medicaid program (Altman and Rosman, 1999). In the planned market²⁴ of most OECD countries, performance-based regulation regulates hospitals through performance-based financing, combined with planning and policy program instruments (Arvidsson, 1995, pp. 66-85); the role of the state is to attain social entitlement for healthcare. In a managed market²⁵, management-based regulation is via managerial tools such as clinical governance to assure quality. Yet challenges faced by most transitional and developing economies are:

²³ Extensive use of private contracts, multi-purchasers and information technology makes U.S. a regulated healthcare market.

²⁴ The state purchases health service, on behalf of principal (taxpayers) in some OECD countries. Such purchase is equity-oriented, so it can be deemed as policy-oriented purchaser, which is largely based on planning. The planned market in OECD countries is dominated by planners, which differs from the regulated market in U.S. where multi-purchasers dominate the market.

²⁵ Refers to U.K. where the internal market reform is halfway, and that management practice or cooperation prevails instead of purchase between internally separated NHS Trusts and Health Authorities.

- a) Financing instruments fail to be a regulatory tool – that is, the market is not structured properly between organised state purchaser and individual consumption;
- b) Market institutions are yet to be developed, resulting in provider-dominated healthcare markets because the market fails to adhere quality-price competition, which leads to high cost, high volume competition; and
- c) The public governance system is not well developed because regulator capture exists (Kokko, Hava et al., 1998; Kumaranayake and Lake, 1998; Bloom and Standing, 2001; Harding and Preker, 2003; OECD, 2003; Phua, 2003; Yip and Hsiao, 2003).

Regulatory design and implementation in transitional and developing economies therefore cannot simply borrow the technical regulation used in the established economies. Regulatory process, governing structure and compliance with regulation are critical for regulation to be effective.

Social institution theory suggests that predisposing social factors embedded in social institutions, such as culture, social structure and routine, can influence mediation on system of norms and state regulatory system, and vice versa (Scott, 1995, p. 51-53). Compliance is achieved when norms and regulatory system are harmonized. Therefore, the design of regulation has to anticipate that social and cultural compromise may be required in implementing regulation although rule making can change social routine. The social institutional perspective on compliance thus informs the real life implementation of regulation.

For a market-based governance system, the mere adoption of technical tools is ineffective; they must mesh with regulatory process, governing structure, and social institution foundation for compliance (Figure 1-2). Thus, the study addresses the following themes:

- a) The study explores the key problems that lead to high cost, high volume competition at an institutional level, and how to address them from a system perspective;
- b) The study then assesses the problems with the use of economic and social regulatory tools, at a time when the regulatory system is not yet in place;
- c) Therefore, the study turns to examine the regulatory process and corporate governance and public governance systems that are in transition (in the

absence of widely acknowledged accreditation program and certification program in China, and in the absence of civil regulatory system);

- d) In the context of the goal to achieve the regulatory objectives by 2010, the study finally examines the options for regulatory systems in China, and the social support needed in order to address the institutional foundation for the reform.

Organization of the thesis

This thesis has twelve chapters. Chapter Two documents health policy, management and clinical practice evolution in China in the past half century. Chapter Three present an overview of the international practice in regulating healthcare markets. Chapter Four presents an understanding of compliance from a norm and a social institutional perspective. Chapter Five presents the research methodology. Chapters Six to Eleven present the main findings. Chapter Twelve contains conclusions and recommendations (Table 1-1).

Table 1-1 Organization of the Thesis

Chapter	Aim
Two	Analyze issues arising from healthcare system evolution and implications for regulation
Three	Review regulatory system, regulatory approaches and issues in different economies
Four	Understand compliance in social institution theory and implications for China
Five	Develop research framework, research strategies, and analytical methods
Six	Present findings on healthcare system marketisation and issues for regulatory responses
Seven	Present findings on an assessment of economic regulation to govern the market
Eight	Present findings on an assessment of social regulation for institutional performance
Nine	Present findings on issues of the state and civil regulatory system in transition
Ten	Present findings on issues of norms and the compliance system in transition
Eleven	Present findings on strategies and challenges of market-based governance in 2010
Twelve	Conclusions and recommendations

Chapter Two analyses the evolution of policy practice, management practice and clinical practice in three time periods: a) instruction-based policy practice and administration practice from 1949-1979, with healthcare system aiming at equity during planned economy and ‘rule of man’ social institution; b) decentralisation program and creation of market incentive for self-managed hospitals from 1980-1999, with its aim of cost recovery and managing for survival; and c) the call for rule-based policy practice, and rule-based management practice since 2000, with a healthcare system aiming at

competition and rule of law social institutions development. Such evolution of policy and management practices has implications for clinical practice and it depicts the stage from where the regulation initiative takes place.

Chapter Three compares health reform programs and regulatory practices among established economies, transitional economies and developing economies. The aims of the review are to draw experiences that are relevant for establishing a regulatory system for China, and to show relationships between competition, cost and quality.

Chapter Four develops a theoretical understanding of social institutions in relation to compliance. It argues that norms, social capital, and enforcement force are critical for compliance, which indicates that trust of public governance system needs to be addressed if social agreement is to be achieved in China.

Chapter Five develops the research framework based on the review of international practices and theory on regulation. It also explains the research approach and methodology in accordance with the research framework.

Research findings related to regulation are presented subsequently, which are organized with regard to:

- a) The technical regulation, an assessment of the impact of the first stage health reform (in Chapter Six); an assessment of economic regulatory tools (in Chapter Seven) and social regulatory tools (in Chapter Eight) used in conjunction with the second stage health reform;
- b) The social support to instituting technical regulation, an examination of the state and civil regulatory system (in Chapter Nine) and norms and compliance system (in Chapter Ten) in transition during the second stage health reform; and
- c) Options and challenges for regulatory strategies to achieve the 2010 reform objectives (in Chapter Eleven).

Chapter Six presents the findings on the role of the state and regulation in the context of marketisation in China. It shows that the economic reform program is the driving force of marketisation, and the emerging healthcare market in China is stratified by geographic economic belts and diversified by governance arrangement between the health department and hospitals.

Chapter Seven presents the findings on the assessment of economic regulatory tools to achieve equity and efficiency. The main themes discussed are that: a) market equity

and efficiency is lopsided due to the crippled state purchaser, and that planning as a regulatory instrument faces governing structural barriers; b) state-mediated competition, through introducing private sector into the healthcare system, faces problems as market institutions are not ready overall for smooth development of the private sector; and c) the NFP hospital sector still behaves in a monopolistic manner, prices are distorted, and information is inadequate – competition practice is unhealthy.

Chapter Eight presents the findings on the assessment of social regulatory tools, which is market entry and institutional performance under the Chinese context, in the absence of accreditation and certification programs. The main themes discussed are that, legal tools for market entry are just starting, but there is no credible performance regulation.

Chapter Nine deals with the state and civil regulatory system in transition in relation to the second stage health reform implementation. The main themes covered are local governance in balancing equity and efficiency, and accountability mechanism for arms-length governing for regulating towards social optimum.

Chapter Ten explores norms and the compliance system in transition when the system of norms confused at time of change. It examines the requirement by the rule of law to regulate the regulator and the ‘new ethics’ needed in accordance with the development of market institutions.

Chapter Eleven synthesizes Chinese health policy makers’ aspirations towards 2010 and an evaluation of regulatory approaches by the researcher. It discusses the governance and regulatory options to assist in the development of a mixed public/private market. The Chapter also presents the challenges seen by the Chinese policy makers, particularly in relation to governance structure, the instituting of a check and balance system, and the capacity building for the civil regulatory system.

Chapter Twelve presents conclusions and recommendations. The thesis points to mechanisms needed:

- a) at the market level, a strong financial lever to influence perverse market incentives of the provider;
- b) at the institutional level, hospital accreditation programs across the hospitals;
- c) at the individual level, to develop risk management systems.

The next chapter introduces the background of China's healthcare system, the picture of future development, and implications for regulation towards a mixed public/private healthcare market in China.

CHAPTER TWO

STATE CONCEPT AND HEALTHCARE SYSTEM EVOLUTION

This chapter introduces the background of the concept of the state, state development policy, and state health policy practice in the past, its current practice and its future direction in China. It establishes the relationships within China's healthcare system from the past to the 2010 objectives, and also the relationships between the system, institutions and individual practice. From these two relationships, issues relating to regulation unfold.

This chapter starts by exploring the concept of state and society in China, and state development planning program (1949-2050). Health policy practice in three time periods is then discussed. The three theoretical governance models for three time periods are presented with respect to the evolving healthcare system – the hierarchy governance model (1949-1979) under a planned economy, the 'self-governed' model with the first stage health reform (1980-1999) under decentralisation, and moves toward a rational goal and open systems governing model with the second stage health reform (2000-2010) under market socialism. The chapter concludes that the self-governed model creates high cost, high volume competition, and that the second stage health reform is aimed to address two fundamental issues for China's healthcare system – financing inequity and governance.

The evolving concept of state and society, and state development policy

A glance at the history of dynastic states (BC 202-AD 1898) in China can foreshadow the future and can help to understand today. From the united 'Central Kingdom' Qin dynasty (BC 221- 207), to imperial empire Han dynasty (BC 207 – AD 220) when the Roman Empire prevailed in Europe; from cosmopolitan Tang dynasty (618-907) just after the European Dark Ages, to early capitalistic and prospering Song dynasty (960-1279) when Europe was in the Middle Ages; from the inward-looking and autocratic Ming dynasty (1368-1644) when the Renaissance movement was starting to enlighten Europe, to the imperialistic and despotic Qing dynasty (1644-1911) when the Industrial Revolution took place in Europe: Chinese dynasties have ruined and fallen in a cyclical manner over the past two thousand years (Patricia, 1996; Huang, 2002). The saying 'long divided, unite; long united, divide' describes integration and disintegration of family-based court-states. For over two thousand years, the concept of the state was

that the ‘Son of Heaven’ is the universal ruler. ‘Long reign and sustaining peace’ is the utmost goal of family-based rule. The modern concept of development can hardly be seen in the court-state²⁶. Confucian ethics (for instance, ‘li’, a ritual or a way of behavior) is the moral base to rule and to be ruled. “Hegel theorized China as a state without a society” in the long feudal society (Brook and Frolic, 1997, p. 3). For there is no constitutionalism to challenge court power, or development of market capitalism to create exchange value, nor is there a public sphere to contain court power unless revolution dismantles the dynasty²⁷: the society of China in the past was unstable. The repetitive recycle ended when the Opium Wars²⁸ brought China a new understanding toward the ‘peripheral’ or Western world.

A time of change came after the Opium Wars for ‘China experiences variation unseen in a thousand years’²⁹. Most notably, the concept of the state evolved into the system of constitutional monarchy (1898)³⁰, the Republic of China (1911-onward)³¹, and the PRC (1949 –onward). China is now described as a ‘state-society’³² for the state controls most social affairs (Frolic 1997, pp. 46-67). This ‘state-society’ has experienced two stages: a planned system (1949-1979) when the state dominated society, and a decentralization program (1980-1999 approximately) when the emphasis was upon to restructuring government and reforming the governing system. For example, university autonomy, trade union development, and rural election are mostly the results of the decentralization program (Brook and Frolic, 1997; Howell, 2004). The development of market institutions and continuing emphasis on constitutional power gave birth to increased public life. Official policy has also changed to promote civil group development in order to complement the shrinking role of the state (Liu, 2002).

²⁶ History of China tells that Chinese prefers revolution than evolution, resulting in dynasty renewal. History of China is different from U.K. where Magna Carta signed in 1215 between Crown and rebellion nobles. Since then whenever Crown violates the Carta, the nobles would drag Crown back asking Crown to conform to the Carta. Charter governs Crown: rule of law society originates; Constitutionalism then is just a matter of time (He, 2004).

²⁷ Brook has discussed Western civil society with respect to constitutionalism, market and public sphere of life, that give birth to Western civil society (Brook, 1997, pp. 19-45).

²⁸ Opium War (1839-1842), the British East India Company, in order to trade opium from India to China, entered into war with China in 1839 known as Opium War, and forced China to sign the Treaty of Nanjing in 1842.

²⁹ This is said by Li Hongzhang, Premier of late Qing Dynasty (CCTV TV series Toward Republic, March, 2004).

³⁰ Historically it is known as Wu Xu Bian Fa or Hundred Days of Reform: A group of intellectuals aimed to establish a constitutional monarchy system but failed.

³¹ The establishment of Republic of China (ROC) in 1911, led by Nationalist Party with a provisional constitution lasted for three months, later receded in Taiwan as ROC, Taiwan.

³² Frolic refers as party-as-the-state and mass-as-society (Frolic, 1997, pp. 46-67). In essence there is

The state is now shifting towards the ‘small state, big society’ configuration along the course of developing ‘people-centered’ market socialism (Jiang, 2002; Mao and Li, 2003). ‘Market institutions’, ‘constitutionalism’, and ‘rule of law’ have become the key national policy goals for the next half-century (Wang, 2002). History reveals that the velocity of change of Chinese society has accelerated in the past century, especially in the past decade. Along with a changing concept of the state, state development policy also changes.

Macro-social and economic reform and development planning in China envisioned a three-stage strategic development. The first stage is the industrialisation (1949 – 1979), through planning to solve supply insufficiency. The second stage is market cultivation (1980 – 2000), through decentralisation to create autonomous entities and market incentive, namely, revenue share by institution in 1980s and system renovation in 1990s. The third stage is the market system build-up and operation (2001 – 2050) for a ‘people-centered, better off’ society (Wang, 2002; Hu, 2003).

The third stage is viewed in two phases. The first phase aims to build market institutions (2001 – 2010), which means developing a sound economic and legal systems suitable for the second phase of market operation (2010-2050; Xinhua News Agency, 2003c). This development objective asks each sector to set policy objectives for 2010 consistent with the requirements of satisfactory market operation. For example, economically, the public ownership structure is under reform; socially, the objective is to develop the rule of law consistent with market socialism by 2010 (Xinhua News Agency, 2004b).

Having laid down a macro-social and economic policy background and development direction, the following section describes state policy and management practice in healthcare system. As any system reform is path-dependent, this review sets the basis for future healthcare system reform policy-making.

State health policy practice evolution

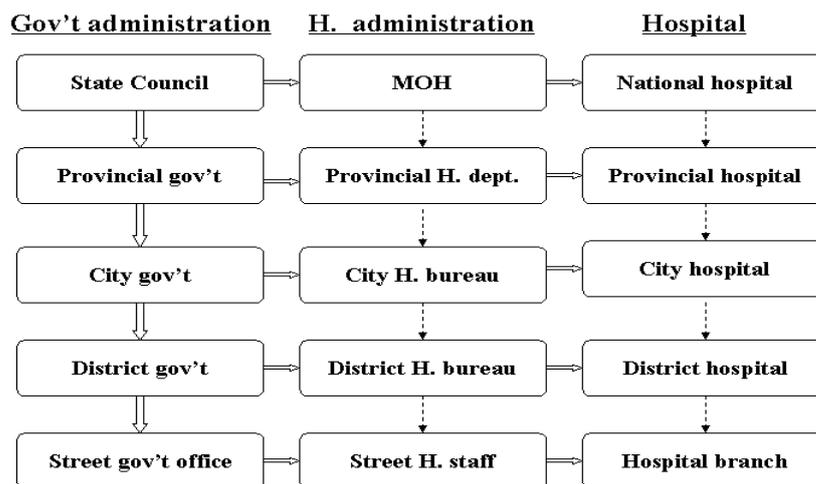
In the context of the above-mentioned three-stage development strategy, the following section summarises the health policy context, policy objectives and policy implementation from the periods of 1949-1979, 1980-1999, and 2000-2010.

‘Public identity, egalitarian behavior’–development of healthcare system (1949-1979)

Health, social and economic status, at the founding of the PRC in 1949, was poor. Average life expectancy was only 35 years (Xu, 1985). The infant mortality rate was more than 200 per 1000 live births and the maternal mortality rate was 150 per 10,000 in the early half of the twentieth century (Sze, 1943). From 1820 to 1952, Gross Domestic Product (GDP) growth rate was 0.22%, compared to a world wide 1.62% average growth rate (Zhang and Lin, 2001, p. 19). Wars, technological backwardness, poverty, diseases, and fragmented state administration across the whole country made China the ‘Sick Man of East Asia’. The main contributing factors to poor health status were malnutrition, infectious diseases, food shortages, and widespread impoverishment. Given the above, the CCP adopted a planned economy to industrialize the backward nation, to ration insufficient supply, and to organize an economy of scale (Wu, 2004).

The role of the state was to provide a framework of rule and order and to govern the public life through central planning and strong administrative regulation. The first national health conference held in 1952 put forward ‘Four Guiding Principles of Health Development’: serving the people, prevention first, embracing Western Medicine with Traditional Chinese Medicine, and integration of health development with mass campaigns (see Appendix D, Policy 1). In 1954, the first Constitution of China affirmed that “the state is to be responsible to promote health development, disease prevention and treatment, and mothers and children’s health protection” (see Appendix D, Policy 2). Equity, availability and accessibility were to be the key policy objectives in healthcare.

To address supply shortages, China adopted the then socialist Soviet Union system of planning. The urban hospital management system followed the administrative structure (Figure 2-1). Administration was based on ‘rule of man’ between health departments and hospitals. There were few laws issued throughout 1950-1970s in China. A planning system culture was the prevailing administration practice (Figure 1-1). There was no real accountability between administrative levels and there were no merit-based performance incentives.



(Gov't = government; H. = health; dept. = department. Solid arrows indicate the administrative relationship while the dotted arrows indicate the up-down technical directive relationship)

Figure 2-1 Government Administrative and Technical Directive Structure

The management practice at the institution level emphasized process management, reporting to the top, and cascading control through successive levels. The policy implementation largely relied on vertical line departmental system. The main features of health administration and finance system at development stage can be described as public provision, public administration and public financing:

- a) Public service provision and public ownership;
- b) Public administration in vertical streams; and
- c) Public financed GIS and LIS insurances. The insurance schemes were entitlements based on staff affiliation to institutions without social pooling.

Norms were reinforced by this administrative system. At the time, both the hospital director and staff were salaried civil servicemen; the hospital was a fully budgeted government institution. There was no incentive for individual innovation. Equally, there was no incentive for any market-based distortion, such as under-use or overuse of services. As the institutional management practice was instruction-based practice, the main functions were task coordination among staff, internal administrative monitoring and supervision. Promotion was the key incentive for diligent work, apart from personal ethical advancement (Mill and Nagel, 1993, pp. 3-20).

Ethical indoctrination was the overwhelming force to conform what was thought as good clinical conduct. Throughout the planning era, ethical education was to indoctrinate staff to be devoted and dedicated to socialism and to strong altruism, with the only constraint being resource limitation and human incapacity (Eggleston and Zeckhauser,

2002, p. 38). Health was welfare, for instance, Mao Zedong instructed the health professionals ‘to serve the people’. ‘The Gang of Four’³³ advocated ‘having socialist weed rather than capitalist seed’. There was no cost concept for hospital staff in an egalitarian society. Quality varied, more dependent on availability of resources and local setting rather than psychological imperative for personal financial gain. Somehow within the health sector, this social engineering did create a powerful psychological imperative to change the face of the ‘East Asian Sick Man’ (Scott, 1998, pp. 193-306).

The main achievement of the planned system was the successful accomplishment of the ‘First Health Revolution’ by late 1970s. Compared with other countries of similar per capita income, health status attainment in China was better than expected (World Bank, 1992). Yet administration-based hospital planning did create allocative inefficiency and lack of dynamic efficiency³⁴ (World Bank, 1992), which was attributed to the hierarchical model of governance (Newman, 2003, p. 94; Box 2-1).

Hierarchy governance model (1949-1979)	
<u>System level</u>	Policy goal is Equity; Instruction-based administration and centralized control;
<u>Institution level</u>	Specification of process approval which is rule of man; Public administration and financing of provider; Institution-based internal management;
<u>Individual level</u>	Weak incentive structure for innovation; Norm: Indoctrination for behavior compliance

Box 2-1 Hierarchy Governance Model (1949 –1979)

‘Public identity, private behaviour’ - the first stage health reform (1980-1999)

The first stage health reform started concurrently with economic reform in the early 1980s. The impetus for the reform came from the abolition of the commune system in

³³ Gang of Four: An extreme leftist group of four, headed by Mao’s wife, formed during the Cultural Revolution.

³⁴ Dynamic efficiency: Technological progressiveness measured as the ratio between revenues and

rural areas. The reform strategy can be summarized by one word: decentralisation. A common phrase for decentralisation is ‘to cross the river by touching the stone’. It means, first, deregulate rigid hierarchical control (devolution of power), so to create an enabling environment for local innovation. Then an understanding of the river or market-oriented practice can be obtained. The critical point is to touch the bottom of the river, the stone, so to affirm and chart the path towards further innovation. The stone thus becomes the basis for regulatory policy re-formulation: spiralling policy adjustments to innovative practices. This pragmatic approach of reform was to have change take place first at peripheral localities, then to expose more widely and express it in a scientific manner, and then to either rectify or disapprove formally and centrally.

Theoretically, decentralisation is described to create a ‘self-regulated’ system (Osborne and Gaebler, 1992; Parsons, 1995, p. 479; Osborne and Plastrick, 1997; Kamarck, 2002, pp. 227-263), and local governance³⁵ (Bovaird and Loffler, 2002, pp. 54-68) or local state corporatism in the China’s context (Oi, 1999, pp. 97-98).

Decentralisation can technically be classified as decentralisation down, where local governance has been created; and decentralisation out, where market incentive has been created. The objective for decentralisation down is participation; its social consequence is diversification, which results in mobilisation. The objective for decentralisation out is efficiency; its social consequence is entrepreneurialism, which results in marketisation (Pierre and Peter, 2000, p. 204). So, the macro policy goal of decentralisation in China is towards local governance and creation of market incentives as the arrows indicated in Figure 2-2.

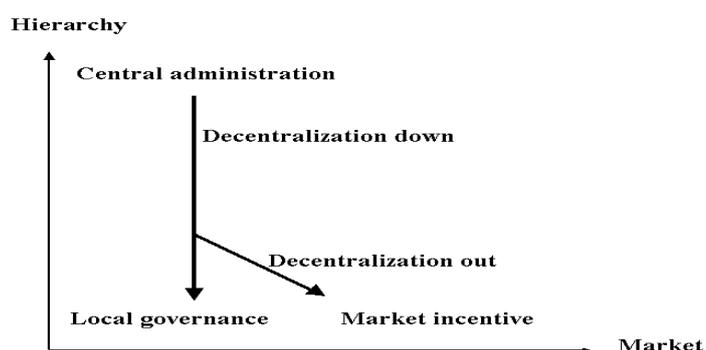


Figure 2-2 Conceptualising the Consequences of China’s Decentralisation Policy

expenditures (Forbes, Hindle, et al., 2002).

³⁵ Local governance: “the set of formal and informal rules, structures and processes by which local stakeholders collectively solve their problems and meet societal needs. This process is inclusive because each local stakeholder brings important qualities, abilities and resources. In this process it is critical to build and maintain trust, commitment and a system of bargaining” (Bovaird, Loffler, et al., 2003, p. 374).

Consistent with the incremental economic reform program and fiscal decentralisation, MOH policy direction focused on holding hospitals accountable fiscally, so as to boost their economic efficiency. Cost recovery, management by objectives, and expansion of revenue earning services were main strategies adopted by hospitals in response to a constrained budget. No systematic policy reform package came out of MOH at the first stage health reform. More often, policy practice was an ad hoc response to market-oriented innovations.

The result of fiscal decentralisation policy in the health sector was that, from 1991 to 2000, the government expenditures increased by 4.17%, but the government health expenditures increased only by 3.15%, so the government health expenditures in proportion to government expenditures actually reduced by 0.6% (Table 2-1). For health care providers, with decreasing government funding, the hospitals had to increase user charge payments. Over the past two decades, there was almost 35% increase in user charges, and more than 20% of user charge increase in the past decade (Table 2-2). WHO has concluded that the fundamental issue in China health sector is financing inequity (WHO, 2000b, p. 155). Without a financing lever, influence on provider behavior has to rely on non-financial regulatory tools.

Table 2-1 Government Health Expenditures, 1991 and 2000 (in billion yuan)

Year	GDP	Gov't expenditure.	Health expenditure	Health/gov't expenditure (%)
1991	2,024	381	8.64	2.3
2000	8,819	1,589	27.2	1.7
change	21%	Increase by 4.17	Increase by 3.15	Decrease by 0.6%

Source: Rao, 2002.

Table 2-2 Trend of National Health Accounts (NHA) and Composition

<u>Expenditure</u>	1980	1991	1995	2000
Total health expenditures (billion yuan)	n.a.	88.7	225.8	476.4
Per capita expenses (yuan)	n.a.	76.7	186.4	376.4
Proportion to GDP (%)	3.17	4.11	3.86	5.33
<u>Composition</u>				
Government budgetary expenses (%)	36	23	17	15
Social health expenses (%)	40	38	33	25
Individual health expenses (%)	24	39	50	61

Sources: Li, 2001; Rao 2002 (n.a. indicates that the data is not reported publicly).

To make up for the decreasing governing financing for hospitals, the key ad hoc policies provided incentives that modified provider behaviours alongside the gradual development of a market-oriented system:

- a) To allow individual practices (see MOH, 1980, Appendix D, Policy 3);
- b) To price new service based on real cost (see MOH, 1985, Appendix D, Policy 4), prices for new medical equipment procedure and imported drug are based on real cost, while prices for medical service is still based on subsidised price stipulated at the time of the planned economy; and
- c) To implement the service contract system (see State Council, 1989, Appendix D, Policy 6), to allow sideline commercial activities to compensate for inadequate budgetary financing.

Inevitably, the emergence of private practice, the distorted price structure³⁶, and fiscal accountability system³⁷ changed the nature of health from welfare-based to a mix of welfare and business. The decentralization program has created an unmanageable task to unify management and finance systems centrally. Encouragement of innovation at the local level, at best, has generated ideas of reform for the center, but at worst it has brought about entrepreneurial behavior in two areas: management and financing arrangement and clinical practice. Anecdotes from various sources have indicated increasing healthcare related grievances. Perverse financing arrangements and clinical practice do require policy intervention (see Appendix D, Policy 5 and Policy 7).

During policy implementation under the first stage health reform, the fiscal decentralisation program led to decreased funding for urban hospitals, and the administrative decentralisation led to increasing local governance and hospital autonomy. Public-based management and finance systems under planning drifted to a market incentive-based discretionary management system. A 'self-regulated' hospital industry has led to the weakening, if not the dissolving, of the top down instruction-based policy implementation system. The hospital director had to find instruments to generate revenues as every other sector does (Mao and Li, 2000; Mao and Li, 2003). Hospitals, under decentralisation, adopted the following strategies to earn income:

- a) Increase user charges (price increase without quality improvement);
- b) Increase dynamic efficiency by introduction of new medical technology and new imported drugs (with cost increase and quality improvement); and

³⁶ It is technically called 'a dual price system': The service price system is based on the old planning system; the prices of new medical procedures and new drugs are based on market. This is the price transition reform initiated at late 1980s to promote 'the planned commodity economy'.

³⁷ The fiscal decentralisation program is the main element of decentralisation program that led to fiscal accountability, which in turn led to service contract system, where hospital business operation revenues retained by hospital as a compensation for reduced budgetary allocation.

- c) Breakdown cost items to increase number of charging items for the payment practice is largely Fee-For-Service (FFS).

The regulatory activities were less effective. For example, regulating the use of high technological medical equipment has less impact (see MOH, 1995, Appendix D, Policy 11; Zhao, 2000). There was no clear price policy at the time, leading to drug price inflation of up to 85% (Yu, 1992). MOH lacked basic costing data to develop price, and could not control breakdown of cost item.

To improve hospital management, MOH initiated a Hospital Accreditation Program in 1989 (see Appendix D, Policy 8). However it largely evolved into a facility building program (Pei, 1998, pp. 39-43). The quality improvement objective was largely unmet and the program became inactive soon afterwards. Overall, regulatory policy and its implementation lagged behind local innovation. Perverse market-oriented behavior coexisted with technical efficiency gains at the market level.

The salary structure has changed over time. The base portion of salary usually is guaranteed by the budget, but the bonus portion has to be earned through providing volume of services (Pei, 1998, pp. 43-46). The proportion between base and bonus parts reflects the degree of changes of management and finance systems. The right to decide the level of bonus largely belonged to hospital directors. Therefore there was a congruence of interests between staff and the hospital director for providing more services because both can have more bonuses, – the ‘public identity, private behavior’ practice has been created with the changed management and financing systems. High cost, high volume mode of service provision spread rapidly across the country.

The checks and balance mechanism instituted was to have health departments supervise hospital directors, but it largely does not work for the hospital is the ‘son of the health department’³⁸. The social structure foundation is that, at macro level, departmental protectionism exists almost in every sector because of planning system culture (Xinhua News Agency, 2003c). China has no civil society because of individuals’ vertical institutional affiliation. As such, it is nearly impossible to supervise conflicts of interest between health departments and hospitals.

Professional ethics changed with economic policy changes. The nature of healthcare changed from welfare to a mix of welfare and business. Without feasible instruments to regulate cost-quality compromise, MOH had to resort to a traditional indoctrination

³⁸ A common phrase describes the relationship between hospitals and health departments.

approach to uphold traditional professional ethics (see Appendix D, Policy 5, Policy 7) Policy directives stressed reeducation of staff on the prevention of overuse of drugs, medical procedures, and other fraudulent medical behavior. Many hospitals displayed such nominal rules usually in the front hall of hospital outpatient department but it was largely ineffective. The strong altruistic and egalitarian society became a story of the past (He, 1998, pp. 2-15). Voluntary compliance was low in a competition environment.

Provider preferences had shifted during transition. Eggleston's concept of cost-quality compromise of provider behavior (Eggleston and Zeckhauser, 2002, pp. 39) is useful explaining provider preference transition from a planning to a market-oriented healthcare system in China. Figure 2-3 depicts a cost function curve to produce quality service.

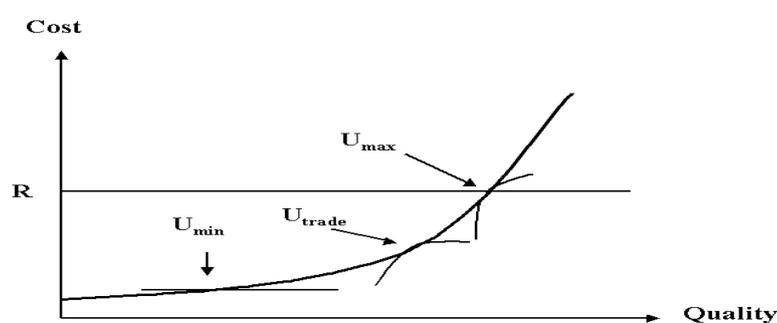


Figure 2-3 Provider Preference for Cost-Quality Compromise under Competition

Assuming that production efficiency holds constant, which means that there is no dynamic efficiency considered (in which case the cost function moves upward); and there is no user charge price increase (in which case cost function has no change but revenue increases). The net revenue (depicted as R in the diagram) can be described as function of quality subtracted from cost. The analysis is to examine individual doctor's preference (or Utility depicts as U) to trade off between cost and quality under competition (Formula 2-1).

Formula 2-1 Provider Cost-Quality Preference Function for Revenue: $R = \{F(\text{quality}) - \text{Cost}\}$

Doctors preferring to maximize net revenue (R_{\max} or U_{\min}) are to minimize cost. They would provide minimum quality (Formula 2-2).

Formula 2-2 Revenue Max: $R_{\max} = U_{\min} = \text{Max}\{F(\text{quality}) - \text{cost}\} = \text{Max}\{\text{economic efficiency}\}$

Doctors preferring to balance social optimum and economic interest (R_{trade} or U_{trade}) are those altruistic doctors value both quality and revenue. The trade off between quality

and revenue would make those doctors opt for behaving clinically around social optimum or social efficiency (Formula 2-3).

Formula 2-3 Revenue Trade-off: $R_{\text{trade}} = U_{\text{trade}} = \text{Opt} \{F(\text{quality}) - \text{cost}\} = \text{Opt} \{\text{Social efficiency}\}$

Doctors preferring to minimize social cost (R_{min} or U_{max}) are those strongly altruistic and high culture doctors. They would look for high quality services at revenue breakeven cost for quality service (Formula 2-4).

Formula 2-4 Revenue Min: $R_{\text{min}} = U_{\text{max}} = \text{Min} \{F(\text{quality}) - \text{cost}\} = \text{Approach} \{\text{Breakeven}\} = 0$

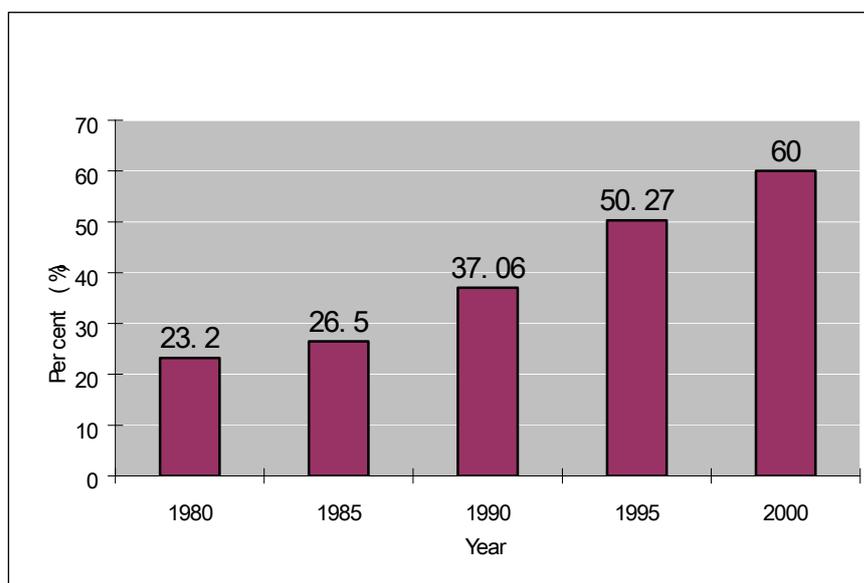
It is important to assess the effectiveness of MOH ethics policy under marketisation. A study on hospital competitive behaviour from 1985-1999 in China found declining hospital productivity and social efficiency (Forbes, Hindle et al., 2002). The study revealed that social efficiency has declined in the tertiary hospitals because these hospitals could easily increase the use of expensive technologies. Large hospitals have dynamic efficiency while lower level hospitals have not. The study concluded that supplier-induced demand is an important negative market force. This study suggests that China health provider behaviour moved between U_{min} to U_{trade} . U_{max} represents provider behaviour during the planning period or those with strong altruistic sentiment. In summary, during the first stage health reform, provider behaviour shifts from U_{max} to U_{trade} and to U_{min} . Social efficiency of service is low and cost is high – a high cost, high volume medical practice emerged as of ‘public identity, private behaviour’ healthcare system.

The high cost, high volume competition revealed the negative impact of hospital fiscal responsibility policy- the unintended adverse effects are cost escalation and consumer dissatisfaction.

Service providers tend to pursue their own ‘survival’ agenda by increasing user charges, and favouring prescription to new medical technologies and new pharmaceuticals. The ‘public identity, private behaviour’ system encourages a moral hazard for revenue maximization by forgoing traditional ethical standards of ‘save the dead and heal the wounds’³⁹. Evidence shows that most urban hospitals received less than 10% of their total revenue from the government budgetary allocation, and generated 60% of their revenue by selling drugs (Dai, 1993). An estimated 30-40% of drug consumption is made up of inappropriate utilization. Unnecessary utilization is more than 30 billion yuan per year (Xinhua News Agency, 1996).

³⁹ This is the advocated ethical code of conduct and phased by Mao Zhedong.

The National Health Accounts (NHA) study has shown that private out of pocket consumption in proportion to total health expenditures accounted for 23.2% in 1980, 26.5% in 1985, 37.06% in 1990 and 50.27% in 1995 (CHEI, 1999, p.162). It was approximately 60% in 2000 (Rao, 2002; Figure 2-4). In addition, during this period, the total health expenditures have increased in proportion to GDP from about 3.17% in 1980 to 5.33% in 2000⁴⁰ (CHEI Task Force, 1999, p. 168; Rao, 2002).



Source: CHEI 1999, p. 162; Rao 2002.

Figure 2-4 Private Health Consumption in Proportion to Total Health Expenditure

The future estimate of health expenditures is that if 15% of medical cost increase continues as shown in the past ten years, the total health expenditures would approach 20% of GDP by 2015; if 7.5% of medical cost increase attains, which is the same as GDP rate projection over next decade, the total health expenditures would approach 9% of GDP by 2015 (Rao, Yin et al., 2000). The hospital industry is driving rising costs. The root causes lie with price regulation (Liu, Liu et al., 2000), the health financing system and the regulatory framework.

The increasing trend of consumer dissatisfaction was found, for instance, on reduced benefits of the previously publicly funded insurance scheme, poor attitudes of doctors and poor qualities of hospital and physician services (see Appendix D, Policy 7). In responding to increasing medical errors and accidents, policies were made by MOH and State Council (see Appendix D, Policy 9 and Policy 10; and Appendix E, Law 4). It was,

⁴⁰ The reported discrepancies of the NHA study result are due to adjustment made in relation to cost and price estimates, because of the 'dual price system' instituted in the later 1980s.

again, not effective. One study reveals that almost 70% of consumers responded “healthcare costs (are) too high and unaffordable” (Lim and Yang, 2002).

In summary, in time of transition without an adequate regulatory framework, over-supply of health services became the dominant trend (Meng, Liu et al., 2000). For hospital staff, the incentive was to achieve the financial goal by linking doctors’ bonuses to institutional revenue, which was generated by their prescription of drugs and/or procedures (Liu, Liu et al., 2000). While each hospital acted rationally in response to the market, their aggregation tended to be a disaster from society’s perspective. This supply-induced demand was of central importance as it shifted costs to consumers, increased cost of service provision and in aggregated terms, it reduced the society’s capacity to use scarce public resources efficiently and legitimately.

The decentralisation program was meant to create local governance and market innovation. However, local governance needs a self-steering network and civil organization (Lewis, 2001; Newman, 2003). ‘Governing from a distance’ does not mean the absence of a system of control and authority. The problem of decentralisation was that while the traditional policy delivery system dissolved, a new governing system did not emerge (Box 2-2).

Self-governance model (1980-1999)	
<u>System level</u>	
Policy goal is to increase autonomy to achieve efficiency;	
Decentralization down and decentralization out;	
<u>Institution level</u>	
Autonomy and cost recovery;	
Innovation-based discretionary management;	
Managerialism for revenue generation;	
<u>Individual level</u>	
Strong incentive for cost-quality compromise;	
Norm: Utility maximization;	

Box 2-2 Self-governance model (1980-1999)

Mixed public/private market - the second stage health reform policy (2000 – 2010)

The second stage health reform originated from two main factors pushing for bolder health reform: the 1993 State Council decision to pursue market socialism, and a changing mode of government financing of health services in urban areas.

On the social and economic development front, the government faced increasing pressure to set up a new urban health insurance system so as to accommodate the State-Owned Enterprises (SOE) market-oriented reform, which could relieve SOEs of their responsibilities of running health facilities for their employees and retirees.

On the health policy front, the chaotic health service behaviour inherited from the first stage reform needed to be rectified to adhere to conceived rules for the market, and the market-oriented system demanded clarity between governments and hospitals – ‘steering’ instead of ‘owning’ or ‘rowing’. MOH envisioned that the separation of public and non-public services could reorient public spending and improve quality through competition. In other words, the public service could improve access for the needy population, and to enhance quality and choices of care needs to introduce private service. This perspective informed the second stage health reform (see Appendix D, Policy 12).

The second stage health reform policy objectives were (see Appendix D, Policy 12):

- a) To promote the viability of institutions. This requires reforming the health administration system and the service system;
- b) Health is of a public welfare nature with government implementing certain welfare policies. Health development must be coordinated with the national economy and social development;
- c) Institutional reform aims to balance the social and economic benefits. To put social benefit first so to prevent unilaterally seeking economic benefit;
- d) By year 2010, the healthcare system should be consistent with the socialist market system.

The policy package of the second stage health reform included more than 60 guidelines, decisions, directives and circulars from various central ministries and commissions, which have been issued mainly since 2000. The reform policy package was structured, purposive, and top-down. The key planks were:

- a) Demand-side financing. The urban health insurance system is to replace the non-functioning GIS and LIS systems (see Appendix D, Policy 13). A purchaser-provider split has been introduced. The hospitals have to generate income through provision of

good services, which is partly paid by insurance departments. This is in sharp contrast to the past institutional set up where hospitals are allocated funds technically from health departments;

- b) Supply-side restructuring. The urban community health services development directive aims to dissolve secondary level service, either into special hospital or community service (see Appendix D, Policy 15). Eventually there will be two layers of services in the marketplace: the community health service and the hospital service. The classified hospital management system directive aims to classify hospitals into NFP hospital and FP hospital (see Appendix D, Policy 16). The key intent of supply-side reform is to modify the ownership structure of public health facilities into either budgetary, autonomous, corporate and/or privatised hospitals, with the aim of delineating the relationship between public administration and public facilities;
- c) Public administration reform, after separation of public administration from public facility administration, aims at steering instead of rowing public facilities, instituting market-oriented financial, non-financial incentives as well as legal and regulatory tools to replace the past administrative measures (see Appendix D, Policy 18).
- d) Fiscal policy relates to subsidy policy for public facilities (see Appendix D, Policy 19), taxation policy for private facilities, and separate management of pharmaceutical revenues and expenditures (Appendix D, Policy 21).
- e) Price reform. Considering that the market is still premature in establishing a competitive price structure, the government will direct drug prices on the essential drug catalogue (for insurance system) and special monopolistic drugs, and leave the rest to market adjustment. Central government will decentralise price administration to localities and only direct retail prices. In addition, government will provide reference prices of services for NFP hospitals and leave FP service prices to market competition (see Appendix D, Policy 22).

Following the reform, the healthcare market structure in China can be conceptualized in the scheme in Figure 2-5. With respect to regulation, the distinctive features of the China healthcare market are:

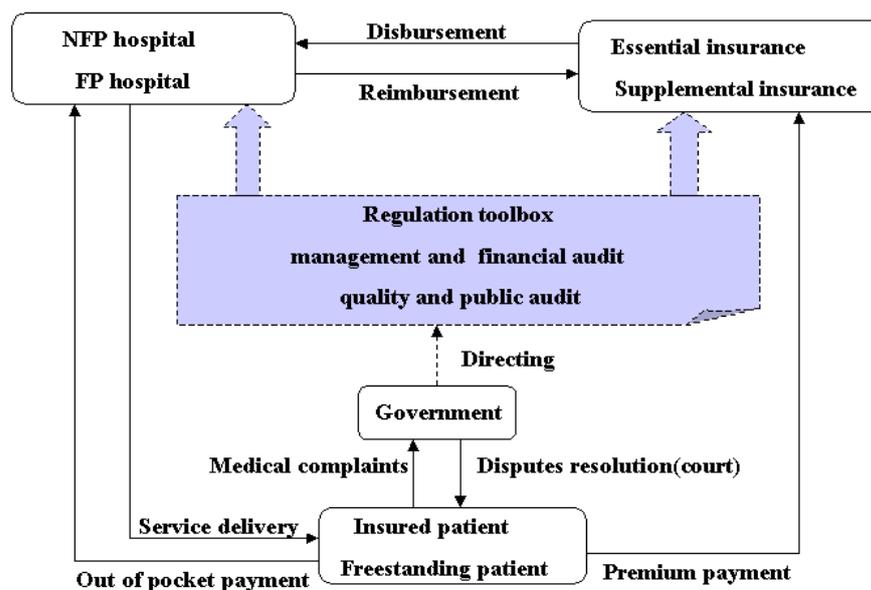


Figure 2-5 Healthcare market Structure in China

- a) Three groups of patients, those covered by state sponsored MSA, those covered by commercial health insurance, and those without any insurance coverage;
- b) The regulatory supporting system is not ready to support regulatory functions, therefore management and financial process audit⁴¹ is largely an idea; and
- c) Governance relationships among market players are to be formed.

This conception of the healthcare market generates two new governance systems out of the previous self-governed system. The first system concerns the demand-side policy purchaser; the second system concerns the supply-side. Newman refers to the first governance system as the rational goal governance model, where regulatory policy is to set the rational goal (equity) on health insurance purchase policy. Newman refers to the second governance system as an open systems governance model (efficiency), where regulatory policy is a reflexive process in the open or market-oriented system (Newman, 2003, p. 94). Figure 2-6 (the dotted arrows indicate the process of development) depicts the evolution of the health governing system, from health planning (1949-1979), to first stage health reform (1980-1999), and now to second stage health reform (2000-2010).

⁴¹ Audit is conceptually defined as either internal or external evaluative intervention in the form of, from the least intrusive to the most intrusive, monitoring, review, supervision, and site inspection and reporting. Public audit means information disclosure, in China context, it means public supervision.

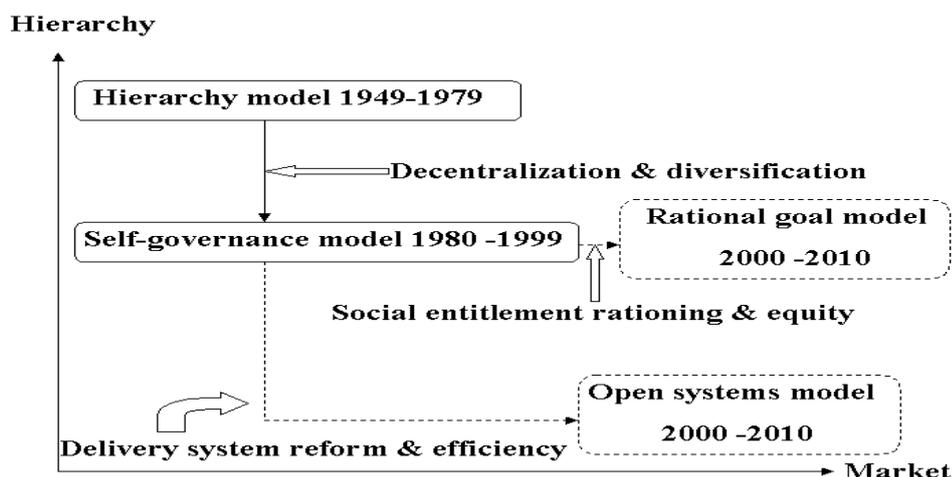


Figure 2-6 Healthcare system Governance Model Evolution in China (1949-2010)

The governance system evolution diagram suggests that China's healthcare system transition is path-dependent. Decentralisation promotes diversification of service delivery, turning a hierarchy model into a self-governance model. The second stage health reform policy indicates that healthcare is of both social entitlement and economic production, leading future development (dotted line in the diagram) toward social insurance (equity) and delivery system governance reform (efficiency). Hierarchy and market are therefore combined in a mixed public/private market.

Summary: A mix of issues due to rules not spelled out or followed

This chapter has documented the change of the healthcare system in China and the driver for those changes as of change in state and society concept. Along the three time periods of healthcare system evolution, a mix of issues relating to incentive, management and financing systems and governing arrangement intertwine, mainly due to the fact that the rules are not spelled out clearly and generally accepted from the first stage health reform. Although the first stage health reform has created innovation yet it has generated excessive entrepreneurial behavior, and such behavior is protected by the public identity of hospitals – a nature of state corporatist practice. The consequence of state corporatist behavior is brutal competition for income, at the price of social and ethical morality. The root cause of raging competition is due to fiscal decentralization and shrinking finance from the state.

To remedy the chaos and inequity in the healthcare system, the second stage health reform is to create a state purchaser and an NFP hospital sector by splitting financing from provision and by detaching hospitals from health departments. Its objectives are to enhance equity and efficiency in a mixed public/private market. The issues are that, the

distorted financing arrangement at the system level resulted in unhealthy competition at the institutional level, at the sacrifice of social efficiency. ‘Public identity, private behavior’ emerged due to the congruent interest between hospitals and health departments. The 1997 reform policy has correctly spelled out separation of financing from provision and detachment of hospitals from health departments – a right move. Therefore, this chapter has unveiled the broad relationships between the tasks of regulation - financing for equity and governance arrangement. These two issues differ according to local variation, governing system, and the understanding of stakeholders on the role of the state and the market under state corporatism (Table 2-3). It therefore created confusion and conflicting views on reform in general. The difficulty lies in the fact that, for a decentralized China, local stakeholders decide on the public financing scheme and governance arrangement between hospitals and health departments.

In summary, the review of the role of the state and healthcare system revolution in China from 1949 to 2010 has informed the research design and methodology. This thesis explores possible regulatory responses to deal with varied situations in China. The next chapter reviews the international experience on regulating healthcare, so as to provide hints on the design of research.

Table 2-3 Healthcare system Evolutions in China: Goal, System, Issues and Options

Logic	Healthcare system development (1949-1979)	First stage health reform (1980-1999)	Second stage health reform (2000-2010)
Goal	Equity	Efficiency	Equity-efficiency trade-off
System	Hierarchy model; Public financing/provision	‘Self-governed’ model for hospitals; State corporatist	Rational goal model/open system model; Mixed public/private market
Hospital	Vertical affiliation; ‘Public identity, egalitarian behavior’	Autonomy; ‘Public identity, private behavior’	Split financing from provision; Detach NFP hospitals from health department
Doctor	Egalitarian norm	Incentive for revenue	Towards social optimum
Issue	Low efficiency	Low equity	Market failure
Option	Decentralisation	Governance reform	Regulation

CHAPTER THREE

INTERNATIONAL APPROACHES TO REGULATING HEALTHCARE

This chapter reviews international practices in regulating healthcare. To contain cost escalation and to promote efficiency, the worldwide trend in healthcare system reform is marketisation. Yet the market itself cannot solve the issue of healthcare, mainly due to the fact that health services are not a standard private product. Therefore, the role of the state is to correct market failure through (from the most intrusive to the least intrusive to the market) direct production, financing, regulation and information for healthcare (Harding, 2001).

In this chapter, the regulatory systems are grouped into technology-based regulation in the regulated market, performance-based regulation in the planned market, and management-based regulation in the healthcare system in transition. It is argued that, the established healthcare markets, such as regulated and planned markets, mainly use technical regulation to achieve healthcare system objectives. In the healthcare system in transition, difficulties exist in relation to institutions and the governing system necessary for the deployment of technical regulation. Therefore, management-based regulation is the preferred regulatory approach. It is also argued that, with technical regulation, the regulatory process then affects the relationships between competition, cost and quality.

This chapter is structured as follows: first a theoretical note on the state and the market in healthcare and a review of practice regulating healthcare towards healthcare system objectives in established market is provided; then, technology-based and performance-based regulation in established markets, and management-based regulation in healthcare system in transition are illustrated; and finally the arguments regarding the effect of the regulatory process on relationships between competition, cost and quality are presented.

State and market in healthcare

Empirically, the U.K. hierarchy National Health Service (NHS) and the U.S. healthcare market represent two extremes of the hierarchy-market continuum across established economies. Most OECD countries, the Commonwealth of Independent States (CIS), Central and East Europe (CEE) countries, High Performing Economies (HPE) such as Singapore and Hong Kong are spread along the continuum (Saltman, 1995; Saltman

and Otter, 1995, p. 67; Saltman, 1998, pp. 21-52; WHO 2000a; Harding and Preker, 2003; OECD, 2003; Phua, 2003; Yip and Hsiao, 2003; Docteur and Oxley, 2003). Figure 3-1 illustrates the healthcare system distributions along the informal/formal market institutions (which are further divided by the hierarchy and market institutions), for instance, the established economies have well-developed market institutions or formal market institutions while developing and transitional economies have less developed or informal market institutions.

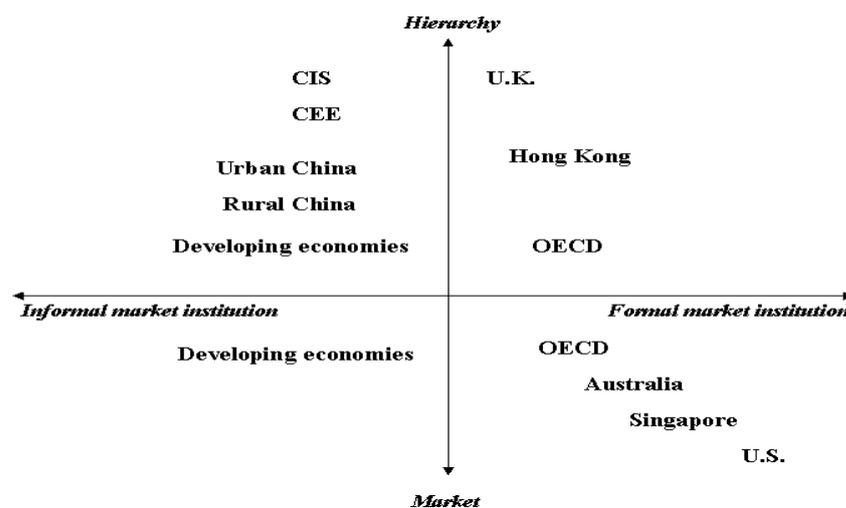


Figure 3-1 Healthcare system Distribution in the World

Almost all healthcare systems have undergone market-oriented reform in the late 20th century (Scarpaci, 1988; Newbrander, 1997, pp. 3-4; Davis and Cooper, 2003; OECD, 2003). Healthcare system marketisation raises a range of challenges: ideological, political, social and economic (Drache and Sullivan, 1999). A core concern is the appropriate role for the state and the market. WHO policy on Health-For-All typically represents the claim that equity and redistribution function of the healthcare system cannot be left to the market. On the other hand, neoliberals envision a minimal state role and maximal market role: “Wherever bodies are separated from government, either competition or regulation must be established to stimulate greater efficiency” (Foster and Plowden, 1996, p. 84). The World Bank attempts to take a middle position by calling for evaluation of public provision and financing for healthcare from a social efficiency perspective (World Bank, 1993).

In theory, the healthcare market has three characteristics:

- a) It differs from standard competitive markets in relation to suppliers, products, consumers and payment methods (Table 3-1; Stiglitz, 1986, p. 290);

- b) It has ‘abnormal economics’ of cluster healthcare sub-markets (Hsiao, 1995, pp. 160-180), i.e. multi-chain of sub-markets from doctor education, pharmaceutical and medical technology supply markets, entry into service market, to health insurance market, and market of information. The dynamic impact between sub-markets is quite often abnormal; and
- c) Incentive determines how hospitals behave (National Forum on Health, 1998; Southwick, 1978, pp. 37-45). The NFP hospitals might only refer to tax status, as NFP hospitals and managed care organizations reveal that they can engage in many practices commonly associated with the FP sector, such as patient dumping or ‘cream skimming’ (Butler, 1999, pp. 29-52; Zelman, 1999, pp. 5-28).

Table 3-1 Standard Competitive Markets vs. Healthcare Market

Market Constructs	Standard Competitive Market	Healthcare Market
Number of suppliers	Many sellers	Limited hospitals
Nature of suppliers	Firms are FP	Many hospitals are NFP
Product and service	Homogeneous	Heterogeneous
Consumer	Well-informed	Ill-informed
Payment method	Direct payment	Patients pay a fraction of cost

Source: Stiglitz, 1986, p. 290.

Therefore, the mere definition of public and private is no longer important in the marketplace. The motive, either morally or ethically, is the key in judging the nature of legally classified FP or NFP hospitals (Southwick, 1978, pp. 37-45). As motive becomes the basis for judging hospital nature, the FP nature of NFP hospital poses challenges for regulation. The characteristics of healthcare market require the state to maintain order for competition (Altman and Rosman, 1999, pp. xxi-xxxiii).

The role of the state is to correct market failure and to provide public goods, yet the aggressive state intervention could lead to inefficiency and lack of innovation (Ignagni, 1999, pp. 239-262; Saltman, Busse et al., 2001, pp. 3-5). For developing economies with less developed market institutions, the role of the state is to protect property rights and promote the rule of law (World Bank, 2001, p. 101).

With a blurred public/private sphere in healthcare, the role of the state is now regarded as stewardship, that is, ‘effective trusteeship of national health’ (WHO, 2000a). This concept of the state is similar to the concept of governance in the pursuit of the public interest (Kamarck, 2002, pp. 227-263). Traditional Weberian government carries vertical control via governance arrangements through regulation, which is what a regulatory state means (Braithwaite, 2003, p. 1). Modern government looks forward for trust building and public will advocacy (World Bank, 1997d; World Bank, 2001).

Deduced from a such definition, the role of the state therefore is evolving from economic man in the public choice theory, to self-actualising in the stewardship theory (Table 3-2; Davis, Donaldson et al., 1997; Saltman and Ferroussier-Davis, 2000).

Table 3-2 Comparison of Agency Theory and Stewardship Theory

Characteristic	Agency Theory	Stewardship Theory
Model of man/Behavior	Economic man/Self-serving	Self-actualizing/collective serving
<u>Psychological mechanism</u>	<u>Lower order/economic need</u>	<u>Higher order need</u>
Motivation	Extrinsic	Intrinsic
Social comparison	Other managers	Stakeholders
Identification	Low value commitment	High value commitment
Power	Institutional: legitimate/coercive	Personal: expert/referent
<u>Situation mechanism</u>	<u>Control-oriented</u>	<u>Involvement-oriented</u>
Management philosophy	Control mechanism	Trust
Risk orientation	Cost control	Performance enhancement
Time frame	Short-term	Long-term
Objective	Individualism	Collectivism
<u>Culture difference</u>	<u>High-power distance</u>	<u>Low-power distance</u>

Source: Adapted from Davis, Donaldson et al., 1997; Saltman and Ferroussier-Davis, 2000.

In summary, in term of the role of the state in healthcare in the marketisation process, according to neoliberals, the state should relinquish its role from direct service production and finance; the state should develop its role in competition and regulation. The state role in competition is to develop market institutions (for developing economies), for instance to safeguard transactions and to ensure a level playing field and market structure. The state role in regulation (for established economies) is to correct market failure, such as inputs or entry regulation and information disclosure. Such notion is different from the notion of ‘stewardship’ as advocated by WHO Report 2000. Arguably, the role of the state in healthcare depends on social consensus on the objectives of the healthcare system, which is socially and culturally embedded (see Chapter Four).

Healthcare system objectives and technical regulation

Each healthcare system has its own objectives in accordance with national development objectives, and its objectives determine the choices of technical regulation tools (Saltman, Busse et al., 2001, pp. 13-15). Generally, objectives for supply-side are: equitable access; efficiency to contain cost; and effectiveness of service delivery - the so-called three ‘E’s. For the demand-side are: policy purchase for public good; choice; and informed decision making (Altman, Reinhardt et al., 1999; OECD, 2004). Technical regulation is instrumental in achieving healthcare system objectives (Roper, 1999, pp.

145-159; Harding, 2001; see Table 3-3). Stewarding mixed public/private market involves three sets of regulations: social regulation, economic regulation, and cost-quality regulation at the time of marketisation, which is to regulate cost-quality compromise that concerns regulatory process and governing structure for healthcare system during transition.

Table 3-3 Healthcare system Objectives vs. Technical Regulatory Tools

Supply-side	Demand-side	Technical regulatory tools
Equity	Policy purchase	Social regulation
Efficiency	Choice	Economic regulation
Effectiveness	Informed decision	Cost-quality regulation

Health regulatory systems can be classified into three models according to market institutions: technology-based regulation (or contract-based) system in the U.S. where an open systems governance model exists; performance-based regulation in most OECD countries where a rational goal model exists; and management-based regulation where a healthcare system is in transition. Management-based regulation can be further divided into three sub-models: a hierarchy governance model as in the U.K; a self-governance model as in CEE and CIS, and an informal governance model seen in developing economies. The technology-based, performance-based, and management-based regulatory systems are consistent with market, social solidarity and hierarchical social institutions where healthcare systems are embedded (Kaufman, Majore et al., 1986; Saltman and Otter, 1995, p. 69).

The U.S. healthcare system represents a market institution with an open systems governance model that emphasizes utility maximization. Most OECD countries represent the social solidarity institution or Bismarckian model with a rational goal model that emphasizes tax contribution for social welfare under the ideology of social cohesiveness. The U.K. represents a hierarchical institutional, or Beveridge, model with hierarchy governance that emphasizes health entitlement. The technical regulation applied to these models varies according to system objectives. For example, U.S. system objectives are to assure service quality and information to consumers (Pauly and Berger, 1999, p. 54). Most OECD countries are primarily concerned with equity, yet with market-oriented reform, efficiency is also on the policy agenda (Docteur and Oxley, 2003). The U.K. aims to improve efficiency and quality with the intent of reducing queues and improving provider performance (OECD, 1992; Marshall, Shekelle et al., 2003).

In either the U.S. or OECD countries, technical regulatory tools, in general, are used for five healthcare sub-markets: the pharmaceutical market, insurance market, labor market, hospital development, and service quality and information disclosure (Table 3-4). For example, on pharmaceutical markets, the international consensus is that all policies should be informed by utilization review; even with cost-effectiveness, prescription of drugs should be based on hard budget caps to control profit (Maynard and Bloor, 2003; Kanavos and Reinhardt, 2003). With such a rationale, most OECD countries use drug reference price to regulate demand.

Table 3-4 Technical Regulatory Tools by Cluster of Sub-Market

Supply-side objective	Demand-side mechanism	Market mediation tools
<u>Pharmaceutical market:</u> Profit control	Essential drug list; PBS (Australia)	Reference price (for instance, Germany, Australia, Netherlands)
<u>Insurance market:</u> Risk adjustment	Purchaser (OECD); HMO model law (U.S.)	Payment system (OECD); MCO CLEAR (U.S.)
<u>Labor market:</u> Malpractice insurance	Setting salaries (OECD); RBRVS (U.S.)	Grievance procedures; Tort law
<u>Service market (hospital):</u> Transform to public firm	Selective contracting; Community representation	Licensure/CON (U.S.); Corporate governance/by-law
<u>Service market (quality):</u> Licensure, certification; Accreditation, training	HEDIS/NCQA (U.S.); Reporting cards; Informed decision	Ethics and code of conduct; Evidence-based medicine; Clinical governance (U.K.)

Source: Brennan and Berwick, 1996; Altman, Reinhardt et al., 1999; Duckett, 2000; Saltman, Busse et al., 2001, p. 15; Kanavos and Reinhardt, 2003; Maynard and Bloor, 2003.

The following describes the technology-based regulatory system and performance-based regulatory system in an established market system and the management-based regulatory system in healthcare system in transition. It highlights the regulatory challenges faced by three regulatory systems in relation to market characteristics.

The technical regulatory approach in established markets

Technology-based (or contract-based) regulatory system

Technology-based regulation⁴² refers to regulation that emphasizes the use of (information) technology and contracts to regulate technical quality and competition. The

⁴² The technology-based regulation is used in environmental sector, workplace safety, chemical sector and agriculture sector (Gunningham and Grabosky, 1998; Gunningham and Johnstone, 1999; Coglianese and Lazer, 2002, pp. 201-226).

U.S. has technology-based regulatory system for homogeneity of services⁴³, DRG payment method that is abided by institutional by-laws⁴⁴, and consumer protection law and antitrust law to prevent market monopoly⁴⁵.

Extensive use of private contracts makes the U.S. a regulated healthcare market. On the positive side, "...private contracts in health ...breath life into the objective of holding service providers accountable for both cost and quality"; on the negative side, "...all present contracts...refer to 'prevailing professional standards' as the definition of what is covered. These standards are contaminated by moral hazard and professional self-interest" (Havighurst, 1995, back cover (editor's comment)). Healthcare markets in the U.S. have multi- competitive managed care organizations, which are consumer-oriented, technology-based and market-driven (Amerongen, 2002, pp. 119-122). The civil mentality in the U.S. regards government as Leviathan (Daily Policy Digest, 2002a; Acton Institute, 2003), regulating market is justified only by protecting consumers, for instance, mandating information disclosure, standardizing services, and antitrust (Pauly and Berger, 1999, p. 54; Butler, 1999, pp. 29-52). Table 3-5 summarizes the regulatory tools used in the U.S.

Technology-based regulation has increased micro regulation for quality resulting in rising administration cost (Rice, 1999, pp. 75-86), legitimacy of private governance for public good (Nudelman, 1999, pp. 301-311; Roper, 1999, pp. 145-159), and reconsideration of the Clinton reform package (Fuchs, 1996; Davis and Cooper, 2003; Davis, 2003). Technology-based regulation is based on mature market institutions to allow multi- competitive purchasers competing for good contracts and that civil groups' role is to disclose quality information.

⁴³ For example, legal professional requirements, set forth by American Health Information Management Association, includes Code of Ethics, Guidelines on Data Quality and Professional Practice Standards (Liebler, 1995, pp. 147-165). In addition, medical provider "has to pass a peer-review exam every year in order to qualify for Federal fund" (Adam Smith Institute, 2000).

⁴⁴ Those participating in Medicare/Medicaid program are to satisfy JCAHO accreditation procedures, and to follow DRG payment procedure. The institutional by-laws are legally binding, and it associates with facility entry regulation

⁴⁵ The antitrust measures include retrospective utilization review for third party payment by legislated PRO under the Medicare program. Legislation is to act on motives to generate income through shared services via subsidiary corporation or cooperative, price discrimination, price fixing as of group-purchasing, and monopolies, and price-fixing and boycotts of participating provider agreements under subscriber contract, and prevention of multi-institutional system from formation of anticompetitive organization structure. Market appraising is to determine competitive effect by testing "cross-elasticity of demand" for substitute product (Southwick, 1988).

Table 3-5 Technical Regulatory Tools under Technology-based Regulation

Market function	Quality	Information
<u>HMOs law</u> on proper private insurance practice, health plans standardization, and choice.	<u>Personnel licensure/malpractice insurance:</u> Primary licensure, secondary licensure; Medical malpractice insurance; and Common law system governing doctor patient relation, doctor hospital relation.	<u>Information sources:</u> NCQA, HEDIS, National Quality Forum, leapfrog group, and CMS.
<u>DRG system</u> defines products, services, and quantities.	<u>Facility certification and accreditation:</u> CON and JCAHO's hospital accreditation;	<u>Insurance information</u> on solvency protection, availability and accessibility of services, quality assurance such as external review and physician credentialing (adverse hospital action, malpractice claim and report from the National Practitioners Data Bank).
<u>RBRVS</u> defines physician payment methods.	List of accreditation results to the National Library of Healthcare Indicators (NLHI).	
<u>General laws</u> on market competition, e.g. anti-monopoly law, consumer protection law	<u>Insurance market:</u> CLEAR model law covering credentialing verification, quality assessment, managed care plan network adequacy, grievance procedure, and utilization review model act.	

Sources: Brennan and Berwick, 1996; Blendon, Brodie et al., 1999, pp. 209-228; Butler, 1999, pp. 29-52; Daily Policy Digest, 2002b; Leatherman and McCarthy, 2002, p. 10; Blendon, Schoen et al., 2003; JCAHO, 2003; Marshall, Shekelle et al., 2003; National Quality Forum (www.qualityforum.org).

Performance-based regulatory system

Performance-based regulation⁴⁶ aims to regulate selected measurements of service output and/or process throughputs. For example, 'visitation' in the Netherlands, accreditation in North American, European Foundation for Quality Management (EFQM), and International Organization for Standardization (ISO) are four models used in external evaluation of healthcare (Shaw, 2000). The performance standards are prevailing practice, "More recent standards tend to follow patient pathways and emphasize the interface between management units" (Shaw, 2000). The regulatory process includes: self-assessment; desk appraisal; site visit; reports and evaluation (Shaw, 2000). Usually, public financing for public hospitals uses socially organized quality accreditation (Heaton, 2000). Performance-based regulation is an external regulation approach that involves stakeholders (Schyve, 2000). It has flexibility on output measures. For example, Taiwan considered adopting advanced quality accreditation but with different standards and procedures (Huang, Hsu et al., 2000).

In most OECD economies, a Bismarckian social insurance model exists to uphold social solidarity as a system objective. Social insurance model is to have an agent to act

⁴⁶ Performance-based regulation is used in environment, chemical industry, workplace safety and food

on behalf of the principal (taxpayers) to purchase services. As such purchase is equity-oriented or planned, so it forms a planned market (Arvidsson, 1995, pp. 66-85).

The technical regulatory tools include defining a benefit package and a payment schedule. It involves developing cost-containment measures, setting wage rates, direct management of public hospital, and accreditation (Kokko, Hava et al., 1998, pp. 289-307). Most OECD countries have a public hospital system, – technical regulatory tools are therefore performance-oriented accreditation (EFQM, 2003). Market-oriented economic regulation aims to balance competition (Chinitz, Preker et al., 1998, pp. 55-77), cost sharing (Kutzin, 1998, pp. 78-112), and rationing (Ham and Honigsbaum, 1998, pp. 113-134).

For example, the marketisation approach in Australia includes designing incentives to develop private health insurance topping up tax funded insurance (Fox, 1999; Vaithianathan, 2003), reviewing hospital performance as basis for case mix funding (National Health Ministers' Benchmarking Working Group, 1999, p. 25), and transformation of public hospital into public firms. Bearing in mind that Australia attains its equity objective through the universal Medicare insurance system, the state then aims to gain efficiency through reform on the supply-side⁴⁷.

In summary, for a planned market, a state purchaser is an essential tool to mediate the behavior of public hospitals. With a financing lever, the state can influence provider behavior by selecting contracting, pricing, cost-sharing, and policy program.

industry (Gunningham and Johnstone, 1999; Coglianese and Lazer, 2002, pp. 201-226).

⁴⁷ For example, business operated hospital clusters reform in Victoria state in 1990s, where government has transformed 32 public-owned hospitals into seven independent networks across the Melbourne area. The Hospital Planning Board, a parastatal committee, between DHS and hospital board of directors, guides the reform (Blair, 2002b). DHS oversees two key network decisions: capital investment and terms and conditions of staff. Fixed case-mix payment to hospital still follows Health Services Agreement that specifies annual output and service price. Hard budget constrains create incentive for hospital to improve performance. Competition starts at government's arms-length (Blair, 2002a and b; Corden, 2003, pp. 345-390).

The governing system viewed as regulation in a healthcare system in transition

Management-based regulatory system

Management-based regulation⁴⁸ aims at integrating public objectives into institutional management practice at the planning and operating stages. The potential advantage of management-based regulation is that “it shifts the discretion as to how a regulation is applied in a particular setting to the actor with the most knowledge of that setting - the regulated party” (Coglianese and Lazer, 2002, p. 202). It aims to have a surrogate regulator to internalise technology-based and performance-based regulation at any stage of operation. This thesis argues that the management-based regulatory approach is used in a healthcare system in transition, largely because that market level institutions are not ready, for instance, rule of law and civil institutions to shape the peer review system for clinical practices. Selected examples using management-based regulation are discussed in the following section. For regulation design and implementation, this review highlights the importance of considering norms, regulatory process, and governing structure for a healthcare system in transition, rather than the conventional technical regulation used in established markets.

From internal market to managed market in the U.K.’s hierarchical NHS

Reform in the U.K. in the early 1990s split NHS into two independent legal entities: the Health Authority to commission services; and the self-governing NHS Trust to manage hospital service delivery, – so as to create an internal market. The regulatory tools are: a) the Health Authority uses selective purchase leverage to improve efficiency of NHS Trust services, and the NHS Trust thus has to improve efficiency to get contract⁴⁹ (Ham, 2003, pp. 265-304); b) information disclosure by establishing the National Institute for Clinical Excellence (NICE), Performance Assessment Framework (Marshall, Shekelle et al., 2003; Ham, 2003, p. 294), and the Commission for Health Improvement (CHI); and c) clinical governance.

⁴⁸ Example of use management-based regulation is food safety regulation by FDA in the U.S., where critical control point has been identified as hazards, and hazard analysis is to suggest where management intervention should be applied. Conceptually, Gunningham refers management-based regulation as system-based regulation (Gunningham and Johnstone, 1999). Others regard management-based regulation as enforced self-regulation, or mandated self-regulation (Ayres and Braithwaite, 1992; Coglianese and Lazer, 2002, pp. 201-226).

⁴⁹ Which means “lowering of barriers to entry for other providers, which opened up the possibility of switching providers” (Ham, 2003, pp. 265-304).

As the transaction is managed internally by NHS rather than exchanged explicitly, “command-and control mechanisms continued”- it constitutes a managed market (Ham, 2003, p. 294). Norms seem pivotal in explaining halfway reform in the U.K. (Smith, 1776). The medical professional culture, such as reluctance to be a whistler-blower to disclose information, creates a ‘NHS family’. Collaboration, rather than competition, is preferred in this hierarchical system (Adam Smith Institute, 2003b).

Hong Kong and Singapore: To detach hospitals from administration

In Hong Kong, the Health Authority has been established to manage an autonomous hospital network. Hospitals create their own boards of directors that can levy user charges with limited residual claim right (Yip and Hsiao, 2003, pp. 391-424). The reform in Hong Kong aims to promote efficiency. Singapore has introduced MSA, a social insurance system that has a built-in cost sharing mechanism (Zhao, 2000; Adam Smith Institute, 2003a). It has also established the Health Corporation of Singapore (HCS) that manages almost all hospitals in Singapore. By adding HCS between MOH and hospitals, the hospitals have become autonomous entities (Phua, 2003, pp. 451-484).

Experiences of U.K. and the HPE suggests that the organizational reforms are concerned with accountability, residual claim right, and social function (Harding and Preker, 2003, pp. 23-78) and the statutory approach as basis for corporate governance⁵⁰ is critical for public firms to work on social responsibility. Experience of arms-length governance also involves clinical governance, – that is, accountability of CEO to board of directors representing society in accordance with the statutory objectives of hospitals as corporations, and accountability of CEO representing the hospital to clinical outcome of staff in accordance with hospital by-laws.

From the Semashko model to laissez faire market in CEE and CIS

The Semashko model refers to a healthcare system under a planned economy, where finance, provision and management of health services are all under a state monopoly. Marketisation in CEE and CIS aims to develop social insurance for equity, and to decentralize and privatize hospitals (Jakab, Preker et al., 2003, p. 207). These economies wish to have the state do less. The healthcare system thus evolved into a laissez faire

⁵⁰ Corporate governance is “the means for keeping corporate actions, agents and assets directed at the corporate objectives established by the corporation’s shareholders” (Institute of Economic Affairs (IEA), 2003). For public firm, stakeholders direct corporate objective.

market, which leads to supply-induced demand (Kokko, Hava et al., 1998, pp. 299-303). Tasks of regulation include negotiation and regulating price between provider and insurance, promotion of equity, and development of hospital information systems to monitor performance. The main problems of the regulatory system are: regulator capture; that the health insurance system is a passive reimbursement financial institution without a built-in cost control mechanism; and a lack of regulatory information system for assessing hospital performance⁵¹ (Kokko, Hava et al., 1998, pp. 301-302; Jakab, Preker et al., 2003, pp. 220-221). Hospitals have undergone organizational reform with different presentations: budgetary units, extra-budgetary units, non-profit institution, trust, separate legal entity, or health enterprises⁵² (Jakab, Preker et al., 2003, p. 214).

Table 3-6 Regulatory Challenges in Healthcare system in Transition

Issues	Regulatory tasks	Regulatory challenges
Insurance as reimbursable financial institution	Proactive purchase role for selective contracting	Service definition/payment method; Establishing transaction price
FP nature of NFP hospital and lack of governance	Satisfy social objective	Clinical governance/bylaw; Statutory corporate governance; State regulator/adjudication
Unmeasured performance	Improve effectiveness; Information disclosure	System of norms on information Consumer protection law

Source: Jakab, Preker et al., 2003, p. 234; Jakab, Preker et al., 2003, pp. 220-221.

In summary, regulatory challenges for a healthcare system in transition are: the system of norms as in the case of the U.K.; the effectiveness of the state regulatory system⁵³ and regulator capture⁵⁴; proactive purchasing role (including payment method and pricing); and information disclosure and consumer protection law (see Table 3-6;

⁵¹ For example, in the Czech Republic, due to no legal framework to govern hospital privatization process, it results in privatized hospitals making profits out of publicly funded health insurance. Without financial audit system instituted, hospitals are eager to buy high technology equipment for competition in the laissez faire market (Kokko, Hava et al., 1998, pp. 304 -305). External regulation now is in use to make hospitals accountable for unfunded social functions (Jakab, Preker et al., 2003, p. 229).

⁵² Independent legal entity that is responsible for raising most revenues from user fees.

⁵³ A common problem associated with reforming hierarchical institution is the governance of public institution itself. For example, NHS reform relies on traditional NHS administrative arrangements that prove to be ineffective (Ham, 2003, p. 294), for physicians are culturally firmly entrenched groups (Adam Smith Institute, 2003b). In CEE/CIS countries, reform policy delivery relies on newly elected public officials, yet, the regulatory agents created opportunities for private gains under the name of public interest (Kokko, Hava et al. 1998, pp. 301-302).

⁵⁴ . “There is a tension in the development of the modern state between ensuring that public officials have sufficient power to deliver good governance and ensuring that they are constrained from using this power arbitrarily in the interests of the privileged few” (World Bank, 2001, p. 99). Here it implies procedural order of governance. “The great difficulty lies in this: you must first enable the government to control the governed, and in the next place oblige it to control itself”(World Bank, 2001, p. 99). Transitional economies have to wage two wars: regulate the regulated and regulate the regulator.

Jakab, Preker et al., 2003, p. 234). Social and market institutions therefore matter for regulation.

Developing state and developing market in developing economies

Many of the developing economies are organized within a maximum production frontier because of lack of dynamic efficiency. Due to resource scarcity, planning rather than the market is critical in rationing health resources. Availability, accessibility, affordability and irregularity or informal service provision and finance are the main facets of healthcare systems in developing economies (Kumaranayake and Lake, 2002, p. 79; Development Committee, 2003; World Bank, 2004, pp. 134-142). Planning and market exist simultaneously in developing economies. Transition from public service provision and financing to market-oriented system is visible (Bloom and Standing, 2001; Kumaranayake and Lake, 2002, pp. 78-79; Reid, Pearse et al., 2002, pp. 12-35; Marquez, Sacoto et al., 2003, pp. 533-548; Hussein, Al-Junid et al., 2003, pp. 425-450; Acbouri and Jarawan, 2003, pp. 485-510; Lieberman and Alkatiri, 2003, pp. 511-532).

Under such circumstances, the task of the state regulatory system is to ensure demand-side equity⁵⁵ and to correct supply-side irregularity. Table 3-7 describes the tasks involved in regulating the provider, the organization, and the market along a continuum from very informal to formal in developing economies⁵⁶. The regulatory challenges in developing economies are: to extend insurance to improve horizontal equity; to establish a civil mechanism to regulate quality; and to institute mechanisms to prevent regulator capture (Bloom and Standing, 2001, p. 18).

⁵⁵ There are tiered purchases: formal insurance purchase with nature of NHS structure (Barnum and Kutzin, 1993, p. 229), irregular community financing and individual buying. The marketisation process has led to pluralistic healthcare system (Bloom and Standing, 2001, pp. 1-5). Pluralistic healthcare system has divided into urban quasi-public health insurance system and irregular community financing scheme (Bennett, Creese et al., 1998). The role of regulatory system is to expand insurance to obtain both equity and efficiency; cost-sharing by consumers to obtain efficiency; prepaid capitation to replace retrospective reimbursement of insurance payment; and case-based payment than FFS to diminish supply-induced demand (Barnum and Kutzin, 1993, pp. 255-256).

⁵⁶ The regulation concerns informal practices are quality, price and distribution (Kumaranayake and Lake, 2002, p. 81). Generally, "the most common guarantor of the quality of service provision has been the public health services" (Bloom and Standing, 2001, p. 17); and a majority of entry restrictions for personnel, drugs and equipment have been largely ineffective (Development Committee, 2003). For existing regulatory regimes (Kumaranayake and Lake, 1998): legislation is most effective; focus on inputs regulation rather than organizational or market levels; focus on entry regulation rather than quantity, price and distribution; and the weakest regulation is competition practice and protection of patient right. This is because that there are no market institutions with that to regulate competition practice and consumer protection; there is also no on-going monitoring and evaluation system to ensure accountability (Development Committee, 2003, pp. 7-8).

Table 3-7 Tasks to Regulate the Supply-side in Developing Economies

By levels	Very informal	Informal	More formal	Formal
Provider	Unskilled	Trained	Licensed	High-tech service
Organization	Unofficial	Selling own services	Organized group	Corporation
Market	Black market	Illegal operating	Legal operating	Venture capital

Source: adapted from Kumaranayake and Lake 2002, pp. 78-81.

Regulatory process affects relations on competition, cost and quality

The above review of regulatory approaches suggests that clinical governance, corporate governance, and public governance systems are integral elements for effective regulation for a healthcare system in transition. The next section argues that regulatory process affects relationships between competition, cost and quality.

Economic theory holds that the market enhances efficiency, and so reduces cost. However empirical evidence shows that, for a planned market system, healthcare system cost escalation relates to aging, technology use and rising expectation (OECD, 2003). For a regulated healthcare market, a survey of fifty U.S. health economists revealed that, 81% have accepted that "the primary reason for the increase in the health sector's share of GDP over the past 30 years is technological change in medicine" (Fuchs, 1996, p. 227). Therefore, technology is a key to competition.

To date, there is little evidence to suggest that competition leads to quality improvement in healthcare (Thompson, 1998). Often the issue is "...not just the measurement of quality outcomes but also their management into practice" (Maynard, 1998). Separation between management process and clinical process cannot obtain quality improvement. Quality improvement "requires cost-quality oriented performance targets with incentives (e.g. reaccreditations and appraisal)" and labor relations in terms of goal setting and motivation (Maynard, 1998). A lesson from the U.S. and the U.K. is that: "poorly regulated competition, in public and private organizations, can distort processes and deliver inefficient outcomes" (Maynard, 1998).

For the regulated market in the U.S., "the bewildering and ethically dubious financial and managerial systems... to foster continuous quality improvement in their healthcare may be self-defeating in the end (Reinhardt, 1998)". Thus its underpinning financial and management systems have counteracted draconian persistence for clinical excellence, as the later is in essence a market-based system. The trick is that the U.S. uses private

contracts as instruments for regulating the market, which means to use private money managing the delivery of public good (Havighurst, 1995, pp. 29-88).

For the planned markets in most OECD countries, “competition represented a way of managing resources constraint in an increasingly complex and demanding political environment; ideas about quality were marginal to their purpose... competition is only made effective by new forms of managerial direction. Across systems [of OECD countries], competition appears less clearly associated with quality than with political control” (Freeman, 1998). “What economists refer to as transaction costs – the administrative costs of contracting and billing and information systems on which they depend – mean that the efficiency gains of competition are used to sustain the system of competition itself, rather than becoming a source of either savings or investment in expanding services and quality improvement” (Freeman, 1998).

For a healthcare system in transition, cost saving is concerned with institutional efficiency. The reform is related to determining ownership and residual claim right, to decide on institution operation objective. However the management and financial systems change leads to decreasing quality at merely pursuing cost-efficient clinical practice. Therefore, cost-efficient clinical practice converts to quality compromise clinical practice under the stimulus of financial incentive when marketisation takes place. In developing economies, healthcare systems are not fully organized. Quality initiative largely focuses on quality assurance, such as pilot accreditation and provider performance measures; there is less evidence linking the market with quality for there is no market yet in developing economies (Nicholas and Silimperi, 2002).

Therefore, in both established markets and healthcare systems in transition, the regulatory process affects the competition, quality and cost. The governance system is critical for effective regulation of a healthcare system in transition.

Summary: How to design and implement regulation for transition

This chapter has reviewed the difference in regulatory approaches between established markets and healthcare systems in transition. In established markets, it is argued that the government should create orderly competition by enforcing rules in a failed market, so to protect consumers against provider monopoly (Pauly and Berger, 1999, pp. 53-74; Altman and Rosman, 1999; Zelman 1999, pp. 5-28); and government should bear the social objective by providing essential care (Gage, 1999, pp. 282-298). The regulatory system is further divided depending on the market characteristics. For a

regulated market, the basic regulatory instrument is the contract. The technology-based regulatory tools aim at regulating market function, mainly on quality, information and competition practice. For a planned market, the performance-based regulatory instruments are purposive financing through selective contracting and policy program, and performance review on public hospitals.

For the healthcare system in transition, the regulatory system faces more challenges in establishing the system than in implementing regulation. Therefore, this study argues that management-based regulatory approach is preferred in managing transition with anticipation that there will be the steady improvement of market institutions. For example, in transitional economies, the challenges are: to develop a pro-active purchase role through establishing a price and payment system, and incentives for hospitals benefiting from competition in the market but also balancing hospital's accountability for their social function; and addressing cost-quality regulation by establishing information systems to monitor institutional performance. For developing economies, the challenges are: equity and irregularity of service provision and financing; lack of system-based information system; and regulator capture.

This review provides the basis for the design and implementation of regulation in a healthcare system in transition. It argues that the corporate governance and public governance systems are essential to assure effective regulation. Furthermore, the arms-length governing mechanism is critical to assure attainment of the social objectives of the NFP hospital sector. Increasing finance to assure equity and clarity of governance arrangements are prerequisites to instituting regulatory system in transition.

In addition, regulatory process concerns underlying relations between competition, cost and quality. Under system-based health provision and marketisation, the four market entities - doctor, consumer, purchaser and health department- use quality differently: the doctor uses clinical definition, the prevailing practice; the consumer uses responsiveness of doctors' services; the purchaser uses cost-effectiveness or value for money; and the health department uses social optimum/social efficiency (Leatherman and McCarthy, 2002, p.10). Because of cost-quality compromises under competition, cost-quality regulation therefore emerges, for instance to translate professional clinical standard into legal standard in contract-based regulated market in U.S. (Havighurst, 1995, pp. 110-156), and to translate measurable performance indicators in performance-based planned market in most OECD countries. The concept of quality therefore concerns management practices, which in turn affect clinical practice. The managerial and financial system is therefore also critical in design and implementation of regulation for transition.

In conclusion, the conceptualization of regulation design and implementation for a healthcare system in transition needs to consider healthcare market characteristics, the role of the state and regulatory system objectives, regulatory process and the existing governing system (see Table 3-8). However the governance system is embedded in social institutions in the particular society. The critical role of social institutions in relation to compliance is presented in the next chapter.

Table 3-8 Regulatory Issues and Approaches for Healthcare system in Transition

Healthcare system	Key regulatory issues	Market governing approaches
<u>Healthcare system in established markets:</u>		
Regulated healthcare market	Market structure and function	Use contract regulating quality/information
Planned healthcare market	Financing, performance	Use financing regulating performance
<u>Healthcare system in transition:</u>		
Managed healthcare market	Contestability	Corporate governance/clinical governance
Laissez faire healthcare market	Provider irregularity; Social pooling based financing	Institution centered, management-based; Instituting system-based regulatory process
Developing healthcare market	Provider irregularity; Social pooling based financing	Institution centered, management-based; Instituting system-based regulatory process

CHAPTER FOUR

NORMS AND SOCIAL INSTITUTIONS

Today, China has emerged as a country mixing tradition with modernity. Although China has shifted to a market-oriented economy, yet it still remains a hierarchical social governing system. China aspires to rule of law through reliance on the Constitutionalism in transition⁵⁷; yet there is no social agreement on the direction of reform. Therefore, China's policy-making is controversial amongst different strata of social groups due to mixed norms, judgment, and thus choices of reform options⁵⁸. China's policy implementation is compromised by low social capital for compliance, lack of law enforcement to contain opportunistic behavior under brutal capitalism, and absence of trust in relation to state regulatory system that is itself in transition. Therefore, an understanding of the complex process of social transition sheds light on the preconditions for regulatory policy-making and implementation. This study argues that regulation is about both rules and norms, and regulation implementation requires alignment between rules set forth by the regulator and norms held by individuals, which is in turn informed by social institutions that are embedded in history and culture.

This chapter presents the theory of social institutions that explains the relationship between the predisposing factors, i.e. culture, social structure, and social routine, and the mediating factors, i.e. system of norms, regulatory system, and compliance system. Social institution theory offers a way of understanding how the predisposing factors affect the mediating factors and vice versa. It helps to understand barriers to policy making from the perspective of the social and culture arena, and to anticipate the problem of policy implementation with respect to the diversified norms individuals held during transition. The transition is therefore a compromised process of policy implementation. With social institution theory, this chapter explores factors affecting the reach of social agreement – i.e. barriers towards compliance. The review finds that: there are mixed norms during transition – tradition and modernity coexist, therefore social capital is weak towards

⁵⁷ See Buchanan, J. and G. Tullock, the *Calculus of Consent: Logic Foundation of Constitutional Democracy*. The University of Michigan. 1962. (Translated into Chinese in 2000, China Social Sciences Publisher. pp. 208-218).

⁵⁸ The debate on reform in China is divided by liberals and New Leftists in the 1990s on how to reform the society while keep the tradition. See, *Thinking: China's "New Leftists" and Their Influence*, edited by Gong Yang, 2003, China Social Sciences Publisher, Beijing.

compliance when brutal competition exists; and a compulsory compliance system is ineffective eradicating the opportunistic behavior. It concludes that trust and a credible public governance system is critical to the formation of social agreement (Ding, 2004; Howell, 2004, pp. 1-7). Therefore reform of the regulatory system needs to build trust.

The chapter is structured as a snapshot on rules, norms and compliance, and issues concerning rules, norms and compliance in transitional China. It also discusses reform of ‘public identity, private behavior’ institutions.

Snapshot on theories about rules, norms and compliance

From self-restraint advocated by Confucius to follow the order of the king, from Machiavelli’s politics to governance of modern states, the principle about how to rule has evolved and so were the system of norms and methods to acquire compliance (Figure 4-1). Donahue suggests that civilization is underpinned by accountability (Donahue, 2002, p. 1). Without accountability, there is no compliance; without civilized rule, there is revolution. The Glorious Revolution, American Revolution, French Revolution, Russian Revolution, and China Revolution, were all fights for new rules.

<u>Originator</u>	<u>Theory</u>	<u>Paradigm</u>	<u>Rule principle evolution</u>
Confucian	Confucianism	Self-discipline	Son of Heaven
Machiavelli	“The Prince”	Politics	Crown order
Marx	Social class	Ownership	Capital
Weber	Bureaucracy	Rational	Knowledge
Neoliberal	Neoliberalism	Equity/efficiency tradeoff	System performance
Buchanan	Constitution economy	Choices within rules	Cooperation
			Norm
			Social capital



Figure 4-1 Relationships between Rule, Norm and Compliance

Marx regarded rules as mechanisms of physical and ideological control of the dominant capitalist class over the working class (Marx, 1966; Marx and Engels, 1967;

Josephs, 1990, p. 28). Breaking old rules needs to bring about new rule by socialism, i.e. where social equality prevails and justice upholds through public ownership of capital. For Marx, capital makes rule, for money speaks.

Weber's bureaucracy theory implied rules as rationality (Weber, 1969; Zhang 2002, pp. 33-82). For Weber, rationality underpins social choices (Mills and Murgatroyd, 1991, p. 16). Instead of class analysis, Weber borrowed Chinese bureaucracy system for social analysis (Weber 1995, p. 87; Zhang, 2002, pp. 80-87). Weber held that a rational economic person's behaviour aims to maximize economic interest, yet rational calculation depends on knowledge. Therefore, for Weber, knowledge makes rule, for knowledge is power (Parsons, 1995, p. 45).

The concept of capital and knowledge as rule-creating instruments has been supplemented today, with a new concept of social capital, which is "an instantiated set of informal values or norms shared" among groups to cooperate (Fukuyama, 2000, p. 98). These groups of persons will "in turn affect the rules and values of societal actors" (World Bank, 2001, p. 150). Such interaction would eventually influence formal social institutions. Procedurally, social institutions always start with informal social norms and networks, then obtain general social acceptance through advocacy and stewardship, and eventually formalize into formal rules and institution (World Bank, 2001, pp. 151-160). Therefore, shared norms lead to the build-up of social capital, and the increase of compliance to rules, i.e. the formation of social agreement towards new social institutions.

Both informal and formal rules become essential elements of social capital that relate to cooperation and trust among peoples, the basis for rule compliance and market exchange (Fukuyama, 2000, p. 105-106). Transaction cost is therefore reduced.

"... 'new institutionalism' is built around the observation that rules and norms are critical to rational economic behaviour. ... Douglass North labels an "institution" is a norm or rule, formal or informal, governing human social interactions. ... norms are critical for reducing transaction costs; if we did not have norms, for example, requiring the respect of property rights, we would have to negotiate ownership rules on a case-by-case basis, a situation that would be conducive neither to market exchange, investment or economic growth" (Fukuyama, 2000, p. 105).

However the debatable point is who can claim the residual value after production. Capitalists would argue for private ownership; socialists would argue for public

ownership; while market socialists would argue for social ownership⁵⁹. The debate lies in what is equitable rule making. The answer to such a question is a value judgment. Lyotard, a French epistemologist, has described neoliberal view:

“Rights do not flow from hardship, but from the fact that the alleviation of hardship improves the system’s performance. The needs of the most underprivileged should not be used as a system regulator as a matter of principle: Since the means of satisfying them is already known, their actual satisfaction will not improve the system’s performance, but only increase its expenditures. The only counter indication is that not satisfying them can destabilize the whole” (Lyotard, 1989, p. 63).

The above epistemological view implies that choices have to be made within rules, that is, the subject Buchanan names as constitutional economics (Buchanan, 1990). The constitutional economics’ cooperative perspective implies reliance on trust, – that is, social capital - for cooperation. Such cooperation forms the basis of constitutional rule.

Yet the social reality is divided in applying constitutional rule. Voluntary compliance depends on shared norms, that is, the social capital⁶⁰. To have high voluntary compliance means to reach high social agreement where informal norms convert to formal norms. The relationship between formal norms (hierarchically generated) and informal norms (spontaneously generated) in relation to rationality is illustrated in Figure 4-2 (Fukuyama, 2000, p. 106).

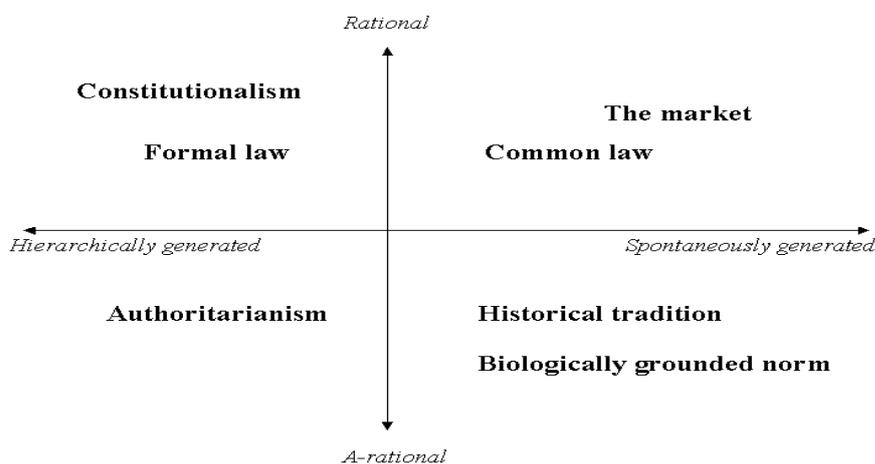


Figure 4-2 The Universe of Norm (Source: adapted from Fukuyama, 2000, p. 106)

For developing economies, norms are characterized by irrational historical tradition and hierarchical structure; while norms in established economies are characterized by

⁵⁹ Defined as public ownership of production capital; private ownership of residual value (Yu, 2003a).

⁶⁰ For persons share common norm behave socially similar (Fukuyama, 2000, p. 98).

spontaneously developed market norms, and constitutionalism (Brook and Frolic, 1997). Thus according to new institutionalism, transition from developing economies to established economies involves norm and rule adaptation. Tradition and sentiment have to be subordinated to rationality.

Figure 4-1 indicates that, in contemporary world, the rule principle evolves from Son of Heaven, to capital, knowledge, system performance and cooperation. Figure 4-1 and Figure 4-2 indicate that for transition to a market-based system and to achieve social agreement, rules should be based on shared norms to achieve cooperation. Informal norms should be formalized and tradition should be subordinated to rationality.

Social institution theory explains the relationship between norms and compliance in a broad social context, where norms are embedded in culture and compliance is embedded in routine as explained in Table 4-1 (Scott, 1995, p. 52). Yet norms and compliance can be mediated by rules. The social institution is therefore a man-made constraint on human relations (North, 1990, pp. 2-6). This understanding therefore shed light on the importance of regulation design in the study. As the concept of mediation under social institution theory is close to the concept of governance system, either public governance or private governance (Messner, 2002, p. iii; World Bank, 2003), the norms (or normative mediation) and rules (or regulative meditation) are therefore important factors for the change of social institutions.

Table 4-1 Social Institution Theory: Influence on Predisposing and Mediating Factors

<u>Predisposing Factor</u>	<u>Mediating Factor</u>	
	<u>Regulative mediation (rules)</u>	<u>Normative mediation (norms)</u>
Culture	Rules and laws	Norms
Social Structure	Governing system	Authority
Routine	Protocol, Procedure	Compliance

Source: adapted from Scott, 1995, p. 52.

In the case of failed voluntary compliance, the design and institution of a compulsory compliance system is an alternative. Figure 4-3 depicts the compulsory compliance system. It follows the order of providing information, noticing, dialogue and persuasion. If these measures fail, then regulatory measures escalate to a deterrence design: prohibition, regulation by public warning, fines, de-licensing and shaming. If these measures fail, regulation then comes to a harsher stage: decapitation. This includes dismissing and criminal penalties, such as jail. An effective compliance system concerns transparency, accountability and credibility of public institutions (Braithwaite and Levi, 1998).

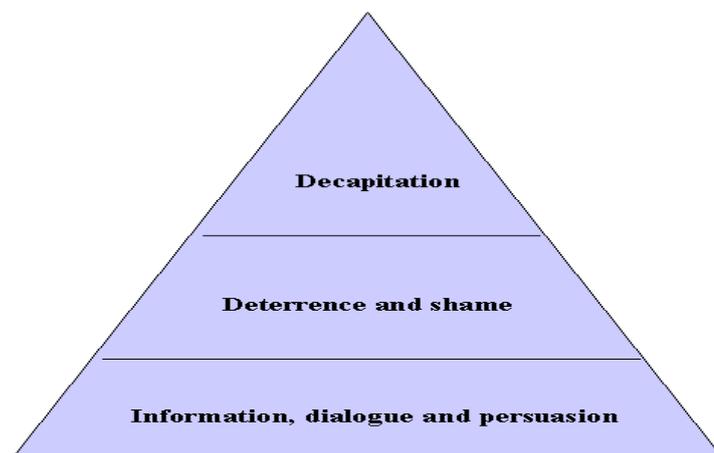


Figure 4-3 Escalation of Enforcement Force (adapted from Braithwaite, 2003)

In summary, social institution theory suggests that rules and norms evolve with time. Now the fundamental regulatory principle is trust. Trust can promote social capital for voluntary compliance. Distrust can trigger violence and revolution. In modern times, regulation aims to institute distrust (deterrence force) in order to trust. Alternatively, to build social capital is to form generally accepted rules, and social capital reduces transaction cost. In an ideal world with high trust, the transaction cost is zero, that is, no regulation is needed. Norm, social capital and deterrence force therefore constitute the basis for a rule-abiding market-based governing system.

Compliance with respect to social institutions in transitional China

Historically, China is known for its centralized bureaucratic administration and Confucian ethical philosophy. Today, although the economic reforms move cautiously for fear of social instability, China is reforming its state institutions and governance (Howell, 2004, p. 3, pp. 58-76, pp. 97-120). China is innovating at the margin of tradition (Sheng, 2003). For instance, the advocacy for its 'new ethics', that is, the integration of Greek rationality with the Chinese universalism (Sheng, 2003, pp. 209- 315), and its embracing of the outside world through accession to the WTO. Between an increasingly liberalized economy and partially reformed policy-making framework (Howell, 2004), China has created four system of norms associated with four voices, – communism, socialism, capitalism and feudalism (Lin and Ma, 1999). The liberalized economy has brought China income-related social stratification (Lu, 2002), and the partially reformed policy yet faces with the problem of the legitimacy of state organs.

The existing governing structure in China includes the CCP, and their Discipline Inspection Committee, the Political Consultative Conference, the State Administration,

NPC and legal systems that include the procurator's office and court. Most of these structures are mirrored at different levels of government. Such structure forms the legal and institutional basis for public governance across the country⁶¹ (Table 4-2). According to Legislation Law (see Appendix E, Law 9), the State Council has the mandate to formulate administrative ordinances, local governments also have the mandate to formulate administrative regulations in accordance with local circumstance and consistent with national administrative regulations.

Table 4-2 Public Governing Structure in China

CCP & Discipline Inspection Committee	Political Consultative Conference	State administration	People's Congress	Legal system
Central Committee	Central Committee	State Council	NPC	Supreme Court, procuratorate
Provincial committee	Provincial committee	Provincial government	Provincial People's Congress	Provincial court, procuratorate
City committee	City committee	City government	City People's Congress	City court, procuratorate
District committee	District committee	District government	District People's Congress	District structures

The crux of matrix institutional structure lies in the dual accountability system. The vertical accountability system or sector leadership headed by ministerial ministries is accountable for sector policy and program development and promulgation of administrative regulations and directives. The horizontal accountability system or territorial local governing administration headed by local governing bodies is accountable for comprehensive local social and economic development policies and programs. The State Council has the mandate to issue ordinance and decrees to the line ministries and local governing bodies in coordinating the national development policies across the regions and sectors. The line ministries have the mandate to issue administrative regulations and directives to their affiliated institutions at the local level. Similarly, local administrations have the mandate to issue local administrative regulations and directives for the localities. Issues of conflict in relation to national policies and directives most often arise in the matrix, as the national and local development priorities are sometimes different and even colliding⁶².

⁶¹ Government organs in urban China consist of four levels of administration: national, provincial, city and district. The highest body of the state is NPC, the highest executive organ or state administration is State Council. Within the State Council, there are line commissions, ministries, special committees and administrations and other ad hoc organizations and offices.

⁶² According to Article 82, Chapter V Application and Memorandum in the PRC Legislation Law 2000, equal effectiveness held between sector directives and local government directives.

The hierarchical matrix is fragmented, and has created a gridlock of policy development and implementation. Lieberthal and Oksenberg (Lieberthal and Oksenberg, 1988) argue that negotiation is the prevailing practice to overcome fragmentation of policy delivery. At this point, culturally defined parameters, such as informal social norms in dealing with negotiation surface in the formal governing system, which in turn influences the scope and potency of policy impact. This is a structural constraint against moving toward a rule-based administrative system.

In addition, social capital is weak during transition. The informal social routine⁶³ leads to: risk uncertainty; high transaction cost and high institutional costs⁶⁴; and high informal costs such as tax evasion⁶⁵ (Robert and Alan, 1998, pp. 129-143), which is a major barrier for market development (World Bank, 2001, pp. 171-180). Culturally, China has under-developed legal institutions⁶⁶ (Werner, 2000, p. 526), which lead to customary practices of internal rule⁶⁷ and *guanxi*⁶⁸. Both internal rule and *guanxi* originate from static culture, see Table 4-3 (Harrison, 2000, pp. 296-307).

Table 4-3 Comparison of Progressive Culture with Static Culture

Attributes	Progressive culture	Static culture
Meritocracy	Merit advancement	Connection
Community	Society perspective	Family perspective
Justice	Universal impersonal	Personal advancement
Authority	Horizontality	Verticality

Sources: adapted from Harrison, 2000, p. 299.

Therefore, at the time of transition, because of an evolving system of norms and weakening social capital, even the harsh compulsory compliance system could not deter the violation of rule of those in power to pursue opportunistic behavior (Table 4-4). The study reveals that 66.23% (51/77) of the leading experts in China worry that social crisis might take place out of social distrust before 2010 (Ding, 2004).

⁶³ Those informal rules and networks exist in the society. (World Bank, 2001, pp. 171-180)

⁶⁴ Defined as payments made by market participants to institutions to allow them to operate in the market (status costs), and to encourage favourable institutional action (influence costs or rent-seeking).

⁶⁵ He has discussed rare high cost of Chinese enterprises as high legal cost (registration cost, review and approval cost, lobby cost, graft cost, appropriation cost, formality cost, and cost for fair legal treatment) and high information cost (useless data, inaccurate data, outdated data and wrong data) (He, 2002).

⁶⁶ China's legal system development is rather late: the first Penalty Law promulgated in 1979, the first Civil Law promulgated in 1986 (Appendix E).

⁶⁷ Wu Si has discovered that "...Behind various specified written circulars, directives and regulations, and out of kinds of formal institutions, Chinese society actually exists an unwritten but widely acknowledged rule, something called internal rule. It is exactly such something, rather than highly decorated and officially pronounced formal regulation that controls real life" (Wu, 2003, p. 2).

⁶⁸ *Guanxi* meanings: reciprocity between individuals and/or organizations and rent seeking: use of

Table 4-4 Chinese Senior Leaders Punished: Selected Years

Seniority level	1993-1995	1996-1998	2000	2003
Div. Director	11201 (3734)	17810 (5937)	4146	5471
Dept. Director	943 (314)	1463 (488)	331	1360
Minister/governor	17 (6)	32 (11)	21	24
Average/year	4055	6436	4498	6855

Sources: Zhang and Lin, 2001, p. 428; Luo, 2003. Parenthesis is for one-year average.

In conclusion, faced with crisis of trust, political reform becomes the number one factor affecting social and economic development in the next decade⁶⁹ (Howell, 2004, p. 31). As shown in Table 4-5, Political reform in the Chinese context means increasing inner-party democracy, changing the functions of government organs, managing well between party and state (Qing, 2003, p. 132), and reforming the CCP as proposed by Hu Angang (Lawrence, 2002). Overall, norms are evolving during transition in China, social capital is low, and so is compliance. As trust concerns the credibility of state regulatory system, the future China thus lies in reforming state institutions (Ding, 2004; Howell, 2004, pp. 1-7).

Table 4-5 Relation between Party and State as Key Elements of Political Reform

Rank	First Semester		Second Semester		Third Semester	
	2001	2002	2001	2002	2001	2002
Change functions of government organs	21.6	24.1	19.6	9.8	41.2	33.9
Manage well between party and state	30.4	13.5	12.7	6.8	43.1	20.3
Increase inner-party democracy	23.5	33.8	15.7	15.8	39.2	49.6
Promote term system for cadres	4.9	5.3	8.8	18.0	13.7	23.3
Improve decision making system	6.9	6.0	10.8	11.3	17.7	17.3

Source: Qing, 2003, p. 132.

Reform ‘public identity, private behaviour’ administrative institutions

This thesis argues that state corporatism is the institutional root of rent-seeking which diminishes public trust in the state regulatory system, and that ‘public identity, private behaviour’ is also the result of state corporatism. Therefore, any regulation design and implementation must take reform of state corporatism.

The gradual formation of local governance has generated ‘self-governance’ model (Figure 2-2; Box 2-2), which leads to brutal competitiveness and declining morality (He,

public resources for private gains.

⁶⁹ “A recent survey of provincial departmental (director general) level cadres studying at the Central Party School asked about the primary factors influencing economic and social development” towards 2010,

1998). The fiscal and administrative decentralization has created local government competition for local state property rights⁷⁰. Consequently, local state corporatists have captured local state institutions and pushed for entrepreneurial and networked behavior to maximize 'local property rights' out of unregulated premature market institutions. State-led market development policy has created an unsolved issue of property rights at the first stage reform, for the state has never clearly separated property rights between local governments and its affiliated institution. The state uses public assets to maximize benefits that may accrue to private hand- this is regarded as a pitfall of the decentralization program (He, 1998). Therefore, there are calls to use an ethical hand to remedy the incapable state hand and the invisible market hand (Li, Mu et al., 1999, pp. 155-170) and to create 'new ethics' dealing with declining morality, as starting point for state institutional reform.

The role of the state under market socialist China is construed as developing a market within the framework of socialism (Jiang, 2002). The key of market socialism lies in ownership reform (Xinhua News Agency, 2003c). The reform objective aims towards mixed social ownership⁷¹ (Yu, 2003b). The basic theory of market socialism is that, upon clarity of property rights, a public firm should be an independent economic entity that is detached from state control, labour and capital are left to the market to allocate (Yu, 2003b). Also, market socialists have proposed three guiding principles to correct market failure: social ownership to realize equality; establishment of democratic political system to protect economic freedom (Xinhua News Agency, 2003c); and state stewardship for market development.

Market socialism theory has shifted orthodox Marxist philosophy to conceive the state as a mediator for economic development. The concept of traditional Weberian hierarchical state has waned and replaced by a theory of new public administration to guide the policy practice (World Bank, 1997d, p. 1; UNDP, 1999, pp. 6-8). For example, governments have retreated from direct economic production, have contracted-out and split financing from direct service provision. Chinese market institutional development is accelerating in this direction⁷² (Mao and Li, 2003).

“the cadres overwhelmingly chosen political structural reform” as number one factor (Howell, 2004, p. 7).

⁷⁰ “the central bureaucracy, severely weakened in the throes of the Cultural Revolution, quietly acquiesced to the shift in the economic power away from the center (World Bank, 1997a).

⁷¹ Mixed social ownership: State and cooperatives ownership under public ownership, and individuals have right to own dividend, but individual income is separated from firm's capital.

⁷² For example, central local fiscal tax separation policy in 1994, policy statement “to rule to the country according to law and to rule the country based on ethics, and policy development to reduce regional disparity, and to increase central mediation for socially coordinated development, and human-based

The decentralization under the first stage health reform generated state corporatism that brought about cross contamination between state hand and market hand. The rule according to law under the second stage health reform has to remedy the cross contamination by clarifying property rights⁷³ - detaching hospitals from health departments. It means the hospital should be governed under a corporate governance system, and the health department should be governed under public governance system in accordance with administrative law. The governance reform therefore aims to apply rule of law as illustrated in Figure 4-4.

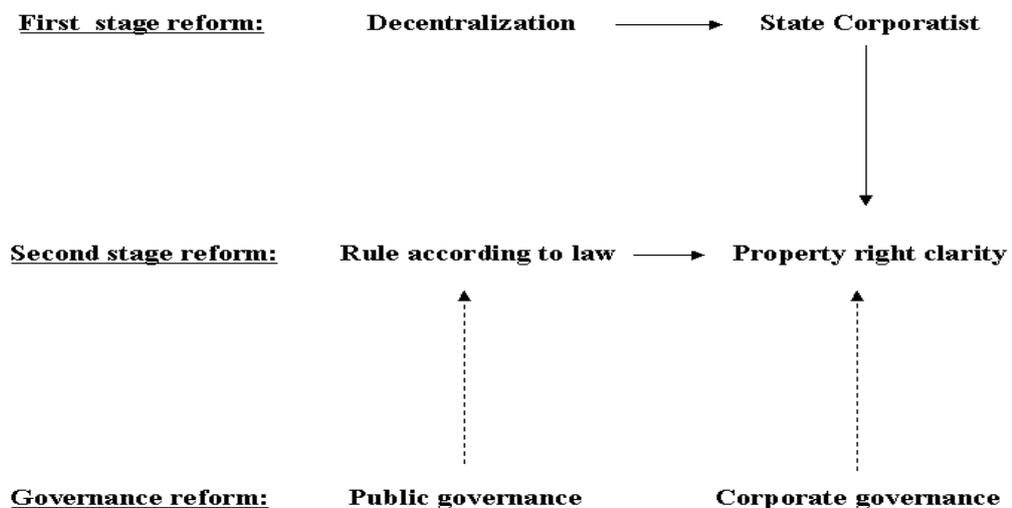


Figure 4-4 China Policy Practice: From Decentralization to Governance Reform

With ‘small state, big society’ and ‘rule according to law’, the state regulatory system is in transition towards rule-based administration (see Appendix E, Law 13). The state has also reoriented the administration function by reducing administration approval power (Zhu, 2003), for example, by establishing the Food & Drug Administration for legal standard setting (Xinhua News Agency, 2003a), by establishing the HIC for market inspection and Government Information Disclosure Ordinance to constrain the state (Wang, 2002), and by rectifying alternative regulators, such as Hospital Management Association (HMA) and Physician Management Association (PMA) (Liu, 2002, p. 31).

development (Hu, 2003, pp. 1-5).

⁷³ Property right is to solve issue of tragedy of the commons (Hardin, 1968, pp. 1243-8). Hardin imaged an unmanaged pasture, in which case many herdsmen tend to overgraze without any external constrains; overtime pasture is unsustainable to many aggressive herdsmen, many herdsmen are therefore the losers of their own aggressive effort. The solver is to assign property-rights for each of them, once a right is created, the owner will maximize utility for it has created market value.

With accession into the WTO, China is promoting the development of a transparent and accountable state, rule-based market and self-restrained civil society. China therefore aims at developing a modern society, where state, market and civil society coexist, so as to sustain stable social development (Brook and Frolic, 1997b). Figure 4-5 Illustrates the concept of social change that originates from a hierarchical governing system.

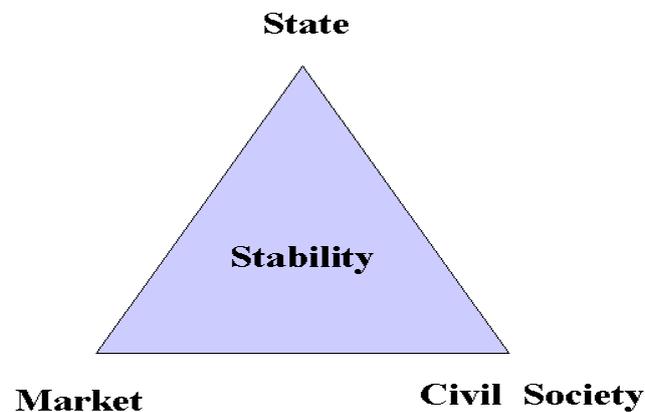


Figure 4-5 Modern State and Social Stability

Summary: Compromise of regulatory effectiveness lies in social institutions

By taking a snapshot of some key concepts on rules, norms and compliance, this chapter aimed to identify issues for non-compliance for China in transition, so to assist regulation design and implementation. It has found that split system of norms, weak social capital, and opportunistic behavior in transition are the major barriers for reaching social agreement, and that reform on 'public identity, private behavior' public administrative institutions is the way forward for obtaining public trust and credibility of the state regulatory system.

Theoretically, compliance requires shared norms and enforcement. For transitional China, because of economic and social change, the income-stratified population does not uniformly share common norms. This therefore reduces the social capital to comply with state regulatory policies. Furthermore, due to state corporatist policy practice, rent seeking is rampant, for its benefits far outweigh the possible punishments, and the enforcement system fails to deter the opportunistic behaviour adopted by the state regulator. Public distrust of state institutions therefore becomes a key issue of governance failure (Ding, 2004).

At the time of accession to the WTO, a new governance framework is emerging for healthcare in China. There is a prospect for reshaping the state and making a mixed public/private market. New policy statements suggest that for the second stage health reform, governing structure reform to rule-based management is to replace state corporatist practice – state hand and market hand are to be separated.

This chapter has reviewed the importance of norms and social institutions with respect to compliance, and the use of enforcement force to deter opportunistic behaviour. These are challenging issues for China's transition to a market-based system. They may be among the most critical factors in achieving a successful transition, for they are about the conditions concerned with rule of law. For "the rule of law is more than putting the government's words into public codes; it fundamentally concerns a relationship between the government and markets that is appropriate for making a credible commitment" (Qian, 1999, p. 41).

"History also suggests that both market and state operate more successfully in civic settings. Social capital and trust, common standards and networks can improve the efficiency of society by facilitating co-ordinated action fostering partnerships of various sorts" (Lewis, 2001, p. 73). These complex rules and their associated networks are important instruments for facilitating compliance. It is apparent that there are neither one-off solutions nor quick fixes to these challenging issues. The fundamental principle is that the state has to reform its institutions to allow these new relations and procedures to develop to compensate for the diminishing role of the state, while ensuring stability of the society. As a saying in Chinese, the 'attitude decides everything'.

Therefore, the state has to coordinate a development strategy and carry out a people-centered development policy credibly to win the public trust (Hu, 2003). It further has to anticipate that the policy impact will be compromised as norms are not shared uniformly (Shan, 2002). The effectiveness of policy is therefore compromised and the cost of regulation increases socially and economically. The perspective of social institutions' influence on rules, norms and compliance informs the design of the research approach and methodology that are discussed in the next chapter.

CHAPTER FIVE

RESEARCH APPROACH AND METHODOLOGY

Chapter two has demonstrated that, the management and financial systems contribute to high cost, high volume competition; and the fiscal decentralization policy and the self-governing healthcare system have shaped the management and financial systems. Chapter three has concluded that corporate and public governance system is the premise for regulating competition for economies in transition. Chapter four has explained that regulation compliance requires both shared norms and an enforcement system. Establishing the above concept has informed the research approach.

As stated in chapter one, the key research question is what are the tools to regulate excessive entrepreneurial behavior of the provider and how can a reasonable balance between equity, quality and cost be achieved in the mixed public/private market? This chapter describes the research methodology used to study this question. It is organized in the order of research question and framework, methodology, research strategy and analytical method, and data collection and analysis.

Research framework and research question

The research aim

Problems arising from the first stage health reform were cost escalation and deteriorating quality that were arising from the self-governed hospital, as hospital management and financial systems changed to cost-recovery and managerialism. It has led to excessive entrepreneurial behaviour. The main objective of the second stage health reform was to provide quality services with cheaper cost. The reform requires that: providers follow clinical protocols (to attain quality); hospitals are classified into FP and NFP hospitals from self-governed public hospitals (to attain efficiency); and new governance arrangement be introduced between hospitals and health departments (arms-length governance arrangement) along with the development of a demand-side policy purchaser mechanism (to attain equity).

The research aim, therefore, is to consider how to effectively regulate the excessive entrepreneurial behavior that has emerged from the first stage health reform, given the

immature institutions of the state, the market, and the civil society. In order to ensure that reasonable cost, quality and equity can be assured in the emerging market-based Chinese healthcare system, equity, efficiency, effectiveness and compliance become the four key parameters for considering effective regulation.

Development of research framework

The goal of the second stage health reform is in essence to construct a mixed public/private healthcare market which can attain both equity and efficiency objectives (see Figure 2-5). The design and implementation of regulation need to reflect policy goal on one hand and link to existing social institution on the other hand. For example, can technical regulatory tools⁷⁴ used in established economies be used in China? What is the regulatory process used in different cities in China? And what is the governing structure existing in China?

The second stage health reform faces two issues: financing and regulating health services in the marketplace (Liu, Liu et al., 2000; Killingsworth, 2002; Liu, 2002), and holistic understanding and response by all stakeholders in implementing the changing (Li, 2001). For a decentralised healthcare system where demand-side institutions are less developed, how to build supply-side regulatory mechanisms responding actively to supply-side moral hazard is of central importance for China's health reform. This is especially the case when a self-regulated hospital industry is formally recognised as NFP sector, the medical profession is now a business, and hospitals operate with market incentive far outweighs professional ethics (Wu, 2002).

The research questions therefore are:

- a) What are the key drivers behind the excessive entrepreneurial behavior in the transition to a market-based governance system?
- b) What are the technical regulatory tools to regulate the behaviour?
- c) What are the institutional and structural issues that may limit/enhance the effectiveness of the technical regulatory tools? And
- d) What are the optimal means to achieve cost containment, quality, and equity towards a mixed public/private market in 2010?

⁷⁴ The technical regulation is to act upon either healthcare system inputs or healthcare system throughputs. Healthcare system inputs are personnel, facilities, equipment and medical supplies, information and public money. Healthcare system throughputs are health services quantity, quality, price, distribution and information. Regulation can also act at organization and market levels (Kumaranayake and

Therefore, technical regulation, effective management and financial process and their associated governing structure constitute the research framework (see Table 5-1). For transitional economies, regulating relations between cost, quality and competition is a challenge as management and financing systems and governance system all evolve (see Figure 1-3). Thus, the research context is embedded in the dynamic social transition.

Table 5-1 Research Framework: High Cost, High Volume Competition vs. Regulation

Level of issues	Policy objectives	Regulation hierarchy
<u>Research question B.</u> Market regulation	Equity and efficiency \leftrightarrow ↑	Technical regulatory tools ↑
<u>Research question A.</u> (quality) excessive entrepreneurial behavior	Internal\external audit \leftrightarrow ↑	Management and financial systems (process) ↑
<u>Research question C.</u> Institutional barriers	Institutional reform \leftrightarrow ↑	Corporate governance (structure) ↑
<u>Research question D.</u> Optional means: (norm)	Social agreement \leftrightarrow	Compliance system (norm and enforcement)

Note: Vertical arrows indicate the bottom-up interrelatedness between the levels, while horizontal arrows indicate the relations between policy objectives and regulation hierarchy.

Methodology, research strategy and analytical method

Methodology is “...a way of thinking about and describing social reality” (Strauss and Corbin, 1998). Modern social science research methodology is categorized as positivist, interpretive, and critical approaches⁷⁵ (Neuman, 2000). Positivism explains the contents of social reality through empirical observation in an objective, value-free manner, so as to induct the facts and obtain inference in reductionistic way (Polgar and Thomas, 1995). Therefore, positivism may lead to the so-called quantitative research by control external erroneous factors through random sampling techniques and standardization of instruments and measurements to obtain external and internal validity of the research.

The interpretive approach describes social reality in a context dependent, holistic, subjective, and deductive manner. It aims to unravel an empathetic understanding of feelings and views imbedded in history and cultural context (Neuman, 2000). The critical

Lake 2002, p. 83).

⁷⁵ These three concepts are consistent with three cognitive interests identified by Habermas, as technical, practical-collaborative, and emancipatory. See Michael Kelly, 1994 Critique and Power:

approach is based on the understanding that people's actions are constrained by material conditions and cultural context, so there are both mediating mechanical tools that are observable and a predisposing unobservable social structure that covers the mechanisms which shape social relations. This approach aims to expose the problem. Interpretive and critical approaches lead to the qualitative investigation that explores personal views, looking for meaning and understanding of complex social and human factors in way that cannot be understood with empirical positivism.

Qualitative research is based on beliefs and feelings about the world with an ethnographic-inductive approach, which is opposite to the hypothetic-deductive quantitative approach that generates hypotheses. The method of data collection includes interviewing the actors concerned, observing the settings with visual methods to get a sense of feeling, reviewing policy and program documents including news letters, and minutes of meetings, examining client records and press articles, immersing oneself in the field to obtain personal experiences and understanding local social routines and cultural context.

In qualitative research, rigor is achieved with correct method, and ethics deals with correct moral conduct (Ezzy, 2002, p.51). Saturation principle of purposive sampling is satisfied with data collection continuing until the emergence of repetitive pattern, and no new themes emanating. Triangulation through multiple independent methods to cross check consistency is applied to assure validity of findings.

Research strategy and analytical method

This research explores the understandings and views of Chinese policy makers on their perception of the regulatory challenges and options to head China towards a mixed public/private healthcare market. Such exploration requires the understanding of context, content and process of regulatory policy design and implementation (Walt and Gilson, 1994). Qualitative research method is the method of choice for understanding attitude, views and concerns about policy issues in relation to context. Document analysis, field study, and interview of key policy makers are the main methods used to understand perception of policy development (Berg, 2001, p. 7; Berg, 2004, p. 11).

The research questions and framework demand a multi-disciplinary approach and a mix of knowledge drawn from sociology, politics, history, economics, management sciences, clinical medicine, law and public administration.

With respect to the nature of each research question, different research strategies combining the selected analytical methods are deployed in investigation, they are discussed below.

- A) What are the key drivers behind the excessive entrepreneurial behavior in the transition to a market-based governance system?

Answering this question needs an understanding of the role of the market and the state in different economies and economies in transition. In order to position Chinese cities' healthcare markets with respect to the role of the market and the state, the semashko model, the managed market, the planned market, the regulated market, the developing market, the laissez faire market, and the social market⁷⁶ are depicted on a healthcare markets continuum (Figure 5-1). A comparative perspective then is used to characterize healthcare markets in cities by revealing reasons behind the excessive entrepreneurial behavior.

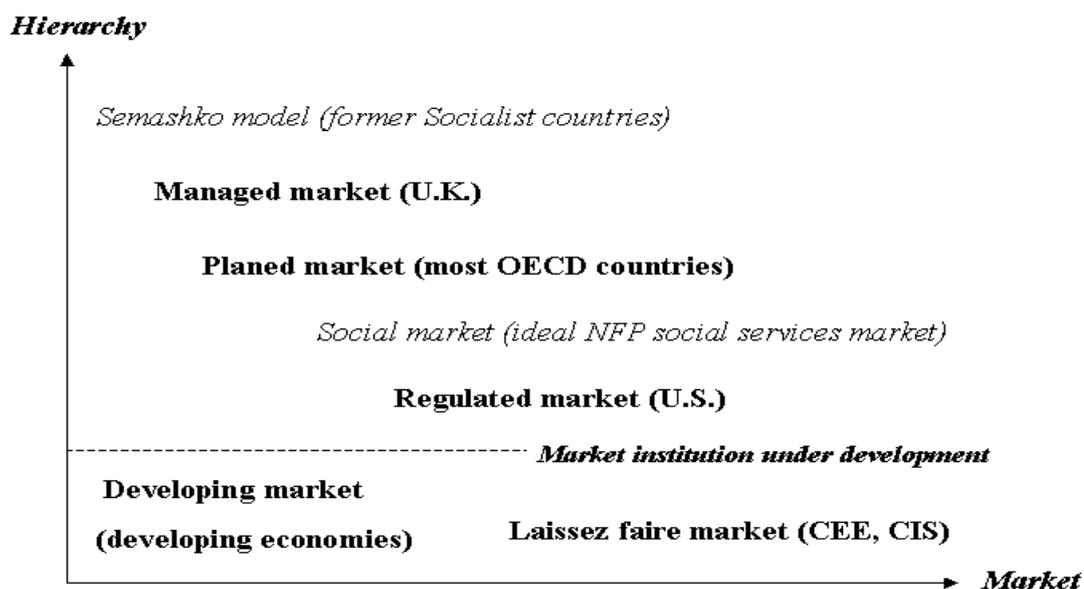


Figure 5-1 Healthcare market Continuum

⁷⁶ Firms in the social market interest in triple bottom lines: environmental externality, social function and economic performance (Fung, 2002, pp. 145-172).

The role of the state under marketisation is entrepreneurial state⁷⁷, network state⁷⁸, and market state⁷⁹. These roles are depicted on the state continuum so as to characterize the role of the state in different cities (Figure 5-2).

Economic analysis, policy analysis and stakeholder analysis are used to analyze the reasons behind the excessive entrepreneurial behavior of the provider.

Economic analysis is used to analyze the market structure and market function with respect to the market parameters of equity and efficiency. It is also used to analyze the technical regulation with respect to technical efficiency, allocative efficiency and dynamic efficiency at the institutional level. The rigor of economic analysis can be assured in that: a) economic theory is a developed formal theory thus it can ensure its internal validity; b) it has empirical consistency thus it can ensure external validity; and c) it also has credibility (objectivity) and transferability (reliability) (Ezzy, 2002, p.52).

Policy analysis is used to examine the second stage health reform policies and to examine the consequences of the policies. This analytical approach could lead to a revisiting of policies and/or local capacity building for implementation. The rigor of policy analysis can be assured in that: it is to provide voices of the silenced and marginalised in political process (voice). The issues with policy analysis are: a) its claims of objective are deceptive (positionality); b) academic, political and participant communities are arbiters (Ezzy, 2002, p.56).

Stakeholder analysis is used to analyze the process of transforming central policy into local policy. It is useful with respect to the local governance that prevails in China. This approach may draw heavily into politics. Therefore, the rigor of stakeholder analysis can be assured by: a) sceptical of the quality of common sense (scepticism); b) focus on process that constructs and transforms social life; c) appreciation of subjectivity as social life is understood based on subjective experience; and d) tolerance for complexity: social life is a complex web of interpretation (Ezzy, 2002, p.54).

⁷⁷ It refers that state is of entrepreneurial spirit the same as private sector - state steering not rowing, much as advocated by new public management school. The U.K. NHS reform and New Zealand internal market reform are examples of entrepreneurial state (Kamarck, 2002, pp. 244-249).

⁷⁸ It refers that policy networks consists of public, para-state and private organizations, and it also refers to implement public policies by NGOs through contracting-out and financing. Example of networked government is JCHAO's quality review standards and results are deemed legally for entering into government supported Medicare program. With networking, the private hospital provider can get reimbursed from public purse (Kamarck, 2002, pp. 227-263).

⁷⁹ It refers to, without use of neither public employees like entrepreneurial state nor public money like networked state, use government power to create market that fulfills public value (Ibid). One example of market creation state is in Australia, where tax credit encourages the development of private insurance.

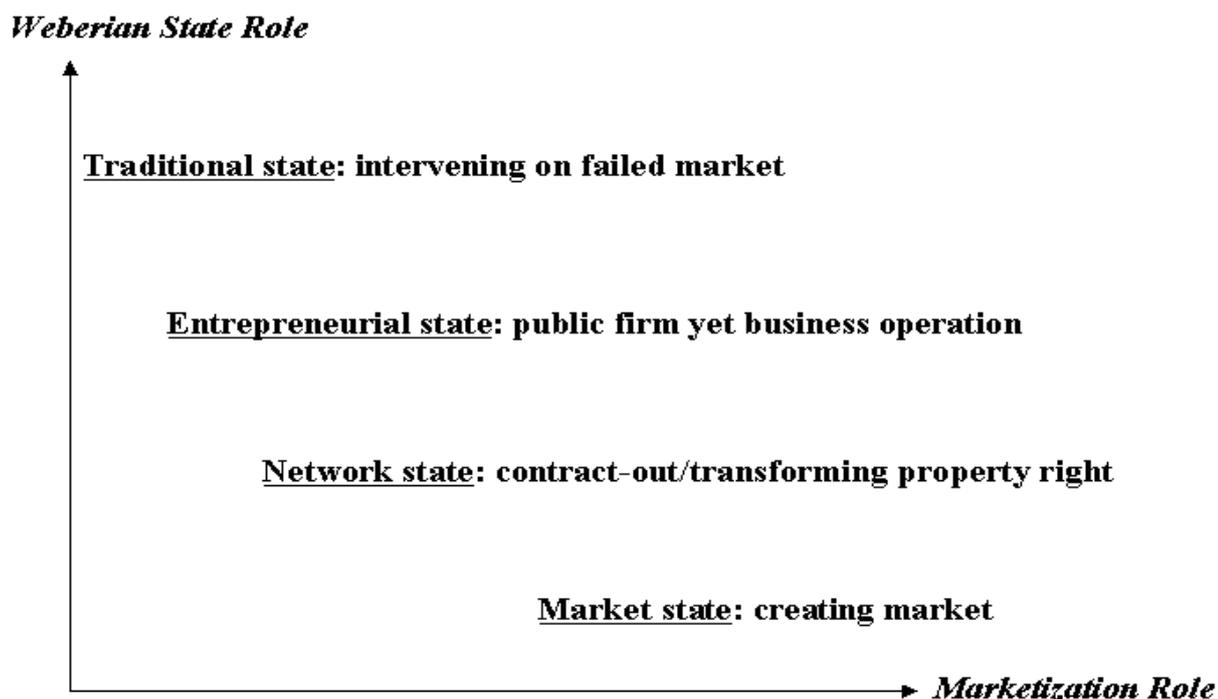


Figure 5-2 State Role Continuum along Marketisation

B) What are the technical regulatory tools to regulate the behaviour?

The status quo of technical regulation in China is assessed so as to analyze their effectiveness and failure in regulating market structure. Economic analysis and policy analysis are used.

C) What are the institutional and structural issues that may limit/enhance the effectiveness of the technical regulatory tools?

Institutional and stakeholder analysis approach is used to analyze what are the institutional requirements for the surrogate regulator to harmonize risks of clinical practices, incentives of providers, and the interest of hospital director (Figure 5-3).

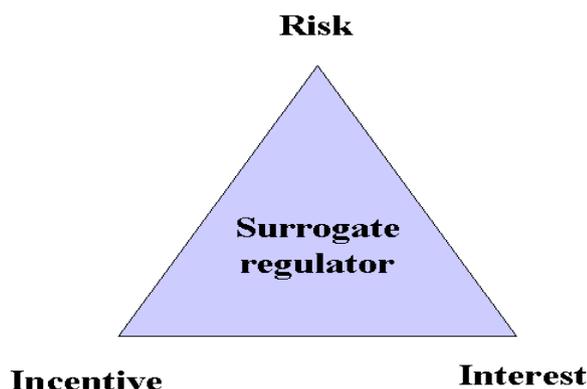


Figure 5-3 Surrogate Regulator to Harmonize Risk, Incentive and Interest

Institutional analysis is used to explore the institutional requirements for effective technical regulation in moving towards market-oriented health reform. The research adopts the institutional analysis approach to analyze the technical regulation in relation to institutional process and governing structure. It is the main analytical method used to link technical regulation, regulation process and governing structure. The rigor of using institutional analysis is that it is “concerned with management systems, including monitoring and evaluation; organizational structure and changes; planning, including planning for an efficient investment process; staffing and personal policies; staff training; financial performance, including financial management and planning, budgeting accounting, and auditing; ...[and] interagency coordination and sector policies regarding institutions” (Israel, 1994, pp. 11-12). In essence, institutional analysis links clinical practice (quality and cost) to process and structure.

D) What are the optimal means to achieve cost containment, quality, and equity in a mixed public/private market in 2010?

Assuming that China starts with management-based regulation (MR), develops performance-based regulation (PR), and absorbs some elements of technology-based regulation (TR) as changing social institutions allow for take up of more regulatory tools (Figure 5-4). The challenges and options regulating the optimal balance between cost, quality and equity are explored. Social analysis and complex social adaptation analysis are deployed to synthesize the analysis.

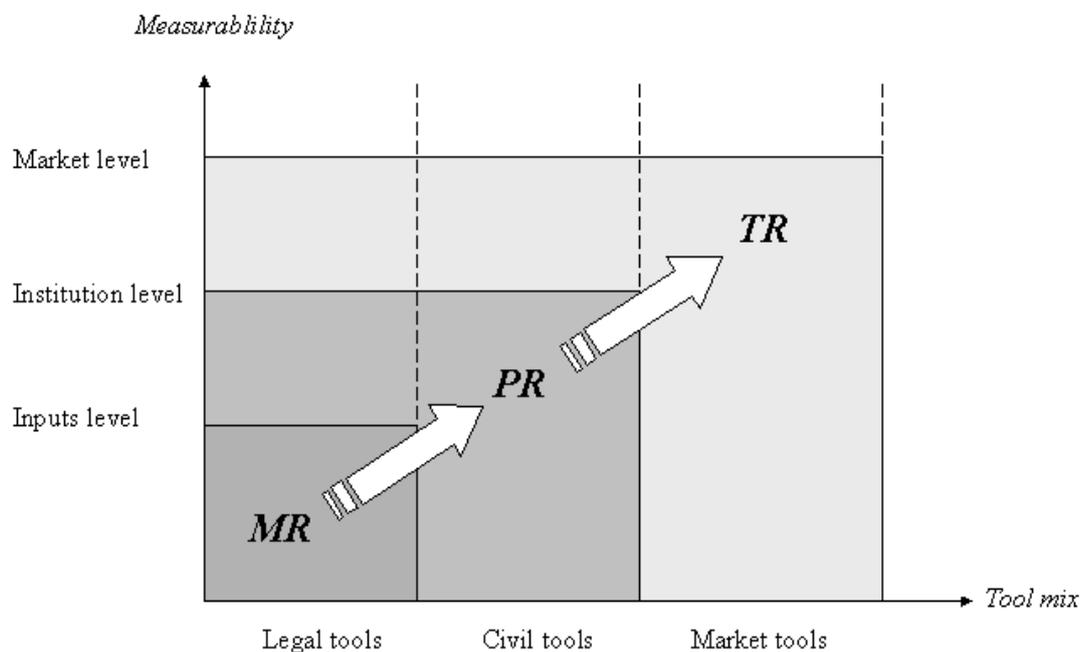


Figure 5-4 Regulation Frontier in Relation to Social Institution Readiness

Social analysis is used to understand the social change and their influence on social agreement formation. This is to provide an understanding with respect to regulation compliance and development of civil society. At the individual level, social analysis is used to understand change norm and their influence to professional ethics and incentives. A historical and cultural view is used in framing issues relating to social agreement formation, and a developmental view is used with respect to future prospects for using regulatory strategies by the civil regulator. The rigor of social analysis can be assured by: a) rich, clear and nuanced description (thick description); b) to notice details of experiences and interpretation (close scrutiny) (Ezzy, 2002, pp.54-56).

Complex social adaptation analysis (Plsek, 2001, pp. 309-316) is used to explain the complex social adaptation process during transition when a corporate governance system⁸⁰ does not exist, which is the fundamental premise for instituting technical

⁸⁰ A most recent assessment by EU on market conditions in China is “a lack of transparent laws and regulations, inconsistencies among laws, weak and inconsistent or arbitrary enforcement, contract repudiation, and the weak capacity of the judicial system”, and lack of sound corporate governance and weak compliance with accounting standards. “In some cases, it was found that companies did not follow basic accounting rules nor had accounts at all”. See Tobias Buck and Mure Dickie, *Europe to Snub China*

regulation. The rigor of complex social adaptation analysis can be by tolerance for complexity, i.e., social life is a complex web of interpretation, and a complex social process and social factors influence adaptation (Ezzy, 2002, pp.54-56).

Data collection and analysis

Research settings and sampling

The marketisation process is stratified as three economic belts exist in China (see Appendix A.1; Zhang and Lin, 2001, pp. 96-109), with the coastal belt being most marketised, followed by the central belt. Marketisation in the western belt is less visible and less reported. Within each belt, the decentralisation program diversified the local governance that further diversified the presentation of marketisation process (Figure 2-2). With 'local property right' and local social institution-bound policy development and implementation (that is local governance), this study aims to explore factors affecting regulation implementation in different localities – to distill contextual factors and to identify mediating factors that are modifiable by regulation.

Therefore, the premises for the research are that:

- a) The perception of stakeholders varies in accordance with the level they positioned in the system, and the degree of marketisation in the locality;
- b) The perception of the role of the state also varies according to the level of marketisation; and
- c) Their understanding of the ambivalent and vaguely expressed principles of market-based governance reflects their deeply buried cultural belief, or social institution-bound understanding about future regulatory strategies.

To embrace variety, the selection of provinces has considered the following principles: higher degree of healthcare marketisation, feature of administration and economic performance variation, and policy passage from the centre to the regulated. Three provinces, Liaoning, Guangdong and Inner Mongolia, are selected for examination, with the first two from the coastal economic zone, and the last from the central zone. Provinces from the western belt are not selected for there are fewer differences between the central and western belts in terms of healthcare marketisation and other social and economic characteristics. Also, in terms of innovation, there is little variation to be observed and reported. The profile of selected provinces is summarized in Table 5-2.

Table 5-2 Sampled Provincial Profile, 2000 (GDP in yuan)

Province	Urban Population %	GDP per capita
National	36	10798
Costal economic belt	45	10768
Liaoning	54	11017
Guangzhou	55	11181
Central economic belt	34	5978
Inner Mongolia	43	5897
Western economic belt	28	4606

Source: China Statistical Yearbook, 2001

Given the fragmented nature of the Chinese government institutions, three cities within the three selected provinces, Shenyang, Shenzhen, and Jining, are selected for examination as another level of analysis on market characteristics and role of the state. The criteria for city selection are:

- a) Features of administration. Shenyang, capital city of Liaoning province, is an industrial base, product of the previous planned economy. It has large number of laid-off workers, and its health sector is under vigorous reform. Shenzhen is situated in a Special Economic Zone, administratively affiliated to Guangdong province. Twenty years ago, it was the first coastal city to institute an economic reform program. Jining, a prefecture city of Inner Mongolia, has some policy flexibilities in implementing central policy because it is a minority region.
 - b) Economic performance level. Shenyang is a middle level economy, with its past economic planning structure under radical reform. Shenzhen is amongst the richest cities in China. Jining is the opposite case of Shenzhen, being amongst the poorest cities in China, and has traditional culture and a traditional economy.
 - c) Policy delivery from policy-making at the centre, policy conversion at the provincial capital, and policy implementation at the prefecture level and hospitals.
- The sampled city profile is in Table 5-3.

Table 5-3 Sampled City Profile, 2000 (GDP in yuan)

Profile	Shenyang	Shenzhen	Jining
Population (1,000)	4,876.8	4,329,4	288
Total hospital	391	80	4
Private hospital	29	4	1
GDP yuan/capita (yuan)	19,992	39,739	2,700

Source: China Statistical Yearbook, 2001. Shenzhen Health Bureau, 2003a and b.

Data Collection

Three frequently used data collection methods in qualitative research are document collection, focus group discussion, and in-depth interview. Document collection in term of policy-making is to collect announced policy documents. Focus group discussion is a brainstorming approach used for generating ideas (not used in this study). In-depth interviews are “repeated face to face encounters between the researcher and the informants directed towards understanding the informants perspective on their lives, experiences or situations expressed in their own words” (Taylor and Bogdan, 1984, p. 77). The interview can be guided by structured or semi-structured questionnaire, or simply the natural flow of interaction between the interviewer and the interviewees.

Legal documents collection is divided into health related law and ordinances (issued by NPC and/or State Council), and health related policy directives and statements (issued by line ministries and State Council). Legal documents reviewed include the first PRC Constitution in 1954 and the first PRC Penalty Law in 1979, the ensuing health related laws, and health related legislation program for the next five years (see Appendix E).

Health policies and government statements collection includes: the statement of the first PRC National Health Conference in 1952, relevant clauses for healthcare in the first PRC Constitution in 1954, the key hospital related administration polices and documents since the first stage health reform when the marketisation process took place, and policy reform statements since the second National Health Conference in 1996 (see Appendix D).

The sources of health related law, ordinance, and policy circulars are from: “Compilation of Common Health Law, Ordinance and Policy Circulars”(MOH, 2002), “China Applied Health Development & Management Collection”(Liu, Wen et al., 1996), and “Contemporary Medical and Healthcare Regulation Collection”(Yin, Wang et al., 1997), Health Paper and People’s Daily (Overseas Edition), Government media such as domestic newspapers and PRC official websites, overseas websites, and local health departments for local policy documents.

For this study, interviewing key policy makers and members of think tanks is critical to understand the policy-making and implementation process (Walt and Gilson, 1994; Berg, 2004, p. 11). Key informant interviews are therefore used to collect opinions, attitudes, and views on regulation. The advantages of open-ended in-depth interview allow searching the unknowns and unthinkable without any predetermined limitation. Furthermore, given that the interviewees identified are senior policy makers, open-ended and in-depth interviews are conducted to allow interviewees’ free expression and

reflection (Morse and Richards, 2002, pp. 25-27). With the saturation sampling technique, the interviewer can absorb ideas and feelings expressed by previous interviewees, so to conceptualize into a charted roadmap and probe for deeply buried social institutional issues. The grounded evidence can then be threaded into the story.

Key informant interviews were organized on a pilot basis at first at La Trobe University and then conducted in the field study in China. The interview schedule was piloted with five Chinese hospital directors studying at La Trobe University. Analysis of pilot interview transcripts indicated that an open-ended questionnaire is better than structured questions. Therefore, an interviewing guide was grouped into core sets of question and optional sets of questions, and into central level policy-makers, local level policy converters, and hospital directors (see Appendix B1).

37 interviewees were recruited, with 18 from central level for policy-making, 8 from the local level for policy delivery, and 11 from the hospital level for policy compliance. The age distribution of the interviewees is from 30 to 70 years old, with 31 are male and 6 female. All the interviewees' have higher education, with work experience for more than ten years. Two interviews are conducted via telephone with no refusal and substitution.

18 are at central level for policy making:

Government policy formulation departments for hospital reform policy (10 in total):

- 1 from Social Development Department, SDPC;
- 1 from Social Development Department, MOF;
- 1 from Medical Insurance Department (MID), MOLSS;
- 1 from Medical Administration Department (MAD), MOH;
- 2 from Health Law and Inspection Department, MOH;
- 3 from Planning & Finance Department (responsible for price, cost and pilot programs) MOH;
- 1 from International Cooperation Department (ICD), MOH.

MOH think tank for health reform and policy-making (8 in total):

- 1 from China Health Economic Institute (CHEI), MOH affiliated policy think tank;
- 1 from Centre of Health and Statistics Information (CHSI), MOH;
- 1 from Institute of Hospital Management (IHM), MOH affiliated policy think tank;
- 5 from MOH health reform policy informal advisory group.

8 are at local level for policy delivery:

4 from provincial health departments from three provincial capital cities;

4 executives from prefecture health departments from three prefecture capital cities.

11 are at hospital level for policy compliance:

5 from common NFP hospitals;

4 were from NFP hospitals with nature of self-survival, with public health service nature, the NFP networked hospital, and the NFP hospital under share-holding transition (business operated);

2 were from the hospital corporation group, and the FP hospital.

Purposive sampling and snowball sampling techniques were used in locating the interviewees. At the central level, interviewees were directly approached. At the local level, potential interviewees were approached either directly or through reference via MOH. At the institutional level, interviewees were approached either directly or through reference via local health departments. The saturation principle was applied in deciding the total number of interviewees.

The criteria for recruiting interviewees are: more than ten years of managerial experience for policy-maker, and more than five years of managerial experience for hospital director. The hospital directors are selected based on types of hospitals and recommendations made by health departments.

The data collection and analysis phase spanned the period from May 2002 to March 2004, with data collection conducted in Beijing and three selected provinces. The data were analysed at La Trobe University. Most interviews were face to face. Telephone interviewing was used as an alternative. Interviews lasted for 1.5 hours on average.

The interviewees were kept in contact with follow-up discussions held later to clarify points and to follow progress on issues. There were concerns about tape-recording interviews among Chinese policy makers for fear of being taken out of context. Therefore, notes were hand taken, and were translated into English before analysis.

To apply the ethical principle of “autonomy (the right to self rule), beneficence (do only good), non-maleficence (above all do no harm), and justice (fair treatment)” (Satur, 2002, p. 106), confidentiality was maintained with data kept locked up. The informed consent was made to those participated in the research (see Appendix B 2). Veracity (truthfulness/honesty) to conduct honest inquiry was applied in the most possible way regardless of the social and political environment. External approval of participation in

the research was not required. Ethical approval was granted by La Trobe University at the commencement of the research.

Data analysis

Qualitative research analysis uses a thematic and reflexive approach. Reflexivity is achieved through empathic neutrality, since epistemologically, the individual inquiry to the social reality often has stigma of beliefs and feelings⁸¹ regardless of the rigor. Therefore the rigor of the subjective qualitative research analysis can be assured by: a) making clear the bias of the researcher, and by identifying the context differences (Denzin and Lincoln, 2000, p. 823); and b) meta-analysis to triangulate the method and the results of individual researches.

In China, the major policy documents are announced by the central government and the policy implementation plans are formulated by the local governments in accordance with central policy documents, the way local governments to interpret the central policy documents and the way local governments to formulate their own policy implementation plan (to tailor their local situation) are two issues concerned by the study. The data analysis methods used are document analysis (mainly on the central policies), and interview transcripts analysis obtained from in-depth interview of both policy-makers at the central level and policy converters at local levels, and as well as in-depth interview of hospital directors as policy implementers.

The document analysis is mainly focused on key concepts of the 1997 reform policy and the discrepancies between central policy statements and local policy adaptation, cohesiveness of sector policies related to health, and timing of policy passage from central level, to provincial level and to the city level.

For analyzing interview transcripts, a coding tree emerged from immersion in the raw data, with the first layer theme nodes coming out as marketisation, social regulation, economic regulation, governance institutions, civil institutions, and market-based governance. The detailed structure of the coding tree is in Appendix C. The rigor of interpreting the findings is assured with triangulation. Critical analysis was used to distil the contextual factors from mediating factors, which are the concern of the thesis.

The analytical framework has been developed (see Table 5-4). Both policy documents and transcripts intertwine to analyse structure and issues, constraints of

⁸¹ The examples are the verdict in Salem village in 1692, and the Cultural Revolution to anti-revisionism in the late 1960s in China.

regulatory policies and strategies to achieve 2010 policy objectives. The factors affecting risks of clinical practices, incentives for providers and the interest of hospital director at the institutional level are revealed. The challenges and options for regulating the market, and to correct market failure are listed.

Table 5-4 Analytical Framework

Existing situation	Regulatory constraints	2010 Objectives
Market description and existing policy and issue: - Market configuration; - Role of state for marketisation, for policy purchase and for delivery system planning and restructuring. - Conclusion: what are the fundamental issues that lead to high cost high volume competition?	To unfold constraints and to analyse buried constraints: - Technical regulation issues for attaining equity and efficiency; - Regulation process issues for effectiveness; - Governing structure issues for effectiveness; - Norm issues for compliance - Conclusion: what affect between risk, incentive and interest?	What regulatory strategies that lead to 2010 objective - Mixed public/private healthcare market structure; - Promising pilots; - Strategies at system level, at institutional level and at individual level. - Conclusion: what are the challenges and options, and what are the risks of regulatory/market failure?

Summary: From research question into reporting

At first, the issue for the healthcare system in China in the last decade emerged as cost escalation that relates to competition practice – high cost, high volume competition. The issue then related to institutional operation objectives – survival and revenue earning of hospitals, which in turn relates to system policy of fiscal decentralization and financing policy change as the role of the state shrank. This created a ‘public identity, private behavior’ self-regulated hospital sector – or state corporatism. It gridlocked the whole system as operational, systemic and structural issues intertwined under the first stage health reform.

The structured, top-down second stage health reform attempts to address the governance reform by splitting financing from provision and by detaching hospital from health departments, so that all the legally independent market entities would engage in fair competition and health departments would not protect NFP hospitals in a mixed public/private market. Governing such a market needs to adopt not only the technical regulation, but also a regulating process and governing structure for NFP hospitals. Furthermore, effectiveness of regulation depends on developing shared norms and

enforcement - a critical factor for compliance. Shared norms create social capital for social agreement towards a new social institutional framework. Thus, the issue of high cost, high volume competition concerns essentially managing the transition from planning to market.

The next chapter through chapter eleven are the research findings. Chapter Six examines the issues of marketisation and the role of the state and regulation in the context of the first health reform. Chapter Seven and eight assess the existing regulatory tools and issues concerned with applying the technical regulation. Chapter Nine and Ten explores the regulatory and compliance systems and challenging issues during transition in the context of the second stage health reform. Chapter Eleven aims to mesh the 'regulatory tools' with the 'regulatory system' that leads to the proposal of regulatory strategies and options for China to transform from a 'healthcare system' to a 'healthcare market' by 2010.

Chapter Six presents findings on the emerging healthcare market in China, a stratified market by economic belts and a diversified market within each economic belt, and the role of the state and regulation in the context of marketisation, in order to define the characteristics of individual markets in the cities and implications for regulatory response. Chapter Seven presents findings on the assessment of economic regulation to govern the market structure and function. Chapter Eight presents findings on social regulation for institutional performance, that is, to set the institutional rules to regulate the managerial and financial system needed to govern competition, quality, and cost. Chapter Nine presents findings on the state and civil regulatory systems in transition, and Chapter Ten presents findings on norms and the compliance system in transition. These two chapters are to examine issues and challenges of norms and social institutions at the system level. Chapter Eleven presents a proposal of a market-based governance system in a mixed public/private market, and regulatory strategies and options at the individual and the institutional level.

CHAPTER SIX

STATE AND REGULATION IN THE CONTEXT OF MARKETIZATION

Chapter six to eleven present research findings. Following the analytical framework presented in Table 5-4 (p. 70), chapter six to chapter eight assesses the existing regulatory tools used for regulating the market and institutions in the context of the first stage health reform. Chapter nine to chapter ten explores the transition of state and civil regulatory systems and norms and the compliance system (that is, to examine the reform of the system that can enable the regulatory tools to be effective) in the context of the second stage health reform. Chapter eleven reviews and proposes options and strategies to reform the 'public identity, private behavior' healthcare system to the market-based governance system by 2010.

Under the decentralization, the spontaneous healthcare market development in the first stage of health reform suggests that the regulatory responses vary between market characteristics and the role of the state. This chapter aims to understand the relation between economic reform and the demand for healthcare and connection of the first stage reform with the second stage reform. More specifically, the chapter discusses the emerging healthcare market in China, to define the characteristics of individual markets in the cities and implications for the role of the state and the regulatory response. The underlying rationale is that the economic reform in China has created a stratified economy and therefore there are distinctive features across cities. In reality this means that any centralized approach to designing regulations is impractical and impossible. Thus, the degree of marketisation determines the regulatory tools to be adopted. The findings in this chapter indicate that: a) the consumer demand for healthcare is the driving force for market development, especially along the coastal economic belt; b) China's healthcare market is stratified by the level of consumer demand (with respect to three economic belts) for example, the Shenzhen market is partly a planned market and partly a managed market, Shenyang market approaches a laissez faire market, while Jining leads to a market; and c) China's healthcare market is also diversified with respect to the role of the state, for example, the role of the state varies in three sampled cities, that is, an entrepreneurial state in Shenzhen, a networked state in Shenyang and a developing state in Jining.

Economic reform and market-driven demand for healthcare

The demand for healthcare in China arises from consumer purchaser power and health insurance purchasing power. The consumer purchaser power derives from the separation of individual affiliation from institutions, and the growth of the private sector in China. The following section describes four key factors that drive the development of the healthcare market: the accelerating mean urban income increase, the stratification of urban income demands for diversified health services, demographic base expansion, and the epidemiological transition leading to changes in service patterns.

With the economic reform program, for urban areas, the dispensable income per capita has increased from 343 yuan in 1978 to 5160 yuan in 1997, or 6.2% increase per year, and the dispensable income has increased further from 5160 yuan per capita in 1997 to 7703 yuan in 2002, an 8.6% actual increase (Zhu, 2003). The per capita GDP is expected to be 15425 yuan by 2010 (Li, Mu et al., 1999). Overall, the mean urban income has accelerated, and so has consumer purchasing power for healthcare (Table 6-1). For example, In urban areas, the income elasticity coefficient of demand for health services increased from 0.5 in 1991 to 0.75 in 1994 (Wang, 1999). The aggregate demand increase has spurred the introduction of medical technology. Studies have documented the high concentration of new medical technologies along the most developed coastal economic belts in China (Zhao, 2000). This has made the coastal economic belt the most volatile healthcare markets in China.

Table 6-1 Per Capita Urban Dispensable Income (in RMB yuan)

Year	1978	1997	2002	2010	Income elasticity for health services
RMB yuan	343	5,160	7,703	15,425	0.5 - 0.75

Source: Li, Mu et al., 1999; Rao, Yin et al., 2000, p. 40; Zhu, 2003.

Due to the uneven development, the urban Gini coefficient (which measures the degree of income inequity) has increased from 0.16 in 1978 to 0.29 in 1997⁸² (Xin, Li et al., 1999), and to 0.415 in 1995 (World Bank, 1999). The salary-based income reduced from 92% in 1978 to 72% in 1997 (Xin, Li et al., 1999, p. 362). The disposable income per capita among the coastal, central and western economic belts, from 1981 to 1997, the coastal belts increased by 12 times, while the central and western belts increased by 10.6 and 10.3 times respectively (Xin, Li et al., 1999). The income gap is widening amongst industries with different ownership structures and amongst sectors with varied market

⁸² The SSB estimates Gini coefficient as 0.370 in 1994. The World Bank estimate is 0.415 in 1995.

monopolies. For example, from 1986 to 1992, per capita income from SOE employees increased by 36.5% while it has increased by 138.1% for self-employed individuals (He, 1998). Distributional inequity of income is one of the major problems in China (World Bank, 1999; Zhang and Lin, 2001; Li, 2002; Lu, 2002). The Engel coefficient (which measures the proportional consumption for food in relation to total dispensable income) is 46.4% for urban area in 1997, compared with 35% and 20% for middle and developed economies respectively, representing a transition from a subsistence level of life to a well off life (Li, Mu et al., 1999).

The increasingly unequal income distribution has stratified the health demand among income related population groups (He, 1998; Wang, 1999; Li, 2002; Lu, 2002). The stratification of income implies that services chosen by specific income group are different. In addition, in terms of demand for change of service patterns due to demographic base expansion and epidemiological transition, the birth rate in China in 1997 was 16.57 per 1,000 (Xin, Li et al., 1999). Life expectancy was 71.8 in 2002 (Zhu, 2003). The total population will be 1.388 billion by 2010, of which 15% are 60 years older (Li, Mu et al., 1999). The urban population has increased from 17.9% in 1978 to 29.9 in 1997 and will reach 35% by 2010 (Li, Mu et al., 1999). Changes of disease patterns associated with aging and epidemiological transition in urban areas is expected to increase the chronic illness prevalence by 40% from 2000 to 2015 (Rao, Yin et al., 2000).

In summary, with the market-oriented economy, the stratification of healthcare demand stimulated hospitals to develop technologically concentrated services. Consequently, the hospital industry drives the service cost escalation and challenges the state to redefine its role as listed in Table 6-2. This underlies the necessity for China to initiate the top-down second stage health reform.

Table 6-2 Market-driven Demand and Implication for State

Purchasing Power	Healthcare Implications	Challenges for State
Mean income increase	High tech services and drugs	Entry regulation
Income stratification	Essential service provision	Financing public service
Service pattern change	Service diversification	Market mediation

Connection of the first stage health reform with the second stage reform

China has officially allowed private practices since the 1980s, but did not recognize the existence of the healthcare market until late 1990s. Table 6-3 shows the growth in private sector utilization. The 1997 health reform policy statement referred to the

‘healthcare system’ not the ‘healthcare market’ (see Appendix D, Policy 12). Wide acknowledgement of a ‘healthcare market’ in the media only started in 2000, when the second stage health reform has been substantially mobilized (Liu, 2002).

Table 6-3 Private Sector Utilization by Outpatient Services (%), 1993-1998

Area	1993	1998
Urban	1.89	9.96
Rural	7.63	9.53
Total	7.63	9.53

Source: National Health Survey, 1998, MOH

Although the development of any market may be about the exchange between buyer and seller, transparent market institutions and business rules, such as the public and corporate governance systems, are viewed as important elements of the ‘healthcare market’ in China. As stated by an interviewee:

[The market should have] high level of non-government sectors with high formation of their ownership, and management system change. Now there is no clear definition on public assets. The change should first start with ownership change then the management system change, and law to govern hospital management (MOH think tank).

The second stage reform aims to institute a rule of law to replace state corporatism that arose from the first stage health reform. The rule-based administration and corporate governing system are pointing concerns for health policy analysts in the development of the ‘healthcare market’. Developing an appropriate role of the state as regulator and as purchaser of healthcare is critical to a successful transition, as stated by interviewees from the central government:

From planning to market, 95% of public hospitals have been transformed to NFP hospitals. The government is also in transition: managing hospitals according to law and in an objective manner, and managing the entry of personnel, facilities and technology. There are also sets of intermediaries in the development: HMA, PA, and China Hospital Management Accreditation Association (MOH think tank).

The funding of utilities and equipment are of a market nature. Formation of trading patterns is consistent with the demand and supply mode. For medical disputes, there is a growing concept of the protection of consumer right and the concept of maintaining (individual) rights. For special services, there are patient choices of doctor, hospital and price. Issues are that the regulator is not clear about market, the doctor is not familiar with market, and patients still feel entitled to have perceived welfare program (Health policy analyst).

The healthcare market exists objectively. The mainstay of medical services is public medical institutions. There are also regulations on entry and behaviour. The government should ‘serve’ this market, and at the same time set norms/standards to regulate the market. The relationship between supply and demand is in constant change. The ownership issue limits the space for development. The service issue is not a major issue (Health policy analyst).

Having the state as regulator means that MOH should follow the rule-based administration by conducting governance reform, which is to define the relationship between hospitals and health departments. There is an agreement that this is a key issue towards a market-based governing system.

Having the state as purchaser means that, MOLSS should purchase health services in accordance with government policy objectives. For instance, governments should decide how to purchase health services in the area of poverty, the area of satisfying basic living, the area of comfortable life and area of affluence⁸³. Because that in the area of the ‘comfortable life’ and the area of ‘affluent life’, the conditions for healthcare market are ripe, and there are also substantial activities designed to pilot innovative relations between hospitals and health departments. As illustrated by an interviewee from one province:

In the area of poverty (substance level), there is a lack of medicines and services. In the area of satisfying basic living, there are medicines and services. In the area of comfortable life, there are good medicine and good services [here there is condition for healthcare market, and need for legal and regulatory system improvement]. In the area of affluence, there are choices of selecting services and production of market demanded drugs (Health policy analyst).

As China entered the second stage health reform, the emerging healthcare market in China could be characterized as stratified by the geographic areas (the level of economy) and diversified in the governance arrangement between hospitals and health departments. More specifically:

- a) The degree of marketisation in China is stratified by geographic distribution which is decided by the stratified income-driven consumer demand;
- b) The service diversification is a response to the productive market force and for the survival of hospitals in a competitive environment; and
- c) The state as purchaser has a minimal role in influencing providers (to be elaborated in chapter seven).

The following section presents the characteristics of the healthcare market and the role of the state in the three sampled provinces and cities that point to the regulatory implications.

⁸³ China has divided its economy into three economic belts. But for health service provision, there is a general tendency to add the fourth category, the poverty areas where most donor agencies work (WHO Beijing Office, 2003). Therefore, China health services are usually divided into four categories.

Marketisation approach in three sampled provinces under the first stage reform

During the first stage health reform, an ad hoc and bottom up approach evolved, with each province adopting different policies directing and responding to local innovative reform. In the three sampled provinces, three different marketisation processes lead to three marketisation models in the three cities. The reason is mainly due to local governance in the particular context of sporadic market-oriented reform.

Guangdong province is the most dynamic market economy in China and also the origin of the Chinese economic reform program two decades ago. The entrepreneurialism brought about by the decentralization program has pushed healthcare into the market much earlier than most other provinces. Public hospitals are business operated, which is entrepreneurial in responding to consumer demand; and the state is to encourage the private sector development. It is a state pushed market for the promotion of competition among public hospitals and the private sector. As introduced by interviewees from Guangdong:

Now in Guangdong, people generally accept the term of medical market. In the early days, people didn't accept it; they spoke about hospital business operations. Now the market is in development, there is constant adjustment between supply and demand, it is a dynamic balance, and competition increasingly intensifies (Official, municipal health department).

A talking about the soundness of market, I would say the Guangdong healthcare market is still in its virgin stage. In the early 1980s, there were some private clinics, with varying capacity. Supervision also varies across region [means cities]. Now we encourage private practices. Our statistics show that there are about 70 to 80 social [private] hospitals. Most of them are small in size, and unitary in service structure (Official, provincial health department).

Liaoning province, an industrial base subjected to strong planning in the past, now faces tremendous challenges in economic restructuring and financing for health insurance⁸⁴. Institution-based planning has brought severe health facility duplications and thus the fierce competition since late 1980s. The documents review at the field study and interview indicated that Liaoning is an over supplied market; there is need but no demand due to restructuring of SOEs (Liaoning Health Bureau, 2001).

Liaoning is an over supplied medical service market. China is also so, as are the rural areas in general [it means that healthcare resources are there but are under-utilised as of ineffective demand: purchasing power is low]. The variables for demand are economic factors, social needs, and proportional relations among different social and economic sectors. The previous situation of lack of medicine and services has been solved, it now moves to a status of balance (Official, provincial department).

⁸⁴ In Lianning province in 1994, among the 18,900 SOEs, 3,940 has an arrear of employee medical expenses, relating to 688,200 employees, some SOEs have an arrear of more than several millions of medical expenses (He, 1998).

Inner Mongolia Autonomous Region, located in the central economic belt, shows the need of financing for public good and the need of reform on the management system. As stated by an interviewee from Inner Mongolia:

I would say there is a healthcare market [in Inner Mongolia], as there are different medical entities: state-owned, collectives and privately owned. This creates competition. But such markets are far from perfect. The Inner Mongolia Region still has a heavy task to engage in infrastructure development, much existing health infrastructure is of poor quality. There is coexistence of inadequate financing and waste. So our slogan is to focus on development with equal importance attached to reform and management. In the future, if there are real FP hospitals, there could be a real market (Official, provincial health department).

The perceptions from three provincial health officials on the market are different in that, provincial officials interpreted the reform from their personal experience. For example, the business operation of public hospitals and emerging private practices are emphasized in Guangdong. Oversupply and ineffective demand are emphasized in Liaoning. Development need is emphasized in Inner Mongolia. These perceptions are grounded in their immersion in the settings. Officials from the center, however, critically focused on governance arrangement. They looked at the ownership reform of hospitals and governance system reform. Issues amongst the provinces and between the center and provinces are viewed differently, as more depends on the policy makers' positions in the system. So, two caveats need to be added in order to understand the stratified and diversified healthcare market.

First, the perceptions of the market vary: they depend on the positioning of the health policy makers in the system. So, the center focuses more on reforming the state corporatist practice out of the first stage reform. Guangdong focuses more on competition between the role of private practice and its counterpart business operated public hospitals – an entrepreneurial state managing the competition between the public and private sectors. Liaoning focuses more on market structure and function – to solve the oversupply issue by either ownership reform or increasing public financing. Inner Mongolia focuses more on development towards market – it implies that development is a priority rather than managing market structure and function.

Second, people prefer competition to state monopoly. The underlying reason is that trust in the public governing system is low, a key factor pushing for a transition towards markets. Although it does not mean that people who advocates for the market can necessarily benefit from the market, it is an aspiration to seek betterment. An interviewee who advocated for the market vividly expressed such feeling:

At times neither planning nor market does work, I would rather choose the market instead of planning. Some SOE cannot do well, but civilian enterprises can do well (Provincial policy analyst from Liaoning).

The crux is the competition mechanism. The government wants to open the door to the market but currently the administration is very tight. It does not allow new mechanisms to appear. It now asks for 'structure adjustment and macro control'⁸⁵. These ideas are temporary; it does not mesh with market. It should open the market; competition mechanism could then be introduced (Provincial policy analyst from Liaoning).

Liaoning health officials see Shanghai's policy practice of 'structure adjustment and macro control' as 'temporary', as the structure adjustment in Shanghai is focused more on service diversification to meet market demand (to attain technical efficiency) and a facility rationing to need (attain allocative efficiency). The objective of Shanghai's planning approach is to control total health expenditures by attaining both technical and allocative efficiencies without resorting to the supply-side ownership reform, – for the 1997 reform paper does not mention the 'healthcare market'. The Liaoning health official argues for the ownership reform and complaints that 'administration is very tight' and 'it should open the market'. This can be interpreted as advocating ownership reform as a way to introduce 'competition mechanism'.

Faced with 'over supplied medical service market', the Liaoning health official implicitly complained about the outdatedness of the 1997 reform paper. With an over supplied medical service market, compounded by under-utilised services because of ineffective demand, and shrinking budget support for public hospitals, Liaoning province has the most diversified supply-side organizational reform embracing ownership reform and innovative governance arrangements between hospitals and health departments. The state therefore evolved into a networked state of selling public assets, contracting out to private business operation and various ownership arrangements so as to have hospitals survive in raging competitive environment (Liaoning Health Bureau, 2001).

Guangdong was the front-runner during the first stage health reform by introducing private practice. Entrepreneurial 'hospital business operation' is natural to Guangdong culturally. To be an entrepreneurial state, Guangdong is more concerned with the size of the private sector so as to mediate the competition. Market structure is therefore a concern, especially due to a favourable market institution that attracts overseas investors to the

⁸⁵ This is the policy practice in Shanghai during the first stage health reform: 'macro control' means to control the total expenditures for healthcare, 'structure adjustment' means supply-side restructuring without emphasis on ownership reform. Cost containment is the reform goal.

healthcare industry. Guangdong therefore was a hybrid approach between the planning approach and the ownership approaches.

Contrary to the situation in the coastal belt, Inner Mongolia focuses on the development of health infrastructure by the state, rather than mediation of market structure by the state. The developing state and developing market capture its stage of development. Due to different marketisation approaches adopted by different provincial health departments, healthcare markets and the role of the state in the three affiliated cities present to be different either as detailed in the following.

Shenzhen: Mix of managed and planned market and entrepreneurial state

Shenzhen city, situated in the Special Economic Zone of Guangdong province, was the first city opened to the outside world since the economic reform program. Its per capita income is 39,739 yuan. Shenzhen is proud of its solid development of social security system; according to the “Report on City Competitiveness in China”, Shenzhen ranked first nationwide in health status and social services indicators (Anonymous, 2004c). Engel coefficient is 28.2% in 2000 (Shenzhen Health Bureau, 2003a).

In Shenzhen, life expectancy was 76 in 1998, infant mortality rate was 6 per 1,000 in 2000 (Shenzhen Health Bureau, 2003a). The profile of mixed public/private healthcare market is in Table 6-4. For the demand-side, organised market demand covers 25% of total population. Of which, the state purchaser covers 66% of the permanent population; private commercial insurance covers 16% of the permanent population; and individual consumption, mainly floating population from other cities and rural areas, accounts for 75% of the total population. On the supply-side, 5% of private hospitals provide 7.83% of total inpatient hospital services, public hospitals get more than half of total recurrent health budget from government.

Table 6-4 Shenzhen: Profile of Mixed public/private Healthcare market, 2000

Indicators	Shenzhen	% of total
Population (1,000)	4,329,4	
Permanent population (PP)	1,249,2	29%
Floating population (FP)	3,080,2	71%
GDP per capita (yuan)	39,739	
Recurrent health budget (yuan)	12,890,000,000	
Hospital budgetary financing (yuan)	6,658,000,000	51.66%
Total hospital	80	
Private hospital	4	5%
MSA insurance coverage	828	20% (66% of PP)

Commercial insurance coverage	200	5% (16% of PP)
Inpatient stay (episode)	266,1000	
Inpatient services by private hospitals	20,8000	7.83%

Source: China Statistical Yearbook, 2001; Shenzhen Health Bureau, 2003a and b.

The exact hospital financial data on the proportion of private consumption, state purchaser and government financing is difficult to obtain during interviews, as hospitals fear disclosing staff bonus status. One interviewee suggests that:

For almost all public hospitals in Shenzhen, their income is roughly 30% from government budgetary allocation, 20% from insurance financing and 50% from out of pocket (Official, city health department).

These proportions show a consistent pattern between documented data and points made by almost all the interviewees. An approximate calculation is that if 51.66% of government financing accounts for roughly 30% of hospital income, the state purchaser and commercial insurance contribute 20% (25% of the total population) of income via service provision, the rest is mainly contributed by the floating population's out of pocket payment – 50% of hospital income. Considering that the per capita income is 39,739 yuan in Shenzhen (including the floating population), the economic analysis concludes that public hospitals in Shenzhen have no problem with survival. The issue for the state therefore is how to promote competition in the mixed public/private market.

Differing views appeared regarding the role of the state, which related to the nature of interviewees positioned in the system. For example, Shenzhen has two types of public hospitals: one is social objective-oriented hospitals and the other is entrepreneurial-networked hospitals. The hospital directors from the two types of hospitals have shown different attitudes: the social objective-oriented hospital cares about the public right of sharing information, yet the view from the networked hospital implies that the health department intervenes more than needed, and the health department should open the market more. Both directors agree that Shenzhen is a public hospital and health department dominated market, – similar to the hospital trust under NHS in U.K. The following comments show that even within the same city, the understanding of the reform issues can be quite different:

Medical services are of a public welfare nature as government claims. It is an issue of life and death. So, for those special services, resort to market; otherwise government should take responsibility for essential services (Director, social objective-oriented NFP hospital⁸⁶).

⁸⁶ This is a chronic disease prevention hospital, financially heavily affiliated to health department.

Overall, the importance of government attachment to health should be reflected in policy support and assurance of funds. There are certain things Shenzhen could do in one year; but other provinces could not handle it. I feel Shenzhen has two successes. One is the set up of the social security system: early planning and early availability of funds; another is the housing reform program. I feel government should do more on entitling the public the right of sharing information. Shenzhen has no market competition; there is only one provider [means hospital services], the government (Director, social objective-oriented hospital).

The current Shenzhen healthcare market is a supply-side dominated market. The mechanism should be changed to have the market adjust services (provision) and let the market decide what should be done. Government should change role from intervention to service; whether to have service institutions or not is the sole question to be decided by the market. Our hospital networks with Beijing [...deleted] Hospital, which are one form of marketisation, its aim is business-oriented. The integration (networking) could reduce cost, like chain stores, and have a brand name effect (Director, networked hospital⁸⁷).

The role of the government in Shenzhen is entrepreneurial, for hospitals have to get half of their income via services. Although there are worries from the director of the networked hospital, and even a bad feeling about an interventionist state in Shenzhen, yet such bad feeling could be the difficulty of balancing between too much of an entrepreneurial approach to hospitals and too tight a control of the health department. Technically, the networked hospital is still regarded as a public hospital – the issue is that the governing relationship is not clear between the two parties. In its neighbouring hospitals in Hong Kong, the Health Authority exists to coordinate the relationship between government and business operated hospitals (Yip and Hsiao, 2003). In Shenzhen, without clear definition of the terms of business operations and without the Health Authority, the governance relationship between the health department and the networked hospital is still a traditional direct affiliation – complaints are natural because the intervention by the health department affects the level of staff bonuses.

The document review at the field suggests that there is a strong state role in planning and financial management in the accruing social objective. The Shenzhen health department aims to represent the society, rather than public hospitals. There are three types of essential policy documents and regulations in existence governing the process of services (regulatory process):

- a) “Basic Medical System in Shenzhen City”, that spells out the market structure in accordance to 1997 reform paper;
- b) “Implementation Method on Medical Workers’ Professional Ethics in Shenzhen City”, and “Common Diseases Diagnostic and Treatment

⁸⁷ This is a business-operated hospital, networked with one famous tertiary hospital in Beijing; also attempting to network with hospitals in Hong Kong.

Protocols in Shenzhen City”, that spells out the rules to regulate provider preferences and medical behavior; and

- c) “Medical Institutions’ Internal Bonus Allocation System in Shenzhen City”, that spells out the rule for bonus management, in accordance to “Hospital Financial System”, and “Hospital Accounting System”, which is issued centrally by MOF and MOH (Shenzhen Health Bureau, 1999).

In the “Medical Institutions’ Internal Bonus Allocation System in Shenzhen City”, it specifies that: monthly staff bonuses should not exceed 20% of hospital income (revenue, or gross income), and annual staff bonuses should not exceed 50% of hospital surplus.

Following the implementation of the above three sets of documents, the sampling survey conducted by Shenzhen Municipal Information Department reveals that people’s satisfaction rate increased from 65% in 1999 to 85% in 2000 (Shenzhen Health Bureau, 2003a). The main strategy used in Shenzhen for regulating entrepreneurial behavior in the market is to enhance professional ethics. The triggering event was a death case, which took place under a plastic surgery; the second strategy is to strictly enforce market entry regulations (Shenzhen Health Bureau, 2003b).

The survey also suggests that Shenzhen is seemed strong in managing hospitals (Shenzhen Health Bureau, 2003a and b). Strong planning and direct management to hospitals, coupled with proportional direct hospital financing, and proportional Medical Insurance Department’s purchaser, make the healthcare market in Shenzhen fall between managed market and planned market (see Figure 5-1). In terms of managed market, there is still no clear delineation between hospitals and the health department – the governance structure is not clear. In terms of planned market, the state financial support is divided into the supply-side support that ranges from 20-50% of total hospital revenues (20% for networked hospital, and 50% for the social objective-oriented hospital), and the demand-side support is about 20-30%. So the hospital’s service income out of market-driven demand is roughly 50%. This reflects that the role of the state is closer to the entrepreneurial state (see Figure 5-2), advocating for business operation of NFP hospitals and an appropriate role for private sector in competition. The market structure is the main concern - to force NFP hospitals to be entrepreneurial by allowing the budget gap to be compensated by consumer demand and to calculate the size of private sector so as to promote competition in the to be constructed mixed public/private market. As stated by an interview Shenzhen:

In healthcare market, [now] the outpatient volume of NFP hospitals accounts for 88% of total services, impatient volume account for 97.1% now. By 2010, it is expected that FP hospital

outpatient service volume could reach to 30%, impatient to 10%. But actually, we expect that by 2006, the FP sector could reach to the above volume. This is the idea of Shenzhen city in introducing competition actively by state (Official, city health department).

Shenyang: A laissez faire healthcare market and networked state

Shenyang, a decaying industrial city in Liaoning province, lags far behind in joining the robust economy of the country. This partly relates to industrial restructuring and lack of capital market for financing modern technology. Selling SOEs, vast unemployment and laid off workers, and lack of social security systems are the main problems in Shenyang (He, 1998). The healthcare market in Shenyang has difficulty in sustaining demand, for its per capita income is 19,992 yuan, less than half of Shenzhen. Shenyang ranks number one in terms of market openness nationwide (Anonymous, 2004c). In healthcare, with decreasing budgetary support and a total of 391 hospitals in city areas, hospitals started competing from late 1980s (see Table 5-3). As stated by an interviewee from Shenyang:

In Liaoning, there are more than 2 doctors per 1000 population, which almost comes to the level of U.S. This is something like a peasant riding in a horse cart but wearing a suit – it does not fit. Supply is more than demand. Whenever there is supply more than demand, there is a market, as a competition condition exists (Official, health department).

However the total demand for healthcare in Shenyang is decreasing due to the inadequacy of the social security system, and a vast number of laid-off industrial workers (He, 1998). Liaoning reflects the fundamental issue of the healthcare system in China - financing inequity for health. Both the national health survey in 1998 and the interviews suggest that there is a decrease in service volumes (CHSI, 1999). Data suggests that in Liaoning, the doctors' service outputs has reduced by 47% from 1991 to 1999, and the hospital's service outputs has reduced by 26% in the same period, while the number of doctors has increased by 12% in the same period as seen in Table 6-5 (Liaoning Health Bureau, 2001).

Table 6-5 Market in Liaoning: Increased Capacity vs. Decreased Outputs, 1991 and 1999

Indicators	1991	1999	Change (%)
Annual outpatient visits	112,530,000	74,940,000	33
Number of doctors	88,475	99,944	12
Visits/day/doctor	6.62	3.50	47
Bed occupancy rate (%)	81	55	26

Source: Liaoning Health Bureau, 2001.

While there was a decrease in service outputs, the government financial responsibility for health was reduced, as announced by the 1997 health reform policy. An interpretation by local health officials is that the government is no longer responsible for the healthcare of the people. As stated by local health officials:

Government is intentionally and unintentionally, mainly unintentionally, giving up power, and to contract their spaces. Many people criticise 2000 urban health reform policies, so do I. The government is partially withdrawing on purpose (Official, health department).

As the supply is more than demand and the government is withdrawing either intentionally or unintentionally, the service area evolves into market. The naming of medical market is a progress in thinking (Official, health department).

The resentment expressed about health reform policies implies that the state should do more on the demand-side financial support, for there is need but no demand (Liaoning Health Bureau, 2001). The 1997 health reform policy has reduced the role of the state compared with 1954 Constitution in that, for the second stage health reform, the role of the state for health should be consistent with the level of economy (see Appendix D, Policy 2, Policy 12). Therefore, healthcare in China is not an entitlement.

Thus, Shenyang is not in the mood to carry out the 1997 health reform in the way Shenzhen does. Hospitals are focused on survival. Shenyang does not have policy documents similar to Shenzhen to regulate provider behavior. They prefer the ownership approach, which is inevitable due to increased capacity in health provision.

The policy makers in Shenyang stated that the degree of healthcare marketisation process in China is very high compared with most OECD countries where there is a planned market, the state acts as the purchaser, and healthcare is an entitlement. Shenyang could be the most marketised healthcare market in China, for it approaches a laissez faire market with 391 hospitals competing for survival. As stated by an interviewee from Shenyang:

Medical services marketisation degree is not higher roughly 60–70%, while family electronic apparatus, financing, and factor market is higher in China roughly 80%. For country specific comparison, comparing with the so-called first and second world countries [OECD]... China should be in the first 20 segment with high level of [health] market development (Official, health department).

To reduce the total size of hospitals, the market configuration in Shenyang is shaping toward two layers, which is consistent with national policy to dissolve the second service layer, through “assets restructuring, auction, selling, transfer property right, acquisition, contracting size of operation, and bankruptcy” (Liaoning Health Bureau, 2001).

The service structure evolves into two layers. Shenyang City has a well-developed transportation system, for a community with 0.5 million population, one large hospital with 3-4 community health centres and GPs [should be fine, and] which is comparable to U.S. So the amount of large urban hospitals should be reduced. Hospitals with over 1000 beds should be responsible for capital operation (Official, health department).

The hospital industry in Shenyang has resorted to the open market system while the state withdraws. Such policies also apply to SOE affiliated hospitals- a big problem in

Shenyang as an industrial base (Liaoning Health Bureau, 2001, p. 108). A laissez faire market emerged due to chaotic merging and acquisition of hospitals (Figure 5-1).

Actually, the merging and acquisition is viewed by local health officials as a way to help those hospitals difficult to operate:

The merging is actually to 'save' [SOE] affiliated hospitals. Guangdong is very fast in responding to market development, but Shenzhen City repeats the inland practice [it means strong government administrative control] (Official, provincial health bureau).

The Liaoning health official argues for an ownership approach for Shenyang city, by referring to Shenzhen's approach of state managed or planning approach – between a managed and planned market. With the heavy duplication in facilities, Shenyang has adopted the ownership approach to reform the urban hospital sector, and the role of the state changes to the networked state (Figure 5-2). As described by a local health official:

Merging relates to ownership reformation, or share holding system [reform], [Shenyang] China Medical University's Affiliated hospital has merged with Dongdi Hospital, of which the affiliated hospital has 30% of share as technology and management input, Dongdi Hospital has 70% of share as capital. Of those 70% shared by Dongdi Hospital, 21% are internal staff share. For the first two years, the affiliated hospital has the management right. It is quite an awkward situation for the affiliated hospital. "The parents shrug off their worry, attention and solicitude to their daughter after her marriage" (zhi ji de gu niang jia chu qu, bo hao ye bo guan) [it means no matter whatever it is good or bad, they don't care] an attitude taken by public institutions [in such cases]. Dalian Medical University's Affiliated Hospital merged with a private hospital (Official from health department).

Without the financial capacity to develop a health insurance system towards a rational goal governing system, the laissez faire market system in Shenyang enters into open systems (Figure 2-6). Equity deteriorates. The state as the purchaser fails. As stated by local health officials:

Market capital is expanding, and services are diversifying. It is quite similar to the U.S. healthcare market. The issue is not whether this is right or wrong, the issue is why? Or what are the health policies? "Yesterday's U.S. is our tomorrow"⁸⁸. The services system is very much like U.S. but the health insurance system is inferior to the U.S. (Official, health department).

The economic situation is not good. The income gap widens. Medical consumption is not high. The supply-side is competing in terms of setting up special service. Over-supply is comparative, and there is competition. Whether or not this is a healthy market, it is in shape, no need to debate, as it exists objectively (Official, health department).

In conclusion, the key issue in the Shenyang market is not about market structure for competition, but about the role of the state in restructuring the delivery system, and the most critical issue relates to the weakening state purchaser role.

⁸⁸ This is to note the saying in China in 1950s: "Today's Soviet Union is our tomorrow".

Jining: Development towards market and developing state for healthcare

Jining city, a poor inland city in the Inner Mongolia Autonomous Region with a per capita income of 2,700 yuan (which is less than one-tenth of Shenzhen), is representative of most cities in the western and central economic belts. It has a total of four hospitals in the city area; one private hospital is an eye hospital. Both market and state are developing. The consumer purchaser power is weak, and the public hospitals are monopolists. As described by interviewees from Jining:

The [health] market [in Jining] exists with three features or three stages, it was difficult to see doctor in the past; to accessibly see doctor as economy develops; and to see doctor or go to hospital selectively. It is inevitable to enter into market for health. But demand is for medical services, not for healthcare. The key is the level of income and consumption... Thus there is no competition in shape: medical oligopoly prevails, which affects consumption; less consumption, no competition (Official from city health department).

The medical oligopoly is the result of uneven development. The prefecture hospital is better positioned than the city hospital: the prefecture hospital has 'eaten' the city hospital. They are not on the same platform to compete, which has its own historical reasons (Official from city health department).

The central policy of separating prescription from dispensing has aggravated the financial conditions of these surviving hospitals further, as public hospitals generally lack funding in central economic belts. As described by the hospital director:

Because of the push to market when the government no longer takes care of services, there are now too many poor people, many emergency operations lead to hospital bad debt. Objectively, the healthcare market should not be to its full opening. However there is a push to the market, which leads hospitals to manage the service prices and to take care of the poor people. The hospital is in a dilemma (Director, surviving hospital).

In the past, to use drug income to subsidise medical services was hospital practice, which is roughly 15% of drug mark-ups counted as revenue. Now, there is no other way to get income for the hospital. The hospital is in loss due to such policy. Hospital management faces a challenge... Currently, management is very unitary, mostly affected and constrained by administration departments, so all the feasible or non-feasible [reform] depends on the leader's preference. Hospital should be an industry group: to accomplish certain government tasks; then leave the rest to its own, such as personnel management, financial management and price setting (Director, surviving hospital).

Jining healthcare market is less developed, public hospitals are monopolistic. It is still under the first stage health reform with no consideration given to corporate governance system. As described by the hospital director:

There must separate ownership from operation. The fundamental dilemma is system. It must separate, willingly or unwillingly... The hospital must follow enterprise management style and emphasise cost saving... For hospital development, share-holding form is the future... The government should not manage on personnel affairs and appointment of cadres... Government should formulate long-term objectives and responsibilities for hospital. The government should not deal with cadre appointment... In the future, the hospital director is a businessman; the

deputy director is a professional person...Hospital should base on own thinking to develop without government intervention (Director, surviving hospital).

The perception from the health department in Jining focuses more on vaguely expressed idea of competition without analyzing the conditions instrumental for competition. It is hard to see any impact of 1997 reform policy in this poor city. The field study found that the 1997 reform policy was passed by the province, yet there is no action plan issued by the city health department to implement the reform policy. As stated by the health official, the local health department would like hospitals to act on their own to implement the reform program:

Competition mechanism and service quality control are issues. There are talks on share-holding hospital or development of special hospital as development direction. Here, TCM & TMM (traditional Mogul Medicine) hospital comes to the verge of closing because of poor operation and management. Now it is to encourage private hospital development. I myself need to change concept either – from previously not approving private hospital entry to encouraging private hospital development (Official, health department).

At the time of planning era, the institution wrote a report to government, then to get the approval from finance department of government, so to get the salary and delivery the equipment. It is very easy to be a leader, no worries, but the hospital has no decision right. Now, hospital receives fixed subsidy from government that is, 42% of total hospital income is from government budgetary support; the rest 58% has to rely on hospital to earn from special services... Hospital development has to rely on its own idea/strength without the support from government finance department (Official, health department).

The overall impression is that healthcare system in Jining is in early transition, the role of the state is not active in terms of state-led market development as detailed in Table 6-6.

Table 6-6 Developing Market in Jining: Weak Market Demand and Provider Monopoly

Indicators to capture the developing market	Value
Per Capita income (RMB yuan)	2,700
Total hospital	4
Private hospital	1
Proportional of government budgetary support (%)	42%
Proportion of income from out of pocket payment	58%
Main source of income for surviving hospitals	15% (drug's mark up)
Role of state purchaser (no data collection system)	0

Source: China Statistical Yearbook, 2001; and interview findings.

In summary, the healthcare market in China is stratified by economic belts and diversified by innovative governance arrangements between hospitals and health departments. The reform approaches taken by the provinces lead to three different healthcare markets, Shenzhen market is between management market and planned market,

Shenyang market approaches a laissez faire market, and Jining is a developing market (see Figure 6-1).



Figure 6-1 Healthcare Market Distribution in Three Cities

In accordance with different reform approaches, the roles of the state in the cities are: an entrepreneurial state in Shenzhen, a networked state in Shenyang, and a developing state in Jining (see Figure 6-2).

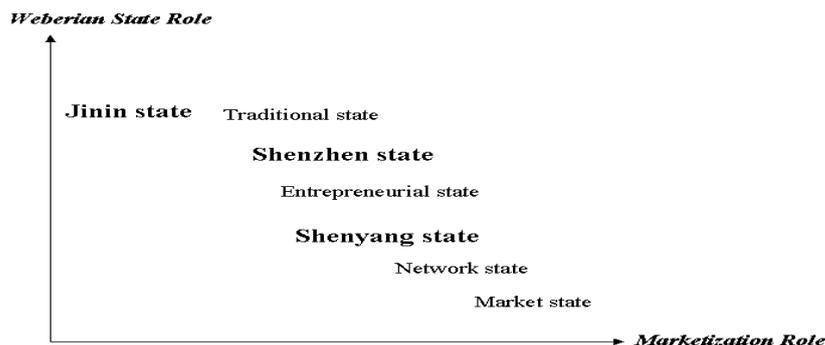


Figure 6-2 State Role Distribution in Three Cities

Summary: Implications for design and implementation of regulation

Around the turn of the century, the economic reform program and epidemiological transition have led the formation of three types of purchasing power for healthcare in China: increased average purchaser power, policy purchase for essential services; and diversified individual purchase. The challenges to the healthcare system are how to respond to the consumers’ increased expectation for high tech services and expensive drugs; how to plan for policy purchase; and how to provide diversified services to different segments of the population.

The first stage health reform was a spontaneous decentralization and marketisation process that partially responded to the above challenges by creating a stratified healthcare

market along the coastal belt, which gradually stretches to the central belt and presumably to the western belt. It created a diversified mixed public/private market within the coastal belt. For a public/private mixed market, the research in the three sampled cities finds that there is a mix of managed and planned markets in Shenzhen, a laissez faire market in Shenyang, and a developing market in Jining. Also, the role of the state varies amongst the entrepreneurial state in Shenzhen, the networked state in Shenyang, and the developing state in Jining.

Broadly, there are three approaches to implement the market-oriented reform policy: the planning approach, ownership approach, and a hybrid approach under the conjunction between the first stage and the second stage of health reforms.

The ‘macro control, structure adjustment’ policy in Shanghai is a typical planning approach. The structure adjustment for service diversification to achieve technical efficiency and also for facility rational distribution to achieve allocative efficiency could achieve the equitable distribution of services according to perceived need. The macro control for total health expenditures is to contain high cost, high volume competition and so to obtain social efficiency at the macro level. This, however, needs sophisticated management resources and expertise to realize.

The ownership approach in Shenyang is to obtain dynamic efficiency in a competitive environment. There are various types of innovative governance arrangements generated between hospitals and the health department. The dilemma for this approach is that it has to address governing structural issues and operational issues as well, that is, how the corporate governance system works within public governing system.

The hybrid approach in Shenzhen is to emphasize open system competition by having entrepreneurial NFP hospitals competing with private hospitals. In essence, the idea is similar to that of creating a managed market in the U.K. with its aim is to create contestability (Ham, 2003, pp. 265-304).

Therefore, there is an emerging dynamic and stratified healthcare market in China (Fudan Hospital Group, 2004). By 2004, it is estimated that there are about 1400 privately operated hospitals in China, with most distributing along the coastal belt (Lei, 2004). The diversified healthcare markets within the coastal belts vary reflecting the open systems governing approach.

Basically, two fundamentals, that is, financing inequity and governing systems that lead to a ‘public identity, private behavior’ healthcare system under the first stage health reform are just being addressed (see Table 6-7 below). It means that the regulation

process and governing structure lags behind what the market requires. It therefore leaves the technical regulation no institutional base to be effective.

Having established the picture on the extent of marketisation in China, the next four chapters are to present findings on regulating towards markets, regulating market entry and institutional performance, and the state regulatory system and compliance system in transition.

Table 6-7 China: Emerging Healthcare market Characterised by Marketisation Parameters

Marketisation parameters	Presentation of stratified and diversified healthcare market		
Economic reform has driven the emerging healthcare market and healthcare demand.	Increased average purchase power – income elasticity for healthcare increases.	Essential services for low-income population – the emerging of state purchaser for services.	Population profile and epidemiological transition - services diversification.
Geographic location has stratified the market.	No market conditions in the Western belt.	Emerging market signs in the Central belt.	Regulations required in the Coastal belt.
Marketisation approach represents varied policy objectives in responding to issues faced by the delivery system in the first stage health reform.	Planning approach in Shanghai: to promote technical/allocative efficiency, and the distributional equity in responding to need.	State mediated competition in Guangdong: to enhance open system competition by introducing private sector in the mixed public/private healthcare market.	Ownership approach in Liaoning: to promote dynamic efficiency – for survival of excessive NFP hospitals.
Governance innovation has diversified the markets in different cities	To plan towards developing healthcare market in Jining.	Mix of managed and planned market in Shenzhen.	Approach to laissez faire market in Shenyang.
Role of state on public hospitals reform.	Developing state in Jining.	Entrepreneurial state in Shenzhen.	Networked state in Shenyang.
Two fundamentals	State as purchaser and state as regulator governing NFP hospitals.		
Objectives of the second stage health reform	Develop rationale goal governance model – state purchaser for healthcare depends on the level of the economy; and develops an open system governance model – to define governance arrangement between NFP hospitals and health department so to spell out the regulatory responses.		
Regulatory implications	a) Financing/price policies, and tax policy; b) governing structure of NFP hospitals; and c) regulatory (process) tools to correct market failure.		

CHAPTER SEVEN

ECONOMIC REGULATION FOR MARKET STRUCTURE AND FUNCTION

Equity and efficiency are the primary health policy objectives at the system level (see Table 3-3). This chapter explores technical regulatory tools to balance equity and efficiency in the context of marketisation as China enters the second stage of health reform. This chapter has assessed the economic regulatory tools for market structure and function. It finds that in China, in regulating market structure, the role of the state purchaser is less obvious, because the state financing tool is crippled, and it is unable to manage organized purchaser to influence the provider. For the supply-side, the existing governing system limits the usefulness of planning tools. For the market function, issues exist in the private sector such as irregular activities, uneven playing field, and unfavorable insurance arrangements. The regulatory responses are to use health planning and market entry to regulate the size of the private sector. The issues in the NFP sector are that overall market institutions are not ready to conduct themselves in healthy competition, particularly as the price signal is not market-mediated. This chapter concludes that both performance-based regulation and technology-based regulation are not applicable to China, mainly due to that financing, price, and market institutions are not ready for transition in China.

This chapter first assesses the financing and planning tools to regulate the formation of the market structure, then, it assesses the regulator tools to enhance the market competition, that is, to enhance the social efficiency of private hospitals and the dynamic efficiency of the NFP hospital sector.

Financing and planning to regulate the formation of market structure

With the first stage health reform, China entered into a stratified and diversified market. Two roles of the state emerged are the purchasing of essential services and the planning to reform the NFP hospital sector. This section presents findings on the regulatory tools that form the market structure.

Crippled financing tool (state purchaser vs. out of pocket consumption)

The institution-based GIS/LIS insurance collapsed in the middle of 1990s because of the decentralization program was to detach individuals' affiliation from their institutions, in order to have a socialized social protection system. The replacement of GIS/LIS is MSA insurance system was started in 1998.

The objective of MOLSS was modest at the time (see Appendix D, Policy 13). By 2003, the coverage of MSA was 55.2% of the total urban population, revealing a decrease in insurance coverage in the past decade as seen in Table 7-1, and a decreasing role of the state for healthcare. Financing for health insurance is a major failure in China (He, 1998, pp. 218-224; Killingsworth, 2002).

Table 7-1 China: Deceasing Urban Health Insurance Coverage (%), 1993-2003

Year	1993	1998	2003
Urban health insurance coverage (% of urban population)	72.7	55.9	55.2
Rural health insurance coverage (% of rural population)	15.9	12.7	21.0

Source: National Health Service Survey (Rao, 2004).

Like many healthcare systems in transition, MSA serves as a financial reimbursement institution, rather than an active state purchaser to influence provider behavior. Therefore, technical regulatory tools used in planned markets are less useful for the Chinese market⁸⁹ (Phua, 1999, personal communication). Interviewees from MOH expressed their concerns about the role of MSA, mainly because the level of financing from the state was inadequate and the payment procedures were not sorted out. One exception is the mix of planned and managed market in Shenzhen where MSA coverage is 66%, and private insurance coverage is 16% (Table 6-4), suggesting an active purchaser role in Shenzhen.

The market economy in China has stimulated demand that is stratified by economic belts and diversified by both income and epidemiological transition. That the state would be a purchaser and subsidize those unable to afford care emerged in the second stage health reform is a major change of concept on the role of the state. As stated by one senior policy maker:

The system in the era of planned economy has achieved internationally accepted good results. Under transition, the issue is the widening gap of income and the obvious social strata formation.

⁸⁹ There are a couple of issues here, the first is system-based data on cost and clinical practices, the second is the criteria to make the payment based on the data system, and the third is to establish market based price through contract between hospitals and Medical Insurance Departments.

[This relates to] public financing. The financing follows disease epidemics: when there is a problem; then there is a strengthening measure of financing. Issues are: no input in advance, discrimination between rural and urban with the view that the financing depends on the level of [tax revenue] contribution, and political contribution at leaders' discretion. The public financing policy is still influenced by earlier Finance Minister Li Xiannian [in 1950s]. At the time, the financing was largely for industrial workers due to their large contribution; less for rural farmers due to their small contribution; and zero for intellectuals as intellectuals are useless in contribution in tax/revenue terms (MOH think tank).

The 1997 health reform policy has basically reduced the role of the state, compared with the statement in the 1954 Constitution. This means that any further change on the role of the state as purchaser has to wait until another major shift of policy announcement. It means that under the second stage health reform, the nature of healthcare was swinging between the private good and the public good. As stated by one policy adviser:

Use of medical insurance ... is a method of market... how much government will manage [means to purchase/commission]? What are the levels of government protection? So [it is] based on the adjustment of medical insurance policies (MOH policy adviser).

With a stratified economy, all the interviewees believe that a universal benefit package of MSA across the country is not feasible. Therefore, the targeted subsidy for the poor and the needy population is under consideration so as to reflect the role of the state in healthcare.

The responsibility for financing service provision could be divided into government responsibility and individual responsibility. In the U.S. the government is responsible for: science and technology development such as National Institute of Health, public health, and essential services, Medicaid and Medicare programs (Policy analyst).

Such considerations relate to public financing reform. Yet, public financing reform concerns political reform, for instance, to change relations and functions of government organs (Qing, 2003, p. 132), it seems that there is no one-off solution and quick fix as it is an issue related to the social institutions. As perceived by one policy maker:

The public financing reform program is under consideration. Over the past 20 years, the government has pursued revenue [collection] system reform. It basically resolved the financial revenue issue [means tax reform program]. In the future, it moves to how to distribute revenue or public financing reform. I would say it would at least take another 20 years or more, and it is more difficult as it affects everyone's interest. It also relates to the sphere of responsibility of program/activities and their ensuring financial rights between governments. The public financing reform program will affect MOH policy on deciding the nature of hospital and policy thinking direction (MOH policy maker).

Given the nature of transition, one MOH official said 'the insurance system now is very superficial, just simply aiming to suit to the market system'. The failed role of the state as purchaser is a market failure (Killingsworth, 2002). Apart from the state purchaser for essential insurance, China also pilots supplementary health insurance. The exact size and nature of such supplementary insurances vary. Currently, the

supplementary insurance is managed and encouraged by the Medical Insurance Department, which means that there is no market entry issue for the time being.

The demand for private insurers comes from the market-driven consumers. They choose to enrol in commercial insurance schemes such as People's Health Insurance, Pacific Ocean Health Insurance. The private health insurance in China is service-specific and targeted at the upper income segment of the population. The government has no fiscal instrument to develop the private health insurance market, for instance, lifetime cover and tax exemption as used in Australia (Francesca and Nicole, 2003).

On the demand-side, eventually, there may be three clusters of buyers' concentration, the market-driven individual consumers, the state purchaser for essential services, and commercial FP purchasers for specialized services. This demand-side financing structure poses challenges on payment arrangements between various NFP hospitals (with partial subsidy from state) and various insurers, for instance, 'the poor subsidizes the rich' may take place. Planning as a regulatory tool to construct market structure is therefore necessary.

Planning in the formation of mixed public/private market structure

In 2001, for urban China, there were 29,000 previously MOH affiliated public hospitals and 7,300 enterprise affiliated hospitals (Killingsworth, 2002). The supply-side reform converted almost all of the above two categories of hospitals into NFP hospitals. By 2004, it is estimated that there are about 1400 privately operated hospitals in China. Most of them distribute along the costal belt (Lei, 2004). Planning is the main tool in restructuring the service delivery system, although different concepts of planning exist, as seen in Table 7-2.

Theoretically, five concepts of planning⁹⁰ can be found under marketisation:

- a) Planning approach in Shanghai to address allocative and technical efficiencies;
- b) Ownership approach in Shenyang to address dynamic efficiency, for instance, networked hospital and share-holding hospitals;

⁹⁰ For MOH, two concepts of planning frequently used are: a) integrated sector management that emphasizes to integrate SOE affiliated hospitals into umbrella management; and b) regional health planning that traces hospital distribution to represent the perceived need to achieve allocative efficiency. These two concepts used by MOH can be grouped into the planning approach.

- c) State mediated competition in Guangdong to enhance social efficiency by introducing private sector competition (to expand the production frontier outward);
- d) Policy purchase that addresses social entitlement; and
- e) Planning for the size of state production for healthcare.

Table 7-2 Approached to Achieve Equity/Efficiency in Mixed public/private Market

Approaches	Need (equity)	Demand (efficiency)
a) Planning approach: to plan to respond to need and demand such as in Shanghai.	Allocative efficiency, to rationalize facility distribution according to need.	Technical efficiency, to respond to market demand by service diversification.
b) Ownership approach: to plan to marketise NFP hospitals to gain dynamic efficiency such as Shenyang.	Social optimum between need and demand, by reform NFP sector so as to have business operations of NFP hospitals.	Dynamic efficiency, to marketise NFP sector for survival of NFP hospitals.
c) State mediated competition: to plan to introduce private sector to compete with NFP sector such as in Guangdong.	Enhanced social efficiency, by determining the size of private sector in the total market so to promote competition.	Planning for private sector to compete with public sector.
d) Planning for state purchase, to determine the size and content of essential care organized by MOLSS.	Planning for essential services – public good.	With its side effect as directing price signals in the mixed public/private market.
e) Planning for state production, and the size and services organized by MOH.	Planning for developing public hospitals – public good.	With its side effect as directing price signals in the mixed market.

In the above, D and E are policy instruments in that they could direct the price signals in the mixed public/private market. State mediated competitions will be discussed in chapter eight in relation to regulating private sector entry. The planning for state purchase has been discussed in the above. The planning for state production or fully budgeted public hospitals will be discussed in chapter Nine and Eleven. The following section contrasts the planning approach and the ownership approach, in relation to the formation of market structure.

The planning approach in the market should be differentiated from the traditional planning concept under the planned economy. The traditional concept of planning can be traced back to the planning system culture. Largely, the planning system is an administrative approval process. Health facilities are planned based on an administrative structure that leads to duplication of resources in a geographic area. As described as an interviewee:

We ourselves call planned economy; actually there is no planning at all. It is a procedural approach, it only emphasise process without considering the input and outcome management. Let others to follow the order to do business (Official, NDPC).

With health planning, which is to manage the totality of health resources based on geographic areas, the aim is that health facility distribution approximates to need. This is the wishful concept of improving equity from supply-side restructuring. Based on this concept of planning, the central role is policy formulation, the province's role is planning, and the prefecture or city's role is program implementation. The city is now regarded as the base unit for planning. The problem with the planning approach relates to the existing governing structure, as the responsibility of each level of government is not clear. As pointed out by an interviewee:

The regional health planning policy is to manage facilities according to its geographic territory, and to be managed by due health administration... Beijing city health department should manage/plan Beijing Medical University affiliated Hospital (MOH affiliated university in the past and now MOE affiliated university but the hospital is still managed by MOH), but actually they can't manage/plan it. West District Hospital [in Beijing] is managed by West District Government, not Beijing city health department (MOH think tank).

Another problem is that the fiscal system determines hospitals' affiliation to governments. The underlying problem is that the social structure is organized with government departments and that all government departments would like to hold the power from their department's perspective instead of a social perspective. This is a major barrier with the use of the planning approach to rationalise facilities. One health policy analyst sarcastically said that, use of planning 'will have quite a long way to go, it is the intellectuals talking on current affairs [means academic, not practical, and difficult to have action]'. Another interviewee expressed similar feeling:

The reason is the fiscal decentralisation management system; each level of government is responsible for each level's affiliated institutions. For regional health planning, it is not a hard requirement but quite soft requirement. So the officials see the difficulties and hard to reach, then they just don't touch it. Their mood is of Laoist thought as to be non-act (wu wei re zhi). This more reflects the incapacitated-ness of the officials (MOH think tank).

The ownership approach is to distance NFP hospitals from the health department. The central idea is to address demand and to survive under marketisation. Yet the issue is that there is no clear governance arrangement made so far – what is the mechanism for arms-length governance between health departments and hospitals. Therefore, both governance arrangement and operational mechanism are critical for the ownership approach to achieve a social optimum. As one interviewee expressed:

Even during the planned economy, there is still no allocation of resources based on need. This is only an assumption. Under the planned economy, the resource allocation is based on possibility [means shortage of health resource and rationing]. The market requires responding to demand but also it should consider need. Wise businessmen will and shall consider need. China has a saying, "hanging the sheep head but selling the dog's meat [gua yang tou, mai go rou]. Seven

persons run a hospital using the planning [mechanism] but of which three persons may already use share holding [mechanism privately] (Policy analyst).

Therefore, health planning is concerned with fragmentation and duplication of facilities, which is determined by the social structure and social relations (Weissert and Weissert, 1996, p. 121). Public financing policy and governance arrangements are two fundamental issues that affect the state as a purchaser and as a regulator. During transition, the financing tool is crippled by flexibility in interpreting the rational goal, and the planning tool is obstructed by the existing governance system. The performance-based regulation is therefore not feasible due to fluid financing arrangements. The technology-based regulation is also not applicable as the conditions for open systems governance are not ready. The effectiveness of the market structure regulatory tools is therefore compromised, as issues are still to be addressed in the second stage health reform. The market structure and possible technical regulatory tools to mediate the market are summarized in Table 7-3.

Table 7-3 Mixed public/private Market Structure: Issues and Regulatory Tools

Mix	Demand-side	Regulation	Supply-side	Regulation
Private:	Private insurer: Size is? Private consumption: 44.8% is uninsured.	Planning and market entry	Private hospitals: 1,400; Accounts for 3.7% of total hospitals;	Planning and market entry (state mediated)
Social:	Supplementary health insurance: Size is? Divided by IP supplementary insurance and OP supplemental insurance;	Managed by MIDs; it expects to integrate to private insurer	NFP hospitals: 36,000; Divided by social objective-oriented hospitals, networked hospitals, and share-holding hospitals	Planning and ownership reform; governing arrangement with health department is an issue.
Public:	MSA purchaser: 55.2%, equivalent to 40% of total health expenditures;	Financing issue for uninsured	Public hospitals: 0; (only as a policy option at the moment).	Financing/price policy is an issue

Source: CHEI, 1999, p162; Rao, 2002; Chen, Ying et al., 2004; Liu, 2004, personnel communication.

MSA was deliberately put into public rather than social sector.

Regulatory tools to enhance market competition

Given the crippled state financing system, China has difficulty using regulatory tools used by most OECD countries in their planned markets. China therefore has to consider a regulated market as in the U.S. Theoretically, in a regulated market (from the least intrusive to the most intrusive), the regulatory policy models are: elective model, directive model, restrictive model and prescriptive model (see Table 7-4). These models deal with regulating market function (or competition), quality and quality information disclosure

(see Table 3-5). With a reference to these models, the following section reviews the existing regulatory tools in regulating both the private sector and the NFP hospital sector in China. This thesis argues that without the development of appropriate policy models at the market level, to simply borrow any regulatory tools to regulate competition is impossible because of a lack of market governing framework, particularly with respect to the competition practice and information asymmetry.

Table 7-4 State Regulatory Policy Model

Model	Explanation
Elective model	Aims at correcting market failure, e.g. NCQA and HEDIS ⁹¹
Directive model	Government voices for desired behavior by availing incentives, e.g. reporting cards, government purchase power in setting minimum quality standards for participating Medicare and Medicaid programs
Restrictive model	Government dictation when social cost of free market greater than social benefits of increased choice, e.g. mandated benefits to require sufficient services provided, and avoidance of risk selection
Prescriptive model	Interventionist government actively dictates statutory external review on FP organizations' service

Source: adapted from Altman and Rosman 1999.

Regulating competition by introducing the private sector

The excess-entry theorem⁹² holds that free entry equilibrium is socially excessive in homogeneous product markets, and is the justification for entry regulation (Von Weizsacker, 1980; Perry, 1984). Other justification for regulation includes income transfer (transfer income to CEO from laying workers off), fairness (monopoly power wants to restrict competition allowing consumers to shift to alternative providers providing identical quality care) and power concentration (control supply so to transfer income to high-tech medical technology). This thesis argues that, due to product differentiation (service diversity), and imperfect competition (vertical oligopoly by NFP hospitals with networking) in China, although NFP providers are excessive, to allow more private providers to compete with NFP hospitals can obtain social efficiency (Ghosh and Morita, 2003).

⁹¹ These are groups for assessing quality of plans by National Committee o of Quality Assurance (NCQA) and their performance by Health Plan Employer Data and Information Set (HEDIS).

⁹² In a homogeneous market, with the increasing of firms, their outputs tend to fall, it is called the "business-stealing effect". Social welfare goes down and that justifies the entry regulation (Ghosh and Morita, 2003).

Therefore, the introduction of the private sector can enhance social efficiency by enhancing production efficiency (technical efficiency at production level), consumption efficiency (substitution in relation to consumer propensity), and product mix efficiency in responding to service diversification (Anonymous, 2003b). At competitive equilibrium where it is pareto-optimal, welfare is maximized⁹³ (Lange, 1942). Therefore, social efficiency is obtained. Regulation, therefore, aims at maintaining a competitive market so that the private sector can exert their role to achieve production efficiency, consumption efficiency, and product mix efficiency.

Interviewees from the social sector, the government and the private sector all expressed the view that there is imperfect competition in the emerging private sector in China, mainly due to service irregularity, illegal practices, lack of a level playing field between public and private practices, and discrimination against private practice in insurances. Thus, the research concludes that private market regulation failure exists.

a) Views from the social sector:

The opening of the market has disturbed the health services and has resulted in chaos. For example, some private medical institutions [self-employed and/or private clinics] have spread their advertisements everywhere; they also want to change private clinics into hospitals by introducing medical equipment (Director, hospital).

Many individual practices are without licenses, they are scattered in every corner. During its daytime, the door is closed but at night, they open the door and put a Red Cross on their door to provide illegal services (Director, social objective-oriented hospital in Shenzhen).

b) Views from the government:

The competition is not orderly, there are wide spread illegal practices, although actions to strike hard are being taken but they are still endemic (Official, health department in Inner Mongolia).

c) Views from the private sector:

The private hospitals are to be supervised by, Price Administration, Drug Quality Control Institute, Calibre Supervision Department, and Medical Services Quality Control Centre. The latter has been set up [only] recently, it [Medical Service Quality Control Centre] is assigned by other [peer] hospitals to issue reports to administration and then action is taken [for any poor quality by administration] (Chairman, private hospital).

Supervision differs. For supervising public facilities, hospitals would make nice arrangement. Supervision bodies ask fewer questions, and to cover up issues. For supervising private hospitals, the legal person has to avoid being at the site so to ask supervision bodies to have strict inspection (Chairman, private hospital).

⁹³ The so-called first and second fundamental welfare theorems hold that, competitive equilibrium is pareto-optimal, and that pareto-optimal allocation can be achieved at a competitive equilibrium after a suitable redistribution of initial endowments (Lange, 1942).

If we can run a good private hospital it is a contribution to society. The hospital director would not necessarily seek to maximise profit. The Government, don't consider this issue...In the future, as long as the government holds fair views; to recognise the private sector from the perspective of market economy and no public monopoly, then it is easy (Chairman, hospital group).

[Both FP and NFP hospitals should] litigate to the justice [dui bo gong tang]: the government appoints special hospitals that are eligible for insurance payments. And only one-third of hospitals have been appointed; the procedure [to be appointed] is very high now. There are too many drugstores. The hospital has been squeezed badly by drugstores. Vice Premier Li Lanqing's policy to reform hospitals by separating hospital pharmacies from hospitals, has had the effect of drug sellers becoming the nouveau riche (Chairman, private hospital group, Shenyang).

The health department's view is that we have not handled public hospitals well, let alone NFP hospitals [to shrink the role of the state]. In Dalian City, there is not a single private hospital that participates in health insurance. But we participated in health insurance; currently there is no discrimination. 'Matters are handled by people, it depends on people' (si zhai ren wei) (Chairman, private hospital, Shenyang).

The above opinions are consistent with other research observations in private sector development in China (Lim and Yang, 2002). As a transitional economy, China has a vertical NFP hospital oligopoly medical market. Further development in the private sector concerns government tax and price policies on the private sector.

To change feudal closeness to openness, foreign consortiums want to run hospitals but they have difficulties in implementation. And the returns are not as good as expected. Three reasons: first, low consumption. Second, current policy on hospital classification which tries to integrate into the international market, but still it has differences. The joint ventures are FP hospitals, and they have to pay tax. But there are conditions for overseas FP hospitals to pay tax, in the U.S., if FP hospitals have provided assistance to the poor, then it is tax exempt. In China, there is no tax-exempt policy for FP hospitals; so overseas consortiums are unwilling to invest. Third, currently, the fee charging is not based on cost, and prices are very strictly set. Government fixes the prices of NFP hospital and drugs. We want to relax drug prices but due to the factor of health insurance it is impossible to relax. Although the medical service prices now are open to the market, it actually can't open, for example, if all the eggs are 2 yuan per half kilo, you can't sell at 2.1. The price is decided by the market, it has no relation with government. [So], price opening is nominal, it should use the market to make adjustment. Based on the above, they [private hospital investors] think that it is not fair, so they don't want to build joint hospitals (Official, health department in Shenyang).

Currently, as the total private sector is only 3.7% of the total number of hospitals in China, the regulatory response is rather lax, informal and irregular management practices prevail. As one private hospital chairman mentioned, 'For private hospitals, there is no tax invoice made available to pay tax'. The policy is that 'for FP hospitals, within three years of establishment, they are tax-exempt. The tax rate is not determined yet, and the government has no [policy] documents for it as fewer public hospitals convert to FP hospitals' (Central official, responsible for price setting).

The regulatory responses to the private sector are to use planning principle to plan for the role of the private sector in terms of production efficiency, consumption efficiency, and product mix efficiency, and to use Medical Institution Management Ordinance to qualify for market entry (see Appendix E, Law 4). For a competitive market, the corporate system is the main advantage of private hospitals, while the disadvantages for the private sector are in the existing system and structure.

To arrange upgrading of professional title, each person has to pay the fee to the Medical Association for registration. For our private hospitals, we ask staff to pay first and then reimburse the payment through our hospital. The public hospital refuses to pay the registration fee. Also professional title has a quota limit. Assessment and recruiting are separated, public hospitals deal with this seriously while the private hospital doesn't care at all. Hospital directors get commissions in public hospitals. The private hospital has no commissions (Chairman, private hospital).

The private hospital spends less and it controls spending, the public hospital spends more and the hospital director increases spending. The public hospital has heavy burdens, historical, social and human relations. The private hospital is that 'one is one and two is two'. It has a normal profit (Chairman, private hospital group).

The conditions are not sound for private hospital development, and they have no momentum for the time being. Society should take responsibility for this. Private practice is just starting, it faces resistance, and it is difficult to compete with public counterparts. This has relevance to the system, which is more difficult to change. I can't see an active change of system for now (Director, networked hospital, Shenzhen).

As the private health sector emerges in China, issues that need to be addressed are: non-competitive market institutions, such as irregular activities, and an uneven playing field. The regulatory responses are 'striking hard' (which is a policemen's action), planning and market entry. The regulatory approach is state mediated competition. There are few tools to manage private hospitals, as one city health official stated, 'there is no management method to control private services, and the only tools are entry and integrated sectoral management [that is health planning]'.

Therefore, it seems that the policy models used in the regulated market in the U.S. have almost nothing to do with regulating the private sector in China, because of the irregularity of practices and a lack of market institutions in the transitional economy (see Table 3-6, p. 49). Thus, this study argues that the state's regulatory intervention should be more prescriptive than the mere use of 'striking hard'.

Guided by the policy models, the regulatory tools used in the regulated market in the U.S. focus on market function, quality and information. For instance, while Medicare and

Medicaid programs use the directive model to correct market failure⁹⁴, they have also brought a set of regulatory tools to be used to govern the market (see Table 3-5, p. 45). With the above, the following section presents an assessment of regulating on market function- that is competition, sub-markets (labor market and insurance market), and information of the NFP hospital sector. Regulating quality will be discussed in chapter eight in relation to social regulatory tools.

Regulating competition (of the NFP hospital sector)

Competition practice: both quantity and quality-based competition exist

In order to survive in the marketplace, the prevailing practice of NFP hospitals is to network with each other. This trend of development is of an oligopolistic nature, that is, it relates to NFP provider concentration. As stated by an interviewee:

As for the market, the competition culture spreads very rapidly. 'All the misfortune comes out of competition' [dou shi jin zhen re de huo]. The result is the concentration of advantageous resources. In the late 1990s, several hospitals monopolised the market in Shenyang City. China Medical University has two affiliated hospitals, its revenue accounts for 10% of total resources in the city, which is equivalent to 15% of total outpatient service volume, 20% inpatient and surgical operations volumes. The competitive entities ten years later will evolve into a situation, which the stronger becomes stronger; and the weaker more weak (Official, provincial department in Liaoning).

The central idea of the second stage health reform is to introduce competition (see Appendix D, Policy 12). Opinions expressed on competition practice vary from respective roles of public and private sectors, fair treatment of private practice, to comparative advantages and so on. Some are concerned that the number of social objective-oriented NFP hospitals may shrink:

Due to the new opening of the market, now private hospitals have to compete with public hospitals. I am not fully in agreement with this. We need to find a point of balance where both public and private hospitals can all have a space [chance] to develop. Otherwise, one party may shrink (Official, health department).

Although competition is a buzzword, there are different ideas about what are competing for. In Shenzhen and Shenyang, many interviewees suggest three perspectives of competitive mechanisms:

⁹⁴ The transfer payment is viewed from Potential Pareto Improvement – everyone is better off, and gainers can fully compensate the losers for their loss and still be better off – the so-called Kaldor-Hicks criterion. In this thesis, such compensation is realised through a political process - a state purchaser (Kaldor, 1939; Hicks, 1940; Stavins, Wagner, et al., 2002).

- a) To compete for more patients – quantity-based competition, this competition mode implies high cost, high volume competition. As stated by an interviewee who has experienced laissez faire market in Shenyang:

Competition [in this context] means competing for more patients. According to World Bank estimates, 20% of the population spends 80% of total health expenditures. The overseas institutions will find ways to capture this 20% of the population (Policy analyst, Shenyang).

- b) To compete for better services, implies for quality-based competition. As stated by an interviewee who has experienced partly managed and partly planned market in Shenzhen:

Competition means competing for high standard services, amenable environments and technologies, personnel and management mechanisms. On personnel, it is the competition of opportunity, proper treatment and status, and sense of satisfaction to the surrounding environment; on management mechanism, according to ISO 9000, if you adopt the ISO 9000, your cost will be reduced by 50% (Policy analyst, Shenzhen).

- c) To compete for quality (in the perspective of consumers) between the public and private sectors. As stated by an interviewee:

Regarding service competition between the public and private sector, it is mainly competing on capability, quality, and amenity and staff attitude. People generally satisfy 'hotel services' and attitude of the private practices as 'cut one knife tender' [wen rou de yi dao] (Policy analyst, Shenzhen).

Jining is more concerned to create the condition for contestability. The official from the health department in Jining summarized the typical situations in economically less developed areas as: 'low consumer demand', 'hospital oligopoly', and 'slow system change':

The key is the level of income and consumption. Families have no health investment plan. So, there are still inadequate health resources overall in terms of talented personnel, technology and equipment. Thus there is no competition. The medical oligopoly prevails, which affects the consumption, that is, less consumption, no competition.

The medical oligopoly is the result of uneven development. In terms of advantage, the prefecture hospital is better positioned than the city hospital: the prefecture hospital has eaten the city hospital, now they are not on the same platform to compete, which has its own historical reasons. To introduce private hospitals and to shape competition in quality and technical capacity is an urgent issue; other sectors are already ahead of the health sector. The comparative advantage is in big hospitals, small hospitals have difficulties in retaining quality personnel.

The core issue is to promote competition, and to improve competition [conditions]. Competition mechanisms and service quality control are issues. There are talks on share-holding hospitals or the development of special hospitals. Here, the Traditional Chinese Medicine and Traditional Mogul Medicine hospital comes to the verge of closing because of poor operation and management. Now the policy is to encourage developing private hospitals. I need to change concept either, from previously not approving private hospital [entering in the market] to encouraging private hospital development (Official from Jining health department).

In summary, ‘competition mechanism’ and ‘service quality control’ are two frequently used words and ‘system change’ is fundamental to bringing the market into function. Therefore, to improve dynamic efficiency, many interviewees suggest promoting competition by introducing the private sector as the aggressive competitor in enhancing production efficiency, product mix and consumption efficiency. As stated by an interview:

Currently the competition is not on the same start-up line such as price and so on. Introduction of overseas hospitals may lead to real competition (Official, health department).

Distorted price does not function well as a regulatory tool

The decentralization program in China introduced a dual price system: market-based prices and planning-based prices. In the health sector, starting from 1985, the service price (derived from human capital and considerable) is based on a planning system, when the new medical technology and new drugs are market-based price (Appendix D, Policy 4). Since the 1990s, reform on service prices aims to have price approaching cost. As stated by an official from MOF, ‘by 2005, the price will gradually approach cost, and the government will withdraw from medical service support. Until this stage, there will be still subsidies from government’. The price structure is distorted as of the dual price system (World Bank, 1997b). A study reveals that by 2002, 56% of the price schedules is higher than cost, 44% of the price schedule is lower than cost (Meng, 2004).

To compensate for the lower price of human capital, there is budgetary allocation to hospitals for subsidizing staff salaries. As stated by one official from MOF, ‘There is still limited allocation based on bed day and outpatient volume, as their price is lower than cost – this is the theory support for allocation’. Therefore, MOH is to standardise cost items in order to establish price⁹⁵. The issue is how to compromise between expensive diagnostic prices and lowly priced services. As stated by an interviewee:

⁹⁵ The central official responsible for price setting said that:

“The central government is responsible for setting up items such as services, drugs, and medical supplies, cost estimate method, and pricing principle. The provincial governments are based on items to set up pricing. For medical services, the pricing work could also be decentralised to prefecture and city levels.

For drugs, within the health insurance scheme, SDPC determines the price. For type A-drugs or common drugs, where they are 100% reimbursement, SDPC sets the highest retail price; For type B-drugs, where they are partial reimbursement, SDPC sets discretionary price with floating range of minus and plus 5%. Outside of the insurance scheme, drug price is market-adjusted. For medical supplies, government only manages key items, and the pricing setting follows the ex-works price plus 5-10% increase; or to base on the prevailing price by adding another 5-10% as market price.

For NFP hospitals, drugs price follows national policy. For services, provincial governments price the majority services; prefecture and city governments price small proportions [of services]. Health

MOH is working on cost estimate method; at present service prices are low. Now the diagnosis benefit is too big, which affect the basis for costing. Currently the cost is shared among the departments. In future we are trying to have disease category based costing. There is also method to base on total discharging patients, which is good for cost control but it is too wide band (Official, MOH).

In addition, the price information has not been disclosed. Anecdotes suggest that, because of the opaque nature of price and cost, there is tension between Medical Insurance Departments and hospitals regarding insurance payments. The centre would like to have the third party MICA as an arbitrator to deal with increased tension between hospitals and Medical Insurance Departments. Interestingly, there is consideration as to who should be ‘a representative of the demand-side’, for MOH is a hospital regulator and MOLSS is a state purchaser. As stated by an interviewee:

On [price] supervision, the price has to be transparent without abuse of charges. We hope MICA could contribute something in this regard, or as a representative of the demand-side, say so (Official, MOF).

One MOH official in charge of price policy said the critical issue is the ‘difficult to manage expenses and difficult to control cost due to the FFS payment methods’. Without defining clinical protocols, and payment methods, use of price as a regulatory instrument is very risk; – it can further inflate cost, contrary to the objective of price regulation. Therefore, it justifies the rate of return regulation that is based on revenue, operating cost, and fixed capital. This warrants high cost, high volume practice to be contained in conjunction with the consideration of promoting dynamic efficiency in the open governance system. As stated by an interviewee:

‘Work for people, but not work for people’s money’ [wei ren ming zhou si, bo wei ren ming bi zhou si]. There are 4000- 7000 price signals in the marketplace, it is too difficult to manage and respond to price signals. To use price as a signal has risks, for a simple illness like tonsillitis, use of medical technology procedures would inflate the price by 20-30% higher. This is not good for expenditure control. It should not research on price; it should research on expenses (MOH policy maker).

Using price as regulatory tool is problematic during transition partly due to:

a) Rent seeking.

Usually, the price of NFP hospitals [FP] is lower than public hospitals [NFP]. For one drug, the public hospital [NFP] price is 27.8, but the NFP hospital [FP] price is 4.8. For example, normal delivery, the stay is 3 days totalling 1000 in an NFP hospital [FP] but 1800 for 7 days in a public hospital [NFP], and for a caesarean section, another 3000 (Chairman, private hospital).

departments plus Price Administrations jointly handle the price setting. For FP hospitals, within three years of establishment, they are tax-exempt. The tax rate has not determined yet, and the government has no [policy] documents for it as fewer public hospitals convert to FP hospitals”.

For one drug, the Price Administration lists the price as 40, but our price is 36. Still we are fined; the reason is that on top of the ex-factory price, we added 17% mark-up increase, which was not allowed by the government. But for public hospitals, their ex-factory price has been set higher, so their price was approaching 40. The fine is 1-2 times the actual amount, and depending on the attitude, all the remaining drugs of 120,000 yuan equivalent would be confiscated. I said to the Price Administration that this is unfair; finally the punishment call has been withdrawn. But a similar case happened to another public hospital and they actually got fined. So I would like to thank those people for their rational judgement when dealing with this issue at micro level (Chairman, private hospital).

b) The price setting variation of the same services in different NFP hospitals differs, and the disease severity and disease mix variations, or consumption inefficiency creates information asymmetry. As stated by interviewees from NFP hospitals and the government:

Price is to be managed by the Price Administration. Price setting is based on government cost accounting and market acceptance. Health departments should first accept the price and then the Price Administration sets the price for market. Now, it is an open market, services or products are self-developed, and prices are varied (Director, NFP hospital).

The price of tertiary level hospitals, for an appendectomy, Beijing Hospital may have 10 LOS and cost 5000 yuan, while the Union Hospital may have 12 LOS with cost of 3000. How to deal with such a fee schedule is a problem (MOH policy analyst).

There is an unfair competition between the state-owned hospitals and social hospitals: For a patient with dermatitis, he doesn't know which one is better, so he naturally enters into hospitals with advertisements. For those private hospitals, the price is set freely. In addition, if the price for a drug is 20 yuan, the private hospital could charge 20 times more than public hospitals. But the public hospitals would not allow breaking regulations and if they do, there is at least a 10 times penalty fine. People don't know this. The public hospitals usually have less input for advertisements, so do not attract more patients. For those public hospitals, the government pays the salaries; infrastructure is given by government, and tax-free. For the same disease, the public hospital would charge 30 yuan while the private hospital would charge 300 yuan. How could they attract more patients? Mainly, it is through TV and other advertisements to spread their products to the masses (Director, NFP hospital).

c) The price policy adjustment to approach cost, that is, price is not stable as an effective tool for the time being. For example, for those 1500 drugs listed in State Essential Medical Insurance Drug Catalogue (to be covered by MSA), the drug prices are regulated through both a fixed price and reference price system. From 2001 to June 2004, the average drug price reduction rate is 15%, with an aggregated amount of 30 billion yuan. Yet these drugs only account for roughly 40% of the market share, the price of the rest of the drugs is market-mediated, and it is hard to monitor so far (Xinhua News Agency, 2004a). Another example, on 8 March 2004 in Nanjing city, about 3,000 drug prices have been reduced in the same day in 78 hospitals, with 103 categories of drug price reduced by more than 50% (Zhi, 2004). Establishing an appropriate price structure is a major task in the next several years.

In summary, with a distorted price structure, use of price to detect services competitiveness is problematic as price is not an effective market signal now.

‘Regulating’ sub-market (developing labor and insurance market institutions)

Labor market is premature in managing employment conditions

Market theory holds that private incentive is the driving force for technological development, and market rewards the individuals with innovativeness. So, in the market, better performing doctors look for better opportunities, better places, better hospitals, and for better pay. This incentive structure is the core driver for cost escalation under the transitional economy, for there is no payment structure in existence. So, in the premature labor market, the hospital management and financial systems are the decisive regulatory instruments to regulate the rate of returns. As stated by interviewees:

The floating of talents requires the government to change their management rules, for example, with entry into WTO, and international hospital competition, all the domestic talents walk away, resulting in the collapse of local public hospitals. So the issue is how to manage personnel. The government policy should maintain the interests of the state. Of course this is a step-by-step process but I feel the conditions given by the government and tasks given by the government are far from each other, I feel trapped and very distressed (Director, NFP hospital).

The hospital emphasises cost accounting and cost benefit calculation. Paying the individuals and personnel management system has changed from a facility-affiliated person to having a job in the facility. People are thus moving to the labour market; the recruiting framework has been formed for attracting needy persons (Policy analyst).

Insurance market is also premature due to a lack of payment method for health services

The payment method for hospital services is one of the several controversial issues of health reform in China (Meng, 2004). Currently, the payment methods are FFS, per episode payment, per case payment, capitation payment, or even lump sum payment (see Table 7-5). The problem with the payment method is that there are no generally accepted diagnostic and treatment protocols. It results in the diagnostic and treatment creeping – high cost, high volume practice therefore originated in response to incentives. To standardise the services, in 2001, MOH announced the definition of more than 3,900 service items, and their cost estimates (Yu Shili, 2002, personal communication; Killingsworth, 2002). A dozen provinces have also published their cost information on several surgical procedures (Wu Mingjiang, 2002, personal communication). Yet a structured utilization review does not exist.

The service sector reform is lagging behind. Cost is rising: irregular rises and abuse of drug use procedures. These are no ways to conduct competition as all belongs to the state. There is inadequate competition. The government should intervene (Official, MOLSS).

There is no way to control hospitals, as incentives cannot be controlled. There should be some global payment system. The biggest issue is that there are no diagnostic and treatment protocols, no discharge criteria and no drug use norms. This also put pressure on doctor. The mainstay of the insurance payment method now is FFS plus global payment; hospital days such as LOS can be as long as 27 days (Official, MOLSS).

Table 7-5 MSA: Payment Method, Hospital Response and Regulatory Tools

Payment method	Hospital response	Possible regulatory tool
FFS	Service item breakdown	Item definition
Per episode	Diagnosis creeping and early discharge	Utilization review
Per case	Diagnosis and treatment creeping	Utilization review
Capitation	Reduce volume of care	Information disclosure
Lump sum	Ditto	Ditto

Source: adapted from World Bank, 1997c; Meng, 2004.

In a regulated market, technology-based regulation uses contracts. Yet, China has no contract-based purchasing. This means that regulation has to start from the very beginning, for instance, from the system based data collection to cull the outliers (Brennan and Berwick, 1996).

On macro management, computer system has been set up for [insurance] policy [disclosure] and for management systems. But at the micro level, it is not. Hospitals usually get the payment two or three months later. There is strong government control here. In the U.S., the government is not involved in payment. The third party payment of paying cash first then services is the biggest issue (Official, MOLSS).

To develop cost information and establish baseline cost data takes time (Yu Shili, 2002, personal communication). For managing the transition, temporary methods such as service block payment methods are used in Shanghai. With a reference to DRG payment system, many interviewees consider how to develop payment methods in the long run for China:

I dare to say that to use protocols, as a basis for insurance payments is impossible. Currently the insurance system in China is very rudimentary, and health insurance is more rudimentary. In the future five to ten years, to coordinate medical and insurance behaviour is not an easy thing to accomplish. The current health insurance is only a minor change to the old GIS and LIS systems. I would rather think the simple issue more complicated. The insurance system now is very superficial, just simply aiming to suit the market system (MOH policy maker).

On medical practice protocols/best practice compliance; there are phenomena of induced demand. Only the payment method could stand in the front line. Payment method relates to the treatment and diagnosis protocols, as U.S. does for its DRG method. The main problem for China is lack of baseline data and no cost information. There are over 20000 service items and 3966 service categories, still new service items keep coming in. But their unit cost estimates

can't come up with payment reform requirements. To control doctor's behaviour, the payment system needs reform. Shanghai has the policy of controlling total expenditure while adjusting the structure. It should be based on service block payments (MOH think tank).

MOH line departments manage hospitals, but if the products of protocols associated with cost information were developed then insurance departments could also use the products. It is known that health and insurance departments are not cooperative, so the health department has neither interest nor active participation in product development. The social insurance department wants to have disease-specific costs but now they have to rely on a fee for service payment method (Policy maker, NDRC).

In Taiwan, 20 disease groups were first developed, and then they expanded to a 50 disease group, and later to a 200 disease group. In the U.S. DRG, at its early stage, they used quality measures to control the cost escalation; later, they shifted to use cost information to control the diagnostic and treatment behaviour. For all these mentioned above, this is the responsibility of government; the government should consider this question before the policy has been put into practice. At present the government is not ready to take up this issue (MOH think tank).

Previously the national HMI has planned to develop 150 disease groups but its proposal was disapproved by MOH. The plan would be a very complex undertaking: [it is] by level by economic development stage, and by different practices of diagnosis and treatment; as China has no unified diagnosis and treatment protocols nationally. We have done the reproductive disease grouping, it cost lots of money and it was very time-consuming in double-checking fees by each service item retrospectively (MOH think tank).

In summary, medical protocols, competition practices, insurance market and labor market are now intertwined. There is no standard for insurance payment; use of medical resources largely depends on the moral obligation of doctors. Under marketisation, when professional morality declines, medical costs rise. Although the government has realized the importance of the payment issue, there is no action plan, nor strategic decisions and vision to solve the long-term challenges.

Regulating information asymmetry on price and quality (of the NFP hospital sector)

China's emerging healthcare market has all the attributes Stiglitz described, for instance information asymmetry, provider monopoly, and lack of payment methods (Stiglitz, 1986, p. 290). In addition, disclosure of healthcare information for consumers are only in their initial stage (Killingsworth, 2002, p. 7). For example, only one-fifth of consumers know the medical price (Meng, 2004). The main barrier is the legal framework, for example, the lack of Government Information Disclosure Ordinance (see Appendix E, Law 27). As stated by interviewees responsible for health information:

The doctor and hospital, due to information asymmetry, further aggravate market failure. The policy is to intensify the market failure [means no disclosure of information]; this is the extreme of culture building and adaptation. So it is a problem and it is induced by policy decision-making. So [although it is] under the condition of market economy but to use the policy with planning feature would aggravate market failure (MOH official).

There is a great lot of information, the issue is whether or not to publicise information to society and how to publicise it. 'Not to disclose a family's shame to the outsider' [jia chou bu wai yang] for government and hospitals are in the same family. To inspect the hospital is equal to inspect me; - the government protects the department's interest! (MOH policy advisor)

The market requires shifting from sponsorship to management. Public disclosure is an effective means. The most important aspect of market is price and competition, so it must give people their right to make choices. Patient choice hinges on the level of information utilisation; this is the most fundamental responsibility of government. Now this does not change, as it can't publicise! (Advisor, MOH)

In an individual capacity, Patients have no medical knowledge, no way to make judgements. The government now has provided little assistance to the people in this aspect, what the government has done is 'image project' [means to have a typical case to substantiate what the government is doing on a large scale] (MOH policy advisor).

Overall, information flow tends to protect the healthcare provider, as observed internationally (Dawson, Munro et al. 2002, pp. 153-155). China is no different but lags far behind, compared with the international practices in established economies. As stated by interviewees:

Culture and legal compliance are issues of current concern. Poor service attitudes, bad medical professionalism, on 315 day⁹⁶, there are many complaints especially on the non-transparency of medical services price (MOH policy maker).

It should strengthen social evaluation. The China Academy of Social Sciences is conducting research in several provinces on developing social evaluation method. More than ten provinces have publicised the price schedules of large hospitals, including An hui and Heilongjiang provinces (MOH policy maker).

Information disclosure is an important market instrument. Among a dozen Shanghai hospitals, the health department collects their price information and analyse those with higher prices, and then they talk to the hospital directors to disclose information. The hospital directors said no, we will analyse it by ourselves and reduce the prices (MOH policy maker).

More specifically, the medical economic burden indicators should be publicised to society, such as, cost per outpatient visit, cost per inpatient stay, LOS of each disease. This has not been done enough. The MOLSS has already made an effort toward publicity of information. As there is no representative for the patient, we also hope MOLSS can do some work here, to supervise the behaviour of doctors and to make it public. We feel as if hospitals are their own son [means MOH is hospital's father], very difficult (Official, MOF).

Certain things could not be immediately opened to market. For example, pricing should be retained within certain time frames by government, and price disclosure should be done. At a time when competition is in shape then pricing can resort to the market. NFP hospitals should disclose their service prices (Official, health department in Shenyang).

⁹⁶ In China, March 15 is the Consumer Right Protection Day, there are many discussions among major media, including TV show.

An example of the above comments is that, on 5 March 2003, the health department and price administration in Liaoning province jointly issued the “Circular on Medical Services Price in Liaoning Province (temporary)” to “ban arbitrary pricing and fee collection, breaking down service items, duplications of fee charges and self-established items for charging fees”, yet the high profile People’s Hospital in Liaoning still abuses the price schedule (Zhao, 2004).

In summary, the NFP hospital sector is accustomed to the ‘public identity, private behaviour’ healthcare system. Market function for competition is not yet effective as overall market institutions are not ready to conduct healthy competition (For instance, there is no rule to regulate NFP monopoly so as to turn high cost, high volume competition into high quality, low cost competition). Price structure is still under development; labour market is not ready to determine the wage payment method; FFS insurance payment leads to diagnostic and treatment ‘creeping’, and information on price and quality is hardly disclosed. Without a price structure and market institutions, any policy models used in the regulated market are hard to be borrowed for China. Therefore, technology-based regulation for China is not applicable.

Summary: The crippled financing and distorted prices during transition

Marketisation in China has created a healthcare system mixing with private, social and public identities. In this dynamic market, two fundamental issues that have continuously not been effectively addressed are first policy purchase at the system level, which is not effectively organized towards the realization of rational-goal governance model, and second NFP hospital governance reform, which is still at a piloting stage, making the open systems governance model far from being realized. Therefore, any technical regulatory tools are compromised for their effective use.

To develop the appropriate market structure, planning and financing are important policy instruments. Yet both of them are limited by the on-going reform. This indicates that performance-based regulation in the planned market is not attainable for China as the financial level is not strong enough to have influence on provider behavior; and that technology-based regulation in the regulated market is also not attainable for China as the price structure is under adjustment and overall market institutions are not ready.

Due to the crippled financing and the distorted price structure, there is essentially only one regulatory choice for China, management-based regulation. Consistent with the stratified and diversified healthcare market in China, to regulate the market at system

level, China can only announce broad policy objectives and reform principles, leaving the implementation details to local levels. The technical interpretation to policy objectives by each province can vary and so can the institutional arrangements in each province.

With local governance, the actual balance of equity and efficiency is in the hands of local stakeholders. For example, the mix of planned market and managed market in Shenzhen, the laissez faire market in Shenyang and the developing market in Jinning are the reflections of local policy-making, rather than central policy dictatorship. The 1997 health reform policy statement on the role of the state therefore is realized by individual cities with consideration given to their economic development and social development. It is the city's Medical Insurance Departments that determine the level and the scope of the purchase. It is also the city's health departments that determine the innovative reforms of NFP hospital governance arrangements. This concerns the complex social adaptation and policy-making process at local levels, for equity always involves political process (Stavins, Wagner et al., 2002).

As discussed in chapter two and six, high cost, high volume competition out of the first stage health reform continues into the second stage health reform. The next chapter explores social regulatory tools for ensuring institutional performance.

CHAPTER EIGHT

SOCIAL REGULATION FOR INSTITUTIONAL PERFORMANCE

Effectiveness is a major health policy objective at the system level (see Table 3-3, p. 42). Chapter seven reviewed economic regulatory tools: financing, planning, and price tools towards market structure and function. Chapter eight will present social regulatory tools, – that is, the social control measures via standard setting.

Social regulation aims to reduce social harm. In healthcare, social regulation is customarily interpreted through licensing, accreditation, and certification⁹⁷ (Hafez, 1997, pp. 1-3). The licensing regime is usually realized through legal institutions. The accreditation program is usually conducted upon institutions where a corporate governance system is a prerequisite for accreditation. The certification program is usually conducted upon individual doctors whose performance should be reviewed against the standard protocols and procedures. In essence, licensing, accreditation and certification involve setting the standard and reviewing procedures, in order to assess institutional performance in relation to clinical practice risks, incentives to providers and the interests of hospital managers.

This chapter aims to present the assessment of social regulatory tools to govern the performance of institutions. The licensing regime is discussed with respect to the market entry of personnel and facilities (that is inputs). As China has neither widely acknowledged hospital accreditation program nor is a credible certification program, institutional performance discussed with respect to the hospital regulatory process by the hospital director in relation to the regulatory decrees announced by the state. This approach raises the issue of corporate governance, and the interests of hospital directors as the state delegated surrogate regulators. Therefore, the social governing system has linked system objectives with institutional performances and individual behaviors.

The institutional governance structure and its managerial and financial system then becomes an important regulatory parameter, particularly the incentive structure has been altered and the public/private governing systems has been blurred under marketisation in China.

⁹⁷ Licensing usually refers to minimum legal requirements by state agency to entry into market; certification usually refers to professional self-regulation on performance of personnel; accreditation usually

This chapter finds that legal imposition on market entry has just started in China, and no credible performance regulation exists across hospitals. The incentives and management and financial systems under marketisation affect the cost-quality compromise.

This chapter concludes that at the institutional and individual levels, regulating clinical risks and provider incentives, needs to define the process and the procedures of credible clinical audit, financial audit, and management audit programs. Accountability mechanisms for arms-length governing ought to contain the interest of the regulator concerns on how to regulate towards social optimum of NFP hospital sector at blurred public/private spheres. As the NFP hospital is managed by a government appointed surrogate regulator, who is also responsible for hospital business operation, conflict of interest endogenously generates, – regulating interest therefore should resort to the alternative regulator and governing force.

This chapter describes first regulatory tools on ‘risk’ and ‘incentive’, that is, market entry and performance; then, regulatory tools on ‘interest’, that is, arms-length governance between NFP hospitals and the health department; and finally, regulatory tools on ‘incentive’ and ‘interest’, that is, the NFP hospital corporate governance reform.

Regulating ‘risk’ and ‘incentive’: Towards legal and regulatory institutions

Safety of medical care: Regulating on market entry (legal tools)

Internationally, organized entry regulation started with state board/college system in the late 19th century as per Figure 1-3. For China, entry regulation started in the 1990s along with market-oriented reform, and the management mode shift toward rule-based administration as shown in Table 8-1.

refers to professional self-regulation on performance of facilities (Hafez, 1997).

Table 8-1 Commencement Time for Entry Regulation

Personnel qualification for practice/entry
<u>Market entry of private sector</u>
Management method on foreign doctors short-term medical practice in China, MOH 1992
<u>Legal regulation of existing doctors (doctors of NFP sector evolved from previous public entity)</u>
Nurse management method, MOH 1993
Physician Law, NPC 1998
Physician qualification examination method (temporary), MOH 1999
Physician registration method (temporary), MOH 1999
Facility qualification for practice/entry
<u>Market entry of private sector</u>
Sino-foreign joint venture, cooperative medical institution management method, MOH 2000
<u>Legal regulation of existing public facilities (NFP sector out of previous public hospitals)</u>
Medical institution management ordinance, State Council 1994
Medical institution management ordinance implementation articles, MOH 1994
Large medical equipment purchase and use management method, MOH 1995

Source: MOH, 2002.

Documentary analysis has found that the 1999 MOH physician registration method largely regards physicians as individual practitioners, while 1994 Medical Institution Management Ordinance Implementation Article (MIMOIA) largely regards physicians as staff affiliated to hospitals. The above two regulations apply to the NFP provider qualifications. The foreign doctors' short-term medical practice management method and Sino-joint medical institution management method aim to address FP providers' market entry.

The role of the health department is, under the guidance of central policies, to realise the transition from sponsoring hospitals to managing hospitals; and to implement integrated sectoral management regardless of public or private hospitals. With respect to hospital business operation, the health department should not intervene in the future regardless of public or private hospitals [entrepreneurial state in Shenzhen]. Even for those small private hospitals such as Sunshine or Love All hospitals, it also intends to have integrated management: managing entry and quality (Official, Shenzhen health department).

For the second stage health reform, the central government is responsible for setting policy principles while local government is responsible for implementation (Li, 2001, pp.60-80). It means that local areas formulate their own management systems within the framework of national guidelines, which is actually the practice based on the traditional social-legal institution inherited from older dynasties (that is, the fragmented customary legal governance system). Policy practice on rule-based administration therefore varies across provinces and cities. For example, Shenzhen can soon implement national policies,

directives and law, and tailor to local situations. In Inner Mongolia, even at provincial level, the policy implementation lags behind. As has been seen below:

The facility entry is based on Medical Institution Ordinance issued by the State Council. Here we have drafted implementation methods. Physician's Law and nurses' management methods govern the entry of personnel (Director, social objective oriented hospital, Shenzhen).

There is medical institution ordinance and its specifics, but no management method to implement it. Management does not exist. The policy implementation cannot catch up with policy statement. The implementation process has problems. For example, Physician's law implementation, their credentials and registration apparatus are not in place, so there is no basis for supervision (Official, provincial health department in Inner Mongolia).

Also under the second stage health reform, entry regulation is administered by the newly established Health Inspection Centre (HIC), that were established as a result of the 2001 governing system reform that required the separation of policy formulation and execution. HIC is the health-related law and regulation enforcement body and is overseen by the health department.

Previously, we usually inspected the usage of disposable medical consumables, and sterilisation products [in relation to healthcare inspection]. Now, we have a total of 6 staff, dealing with medical accidents, licensing medical doctors, and supervision on blood products and blood bank management. Under the new functions, these six staff should manage facility entry, personnel entry, technology introduction entry and equipment entry. Because the technology introduction and equipment entry management methods have not developed yet, so they are not going on. I have attended a workshop in Shanghai, and found that Shanghai and Zhejiang province are very advanced in this area, and they have very sound rules and methods in implementing market inspection and supervision. The reform now requests the separation of administration from law enforcement, so we are on behalf of provincial health department to enforce law. 'The Health Administration Penalty Procedures' is implemented by HIC [Appendix E, Law 5] (Inspector, Inner Mongolia HIC).

In summary, for market entry, the sampled cities revealed uncoordinated policy implementation among various government departments. In addition, the administrative and management systems are locally determined.

Quality of medical care: Regulating on performance (traditional administrative tools)

With the marketisation of healthcare, the definition of health service performance differs from clinical, consumer, purchaser and health department perspective (Leatherman and McCarthy, 2002, p.10): the clinical definition of performance centers on quality⁹⁸; is the prevailing practice, the consumer definition centers on responsiveness of doctors, the purchaser definition is the cost-effectiveness or value for money, and the health

⁹⁸ Clinical definition of quality is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine, 1990).

department definition is social optimum/social efficiency or equity. The following discussion is found on clinical definition of quality.

In China, both entry and performance are dealt with by MIMOIA⁹⁹. In practice, the provinces and/or cities formulate their own performance management plan and specifics. This creates a fragmented and hospital-based performance management system. As supply-induced demand had become a major issue in the past decade, managing provider performance had become a key regulatory challenge for MOH. Slow response by MOH has brought about criticism and consumer dissatisfaction (see section below on consumer complaints).

Now there are 'three su' doctors [it means: antibiotics, vitamins and hormones]. Whenever there is a cough, just give three Su. The farmer would say, I am no longer having fever, and can do farm work again. This is a good doctor. These issues should be handled by MOH, but they don't do it (Official, NDPC).

The quality of healthcare is now handled by professional groups in China, for instance, the China Medical Association (CMA), was designated to be responsible for developing practice guidelines. Flexibility has been allowed to reflect the need of different medical education and training facilities¹⁰⁰. The development of clinical protocols also needs to consider variations in medical resources availability. In practice, cities have to develop their own clinical protocols, so diagnostic and treatment 'creeping' (that is over use of services) is therefore unavoidable.

On technical protocols, China Medical Association (CMA) is drafting PRC technical protocols. In the future, each branch association will draft special technical protocols. What we do now is more like diagnosis and treatment guidelines: diagnosis and treatment principles. It requires following protocols but not limiting creative treatment and diagnosis methods. The clinical diagnosis and treatment protocols and nursing operation protocols will be issued next year. On special protocols such as the use of antibiotics, therapeutic drugs, drugs for diagnosis and treatment, these special protocols will also be published (MOH official).

There could be technical creep as the guidelines are of a wide band. The guidelines have not considered the resource use, and it has not considered linking to insurance payments. The guidelines also allow each locality to make adjustments to suit local situation. Shanghai has already developed a set of protocols (MOH official).

⁹⁹ For example, the quality assurance on service provision process is stipulated in article 55-58 in chapter V Operation of MIMOIA. Article 55 specifies that medical institutions should follow the technical specifications, protocols issued by health departments. Article 56 specifies the by-laws of hospitals to be supervised by the medical institutions. Article 57 specifies that the staff should follow the professional code of conduct. Article 58 specifies the professional ethics and the spirit of professionalism. In chapter VI Inspection and Supervision of MIMOLA, article 67 specifies the need to exert role of professional bodies in clinical supervision, and article 73 specifies the implementation of national medical institution accreditation system.

¹⁰⁰ All the medical education institutions should be rectified by MOE. The teaching syllabus is rectified by MOH. Medical education institutions are accredited jointly by MOE and MOH. Medical education programs vary from three years (secondary vocational education targeted for rural areas in the past) to six years (college education targeted for cities).

With flexible and elusive rules, management is a discretionary, rather than rule-based practice, which has formed the individual hospital-based quality system. Regulation on performance is therefore management-based. This has created problems when market-oriented institutions, for instance MSA and MATO law, ask for clarity and rule-based practices. The under-developed clinical protocols fail to act as regulatory tools to contain cost escalation, to serve as insurance payment methods, and to define risks under MATO law.

There is no institutionalized monitoring and reporting schemes for hospitals, and no information system to disclose such information to the public. The main issue is the lack of a regulatory information system, as one MOH official said, ‘the main problem for China is lack of baseline data and no cost information’. Therefore, suspicion about the role of insurance is obvious as one MOH official said, ‘...to use protocols, as basis for insurance payment is impossible ...In the future five to ten years, to coordinate medical and insurance behaviour is not an easy thing to accomplish’.

The above opinion coincides with the statement that health insurance schemes in developing and transitional economies are financial reimbursement institutions, not policy purchaser instruments (Bloom and Standing, 2001; Harding and Preker, 2003). Use of insurance to influence provider behaviour is therefore marginal for China. For example, In Shanghai, payment to insurance is based on block payments. The conclusion is that the management system and information systems are not in place for cost-based and protocol-based insurance payment (that is, technology-based regulation is impossible).

To control doctor's behaviour, the payment system needs reform. Shanghai has the policy of controlling total expenditure while adjusting structure [hospital distribution in the city according to plan]...There are over 20,000 service items and 3,966 service categories, still new service items keep coming in. But their unit cost estimates can't come up with payment reform requirements (MOH think tank).

In theory, the clinical quality is legally defined in MATO, that is, the prevailing clinical practice serves as clinical standards. MATO also stipulates that in case of malpractice, tort law applies (Appendix E, Law 2). In practice, unless major medical accidents¹⁰¹ happen, the legal provision cannot operate to control provider-induced demand on a routine basis. Therefore the main tool used is ethical and moral education. administrative fines are applied in case of failure in ethical and moral education. In the

¹⁰¹ For example, Diao Chongjin's death for plastic surgery in Red Cross Hospital, and iatrogenic infection after surgery in MCH Hospital in Shenzhen in 1998 trigger the professional ethics education campaign (Shenzhen Health Bureau, 2003a).

U.S., the use of tort law is based on contract and technology-based assessment, which is the legal basis for judgment malpractice (Jacobson, 2002, pp. 178-179). For China, since MATO is newly established, the legal procedure is still under development, traditional administrative coordination mechanisms prevail for risk management.

Overseas management on modern hospitals is through a system, the so-called modern hospital [management] system. But in China at present, it is only in the administrative management mode. Hospital director has to complete tasks without power to manage. For the time being, it mainly relies on individual conscience because although there are laws, there is no law enforcement centre or brigade. The mutual constraining relation between government and hospital is therefore maintained by ethics. The health ministry recently has set up HIC in an effort to strengthen regulations on private sector entry. But on process supervision, [MOH] still needs to learn. At this time HIC can only handle sterilisation supervision, infection control and equipment maintenance (MOH policy analyst).

In summary, China has only recently developed legal provisions on entry licensing. There is no certification and accreditation program existing to assess provider performance, and clinical protocols and insurance payment method are under-developed. Managing hospital quality largely depends on ethic indoctrination and self-restraint to conform to professional ethics. The newly formed HIC is not ready to handle quality monitoring and supervision. In essence, there is basically no structured performance-based regulation on quality. The state only has legislative regulations on input. Civil society groups acting as regulators do not exist. While new policy initiatives ask the health department to steer but not to intervene in hospital internal business operations. There are basically no external mechanisms available to conduct credible quality supervision and inspection, as the traditional administrative approach regulating performance is compromised by the shift of focus of regulatory process under marketisation (see chapter three on relationships between competition, quality and cost).

Risks of medical practices: Regulating medical disputes (legal tools)

MATO, promulgated in 2002 (Appendix E, Law 12), is the legal basis for the protection of patients and doctors in cases of medical disputes on quality.

The birth of the Medical Accidents Treatment Ordinance is a revolutionary change; it stands from the point of view of government. Its importance has not been fully realised now: mainly the administrative protection is no longer in consideration. It is intended to protect the patient more as the doctor is in the position of monopoly. After the enactment of the law, both the patient and doctor have complaints to the law, which is a verification of law success (MOH official).

Now for medical accidents, whether it is a medical accident or not, is not to be determined by the doctor, but the nature is to be determined by the expert. The court has the right to reject or accept this, and the amount to be claimed from the hospital should be decided by the court. The new law's premise is that whether the law has been breached or not, it is not based on adverse outcomes brought to the hospital as a premise (MOH official).

With MATO¹⁰², doctors tend to protect themselves by providing more procedures as a protection. Many reports disclosed that hospitals were protecting themselves. For example, on 30 January 2004, CCTV program Talking Law on Today under the title “A Changed Patient Record” disclosed the story that the hospital had purposely changed the patient records in order to protect the doctor (Anonymous, 2004b).

There is one issue here: the incentive of prescribing big prescriptions by doctor and the frequent use of procedures regardless of their negativity rate [the detecting rate] is driven by volume-based bonus system. But the Medical Accidents Treatment Ordinance stipulates that, in case of medical disputes, the doctor has to present evidence in substantiating their innocence, or they are guilty. As such, the doctor often orders unnecessary procedures whenever there is a clinical uncertainty or whenever he/she feels insecure about protecting him- herself. This will add a burden to patients. The doctor has also asked the patient to sign their names, as a protection measure [Hospital director, Shenzhen].

Better to integrate both internal and external rules and regulations, in case of medical disputes, it is comparatively easy to solve. Now for major surgical operations, the doctor would rather refer to a higher level for fear of medical risk [Director, hospital in Jining].

There is an increasing medical dispute. The hospital has to learn how to protect itself [legally], and the doctor has to sign their name for their activity as verification (MOH official).

The supposed reason for such protection is that there is no malpractice insurance for doctors. Although MOH has announced the MATO Implementation Method and Method to Employ Lawyer in 2002 to regulate the irregular behaviors of hospitals, their implementation is in question. As stated by interviewees:

On medical services risk insurance, it is still under calculation on classified premiums for different services (Policy analyst).

The concept of handling business according to law by hospitals is very weak or almost non-exist. After stipulating law on MATO, health departments mobilise hospitals to study the law, but hospitals are not aware of protecting themselves. They still think that MOH would protect them and rely on MOH. They don't understand that if a patient's family has beaten a doctor, there is no need for doctor to go the provincial health departments, just resort to legal procedures (MOH official).

In summary, market entry registration has just begun. The regulatory process for institutional performance is under managerial discretion that is heavily influenced by the bonuses hospital staff. With market-based financial incentives, and mutual protection between public institutions, the internal financial audit and hospital financial system are not effective. MATO is the legal base to assess clinical risk, but there are no firmly based hospital risk programs to avoid clinical risks.

¹⁰² In the article 11, chapter II Prevention and Treatment of MATO, it specifies that the health provider should inform the patient of the illness, medical treatment and risk.

Regulatory process: Regulating provider incentives (financial and managerial audit)

Cost-quality regulation can influence provider preferences and hence the degree of social optimum (Formula 2-1). The social optimum hinges on the system of corporate governance, the financial audit program and hospital operation objectives¹⁰³ (Cutt and Murray, 2000; Marcuello, Marcuello et al. 2004). This section discusses the staff payment system and financial audit program.

The financial and social audits of NFP organizations have attracted increasing attention in the past decade (Salamon and Anheier, 1994; Gray, Dey et al., 1997). Financial audits of public institutions in China was less obvious in the past because of mutual protection among public institutions, although in the recent years there have been increasing efforts made to audit public institutions (Xinhua News Agency, 2003c). For the NFP hospital sector, as the management system is market-based, the regulation requires financial audit. The key issues are assessment of accountability, audit procedures, and the degree of flexibility for hospitals to decide on staff bonuses. As stated by interviewees:

On entrepreneurial behaviour of hospitals, for special services, profit maximisation is the nature of services. To define the issue in a holistic way, this is the issue that the Chinese could not solve. The international community have not solved it either. "Harvard Business Review" mentioned that as long as they follows accounting methods that show the status of non-profit. But how to handle financial audit? The idea is that no dividends are allowed; then it is of public nature and of welfare nature (MOH policy maker).

For big corporations, their management relies on culture, for middle level companies their management relies on system and regulations, for small businesses, their management relies on their boss. I feel how to balance the principles and flexibility is of critical importance. The preconditions for change are very important or the principle is very important and what is a market? It should have criteria and show how to implement it (Director, networked hospital)?

With the 'public identity, private behavior' healthcare system, the payment structure is the key incentive pushing for volume-based service provision. For the NFP hospital sector, the salary consists of two parts, the fixed base part and output-based bonuses. The surrogate regulator manages the range of output-based bonus. The rule to manage the financial incentive is based on "Hospital Financial System" and "Hospital Accounting System"¹⁰⁴ (MOH, 2001b). The health department and the hospital director jointly

¹⁰³ Social audit is to examine beyond the financial control of costs and expenses of NFP organizations, it is to assess NFP organizations' social well being in terms of those most directly affected by its actions (Cutt and Murray, 2000).

¹⁰⁴ Other rules are Budget Law, Accounting Law, Price Law, Statistics Law, Audit Law, Construction Law, and Government Institutions' State Assets Law (MOH, 2001b, pp. 58-9).

formulate the formula for paying the staff. The government regulation is that individual bonuses should not surpass 40% of total revenues.

Under state corporatist practice, because public institutions are protected each other, external financial audit is ad hoc, breaching of the 40% revenue rule for staff dividends is a common phenomenon. As one policy analyst said, financial audit is ‘poorly implemented and not adequately done as it relates to financial incentives [of hospital]’, for the financial audit is internally conducted in accordance with the “Health Sector Internal (Financial) Audit rule” (see Table 10-1). As stated by an interviewee that ‘survival’ is a major impetus rather than to follow the financial audit rules:

Everyone expresses the poor quality of services, internal reform doesn't work, there must be external forces to promote competition, and to create competition... The current approach is only for the survival of medical institutions (MOH policy maker).

Although clinical quality relates to technical standards setting and compliance with clinical protocols, with marketisation, it is the change of financial management system that initiates changes on clinical practice. The market distorts clinical practice towards volume-based services. Social efficiency depends on NFP hospitals, yet they are largely accountable for revenue of their own. The regulatory procedures are therefore important under marketisation. As stated by an interviewee:

On quality management and hospital accreditation, only through criteria management can it focuses on quality management. Quality management is persistent, continuing, comprehensive but the most important is [that it should be] regular and with criteria. The previous hospital accreditation review was very passive; there is a need to have good clinical practice management methods. In a word, the more efficient, the less government input (Official, provincial health department in Inner Mongolia).

With the financial incentive distorting the clinical practice, the study reveals that the patient satisfaction rate in China is 45% (Meng, 2004). Quality is a major issue (Lim, 2002). In conclusion, it is less effective to promote quality enhancement through internal audit, for it is the surrogate regulator who decides staff bonuses. The external review has to be instituted.

In line with the changed nature of ‘risk’ and ‘incentive’ under marketisation, and in the absence of accreditation and certification programs in China, ‘self-governed’ hospitals have to rely on the management system and the governing system to achieve the purpose of regulation. Institutional performance therefore must be concerned with regulating ‘interest’. This is examined in the following section.

Regulating ‘interest’: Developing arms-length governance structure

As the surrogate regulator heavily influences performance regulation, the institutional issue has emerged as central for regulating high cost, high volume practice. This section presents the paradoxical institutional arrangements during transition, that is, the dual regulating institutions for NFP hospitals - from previous government institutions to the statutory-based corporate governance. Under the ‘self-governed’ hospital management practice¹⁰⁵ (Chow, 1993, pp. 105-122; Huang, 1993, pp. 97-104; Dong, 1993, pp. 123-130; Pei, 1998, pp. 30-42), the existing management and financial practice is institution-based management and financial practice. Therefore, both institutional rules and surrogate regulator are important elements in analyzing the institutional behavior in the market.

Dual regulating institutions for NFP hospitals at time of transition

To date, although the MOP still oversees skilled labour employment, the recruitment of doctors is on a competitive basis. The personnel system reform (which starts in 2000, in relation to the NFP hospital reform) aims to de-link the doctors from hospital and the hospital reform aims to develop towards open system model under which the NFP hospital is in essence a corporate¹⁰⁶. Corporation Law and Contract Law (see Appendix E) should govern the NFP hospital as corporation.

Yet most of the NFP hospitals now are still overseen by government personnel departments in approving the executives. The Corporation Law to direct the development of by-laws of hospitals is still invisible. Under the dual regulating institutions, governing challenges concern the clarity of the NFP operation objectives and whether doctors should be managed internally by the hospital or externally by the professional body, see Table 8-2.

¹⁰⁵ China has a strong administrative capacity, but less entrenched planning. For example, in the 70s, the Soviet Union had 60,000 commodities planned but China had only about 600 planned; also, “Chinese entrepreneurs needed little encouragement to expand”. Strong administrative capacity and high entrepreneurial spirit is very easily emerging into entrepreneurial state corporatism and so the management-based regulation, i.e. to internalise the regulation into management practices (World Bank, 1997a).

¹⁰⁶ The organization and management of a corporate hospital in the West is that a corporation by definition is an artificial being, and existing only in law. It possesses only those properties that the charter confers upon (Southwick, 1978, p.31). NFP Corporation is that no part of the income or profit of the organization can be distributed for private gain to the members, the directors or trustees, or the officers of the corporation (Southwick, 1978, p.37). The internal management of a corporation is governed by the by-law, which is regulated by statute. The board of directors of a hospital decides hospital development policy,

Table 8-2 NFP Hospital Governing Challenges under Dual Regulating Institutions

Legal governance under corporation	Organization rules under government institution	Governing challenges
<u>Hospital as corporation and as government institution</u>		
Statute/Corporation Law; CEO acts in accordance to by-law of the company	Internal regulation; Duty statement by health department directive	Legal governance vs. government policy; Business incentives in the market vs. social responsibility
<u>Employment conditions as contract-based staff and as government employees</u>		
Contract-based Code of conduct	Government employees Professional ethics	External market vs. internal affiliation Incentive and interest

Under the second stage health reform, central policy calls for withdrawal of MOH and health departments from directly managing hospitals, but the policy is unclear about how to handle the ownership issue of the hospital. It seems that the purpose of the reform is clear but its operation is complicated. As stated by interviewees:

Legal governance structure reform is under consideration. The power of a hospital director is difficult to describe whether it is too much or too little. You could say it is little, as they have no rights on personnel management and recruiting, or you could say it is big, as no constraints on their power, purchasing their equipment without approval (Official, MOF).

Regarding the relationship of universities and affiliated hospitals, universities are managed by MOE, but the personnel appointment of central government affiliated hospitals is managed jointly by MOE and Ministry of Science & Technology, furthermore, the financing and assets are managed by MOH. Such a structure makes the coordination work very difficult. The issue has been brought to Vice Premier Li Lanqing for coordination. Who can have a solution? Each ministry speaks their point of view. Generally MOH still needs to take care of quality. Lanqing said, if the issue can't be solved for the time being, to maintain the existing situation is comparatively good, as it will not turn into chaos (Official, MOF).

The key issue is how to transform the financial and personal management systems to a modern corporate governance system. The main barrier for reform is that the management and financing systems are not rule-based. As described by interviewees:

Now we are thinking MOH only manages Union Hospital. There is a need to strengthen financial management based on "Hospital Accounting System", and "Hospital Financial System". Supervision of NFP hospitals should be based on the nature of non-profit organizations to operate. For example, it can have a surplus and the usage of the surplus should follow the "Salary Management System" and "Personal Management System", it should not be used for dividend but for hospital development.

Currently, there is no supervision method for NFP hospitals. Internationally, there are sound practices, such as financial management system. For issuing rules on regulating NFP sector, we are hoping that MOCA could contribute something or to have a unified approach. Insurance should maintain the public interest [for example, policy purchase]; government should also protect the patient's interest [for example, MATO]. For NFP hospitals, cost accounting and cost

appoints staff, and evaluates performance of Chief Executive Officer.

sharing by sub-divisional cost centres should follow Corporation Law. Surplus allocation should follow rules. Assets should not be used for profiting activities (Official, MOF).

State ownership needs to 'separate two powers', state ownership with publicly operated hospitals should have a board of directors for market forecast, and hospital directors have a contract relation, thus, to set up modern hospital system. Management is an important issue: Governance structure, organisation structure and contract relations. Doctors should be freestanding professionals. In the U.S. and Australia, finance and personnel management is very good. Overseas management on modern hospitals is through a system, so called modern hospital system, but in China at present, it is only the administrative management model, hospital director is to complete tasks without power to manage (MOH policy analyst).

The dual regulating institutions relate to the idea of market socialism theory. The core concept being promoted is to create social ownership out of the state ownership, and ideally, to shift to a social governing system.

The state ownership system is department ownership represented by government ministries and institutions and its affiliations. State ownership system also refers to the whole public ownership system. To shift from the whole public ownership system to social ownership system is deemed as unfair in some people's mind. The separation from state to society is an issue of concern (MOH think tank).

Yet the problem is that no societal groups aim to govern hospital production for social optimum. This is a paradox of the public/private mixed management system in China. As one policy analyst said, 'the current reality is, all the parties want to be profitable, and there is a government-led market development. The operation objectives are that all should be profitable'. Such phenomena are observed throughout the country. Mechanisms to de-link and detach the state corporatist entity are under investigation. As stated by several interviewees:

The government-managed hospitals will have the following changes. A) Management system change, a management committee to be established, which is similar to or is board of directors. Outpatient and inpatient departments are to be separated. Government will appoint the director and government will be responsible for the hospital. On management of state assets, currently this is not in place. B) Legal entity management structure is to be set up with administrative supervision (MOH policy analyst).

Now the issue of legal entity management structure and government supervision is not fully solved. There is a need to set up financial institutions and supervision institutions. Here Hong Kong Hospital Management Administration is a good reference. In Shanghai City, they set up a Health Investment Company to be responsible for supervision and to prepare justification for investment. Now it is the time to gradually shape into common understanding on independent legal entity systems and the organisation and management forms. MOH is piloting these schemes now (MOH policy maker).

There must be separate ownership from operations. The fundamental dilemma is the system. It must separate, willingly or unwillingly. Entering into WTO is international competition... Mechanism must change. The hospital must follow the enterprise management style and emphasise cost saving (Director, hospital).

In summary, the dual regulating institutions have created a paradox for the NFP hospital- it has enabled a continuation of state corporatist behaviour. As the NFP hospital reform is in essence governance reform, the regulatory tools are therefore mainly the financial and accounting systems, and corporate governance measures.

Towards an open governing systems model by piloting arms-length governing

In order to move out of the dual regulating institution, the corporate governance system is being piloted. In essence, the reform is to legalize the relationship between health departments and NFP hospitals, or a market-based governance system (Figure 1-2).

As stated by national health policy-makers:

The so-called legal person governance reform is to activate the mechanism of public hospitals. The hospital is responsible for its own personnel policy and revenue management (MOH think tank).

In theory this is easy, operation is difficult. To develop what and to control what? In observation, the provincial health departments would slowly adjust their functions. The hard issue is still 'the closest son' [means hospitals], now the provincial health department is to become 'the step mother' [means keep certain distance from hospital] (Official, NDPC).

Legal governance, currently the fashion word, is to explore the relationship between government and hospital. The tendency is that the government will empower the hospital director to manage the hospital on behalf the government (MOH think tank).

People from Wenzhou City [a southern city, famous for its private sector development and entrepreneurialism] have the saying of, 'even for close brothers, a clear statement of accounting is necessary' (qing xiong di, ming shuan zhang). People from North East China are the other way round, where there are no pre-determined rules to follow, and if problems arise even the brothers would fight each other. So the reform thinking is to try to set the legal basis beforehand in governing the two parties: government and hospital (MOH think tank).

As discussed in chapter six, the governance arrangement is one of the two fundamentals for China's health reform. As discussed in relation to policy implementation, local governance decides the way, the presentation, and the speed of reform. As one policy analyst said, 'across the country, progress is uneven, affected by the influence of local governments. Local governments' influence is very substantial. The general principle is to open up the market gradually. But to what extent and in what way to open is not clear...all the localities are in experiment'.

The next section presents an overview of various types of pilot schemes on arms length-governing arrangements between hospitals and health departments. These pilots reflect innovations in creating an open governing systems model for the supply-side market. Largely, these innovations reflect the responses by local authorities to the second

stage health reform policy in seeking for management and system changes for NFP hospitals.

The reforms in Qingdao, Liuzhou and Xining cities aim to separate prescription from dispensing. As high cost, high volume competition originates from overuse of pharmaceuticals, a mix of regulatory tools was used, for instance governance system reform, price and tax.

The State Council has selected three sites for study of separating outpatient drug stores, Qingdao, Liuzhou and Xining cities. The investigation finds the obstacle forces are very strong. Both hospitals and pharmacists are unwilling to reform. We then tried some preferential policies for pushing reform, i.e. to return tax completely. The following methods have also been tried, sale of pharmacy building (assets selling), with income returning to hospital, inpatient drugs counted as cost, service price increase, tax return, and arrange government subsidy (Official, MOF).

The Investment Development Company is established between health department and NFP hospitals in Shanghai city, in order to retain public ownership. Corporation Law has been applied to reduce the dual regulating institutions.

To open the medical market, 'walking in the market' is clear. In terms of the management system, it is similar to the mixture of Singapore and Hong Kong systems, what here in Shanghai is called Investment Development Company (IDC), in Hong Kong, it is the Hospital Administration; in Singapore, it is the Hospital Group. IDC would allow more flexible investment and financing. IDC operates according to Corporation Law. IDC is state-owned, with business operation. In theory this is clear, the so-called agent principal relation. IDC adds a buffer between government and society - government does not directly operate. How the social development sector walks in the market to promote efficiency and to release operations from government constraint is not clear (MOH policy analyst).

In Nanjing city, NFP hospitals have established network management in order to avoid the ownership reform. It may lead the NFP hospital to monopolise, given the absence of antitrust law.

The Nanjing Drum Building Hospital is shaping a hospital group that is to integrate the medical services and logistical services without assets restructuring" (MOH think tank).

In Jining city, there is an idea of creating a share-holding hospital by staff – that is, an 'internal person control' model. With such a governance structure, high cost, high volume competition may continue and the regulatory response should be the third party review of their practices.

I am thinking about the way forward, to borrow money from staff for hospital development and then to return the principal interest to staff. So, I use this name to make changes. It is not a share-holding hospital but it is in essence. In the future, the hospital director will be a businessman; the deputy director will be a professional person. The state holds large share of the hospital, director small share, and staff small share. The hospital should be based on its own thinking to develop without government intervention (Director, hospital).

The ownership reform approach is used in Shenyang to merge hospitals to form share-holding corporations. The regulatory response is Corporation Law.

Merging relates to ownership reformation, or share holding system, China Medical University's affiliated hospital has merged with Dongdi Hospital, of which affiliated hospital has 30% of share as technology and management input, Dong Di Hospital has 70% of share as capital. Of those 70% shared by Dong Di Hospital, 21% are internal staff share. For the first two years, affiliated hospital has the management right. It is quite an awkward situation for the affiliated hospital. 'The parents shrug off their worry, attention and solicitude to their daughter with her marriage' (zhi ji de gu niang jia chu qu, bo yao ye bo guan), an attitude taken by the public institutions. Da lian Medical University's affiliated Hospital merged with a private hospital (Official, provincial health department in Liaoning).

A hybrid hospital group is developed in Shenyang by having a private subsidiary hospital under a large share-holding hospital group. Tax and health planning principles are the main tools regulating the subsidiary private hospital at the moment.

The [xxx] Medical Group is a share-holding group adopting a corporatist development strategy. It has more than ten year's history. Now it has 8 institutions and 3 community health stations. All the institutions connect through capital operation; administratively it is still under district health bureau. [There are total] 610 staff, one-third is recruited based on contract; two-third still holds the previous government institutions' staff status. In 1987, total assets were one million, now it approaches to 100 million. On organisation form, it takes the form of corporatist group operation. At the beginning, the staff consisted of retired staff and half of the active staff; it has two small community hospitals. In 1989, it transformed into a hotel type hospital. In 94, the [xxx] Medical Group formally established. The District [xxx] Hospital is the dragon's head, which follows the principle of state ownership but business operation (Chairman, [xxx] Medical Group)

On ownership system, individuals, collectives, and those inside the group and outside the group are all connected through shares. For government institutions, it adopts the internal share-holding system. Dividends, for a total of ten, 4 goes to the whole group, 3 goes to the welfare and 3 goes to individuals. Dividends are divided into fixed dividends plus variable dividends. Ownership system is reflected through the capital operation. Board of Directors of the group consists of hospital director, state assets representative, foreign assets delegate, and other stakeholders. For internal management, Hospital director responsibility system is in use. On director appointing procedures, the President would discuss informally with district health bureau, and then make appointments. Hospital assets are held through internal share-holding systems. We regard state assets as our own business. The share owned by social group is small, overseas investment has no share, the largest increase of share is still the state assets, now we feel a kind of regret as the ownership reform is going to start (Chairman, [xxx] Medical Group)

For one private hospital, 204 Hospital, the government is mainly interested in two things, tax collected and target are met, as integrated sectoral management requires. The Health Association charges 204 Hospital, not in tax form but fees. The Health Association has a fee charge schedule, as it is not taxes, it could lead to corruption. The Health Association has membership chapters, asking for membership fees and management fees for reaching targets, but actually the areas the Health Association should manage has no management. The Health Association is a city-sponsored fully budgeted government institution. On safety, complaints go to the health bureau, but the health bureau has advised to solve it internally between hospital and the person who complains (Chairman, [xxx] Medical Group)

For a laissez faire market in Shenyang, as the role of the state is a networked state, there are various governing arrangements, and the private sector is booming. The birth of

two privately invested hospitals in Shenyang city indicates that the investors like to buy NFP hospitals, and like to form share-holding companies with public entities. Regulating towards these private hospitals of such governing structures is a challenge.

In 1999, I briefed the idea to the leader of Provincial Health Department; I suggested having 80% share as investor of 7 million investments and 20% technical share held by the Provincial Health Department. Then the issue was to find a legal person to represent the non-government hospital. I found a person with an overseas PhD, at the time a director of a hospital. He has to resign from the public hospital post. The plastic hospital was in operation then. For the first month, it was 60,000 loss, second month, break-even, and the third month, it profited. The technical share held by health department is cleared each year.

There is an Employees' Hospital, which has been asked to separate from its original affiliation; I tried to have another private Women's Hospital. But the provincial health department didn't agree, instead they would like to have an NFP hospital [at time NFP hospital policy was going to be issued, which was in September]. The old Employees' Hospital started to separate from SOE in 1997, by the time of transformation, there were 120 retired staff and 120 active staff, 2.8 million liabilities. I have accepted all this, something like a turnkey contract. In 2000, there was no progress. Last year it looked promising, this January, it broken even, this May it began to profit. Now it has 80,000 to 90,000 revenues. For normal delivery, it is 20 yuan per bed day, which is lower than the province's affiliated hospital (President of the above two private hospitals).

The enterprise's affiliated hospitals are under restructuring, merging and acquisition.

In Tianshui City of Gansu province, The MOH has a pilot on reforming enterprise's affiliated hospitals. The basic idea is to convert those hospitals into community services, merging, restructuring, and acquisition. The services are towards special services and aged care. Currently this is in its initial stage, no preliminary conclusions yet summarised (MOH policy maker).

Nationwide, there are three forms for ownership reform: independent investor, such as the 999 Group Limited in Shenzheng; joint venture (such as Changkang Hospital jointly invested by Taiwan businessman Wang Yongqin and local governments in Guangdong) and acquisition (Lei, 2004). For acquisitions, there are also three types: to become a trustee, or the so-called separation of ownership from business operations, and then to have property reform. For example, Sino-China Tongji Huayi Investment Corporation Limited has owned more than a dozen hospitals; directly purchased shares by famous pharmaceutical companies; and merging, through use of working capital, assets, or exchange of shares to become the legal person. For example, Tong Ren Tang Group to acquire Beijing Chongwen District Traditional Chinese Medicine Hospital through the use of assets (Lei, 2004). Apart from independent private investors, the rest of the pilots all involve arms-length governing arrangements between health departments and hospitals. The regulatory responses therefore vary.

In summary, when NFP hospitals are being transformed from government institutions into corporations in an open market, the traditional regulatory tools are used,

for instance, “Hospital Financial System” and “Hospital Accounting System” (MOH, 2001b). Corporate-oriented governing structures, legal governance, by-laws, staff contracts, and codes of conduct are important tools to regulate medical behaviour. The next section describes the key issues arising from the reform, that is, how to assure NFP hospitals are accountable for their social responsibility.

Regulating ‘incentive’ and ‘interest’: Developing corporate governance

The concept of market socialism is to use capitalist mechanisms for socialism. It means to maintain public ownership, with business/private operation, and to claim social dividends amongst those who contribute. In practice, as the reform policy is still not clear with respect to the privatization of the NFP hospital sector, the pace of the reform depends on the understanding of the stakeholders who are in power (Anonymous, 2004d).

It is the terror of officials who fear selling public hospitals. Don't sell hospitals while I am on this post. Selling hospitals means less power for officials. Ownership is the property of officials (MOH think tank).

Currently, public hospitals are the ‘closest sons’. Whenever there is a mistake with them, it is always to raise the hands higher and higher but to tap softly and softly’ [gao gao ju qi, qin qin fang xia]. The social organisations hold the view that they have no authority and reputation for any evaluation work to be assigned by government. Before the comments are to be made, they have to consider whether this will affect the reputation of the sector and to prevent from hurting the sector badly. ‘Old friends deal with each other politely’ [lao pen yu bu si pe lian] (MOH think tank).

Therefore, the public identity is a good instrument to protect from attack from any source and most critically, it can protect the interests of those stakeholders that have stakes under public name. The second stage health reform has therefore been politicized more than the first stage health reform (Shan, 2002, pp. 1-5).

All such behaviour is to maintain the objective image of the public ownership system. This mask is that, to protect him is equally to protect me. In the final analysis it is to protect the mask of public ownership system. The property right is yours regardless of good or bad, all yours (MOH think tank)!

After 5 March 2004, when Premier Wen said, the share-holding system is the main form of public ownership, more robust and proactive reform on the NFP hospital sector began, (see Figure 9-1). Issues such as how to claim dividends and how to deal with state assets came into the mainstream thinking. The following section discusses issues on the right to claim hospital operation residuals; regulating NFP hospital social objectives by surrogate regulators; the capture of surrogate regulators; alternative accountability mechanisms to regulate the NFP hospitals; and regulating conflict of interest in blurred public/private governing systems.

No credible regulation to ascertain the right to claim hospital operation residuals

To date, NFP hospitals operate under dual regulating institutions since the second stage health reform. That is, they are governed by Corporation Law in terms of their business operation and overseen by health departments, with hospital director appointed by government as the surrogate regulator.

The “Hospital Financial System” and the “Hospital Accounting System” regulate the hospital operation revenue, yet they are not effective due to fluid financial systems under marketisation. The governing structure of NFP hospitals therefore leads to high cost, high volume provision of health service. A loophole between public governance system and corporate governance system has been generated under market socialism. The underlying theory to explain the incentive of business operations to gain dividends is property rights and incomplete contract theory (Hardin, 1968; Hart and Moore, 1990; Harding and Preker, 2000; Harding and Preker, 2003).

According to the property rights theory of ownership at the time the contract of ownership is incomplete¹⁰⁷ (Williamson, 1985; Grossman and Hart, 1986; Harding and Preker, 2000, pp. 6-7; Harding and Preker, 2003). For a healthcare provider, it could produce “moral hazard, adverse selection, non-contractible quality and costly consumer search. These factors accompany the supply-side market power wielded by highly trained medical professionals, with their monopoly license, and by hospitals and provider networks in some markets... The incomplete contract theory of ownership highlights the linkage that bestows power upon those with residual control rights. This spotlight on innovation is particularly helpful, given the undisputed importance of rapid technological advance in modern healthcare” (Eggleston and Zeckhauser, 2002, pp. 29-30).

At the time when the residual right and use right has not been clarified, and at the time when there is no sound NFP hospital management system, the residuals can easily be converted into doctors’ bonus payment. As the hospital director has the right to decide the revenue redistribution, the interest of the hospital director is therefore critical in deciding the social objectives of the NFP hospital operations. Without any immediate regulatory tools to use effectively during transition, the government uses its power to appoint the hospital director as a surrogate regulator managing both state assets and hospital

¹⁰⁷ “The incomplete contracting approach recognizes that contracts are difficult to write in sufficient detail to cover all possible contingencies, so any contract will contain gaps or ambiguities. This contract incompleteness bestows power on owners, who enjoy the right to control the relevant asset in any circumstance not explicitly delegated to others by contract” (Eggleston and Zeckhauser, 2002).

operation residuals. This management-based regulatory approach requires corporate governance system to achieve social objectives.

Regulating NFP hospital social objectives by surrogate regulators

Internationally, the hospital manager, the surrogate, should aim management objective towards the maximization of the wellbeing of the patient. The government claims that the NFP hospital director's role is to manage both economic and social responsibilities towards the social optimum (MOH, 2001a), yet some policy analysts responsible for hospital policy-making insist that the hospital director should only be responsible for the interest of hospital, that is, the dynamic efficiency of hospitals. These two contradictory views can lead to contradictory conclusions with respect to the role of the surrogate regulator. As stated by interviewees:

The health bureau on behalf of government, manages the public assets. So, the Medical Association or other social groups are absolutely not the representatives of the interest of the NFP hospital. NFP hospital is to serve the government objectives (Director, hospital).

The hospital manager is to represent the interest of staff and patient, and he serves the board that is, as long as the board of directors is satisfied by his performance. The hospital director only maintains the interest in the hospital. Currently, it is not the hospital director's role to play on government assets management, specifically assets depreciation and tax payment (MOH think tank).

The government still wants to control, which is not promising in the future. The root is in the system. The hospital director has a term of four years in office, so his behaviour is short sighted, mainly thinking of protecting himself so as to verify that he is not wrong during his term. He is afraid of reform, although the saying is 'hospital director responsibility system' but this is not definite. Since the annual democratic assessment on the performance of the director is by the staff, it is very confusing then to ascertain whether the hospital director is capable or the staff capable? (Director, hospital)

The regulatory issue then centers on how to select a surrogate by the government to represent their interest. Two views are expressed by interviewees: to be appointed by the board of directors, or to be elected by the staff:

The appointment of hospital director should be based on election for NFP hospitals, or through the board of directors to appoint (Director, hospital). The government should not deal with cadre appointment (Director, hospital).

On how to have a hospital director, It should be on a competitive recruiting. The Medical Association or government decide the responsibilities and function of the hospital, the board of directors [in managing government assets] put forward the requirements for hospital director. It is then for hospital director to handle the issues of social benefit and market suitability (Director, networked hospital).

It should be on a competitive recruiting. The Medical Association or government decide the responsibilities and function of the hospital, the board of directors (in managing government assets) put forward the requirements for hospital director (or in accordance to government

requirements). It is then for hospital director to handle the issues of social benefit and market suitability (Director, hospital).

My suggestion is that: Hospital director is for business operation; Hospital director is not the representative of government assets; Hospital development policy-making is subject to the board of directors; Supervision is to be made by the party committee, discipline body and audit department. The hospital manager is to represent the interest of staff and patient, and he serves to the board that is, as long as the board of directors satisfies his performance. The hospital director only maintains the interest in hospital (MOH think tank).

Internationally, with Board of Directors system, there are voices from different stakeholders, including a voice of government authority. Under such case for NFP hospital, a surrogate regulator is a decisive determinant for social objectives through his use of management-based regulation, and that the residual “control rights” and control of use-right is a choice of a surrogate regulator.

The real issue lies in how to assess the performance of the surrogate regulator. The contradiction is that the surrogate regulator is on behalf of the government yet hospital staff does the annual assessment of surrogate regulator. This is a difficult position for the surrogate regulator – that is, it has to satisfy both internal and external clients by balance staff incentive for bonuses and the interest of the health department. In practice, staff frequently captures the surrogate regulator. As stated by interviewees:

The annual staff democratic assessment is based on the four elements, professionalism, diligence, capability and performance. In the annual performance evaluation, if one’s performance ranks at the bottom, one should be eliminated from the services (Official, health department).

The hospital director has to gain the support from the staff by generating good bonus, their support is reflected by the annual staff democratic assessment result, if it is bad, the director should leave the job. On the other hand, if the bonus given to staff is too higher, then the government will punish the director (Director, networked hospital).

The capture of surrogate regulator

Over the past decade, nationwide, the total service volume has decreased, as seen in Table 8-3, there was 20% reduction of bed occupancy rate in the past decade. At the same time, total health expenditure has increased five times per capita (see Table 2-2, p. 26). The plausible explanation is that there is service volume increase per episode¹⁰⁸, implying supply-induced demand, or low social efficiency. This suggests that the surrogate regulator of NFP hospital cannot regulate for the social optimum, as a MOH policy maker stated, ‘hospitals definitely look for profit. This is the inevitable result of marketisation; [we] should not deny it’.

¹⁰⁸ The medical inflation index is 11-12% over the past decade (CHEI Task Force, 1999, p. 168).

Table 8-3 Decreasing Total Services Volume, Early 1990s to 2000

Health services	Early 1990	2000	Change
Total Visits (in billion)	2.6	2.1	16%
Bed occupancy (%)	81	61	20%

Source: Rao, 2002.

The question is how to affect the external audit of NFP hospitals so as to assess their accountability for the social objectives. Market socialism in China seems to be facing a dilemma in managing conflict of interest for those with public ownership, yet business operation entities – rent seeking seems unavoidable under such a system. As stated by interviewees:

Hospitals have a lot of information not disclosed to MOH. Hospital directors have many methods to deal with government officials. They would say government input is not adequate. So there is information asymmetry between the principal (government) and agent (hospital director), so how can the government constrain the hospital director? There is a need for information disclosure: public agencies have the right to review the activities of the institutions regarded as public enterprises (MOH think tank).

What are state assets? Those that can exert effect are state assets. A kettle that can boil the water is resource, but a kettle with a hole leaking water is not a resource. Hospitals with large debt and liability are no longer resources as no benefits are exerted. The effect and role of the state assets need to be considered or they are just wasted. Shenyang City has 13 billion state assets as waste, which no one wants, and it occupies the land there. How to judge such assets in terms of effect and potency? (Official, Shenyang health department)

Alternative accountability mechanism to regulate the NFP hospitals

In China, the CCP holds paramount power in directing government reform and development programs, although there is a growing trend of separation of party from state in economic life (Howell, 2004, pp. 1-3). The problem is that the CCP discipline often fails to contain the rent seeking behaviour of those in power, which in turn creates public distrust of state institutions.

The party manages cadres. This is a Chinese socialistic characteristic. There is a need to form a mechanism so the able person has the opportunity to be the leader. Those representing the interest of the people should be the legal person for managing hospitals (MOH policy maker).

Although the CCP is strengthening its capacity to improve inspection, China has a saying that ‘the sky is high and the emperor is far’. The worry is that, under local governance, local interest groups use the name of the CCP to protect their interests. Therefore, instituting checks and balance system seems the most critical element for reform, for instance, to separate the party from the state.

The Enterprise Working Committee and Organisation Department should retain the party relation. In such a way, the hospital will eventually become a free competitive entity (Central official).

The reform is to de-affiliate person from work unit (institution), so as to have person affiliated to the (health) sector; then to de-affiliate person from sector, so as to have person affiliated to the society. That forms the basis of democratic electoral system. The party then goes into society and community (Director, hospital).

Regulating conflict of interest in blurred public/private governing systems

With the second stage health reform, the NFP hospital is regarded as the social sector, with its operation objectives as social optimum. The problem is that the management information system across hospitals has not been developed. This means that the health department and hospital staff can both blame the hospital director, based on their own interest and prejudices.

The requirement is that the hospital director should represent all the parties, that is, to represent the hospital as well as the people and at the same time represent the interests of doctors. The issue here really is how to have a fair means to reflect the two pressuring issues hospital directors are facing: hospital development issues and fair distribution of net income within the hospital. The evaluation of his performance should use systemic data (Director, hospital).

One has to accomplish administrative tasks, if not one has to accept blame and criticism; but also one has to consider development. So both ends squeeze the hospital director (Director, hospital).

The official rule is that the surrogate regulator should listen to the government. This is a sole regulatory instrument that existed at a time when no established procedures and criteria to assess the performance of the hospital management existed.

On how to manage NFP hospital director's interest, I would say their interest is consistent with government interest as the health departments rectify them. But on balance, the interests between government and hospital staff, it belongs to the art of management. In France, there is a similar situation; the issue is a trade-off between the choices. So, as long as they are not in breach of the regulation, and to accomplish the tasks the government want them to do, such as emergency services and prevention, then accept the reality (MOH policy maker)!

On the issue of representing the hospital director as the interest of health department or the interest of staff, the hospital directors have to balance the interests of the both internally in their minds, and to take care of the interests of both parties. On the premise of compliance with policy statements, the hospital director's thinking is always to make more money and solve the staff issues. But the precondition is that, whenever there is a major conflict of interests between the two, the priority is always 'to keep the hat on their head' [to protect the official position from losing, bao wu sa mao in Chinese]. So, the claimed statement is to do better to the society but also to be a good performer for the hospital (Director, NFP hospital).

Interestingly, health departments put the task of balancing social and economic objectives to the hospital director that is equivalent to a transfer of political risk to the NFP sector – for people tend to criticize the hospitals. The hospital director is therefore sandwiched by the staff and the health department as stated by an interviewee:

It is only through the comprehensive targets to be managed by the health bureau (without interfering with their internal personnel management issues). Within their term, the technical capacity and quality, medical ethics and professionalism, and prices are to be under the scrutiny of the health bureau. The health bureau has no right to intervene in the internal affairs of hospitals. The hospital director is openly recruited on a competitive basis with the approval of the health bureau. In this regard, to balance social objective and economic objective is solely the tasks of hospital director, this is also why he has been recruited as director. It is his discretion to balance the dual conflict objectives (Official, health department in Shenzhen).

Then whom should the hospital director represent? The hospital director should find a way to satisfy the inside and the outside clients, his reward for such good performance should be recognised financially. The government hands over difficult issues to the hospital director. This is a transfer of moral hazard. After all, the hospital director is a human being, not God; this is a humanity issue (Director, networked hospital).

So, to implement the second stage health reform policy on the supply-side (that is, to shift towards open systems governing model), the issue of dual regulating institutions for NFP hospitals during transition centers on the governing arrangement between government and NFP hospitals. With weak external audits, lack of hospital accreditation programs, and no system-based data to judge the performance of surrogate regulators, hospital staff can easily capture the surrogate regulator.

As CCP is the final arbitrator to decide the appointment of the surrogate regulator, when local governance prevails, local interest groups continue the practice of state corporatism. Regulating interest in the blurred public/private spheres needs innovative governing structure reform under market socialism, otherwise, high cost, high volume practice may continue from the first stage health reform.

Summary: Regulating risk, incentive and interest institutionally

This chapter started with reviewing legal entry and performance regulations. It concluded with dilemma about the significance of management and financial systems for effective cost-quality regulation, and the control of the interest under blurred public/private governing system. It demonstrates that effective cost-quality regulation needs to spell out rules on clinical risk, procedures to ascertain staff financial incentive and to reform governance structure to contain the interests of the surrogate regulator. It also demonstrates that quality is a “break-through” point in regulatory development.

Regulating risk requires the establishment of risk management systems that concern evaluating and credentialing of providers, use of electronic medicine to track error, and then reporting (Amerongen, 2002, pp. 128-129). Historically, “Physician: First, do no harm” is the dictum from Hippocrates (Omenn, 2002, p. ix). In contemporary time, medical practice has been viewed from a system perspective, as the healthcare system

determines the clinical performance (WHO 2000a, pp. xiii-xiv). The process of risk management includes benchmarking to share data to guide system performance, increasing accountability through management systems, such as by-laws, and clinical governance and mapping against standards, so as to track individual clinical practice (the technology-based regulation), and to identify the outliers. By tracking the individual clinical behavior and identifying the outliers, quality among providers are compared (Amerongen, 2002, pp. 129-130). Internationally, there is well-accepted practice: the hospital accreditation system, clinical information collected for benchmarking and comparison across hospitals is a solution for management-based regulatory strategy to be upgraded toward performance-based regulation.

But information must be reported and benchmarking standards should be internationally accepted for true comparison. This is a “break through” point for higher performance and quality improvement. The information framework therefore should be addressed at three levels for upgrading towards the performance-based regulation as most OECD countries do.

With marketisation and its accompanying management and financing systems, the clinical risk has combined with staff incentive. In this context, entrepreneurial behaviour “of identifying, developing, introducing and commercialising a new product or services” appears (Saltman, Busse et al., 2001, p. 3). While the entrepreneurialism is essential for services renovation and market development, it “ combines the passion of a social mission with the image of business-like discipline, innovation and determination” (Hunt, 2000, p. 27). Although the social optimum appears to be the goal for NFP hospital sector, the hospital has to balance between risks and financial incentives with appropriate management and financial systems (Dawson, Munro et al., 2002, p. 141).

The negative externalities due to medical mistakes, expired medications, improper training, and absence of proper ethical procedures have not counted properly. Lack of reporting and compliance cost society greatly. Even additional costs for information collection and enforcement are worthwhile and could achieve more efficient resource allocation. Such policy-oriented practice is a condition to upgrade management-based regulation to performance-based regulation.

For the emerging healthcare market in China, there is a more negative side of the entrepreneurialism - for instance, the declining hospital productivity and social efficiency (Forbes, Hindle et al., 2002). The supply-induced demand is an important negative consequence of market forces that relate to the incentive structure change and quality management systems. The basic problem is that the regulatory process is not defined

clearly and followed strictly, and performance review and financial audit are not openly conducted across hospitals. Thus system for regulating risk and incentive are non-existent. The reason is that hospitals and health departments are still deemed to belong to the same family. Failure to regulate incentive properly is the major contributing factor for high cost, high volume competition.

With management-based regulation strategy, good governance on personal management and financing management system, coupled with upgraded performance-based regulation, there is good hope that China may curb “public identity, private behaviour” healthcare system. This is on the high side picture.

The problem is that the governing structure has not been sorted out clearly in the first stage health reform. The issue is that the accountability mechanism to contain the interests of the surrogate regulator is not clear. Under the second stage health reform, the NFP hospital governing system develops towards a corporate governance system. A transitional arrangement is to have a surrogate regulator. According to government, the surrogate regulator has two roles, economic viability for the hospital and social responsibility, that is, to attain the social optimum in the mixed public/private healthcare market. In practice, this arrangement quite often puts hospital directors under conflict of interest conditions for the aim of management and financing systems within hospitals is for revenue generation, and staff is quite often capturing the surrogate regulator.

At the macro level, China aims to make a transition from rule of man to rule of law. The previous salary and personnel management system are largely not suitable to the newly formed relations between individuals and hospitals. The newly developed “Hospital Financial System” and “Hospital Accounting System” are not implementable because the interests of the local stakeholders are to accrue dividends. Therefore, there is a call for external financial audit, restoration of hospital accreditation, and the system-based performance assessment. This raises a question on the regulatory system that will be discussed in the next chapter.

CHAPTER NINE

THE STATE AND CIVIL REGULATORY SYSTEMS IN TRANSITION

China embarked on marketisation under the first stage health reform, and aimed to establish a mixed public/private healthcare market with the second stage health reform. Through the assessment of the existing regulatory tools used in conjunction with the second stage health reform in chapter six to eight, so far, the research has found that to govern the market, the financing regulatory tool is crippled and the price regulatory tool is distorted. Furthermore, governance of institutional performance, management and financial audit are not based on the corporate system, with hospitals still administratively affiliated to health departments but financially self-governed. Therefore, the root cause of the failure of the technical regulatory tools lies in the system that is the state and civil regulatory system, which is still in transition.

Given the above, and as effectiveness of regulation has to be built on an effective governance system, this chapter and chapter ten explore the implementation issues of the second stage health reform policy, in relation to the reform of state and civil regulatory systems, and norms and the compliance system (see Formula 1-1; Formula 1-2, p. 12). In essence, chapter nine to eleven aim to examine the system that can enable the regulatory tools to be effective. From a larger societal perspective, both the regulatory system and norms and compliance system are in transition (Stiglitz, 2000, pp. 95- 134). Therefore, chapter nine and ten are focused on analysing the issues and challenges of the Chinese system in relation to health reform, which is to serve the analysis in chapter eleven, that is, how to achieve the health reform objectives in 2010.

Internationally, an effective governing system is the basis of instituting technical and process regulations (see Table 3-3, p. 42; Figure 4-4, p. 65). For example, most non-legislative regulations are not effective in developing and transitional economies (Kumaranayake and Lake, 1998). Even in the U.K., Singapore and Hong Kong, the supply-side reform has to include strengthening of corporate governance.

Therefore, Chapter Nine examines the public governing structure and the accountability of government departments concerning health. It concludes that MOH has no effective regulatory tools to regulate service quality, and that local governance is decisive in determining the balance between equity and efficiency. This chapter explores

first, the public governing system, and then the second stage reform approach and dilemmas in relation to the state and civil regulation systems.

Public governing system: Structure, reform, and issues

This section presents the role of central government and local governance and policy to accommodate local variation and negotiated policy implementation.

The influence of governing structures on policy making and implementation

Weakening role of central government and local governance

The decentralisation program of the past two decades has led to increasing local autonomy administratively and financially. Herrmann (Herrmann-Pillath, 2003) argues that as of the large geographic differences in China, national policies and directives would be responded to differently by local authorities. The development path would thus differ due to the differences of local policy adaptation process. Such different adaptations would then create different institutional arrangements and structures, which eventually lead to the growing importance of local interest. The concentration of such interest would then be reflected in the interaction between central and local governments in term of new policy development direction.

Herrmann-Pillath (Herrmann-Pillath, 2003) names such phenomenon, 'regional property rights of the local governments'. The 1994 central-local tax separation reform has further reinforced local autonomy in that of local dominance in local policy adaptation, especially as many central policies, such as health reform policies, are unfunded mandates. The problem is the transition of discretionary and mandatory instructions from the central government to central fiscal control of loans and credit to the provinces. This is a decisive rule change in modifying the central/local government relationship.

For instance, the taxation reform program in 1994 has averted the lowest point of central revenue. The central government taxation revenue is expected to increase from 11.5% in 1997 to 15% in 2010 (Li, Mu et al., 1999). The central transfer payment to the provinces has already increased from 66.4 billion yuan in 1997 to 402.5 billion yuan in 2002 (Zhu, 2003).

In practice, public financing decisions are highly discretionary - that is, they are based on negotiation, guanxi and power politics. Most provinces still operate on a fiscal

responsibility system at each level for regular programs. As such, inequality widens among the provinces. A World Bank study (World Bank, 2002) has shown accelerating per capita public expenditures variation across provinces in the 1990s. An interviewee suggests that such situation could not be averted in the near future:

The tax system will not change for years. This is the basic system. In the future how the centre would influence the localities is not clear. Currently it is fish baiting by the central ministries. The local government is responsible for local development. There are concept and understanding issues, and understanding to the reform program (Policy maker, NDPC).

To compensate for inadequate budgetary support, government affiliated institutions have started to levy fees and collect fines for their own survival. With the existence of extra-budgetary income for subsidizing government-affiliated institutions to perform administrative functions, there is a small treasury for institutional welfare. Government administrative institutions are therefore pursuing the so-called three arbitrariness: arbitrary taxation, arbitrary fines and arbitrary expropriation (Wedeman, 2000). The consequence is dissolution of the governance system: trust, authority and legitimacy of governments are in question.

In summary, at a time of increasing reorienting towards sector protectionism and increasing local protectionism at horizontal geographic region, sectoral regulations show an increasingly inward looking trend. Negotiation mechanisms to deal with sector and local protectionism are not rule-based.

Policy to accommodate local variation and negotiated policy implementation

To accommodate local variation, policy-making can only be guidelines and principles. Implementation of health reform, therefore, rests with provincial capacity and intergovernmental departmental relations. Policy implementation is a negotiated process due to the nature of the governing system. As stated by the interviewees:

At the time of planning, the policies would come down to the bottom from the centre... At the time of market, the formats are multi-ways or multi-formatted (MOH think tank).

For most policies, Shanghai and Guangdong implement better and poor provinces poorer. So many poor provinces would instead prefer the central policies to nail down every detail for the provinces to follow; then they would use these expressions to talk to local planning and finance departments to look for support. But the centre still prefers more flexible policies so as to give more power to the localities (MOH policy maker).

Some poor provinces lack the willingness, creativity and initiation in implementing central policies. Of course poor provinces have difficulties in coordinating other government departments. Generally, Shnanxi, Gansu and other poor provinces prefer the central policies to be as detailed as possible, while Guangdong and other rich provinces prefer the central policies

to be more broadly outlined. For example, Guangdong province has already accomplished 5% government annual health budget increasing rate. Now they have difficulty to ask for more from the finance department (MOH policy maker).

China's social structure is to have government departments as systems: this is the weakness of the current political system. The idea is to have each government department handling their sphere of business but there are no coordination mechanisms among them. The reform ends up with three parties, health services, pharmaceutical sector and insurance sector, such reform reinforces their positions, as it is more difficult to coordinate (MOH think tank).

New role of MOH and regulatory approach under the second stage health reform

New role of MOH since government restructuring in 2000

In 2000, the government restructuring required governments to use economic, regulatory and legal measures to guide overall development. Administrative approval power has greatly reduced ¹⁰⁹(Zhu, 2003). Market monitoring and inspection functions have increased with respect to 'regulate and rectify' the market order. In MOH, the HIC has been established to inspect the healthcare market. Table 9-1 lists the healthcare stewardship functions by government departments.

¹⁰⁹ In 2002 in the Government Administrative Approval Power reform program, the State Council has abolished 1195 items that need administrative approval.

Table 9-1 China: Government Departments Concerning Healthcare, 2002

Healthcare stewardship function	Gov't involved
<u>Long-term health development & planning:</u> Ten years health development outline/Five-year health development plan; Special development programs; Public/private provider market entry;	NRPC, MOH
<u>Service provision:</u> NFP hospital performance/FP provider inspection	MOH
<u>Finance of service:</u> Supplemental insurance for civil servants	MOH
Essential urban health insurance	MOLSS
Social protection for the poor and unemployed	MOCA
Business licensure and registration for FP health insurance	SAIC
<u>Consumer protection:</u> Medical Accidents Treatment Ordinance	Supreme Court
<u>Labour market:</u> Cadres personnel registration/Registration of public sector skilled workers	MOP
Registration of public sector semi- and unskilled workers	MOLSS
<u>Service market:</u> Healthcare quality regulations and directives	MOH
<u>Pharmaceutical market:</u> Pharmaceutical regulation/Oversight on pharmaceutical companies	SDA
<u>NFP hospital:</u> Healthcare regular budgetary allocation	MOF
Civil organization registration	MCA, MOH
Financial audit	SAA
Health services pricing	SPB
<u>Market instruments:</u> Tax collection of private hospitals	SAT
Business licensure and registration of private hospitals	SAIC

With the call for steering health development, MOH has to externalize and formalize the tools previously used as internal hospital control measures. MOH realizes that quality provision of services relates to: insurance payment methods; the pharmaceutical market; the labour market; civil organization self-management; and the financing for social functions by governments. Yet many of these functions fall outside MOH responsibilities. MOH is thus instrumentally crippled in attempting to implement the mandate. As stated by MOH officials:

Currently the supervision mechanisms are quality assessment by intermediators, financial management by audit administration, price management by price administration, tax collection by tax administration, Entry by health department on personnel, technology, facility licenses and, cost review by health department. The MAD of MOH now only cares for medical accidents and quality, which leaves the personnel department and finance department taking their respective roles to play (MOH policy maker).

The government [MOH] wants to manage hospitals but how? What is the method to do this and the capacity? All are not there or not enough. The main issue is that supervision and inspection mechanisms have not been shaped. The key is not the government capacity to supervise but the

capacity of people's strong awareness of supervision. This relates to social humane factors (MOH think tank).

Overall there is no leverage. MOH has no power, price in Price Administration, finance in Finance Ministry, personnel management in MOP, so MOH has no means to coordinate and control. So Premier Zhu Rongji said, 'don't blame the health minister, it is difficult to do the business'. He also believes that there is not a generally accepted legal document for it to be based upon (MOH policy maker).

The idea is that the power associated with responsibility for managing the operation should be decentralised to the departments concerned, e.g. MOH should have the budgetary power. Within the budget, MOH should have absolute power. Now the practice is the budget proposal system, MOF manages the civil works of Beijing Hospital. All focus on seeking power, and the money is the greatest grandfather. But whenever there is a problem, it is MOH to be blamed. So the money power is in MOF, problem settling is in MOH, this is much more conspicuous for MOH (MOH policy maker).

As MOH is not equipped with the necessary instruments to perform its new role, it can only 'observe and investigate' the issues. As a matter of fact, the governing structure itself implies the negotiated policy implementation. The effectiveness of policy implementation is therefore compromised.

As the role of MOH is defined as 'entry, quality and efficiency' under the second stage health reform, yet MOH has fewer levers to influence quality, one central official lamented that, 'China is different from Australia where there is government financing so government can influence doctors, in China as the government has less input so there is no way to control supply-side'.

The policy framework for MOH is that whenever the market can perform well, resort to the market; whenever market can't perform well, then MOH would think what they could do. If MOH can do, then do it. If [MOH] can't [do]; don't do it – observe and investigate. 'Who approves who is accountable' is another slogan MOH has proposed now. For those MOH is not directly involved in approval, MOH asks for files for records (MOH policy advisor).

MOH is therefore incapacitated to carry out the second stage reform especially as the reform momentum largely depends on willingness and capacities of local authorities, subject to the consideration of local interests. Within government, opposition exists, as government departments lost power due to the separation of financing and detachment of hospital affiliation. More importantly, doctors disagree with the reform! So, implementing the second stage health reform is faced with opposition from interest groups, mainly due to the 'marketisation of power (it means to hold power can obtain benefits in the process of marketisation)' (He, 1998; Hu, 2001). As stated by MOH officials:

The central government has the saying: objectives clarified; thought [becomes] clear; attitude [is] active; execution [is] firm; operation [is] steady. The reform is based on pilots, which are the processes for reaching common understanding and to train the cadres, so as to form the model. The momentum depends on people handling the operation, and their calculation of gain and loss out of reform. Clinical protocols constrain the doctor; so the value of the doctor is

expressed economically in the form of the red envelope, and a concurrent job. This is very natural. Here the relation is long-term interest vs. current interest; people's interests vs. department interests. 'You cannot throw away the baby for fearing dirty water'. The influence of market is multi-faceted. The market now opens; competition is in, stabilising the contingency of doctors is an issue. There are doctors complaining about government policies, we have to analyse the curses, and to use diluting, directing and obstructing to deal with different situations. 'There are people who scold the mother while eating the meat' (MOH policy maker).

On behaviour of government departments, some provincial governments should at least push reform at provincial capitals, or one rich area of the provincial capital... Reform is a process; it will not be stopped in obedience to personal will. But overall there is still too much interference by the government, the so-called 'Officialism' (guan ben wei). There is a proposal to have 200 public hospitals become the third sector, but immediately, a deputy director general from MAD shows his worries. There are still people enjoying administrative approval, to have approval is to have the power, and so the benefits of such power. So the power must be in my hands (MOH think tank).

The second stage health reform policy implementation in three sampled provinces

The policy implementation depends on local understanding and capacity to implementation. The findings from Liaoning province and Shenyang city suggest that the state is withdrawing (see chapter six). This reveals why the role of the state in Shenyang has become the networked state. Given that Shenyang adopted the ownership reform approach, the policy adaptation process described by the interviewees from Shenyang is less encouraging. As stated by an interviewee from Shenyang:

The provincial policy formulation process is to have staff to write drafts, revised and approved by the director of the division, then revised and approved by the director general of the provincial health bureau. In between there could be some consultations. This is the reason why the policy consideration and level is so poor (Official, provincial health department in Liaoning).

The policy should be based on average, or be general sable, otherwise reduce the number of policies. Systems and policies are the reputation of government, so government should act on behalf of the 1.2 billion populations to enforce the law (Official, provincial health department in Liaoning).

The findings from Inner Mongolia province suggest that the government matrix structure is a severe hindrance to implement cohesive policy reform programs:

Some of the central policies such as classification of hospitals, when put into implementation at provincial level, create the problem of inter-government department coordination, eg, the Industry & Commerce Administration, and Taxation Administration refuse to jointly issue the circular on managing both FP and NFP hospitals. The provincial health bureau wants to formulate management methods but other institutions or government bodies are not cooperative. So the detailed management tools are not in-place, these are process issues (Official, health department in Inner Mongolia).

The policy implementation could not catch up with policy statements, the implementation process has problems, such as Physician Law implementation, and their credentials and registration apparatus are not in place, so there is no basis for supervision... The director general of provincial health department cannot manage the hospital directors because he has better

connections with more powerful leaders. Some times, the administrative rank of hospital director is the same as the rank of provincial health department director general. How to supervise this hospital by health departments (Official, health department in Inner Mongolia)?

The findings from Shenzhen suggest that there is a strong role played by the state. It seems that the state is steering towards a carefully planned market, and that the role of the state is entrepreneurial.

The role of the health department is under the guidance of central policies to realise the transition from sponsoring hospital to managing hospital, and to implement integrated sectoral management regardless of public or private hospital. With respect to hospital business operation, the health bureau should not intervene in the future regardless of public or private hospitals... (Official, health department in Shenzhen).

On transformation of central policy to the locals, under the premise of not conflicting with central and provincial policies, and under this background, to formulate corresponding implementation policies tailored to local circumstance, such as the materialisation of eight health reform policy documents. The key is that the economic development level determines the development mode (Director, networked hospital).

After the government institutional reform, the efficiency of the health department has improved a lot, and we are willing to do better. Regarding the government's willingness to spend more money in the realisation of policy compliance, we know the management is different comparing China with foreign countries in terms of mode of management. There is always a process of development (Official, Shenzhen health department).

Overall, the extent of policy implementation varies. The capacity and understanding are the critical factors apart from the interest of the stakeholders.

Policy effectiveness is compromised by the interest of local governance

For the second stage health reform, the localities are meant to formulate an implementation method. As policy implementation is a negotiated process, the willingness to reform becomes the key to understanding the reform process at local levels for a decentralized system.

The central government has the will and is eager to do and to push. The local government's willingness is weak. At localities, there are some people who want to do but need support. The provincial capacity is far behind. 'Who appoints me, works for whom'. This needs political reform. Please look at the 'Three Represents' booklet written by Jiang Zheming¹¹⁰. Each department comes from the perspective of their interest, if it benefits, do it; otherwise leave it as it is (MOH policy maker).

¹¹⁰ See Three Representation theory by Jiang Zheming (Jiang, 2002).

The decentralization program has created conditions for local governance¹¹¹ (Bovaird and Loffler, 2002, pp. 54-68). Under local governance, the willingness of reform is a matter of judgment made by local stakeholders and negotiations with various players during the policy process.

Regarding the willingness of local government on policy implementation, there is a saying, 'this is not my money; who cares'? There are such persons in poor areas, and there is the foundation for such concepts prevailing (Official, NDPC).

The willingness of the provincial level in terms of reform is not strong, as the local health officials are appointed locally, as the decentralised system requires. Thus their willingness is consistent with the local governments not the central governments except those vertical systems such as SAIC. The local governments do not definitely understand the centre's sectoral policies... Overall, the more the reform is, the more the decentralisation is. The issue is how to strengthen the local government capacity (MOH policy maker).

Currently there is government administrative approval system reform... The best solution is to cancel all approval mechanisms so as to cut the origins of power abuse: 'to remove the charcoal from beneath the boiling pot [fu di chou xing]' (MOH policy maker).

On dissemination of central reform policies to the localities, in terms of reform contents, if it is conducive to the local entities, they would do it by assigning to individual departments; if no benefits are brought to the localities, they are idle without incentives. In terms of reform speediness, the 1997 reform policy comes to the provincial level at 1998, to the prefecture level at 1999, to the county level at 2000, and township 2001, almost one year one government level in terms of policy documents discussion and reformation of local policies (MOH policy maker).

In China, policy implementation is usually compromised by local adaptation. The commonly cited phrase of 'from above comes policy; from below comes strategy to counter the policy' means that for policy implementation, level-by-level, down to the bottom, the formal institutional arrangement evolves into informal arrangements in tailoring the local customs and conditions. As customary rules across the country are, in many instances, in conflict with the established legal system (Zhu, 1996, p. 295), such adaptation processes dilute policy effectiveness. Local governments "...have not regarded this phenomenon as problem [to solve]. They [the government] have obviously known but prefer not to intervene ...this situation is not what I initially thought of as issue of ethically good or bad; what I faced is the normal behaviour of the majority in the gaming stake. It is the realistic calculation of accessing benefit and avoidance of loss that are understood by commons" (Wu, 2003, pp. 2-3). Selective implementation of policies is a characteristic of the reform. As stated by interviewees:

¹¹¹ Local governance is "the set of formal and informal rules, structures and processes by which local stakeholders collectively solve their problems and meet societal needs. This process is inclusive because each local stakeholder brings important qualities, abilities and resources. In this process it is critical to build and maintain trust, commitment and a system of bargaining" (Bovaird, Loffler et al., 2003, p. 374).

One Deputy Director General of MOH, now the Party Secretary of Beijing Hospital mentioned that, previously when she worked at MOH, she thought the policy was ok; now she feels that the policy implementation is poor. Many hospitals don't know policies, even if they know they would think it is irrelevant to them. Another thought is that policies have problems and thus are not appropriate to implement. They would regard the policies as of academic nature, and so of the 'smell of students' [su shen qi] (MOH policy maker).

For the previous policies have their inertia to continuously carry on. As such, the new policies are either to implement or not implement. The law should clarify what the central level should do and what the provincial level should do, so as to avoid that when issues raised; there were mutual complaints between the centre and the provincial level governments (MOH policy maker).

In the health sector, there are phenomena of blaming the upper level governments, I think the issue should be analysed objectively. But there are phenomena of scholars making policies (means without consider the reality, only copy the books). Reform is good for large hospitals. There are stories that the government of China is government of Shanghai City [means only consider the developed areas] (Official, provincial health department).

Public choice theory explains such street level bureaucracy, as it can stop the functioning of formal institutions (World Bank, 2001, pp. 175-178). Culturally-defined guanxi has come into play under such circumstance (Perkins, 2000, pp. 232-243; Pye, 2000, pp. 244-255). So “Although the rules are the same, the enforcement mechanisms, the way enforcement occurs, the norms of behaviour...are not” (North, 1990, p. 101).

The main problem with local governance is that the state corporatist practice may continue. This means that the equity-efficiency trade-off cannot be balanced towards the social optimum when local interest groups care more for their personal political careers, and when public financing is discretionary.

In summary, with the structure of the public governing system as a dual accountability system, the policy-making has to accommodate the local variation and the policy implementation is a negotiated process. With a decentralisation program, local governance dominates the policy effectiveness. To implement the second stage health reform program through existing governing systems, health departments are not well equipped as there is no effective instrument to carry out the quality management work.

In addition, with local governance and the formation of local interest groups (refers to those who hold the power for policy adaptation and policy implementation), the link between the centre and the localities has weakened. Local interest groups will selectively implement the central policies. In three sampled provinces and cities, only Shenzhen can implement the central policies effectively, indicating the difficulties on quality management in a market-oriented healthcare system. The views on central policies are mixed; even with wide flexibility it is still deemed inappropriate to local conditions. Interest is a key parameter in ascertaining the views he/she represents. Regulating interest

is therefore a daunting task to improve the effectiveness of the second stage health reform policy. Trust and credibility of public institutions at street level is critical for the success of reform.

On the local management perspective, it always starts from concrete interests, for those policies which benefit them, implementation is fast, and for those harmful to their interests, it is difficult to implement. At year-end, there is an evaluation on managers, but how to judge and from what perspective (Official, Inner Mongolia health department)?

New initiative on NFP hospital organizational reform

After the announcement of the NFP and FP hospital reform policy in 2000, MOH conceived further reform according to the FP nature of NFP hospitals. The reasons are that the governance relation between health departments and NFP hospitals is still not clear. For instance, supply-side financing is still a major issue to be solved given that the state purchaser role is under-developed. As the regulatory tools, such as price and financing, are hard to operate for the NFP hospital sector, to date, MOH considers to have fully budgeted public hospitals.

Since the issuance of eight ministries' jointly signed documents [Appendix D, Policy 15], urban reform is in rapid progress; non-government institutions develop much faster. Multi-form sponsorship of medical services is in shape. The government does not necessarily need to manage all public hospitals; some are given society to run. Public hospitals are government monopoly, broadly public hospitals refer to both SOE affiliated hospitals and MOH affiliated Hospitals, narrowly, it refers to MOH hospitals. How to reform government monopolised hospitals and what is the direction? If [public hospital are] still monopolised by government then there is no competition and no law and regulation required. My opinion is that there are two directions of reform (MOH policy maker).

First, to reflect equity and government function: what should government purchase? And what should be run [means produced] by government? Government production should be of those basic functions reflecting equity like Medicare and Medicaid programs. For this, the government should use budget systems to manage; this amount of hospitals should be one-third to one-fourth of total hospitals or 20–30% of total hospitals. Second, to reflect efficiency, at present this is weak. Quality and responsiveness should reflect multi-layer demands. Absorbing social capital and service price slightly higher than cost should solve issue of inadequate financing (MOH official).

The states also have many non-private non-public operated medical institutions, the so-called third sector. Shao Yifu Hospital in China is an example [Shao Yifu is a Hong Kong-based businessman]. In China, I would say government should operate one-fifth of total hospitals. The government should transfer out those hospitals that they could not digest well (MOH think tank).

Assuming the size of public hospitals has been decided, the issue then is how to deal with those remaining NFP hospitals. In principle, there are two approaches: the planning approach is to achieve technical efficiency (through service diversification) and allocative efficiency (through rational distribution); and an ownership approach to achieve dynamic efficiency.

Shanghai has proposed that for urban health, there should be a very small number of medical centres to represent the most advanced medicine development; currently changes toward this direction are not obvious. The finance for such centres may come from government, as said to centralise finance to support a few good public hospitals. Apart from this, government should support common hospitals providing common services and also support for community services centres (MOH policy advisor).

The planning approach suggests integrating hospital distribution (encompassing SOE affiliated hospitals, MOH affiliated hospitals, or hospitals belonging to various levels of governments), the so-called integrated management. However, the planning approach faces structural constraint. The existing public governing system hinders the planning approach. The ownership approach concerns governing structure reform, which is the key issue for the second stage reform (see Figure 4-4, p. 65). As stated by interviewees:

Based on this structural thinking, Shanghai's progress is not fast; the whole countries' progress is not fast. The biggest problem is institutions affiliated to different governments. How to implement the management principle based on geographic territory? So how to advocate for promotion of integrated sectoral management, this relates to inter-government relation - a cause of slow progress (MOH policy analyst).

The classified hospital policy is far from perfect. Simplification is equal to a non-scientific approach. Currently there are roughly 98% state-owned hospitals including SOE affiliated hospitals, and there are roughly less than 3% of private hospitals (although this uses the number of institutions but ideally it should use number of persons employed by the private sector and total private assets). The issue is to change the management system/ownership system from a state-owned system to the third sector. The objective of the third sector is to retain equity, not too much emphasis on profit seeking; the main purpose is to create the reputation of their brand name and to establish business relations (MOH think tank).

For the second stage health reform, the first fundamental issue is to ensure equity through a rational goal governance model; the second fundamental issue is to ensure efficiency through an open systems governance model. Within the open systems model, there are also trade-offs between equity and efficiency: the size of public hospitals is to assure equity through public financing for the provider; social ownership is to balance between equity and efficiency (for ownership concerns organization of services, and services to be provided by NFP sector with various FP nature, at this point public/private governance structure blurs); and FP private hospitals are for efficiency. Issues of efficiency and equity are combined with governance issue.

On 5 March 2004, Wen Jiabao, the premier of State Council, asserted that it was important “to make the share-holding system the main form of public ownership system”(Wen, 2004). With that, the most recently conceived picture by MOH think tank in 2004 on hospital reform is in Figure 9-1 (Liu, 2004). The regulatory implications are a mix of regulatory tools to be adopted: financing and price, governing structure reform, tools to correct market failure, planning for market entry of private sector and tax policies.

NFP Nature

- ↑ a) Public hospitals, devolved from NFP hospitals, are to account for 10-25% of total hospital size. The way to regulate these public hospitals is conceived as direct financing, salaried doctor, reference price, such as social objective-oriented hospital.
- b) NFP hospitals: Divided by previously MOH and SOE affiliated hospitals:
- MOH affiliated hospitals, that have converted to NFP hospitals since 2000, are to move to governing structure reform. The innovative piloting is to create innovative arms' length governing control relations between the health department and NFP hospitals, such as business operated and networked hospitals. The way to regulate these new market entities is conceived to arise from governing structure reform;
- SOE affiliated hospitals, that have already transformed into business operated hospitals in the past decade, such as networked hospitals, share-holding hospital groups, and those contract-out to investors for internal operation restructuring, are to survive in the market. The way to regulate these hospitals is the regulatory tools to correct market failure?
- c) FP hospitals, devolved from either MOH or SOE affiliated hospitals, are to depend on the marketization process, some say 10%. The way to regulate these hospitals is regulatory tools to correct market failure;
- d). Private hospitals, the total size is unclear. The way to regulate these hospitals is conceived as planning for market entry, tax policy, and to correct market failure.
- ↓

FP Nature

Figure 9-1 NFP Hospitals Reform Perspective and Regulatory Responses (Liu 2004)

In summary, for policy implementation, the difficulty in implementing the planning approach is the barrier posed by the governing system; the difficulty in implementing the ownership approach lies in the barrier of the governing system and the operational mechanisms (see chapter six and seven). The solution is to have an innovative ownership approach to overcome the planning approach so that the barrier of the governing system can be removed, as the ownership approach adds the accountability to the government concerned.

To Develop the alternative regulator during transition

NFP hospitals as NGOs

To develop towards a civil society means to have a public place, to begin free talking, and to institute new social institutions (Lin, Personal communication, 2004). As market socialist China devolves from a state-society, most NGOs in China are therefore government- owned NGOs or GONGO. As stated by an interviewee:

...Chinese community representatives... [are] ...local People's Congress, and Political Consultative Conference for the time-being. China deems that these organisations are of civic society nature. The true community representatives could come into being in the future (MOH policy maker).

Yet the historic stigma is that the social structure in China is organized through government departments, that is, state-society. With the second stage health reform requesting NFP hospitals to detach from the health department, large hospitals are increasingly self-governed and independent. This demands an alternative regulator apart from the state, which is the traditional regulator, because the relationship between hospitals and health departments is not clear. Interviewees offered differing perspectives:

On [the relation between] MOH and hospital, in the past it was the 'father' and 'son' relation, now with associations established, it is the uncle and son relationship (Policy maker, NDPC).

I am not in a position to agree about the 'father' and 'son' relation, health administration works on behalf of the government to manage social services. Currently, the hospital has developed very well, if one insists on using the 'father-son' relationship. I would say that the 'son' is a big son now; it is an independent and grown up 'son' (Official from provincial health department).

Regarding representing interest, this has relevance to the transition period. In the past, MOH represented the sectoral departments, now it represents the interest of peoples, but this needs time (Director, hospital).

Internationally, it is believed that the government should not recede too far. In China, large hospitals have great political and civil influence. But China has very limited tools to influence the large hospitals (MOH policy maker).

Professional bodies as civil regulator

Professional organizations appear to be coming on to the governing platform at a time when the role of the state is diminishing. Yet their role is still limited, give their capacity is inadequate. The government and the hospital do not like the GONGO to be an opposing force¹¹², and the image of GONGO is not established. As stated by almost all types of interviewees:

MOH now is in the process of establishing professional associations such as a hospital association and other associations. At a time of transition, it is impossible to take care of every aspect of the issues. The associations should go through the process of coming into existence, developing and becoming sound. Now the associations don't know how to represent, doctors and hospitals don't know how to use these associations (MOH policy maker).

The Chinese do not like to be confrontational, instead, Chinese like reconciliation, and the Governments and Associations are run on dialogue relations, not of confrontation. The associations are not labour unions (MOH policy maker).

...The representative of hospital interests is still the health bureau, not the Medical Association, as the latter is a profit-seeking unit, and it could not serve as a self-disciplined body at least for the time being" (Director, hospital).

¹¹² In practice, it means that any professional organization has to make application to the line ministries first, and then to register to MICA as professional organizations.

The Health Association has membership chapters, asking for membership fees and management fees for reaching targets, but actually areas Health Association should manage have no management (Chairman, the private hospital group).

The professional association in Guangdong is still in its very early stage. But this is the trend like foreign countries; the government cannot handle everything. To leave the technical and academic issues to others is right. Now I think professional bodies can't do much. There is still no clear policy on this. The Medical Association is a typical example, actually Medical Association is playing the role of substituting for government, it is by nature a semi-government body, and it is not completely independent. Many leaders in the Medical Association are from government departments. After the government restructuring, we have fewer staff, so we give many tasks to the Medical Association to handle. They are not pro-active; they mainly accomplish tasks assigned by us. The associations are not becoming powerful enough to be authoritative and independent (Official from provincial health department).

In theory, the Medical Association should represent the interests of doctors and set norms to influence doctors but this has been changed in Shenzhen. The Medical Association in Shenzhen is not qualified to take part in such a role. It may take long and long time to have this comes into reality. By that time we may say it is a sound market (Director, hospital).

Nevertheless, MOH is determined to develop the capacity of professional bodies, given there are no regulatory tools to accomplish its new role on quality management, for it is clear that only the civil regulator can handle the on-going health services' peer review, given that high cost, high volume practice is the main problem in China's healthcare system. As stated by a policy maker:

A peer review system will be adopted, similar to the joint hospital accreditation system in the U.S. Market intermediators will manage the accreditation process and report to MOH for administrative punishment or whatever. At this time, China is not ready to follow the idea. So government will finance the shaping of the intermediators initially, when their authority is in place, they can independently conduct matters on their own (MOH policy maker).

Summary: Compromised policy implementation under local governance

The second stage health reform is a top down structured reform. It aims to address two fundamental issues that the first stage health reform fails to address: to address equity by split financing from provision, so a state purchaser can rationally purchasing essential public good; and to address both efficiency and equity by detaching public hospitals from government affiliation, so an NFP hospital sector can provide diversified services. In essence, the hospital practice of 'public identity, private behavior' under state corporatism has to be reformed so that private behavior can be regulated appropriately.

This chapter explores the governing system issues for the implementation of the health reform policy from the supply-side perspective. Since the second stage health reform, MOH has been assigned to regulate quality healthcare provisions. The major issue

to be addressed on quality is the overuse of services and excessive entrepreneurialism. To implement the second stage health policy, the local stakeholders' interest in the era of local governance is the major impediment to equity-efficiency trade-off.

Within public institutions, negotiated practice prevails rather than rule-based administration. So, although the policy statement is to have professional organizations to regulate the quality of healthcare, the capacity of the civil regulator at the time is not ready to attain the intended role.

Local governance has become an important concept since the decentralization program. The local stakeholders decide who will be the hospital director and whether the surrogate regulator's performance is consistent with their interest. It is the local stakeholders, who appoint the surrogate regulator, and the CCP is the final arbitrator to judge whether the surrogate regulator is to represent the fundamental interests of the masses (social objective) or represent the foremost productivity (economic development) as elucidated by the 'Three Representation Theory' (Jiang, 2002). At the time of brutal capitalism, rampant corruption exists among public institutions (Hu, 2001; Table 4-4). Both market failure and government failure exists in healthcare. The CCP therefore aims to have the civil regulator to regulate the interests. This would bring fundamental social change that will be discussed in the next chapter, in relation to compliance, norms and the development of legal institutions.

CHAPTER TEN

NORMS AND THE COMPLIANCE SYSTEM IN TRANSITION

With the birth of the NFP sector, the public/private governing system is blurred (He, 1998, pp. 1-15; Hu, 2001). With decentralization, local governance prevails in protecting local interests (Shan, 2002, pp. 35-61). As discussed in chapter ten, the reason that technical regulation has fallen short of achieving the intended regulatory objectives is mainly due to low compliance to the state regulatory system. This chapter explores the change of the compliance system, that is, the emergence of legal and civil institutions in response to the 'small state, big society' initiative.

This chapter finds that, for the regulatory system, the rule of law requires institutions to regulate the regulator; for the system of norms, the 'new ethics' is needed to replace the planning system culture, and the formation of social agreement is needed so as to create social capital for compliance. The critical findings are that rule-based administration is essential to gain the trust of public institutions, which in turn can obtain compliance. This is equally important for the state regulator, the civil regulator and the law enforcement agencies. The chapter concludes that, between moral aspiration, social rejection and legal sanction, designing the compulsory regulatory system to deter opportunistic behaviour is critical during transition. In addition, between the credibility of the regulator and the compliance of the regulated, to build the trust of public institutions so as to comply with state regulations, is also critical during transition.

This chapter describes first, the need of a legal regulatory system and the change of system of norms during transition and then, the formation of social agreement as social capital for the development of market-based governance.

Towards rule of law: To regulate the regulator

The first Constitution in 1954 (see Appendix D, Policy 2) states that the state is responsible to promote health development, disease prevention and treatment. The 1997 Health Reform decision paper (see Appendix D, Policy 12) states that "health is of a public welfare nature with the government implementing certain welfare policies", and "health development must be coordinated with the national economy and social development". From planning to market, the changing role of the state means a shift of financial responsibilities from state to individuals (Zhao, 2000), and the renewed

relationship between the state and individuals in a normative and legal sense, for instance, the advocacy for a limited state and the awareness of individual rights.

Law is the embodiment of the nation's spirit, and it reflects the story of the nation's development (Zhu, 1996, p. 301). The past two decades have witnessed an unprecedented legal development in China. For healthcare, the NPC has issued nine laws, State Council has issued 24 ordinances, MOH has issued 430 decrees and policy directives, and more than 1400 technical specifications and criteria (MOH, 2002). In addition, local congress and governments have also issued a large number of health related regulations and directives. In 1999, MOH has promulgated the MOH health legislation management regulation. These laws, ordinances, decrees and directives form the legal institutional basis for the rule of law within the health sector. The main problem is law enforcement.

As stated by the interviewees:

Without the 'law of mother', say healthcare law, enacting of the 'law of son' widely exists in China. So, it is common to issue many sub-sector regulations and rules 'to start to work' and 'to deal with the matter whenever it is encountered'. Many localities have enacted many local laws and regulations in an attempt to solve local issues being faced at the time. These local enactments are trying to be in the large framework of national laws and regulations whenever possible. In summary, by now:

Having laws to base upon is satisfied;

Having laws so must follow is not satisfied;

Having laws so must enforce strictly is not satisfied;

Breaching laws must be investigated is poorly implemented and not adequately done as it relates to financial incentives (Policy analyst).

The NPC evaluation on 1990s' health related law work is as follows: good legislation but poor law enforcement, the so-called 'intellectual's legislation without enough enforcement' (xiu cai li fa li du bu gou)(MOH policy maker).

Administrative adjudication to limit power abuse by state regulator

After the government restructuring in 2000, development of legal institutions has shifted focus from substantive governance to procedural governance, for instance, the promulgation of Legislation Law in 2000 and Administrative Approval Law in 2002 (see Appendix E). The health administrative adjudication is listed in Table 10-1. The main issue is how to balance between legality and rationality. The transition in practice is a muddle-through process with possible misplacement between the role of the government and legal institutions.

Table 10-1 Deterrence System: Administrative Adjudication and Legal Punishment

Administrative adjudication rule	Year
Medical institutions inspection administrative punishment procedures	MOH 1994
Health sector internal (financial) audit rule	MOH 1997
Health administrative punishment procedures	MOH 1997
Separation of fine decision-making and fine collection implementation method	MOH 1997
MOH administrative adjudication review and administrative litigation method	MOH 1999
Management method of medical accidents treatment ordinance	MOH 2002

Source: MOH, 2002.

As the transition is a muddle-through process, resentments (of the law enforcement officers perceived as being treated unfairly), worries (about the existing situations as perceived as chaotic without any rules to follow), and bounded rationality (during transition in anticipation for the rule of law) all exist. It seems that only the complex social adaptation theory can interpret the transitional process, or ‘Chinese characteristics’ may be the words to describe the ‘black box’ process of transition:

Now there is a call for rational government behaviour. Issues as such could not be handled through normal means; it only relies on the discovery of benevolence. No mechanism to assure that all government behaviour is rational. ‘Right to the context but not right to the rational, right to the rational but not right to the context (he qin bo he li, he li bo he qin)’. Here the supervising body has the marginal right of freedom of judgement (Policy maker, MOH).

Currently, I would name the transition as from a government administration status to a ‘quasi-judicial status’, that is, although it is still a government (structure) administration status, but it tries to operate in a judicial manner. For example, the litigator is a patient, the defence is a provider to provide evidence, and health departments are in a position to judge the case or evidence, which is not the court (Policy analyst).

Inadequate capacity for law enforcement

In 2002, the HIC was established as a fully budgeted regulation enforcement unit. Yet there were only about 100,000 health inspectors in HIC in 2002 across China (Liu, 2002, p. 9). A large majority of the health inspectors deal with food, drugs, cosmetics and illegal private practices. The substantial inspection for quality health services provision has not started yet. Some have said, HIC inspection is ‘a catching-one-missing-10, 000 policy’ (MOH think tank), for the inspector cannot handle so many doctors practising individually. Others have said that there are ‘no law enforcement conditions, budget, people and capacity’ (MOH policy maker). As stated by an interviewee:

The issue is to have professionals to set up the law but at the same time to have professionals to handle law enforcement, for example, MCH department to implement MCH Law, EPS to implement Food Law. Such arrangements have put law enforcement as secondary, and to create fee services, that is, those law enforcement unit charge fees for law enforcement. The society would deem such an arrangement as not just, and interest-driven (MOH policy maker).

No legal framework for rule-based administration

As policy implementation is a negotiation process, MOH, having realised its limited bargaining power in dealing with planning and finance departments, is constantly proposing health law. The draft content is basically consistent with the 1997 health reform decision paper, requesting all levels of governments to ensure that the increase rate of government budgetary allocation to health is consistent with the increase rate of government financial revenues. The bill has been circulated in NPC but has never been passed. Local flexibility and negotiation are therefore expected instead of rule-based funding for health. Irritated by such power politics, an angry MOH official expressed that, 'In the future, even for the government reform program, it should be based on law to contain power and department interest.

So, the challenge in moving towards the rule of law is law enforcement during transition. For MOH, to enact Health Law is seen as a guarantee of finance for health, yet the dilemma is that the NPC has to consider local variations before putting law into being. Therefore, rule-based administration has no legal basis, and negotiated policy implementation continues.

System of norms and voluntary compliance

Medical profession drifts into business under the first stage health reform

Historically, the doctor had to commit to the Hippocrates oath (Wolper, 1995, pp. 3-10). With marketisation, professional ethics shifts towards profit maximization (Figure 2-3). Ethical indoctrination alone failed to influence the behavior of providers. Policies therefore tend to have both ethical indoctrination and legal imposition now, as the traditional internal management practice becomes a formality. Therefore, externalizing the internal management practice and making them transparent, regular and creating a new social routine, seems important in the development of the new professionalism under marketisation. As stated by an interviewee:

We also have medical ethics cards, [but they are] usually managed by hospital directors without disclosure. It is mainly used for internal management and used by Medical Professional Ethics Office and Party Committee. All is formality without substantial meaning (President, private hospital group).

Low voluntary compliance to the second stage health reform

As one external measure and to curb the excessive entrepreneurial behavior of providers, the second stage health reform policy has asked hospitals to submit their revenue from drug sales to the finance department for reallocation to public health (see Appendix D. Policy 21). However, as drug revenue is the major source of revenue for hospitals, such a policy meets opposition from doctors and in some instances from local health departments, because the policy hurts the incentive of doctors and the interests of the surrogate regulator. Anecdotes and opinions suggest that the reform faces strong opposition from doctors across the countries:

Can one have the driving force for revolutionising oneself? Then on whom should the health reform rely? Health Minister Zhang says to integrate the interests of 6 million doctors into the interests of 1.3 billion populations. But the lower levels resist and refuse - passively reacting to the reform policy from the top. Doctors have technological advantages and monopoly power. So even with passive reaction to the upper level policy, the top has no means (MOH policy maker).

Mechanism change is to replace not to cut off. Using drugs to subsidise medicine was the previous policy, now with drug profit taken away, but nothing more has been provided. It turns out [that it is] only to want to take away [but] not want to give. Reform should go around; it should not 'cut one knife heavily'. The most successful reform in China is rural reform because it is the reflection of interest that people want (MOH think tank).

Provide the benefit that one should have and take away the benefit that one should not have. If one wants 'to get something from someone, one must provide something to someone' [jiang yu qu zhi, bi xian yu zhi]. I have briefed Minister Zhang a couple of times, if you don't provide the benefits to 6 million doctors, the reform program can't move on (MOH think tank).

The first stage health reform has encouraged the autonomy of hospitals and cost recovery by retaining revenues within hospitals. The salary structure has encouraged the provision of more services in order to earn bonus payments, thus inducing high cost, high volume practice. Now the second stage health reform policy is to have drug revenues submitted to the finance department. As can be expected, the voluntary compliance is low, as stated by an interviewee:

Large hospitals are all observing now, no one likes to be the scapegoat; for whoever is in the front the loser... we refuse the policy (Director, hospital).

The consequence of such policy practice is that the patient has been sandwiched between the limited role of the state purchaser and the market-based financial system of hospitals. 'To service the patient' under Mao's time became to attract more patients for more revenues under the 'public identity, private behavior' healthcare system. As stated by an interviewee:

Culture has a relationship with the system [or institution] arrangements. Hospital services income as an income subsidy policy to support hospitals is a distorted policy, which basically asks hospitals to find ways to earn more. Doctors' salaries were fixed at 56 yuan per month ten years ago [refers to the era of planned economy]; at the time there was no relation between doctor's income and drugs. Now the market requires the creation of demand and to seek maximisation of individual interest. So there is no culture in existence to 'serve' the patient (Director, networked hospital).

MOH is also sandwiched between hospital lobbyist groups and the external clients, for instance, MOF, NDRC, and the consumers. So, the implementation of the second stage reform policy has been compromised by the interest of different stakeholders, and by the understanding of the reform (Anonymous, 2004d). This suggests that social routines are significant in understanding the policy implementation process. As stated by an interviewee:

There is a practice of regarding the abnormal way of handling business as normal. MOH keeps protecting hospitals without disclosure of the insight. Then people begin to attack the government, for example, for medical accidents. Only now the health department has realised that protection is no longer feasible, and begins to look at the alternatives (MOH think tank).

Towards the formation of social agreement for market-based governance

To build a market-based governing system, it is important to harmonize the legal regulatory system, the civil regulatory system, the state regulatory system and the norm/compliance system, so as to reach social agreement (see Figure 1-2). The social institution theory (see Table 4-1) reveals that shared norms and social capital are essential for a market to operate. The following section explores regulation and compliance from the perspective of social norm evolution.

Evolution of norms at a time of social transition

The absorption of Western thought in the early 1980s has been the inspiration for fundamental political changes, given the failure of radical utopianism as exemplified by the Great Leap Forward and the Cultural Revolution. Since the end of 1980s, the balance between stability, growth and reform has been carefully managed since then. To understand the deep reality of China, some intellectuals have investigated the Legalist School¹¹³ from old Chinese dynasties to bridge the thought of the rule of law. With Neo-Confucianism emerging in the early 1990s, to rebuild social ethics is in cultivation (Bunnin, 2003), for instance, communitarianism and local autonomy in formulating people-centered development policy (Hu, 2003; Liu, 2004). Yet the most difficult part of

¹¹³ The school advocates legality, rather than the king's order.

change is the norm and the behavior of people. The planning system culture, power politics, and backward culture are significant barriers to the reform (Xinhua News Agency, 2003c). As stated by central level policy-makers and think tank:

Chinese political culture is that if the top asks, 'to turn left by one', the subordinates would follow by 'turning left by three' without any thinking or tailoring. The rational approach is to first accept the reality then to regulate; but quite often officials do not acknowledge the situation and instead try to avoid accepting the reality (MOH think tank).

In 1999, I wrote a paper and mentioned the word 'market-ising', '-ising' is a process. But a very senior top official [name has been deleted here] wrote a paper criticising me by using the words, 'the trees prefer to be quiet but the wind keeps blowing [su yu jin re fen bu zhi]'. As you know this is the phrase used during the Cultural Revolution - it is an indication of the new direction of class struggle. But this senior official himself opened a Traditional Chinese Medicine private clinic in the commercial area bordering the Hong Kong Macau Centre in downtown Beijing, he mobilised many old famous Traditional Chinese Medicine doctors in Beijing by using his influence. This is a Chinese characteristic. 'Only allowing the state officials to ignite fire without allowing people to ignite the oil light [zhi xu zhou guan fang ho bu xu bai xin dian den]' (MOH think tank).

The administrative departments follow power economics: the power of approval and disapproval. Power is a benefit (MOH think tank).

Reform is the readjustment of interest structures yet the strength of the middle level is not enough. Power and economic interest is in the process of adjustment. Such adjustment would push reform forward with the improvement of people's concept and cadres' understanding. But cultural precipitation is profound; this should always be remembered! (MOH policy maker)

Reform is concerned with the adjustment of interest. The 'public identity, private behavior' healthcare system has created the public loss, private gains, and the trust crisis on public institutions. The state has responded to this crisis by the 'Three Representations Theory',¹¹⁴ and the call for the constitutionalism. The fact is that the Chinese problem needs a Chinese solution. The foreign model serves more as a reference point in internalizing the existing Chinese culture and in externalizing its system and institutional presentation.

Gradually, market-based governance is replacing the planning system culture along with the rethinking of the Chinese way of development (Sheng, 2003). For instance, people-centered development has become the primary policy statement since 2003 in China, and the global subject of sustainable development has rediscovered the meaning of harmonization between human beings and the maximum frontier of exploring nature.

¹¹⁴ The Three Representation means the Communist Party to represent the most foremost productivity, to represent the most advanced culture and to represent the fundamental interests of the masses (Task Force Group, 2002).

With regard to the public institutions, a survey on senior cadres studying at the Central Party School indicates that, overwhelmingly, ‘political structural reform’ and ‘healthy legal system’ are two key issues for future reform, as seen in Table 10-2 (Howell, 2004, p. 31). The rule of law society is expected by 2020 (Li, 1999). Yet, with incremental reform, its assurance of success could be more grounded as it allows for trial and error, pause and adjustment.

Table 10-2 Factors Constraining Economic and Social Development towards 2010

Factor	Percentage	Rank
Political Structural Reform	79.8	1
Healthy Legal System	60.3	2
Science and Technology Innovation	58.6	3
Economic Structural Reform	55.7	4
Corruption	50.4	5

Source: Qing, 2003.

Rule-based administration and ‘new ethics’ as social routine

With the ruling principle changing from rule of man to the policy of ‘ruling the country according to law’ and advocacy for constitutionalism, China aims to have rule-based administration as a mainstream social norm. As stated by an interviewee:

The background of ‘Ruling the country according to law’ is against the background of ruling the country according to man. This is the large background. In the past 50 years, the central government has continuously struggled on how to govern the country under the situation of different thought. In a good situation when a unified situation exists, it could generate great social values but when the leader is wrong such as the Cultural Revolution demonstrated, it is a disaster. In this regard, it should allow different voices to exist, not to seek one thought. Although different thought could delay the development, it is still in development. Also different thought could on the contrary constrain mistakes from happening. One could not possibly always be correct so to maintain different voices is very important. The thought of the emperor is still prevailing in the masses. Among a portion of leaders, such thought is still very severe (MOH policy maker).

Further, ‘new ethics’¹¹⁵ comes as an alternative system of norms (Sheng, 2002; Sheng, 2003), for instance, the call for ‘political civilisation’ on top of the traditional call on ‘material civilisation’ (material prosperity) and ‘spiritual civilisation’ (civil advancement) (Xinhua News Agency, 2004b). Fundamentally, ‘new ethics’ is about trust building for market-based governing systems, for the market is about trust (Harlow and Rawlings, 1997, back cover, editor’s comment). The system of norms has shed light on the

¹¹⁵ The ‘new ethics’ has a meaning of universalism, rather than social Darwinism (Sheng, 2003).

complexity of compliance during transition (Aikman, 2003). As stated by the interviewees:

'To govern the country according to ethics', ethics needs a religion so as to reach the public in the mainstream; the traditional Confucianism is for the intellectuals (elites), which is a small proportion of the population. Ethics need indoctrinating. Church, monastery, lamasery etc, are places for spiritual education. Material attraction, compared with spiritual education, is stronger (MOH policy analyst).

Spiritual education needs a God, like Chairman Mao in the 1960s, but the problem is if others find that the God is not true, as Chairman Mao is also a man with mistakes afterwards, then there is no belief. So the key is, I am a god and I die for the sake of being God... so he is God as he is for others. A person God to be prayed to would eventually end (Policy observer).

Historically, the social institutions in China are supported by the existence of penalty codes as deterrent forces, coupled with ethical indoctrination. During the time of planned economy, China maintained similar social governing institutions but replaced Confucian ethics with communist thought. In the transition to a market-based governance system, a system of norms needs to be established to embrace the changed relationship and to embrace trust to reduce market transaction costs (Fang, 2000, p. 227). From ethical indoctrination to the establishment of formal rule-based institutions, social agreement has to be built for the transition. The formation of social agreement is more fundamental than a set of rules promulgated without binding power. In essence, compliance requires harmonisation between formal rules and individual norms.

The success of the market cannot be explained just by economic factors. Norm, social institutions, social capital and trust all play important roles. Government legislation, ordinance and directives cannot replace the role the implicit social agreement plays in necessitating market operations (Putnam, 1993; Fukuyama, 1995). The most difficult part of the transition is to transform from a past implicit social agreement to a new social agreement. If the reformers have simply smashed the past social agreement without time to build new norms, then the new one could not be established (Stiglitz, 2000). The Great Leap Forward and the Cultural Revolution have taught Chinese to have a pragmatic approach. The Chinese consider shock therapy as a failure for Russia (Sheng, 2002). However, the consequence of the incremental approach is that local governance and associated stakeholders exert influence on policy-making and implementation (Shan, 2002).

Reform challenge: To harmonise between rules and norms

This thesis discusses the state regulatory system in chapter nine, and the compliance system in this chapter. The thesis argues that social agreement is fundamental for rule-based management and for compliance.

Over the past two decades, there has been unsynchronised reform between social institutions development and the economy. The economy is in rapid development yet market institutions lag behind. The robust market therefore faces an obsolete regulatory system. Non-compliance prevails and the traditional routine continues. As described by the interviewees from the central government:

So under the conditions of a market economy, to use the policy with planning features would gravitate the market failure (MOH policy advisor).

China's human development cannot fit with market requirement. Fewer people would like to be the good model. More people would like to be opportunistic lucky persons. The culture has not developed to that level. 'One can't walk [means quality of the person] after wearing leather shoes [means economic development]' (MOH think tank).

Some local government departments abuse their power to charge hospitals without rationale; the hospital would then come to the health department to complain instead of using legal measures. Without relying on legal protection, instead, to replace it by administrative department's protection is a Chinese tradition (MOH policy maker).

But the core is what is the 'mainstream concept' of the general public, a story tells that a Chinese comes into the U.S. and suddenly finds that he does not know what he should do as everything has been designed for him previously in China (MOH policy maker).

Chinese do not get used to being compliant with laws and regulations; entry into WTO is a good thing. People's awareness of legal concepts is enhancing and it will be better and better in the future. The external influence will be increasingly important (MOH think tank).

The reason for non-compliance with the law is that its benefits are larger and the chance of being caught is low. Therefore, shared norms, social capital, cooperation and choices within rules are important elements to be considered for China at transition. A critical mass, a triggering event, and a role model seem important for formation of a new social agreement. At the same time, compulsory compliance and legal sanctions are also important to deter opportunistic behavior. Theory implies that judgment for compliance depends on the calculation of benefits of complying and the liability of not complying (see Figure 4-3, p. 60).

If you abide by the law, you are unlucky; if you find way to slip away from law, you may benefit. This has relevance with economic, financing and political system (MOH think tank).

'Let's hooligan manages stealer'. At the front gate of the old MOH compound near the Rear Sea, there were many sellers with their three wheel carts selling different things, staff from the Industry and Commerce Administration kept inspecting and issuing fines for banning the selling but they would appear again in the next day. Then, they hired peasants to deal with the sellers; the peasants threw the entire cart into the Rear Sea. The sellers never come again, next year; some people pulled a cart from the Rear Sea! So let soldiers deal with soldiers and intellectuals deal with intellectuals but not 'soldier vs. intellectuals (xiu cai jan da bin), who have nothing to say each other' (MOH think tank).

Managing the transition needs the institution of the threatening force (the distrust institutions) in order to obtain compliance (World Bank, 2001, p. 101; Braithwaite, 1998).

As stated by an interviewee:

Law compliance is the result of enforcement and inspection; law is not abided by voluntarily. Ideally, the benefit of those abiding by the law is more than those who breaches the law, and then society would have the tendency to abide by law. Now, the cheater has a higher return and the law conformer a low return (MOH think tank).

Therefore, to manage the transition towards a market-based governing system, both the design of regulations and enforcement of regulations are important, with the latter seeming more critical. Yet, the most severe issue is the crisis of trust on public institutions. The society seems to have lost normative standards, as one MOH policy maker said, 'the Chinese have nothing to believe in, and the society has lost the norm'. This suggests that China is on the eve of fundamental social change, along the improved understanding of the concept of state institutions. As described by the interviewees:

The legal system is not complete; people are not in compliance with laws. The people should not be blamed as it relates to economic situations. Agriculture culture, rural society, 'all under the heaven belongs to the emperor'. This is different from industrial society where there are strong independent entities that constrain the government (MOH policy maker).

It is the government first that is not abiding by laws then it is the masses... It is the government who strides the law... If I do not execute the law, then I cannot comment on the masses (Official, provincial health department).

So it is through watching individuals to see the modernisation process. History, culture and ethics all have a stigma in today's society. There is no punishment for those not following the rules (MOH think tank).

Without trust in public institutions, there is less obedience with state regulation. Contemporary China could be described as a time when everything seems impossible yet everything seems possible. Understanding of issues and efforts made by the policy-maker today determine the trajectory of development in the future.

In summary, at the time of change, there is little agreement about the role of the state, the society, and the market. The trust crisis on public institutions leads to low compliance of state regulations. To respond to challenges, there are calls for 'new ethics' and strict

legal sanctions and the formation of a public sphere (civil society), which are important elements towards the rule of law society (Harrison and Huntington, 2000, p. xxxviii). All indication suggests that the society is cultivating change.

Summary: Trust, judgment, compromise and reform

This chapter has explored the issues concerning the legal system and the system of norms at time of diminishing role of the state. The conclusion is that it is necessary to build trust of public institutions so as to ensure compliance with state regulations and to use compulsory regulatory systems in order to deter opportunistic behaviour. These are the fundamental regulatory strategies for managing the transition.

People generally have moral aspirations to behave as socially acceptable, yet, people's behavior depends on the complex adaptive systems embedded in the society (Plsek, 2001, pp. 309-316). With marketisation, the medical profession drifts into business. Professional norms change into mercantilism as market incentive and market-based management and financial systems outweigh the traditional ethical indoctrination. The implementation of the second stage health reform therefore faces opposition from interest groups. For the reform has asked hospitals to submit their business operation revenues to the government's finance department, instead of retaining the revenues within the hospital for staff bonuses, which was the incentive instituted under the first stage health reform. The policy is grounded in the idea that the financial review by the government's finance department would correct the high cost, high volume medical practice. Yet it hurts the interests of doctors. Politically, MOH claims to represent the interests of both 6 million doctors and 1.3 million people, yet the actual intention of local health departments is dubious. Policy implementation therefore halts because of a conflict of interests. Containing self-interest becomes a key parameter in designing a system of regulation and its implementation.

The success of reform depends on the formation of social agreement for complying with the reform policy. To implement the reform policy at the individual level, effective compliance depends on the calculation between benefits brought about by opportunistic behavior for not complying with the rules and fear of social rejection and legal sanctions for being caught. Regulation design has to build deterrent forces to deter violation, when the system of norms evolves during transition.

Seeking trust can lead to the formation of social agreement. The call for 'new ethics' is to reshape the culture for market institution development, this is an innovation at the

margin of tradition. For Chinese, learning from the traditional wisdom ‘governs a large country is like cooking a small fish’¹¹⁶ (Sheng, 2002), the adoption of incremental reform is to allow trial and error, but not total failure. Mixed views on the state, the society, and the market are inevitable during the transition as people view the reform from different positions in the system – for the degree of stratified and diversified marketisation process provides people with experiences in that particular area.

Nevertheless, with the crisis of trust in public institutions, the credibility of the state regulator needs to be enhanced so as to promote the compliance of the regulated. Therefore, to regulate the regulator and to institute a check and balance system would win the acceptance in the normative sense and so gain the compliance of the regulated. In essence, the transparency, accountability and credibility of public institutions are important issues for the regulatory system design and for policy implementation (Deighton, 2004). These are important factors to shape the system of norms and to enable the effectiveness of the norm regulatory system (Braithwaite and Levi, 1998, pp. 376-380; World Bank, 2001). The credibility of public institutions therefore can promote social capital, which in turn increases compliance.

In conclusion, with trust and shared norms, there is voluntary compliance. The design of regulatory system only needs to consider the technical regulatory tools as seen in Figure 10-1. The implementation of regulation is to monitor performance, to institute compulsory systems and to inspect and cull the opportunistic. This is the situation observed in most established economies. If there are spitted norms, there is a need to develop ‘new ethics’ or demoralization can lead to compromised compliance. Otherwise, reform is necessary or revolution may come. So, in developing and transitional economies, with the issue of trust of public institutions and the stages of development in terms of ‘rule principles’ (see Figure 4-1, p. 56), there are more challenge issues than simply the use of regulatory tools developed by the established economies. Because the core issue is the relationship amongst norms, rules and compliance, mismatch of any of the two can lead to ineffective regulatory system.

Therefore, social institutions matter in the design and implementation of the regulatory system, and in the consideration of use regulatory tools.

¹¹⁶ Cooking a small fish cannot turn over and over, it has to manage carefully without major mistakes.

		Norm	
		Compliance	Non- Compliance
Rule	Compliance	Voluntary compliance: Monitor performance	Demoralization: Develop new ethics
	Non- Compliance	Compulsory compliance: Inspect for enforcement	Trust crisis: Reform or revolution

Figure 10-1 Regulation Design to Harmonize between Norms and Rules

The next chapter presents the regulatory strategies and challenges understood by the researcher, in line with the perceptions expressed by the interviewees and international practices on regulating the market.

CHAPTER ELEVEN

REGULATORY STRATEGIES TO ACHIEVE REFORM OBJECTIVES 2010

This thesis aims to identify the effective regulatory options and challenges towards a mixed public/private healthcare market in China by 2010. Chapter six to eight have assessed the existing economic and social regulatory tools to regulate the market and institutional performance in conjunction with the second stage health reform. The conclusion of the assessment is that the technical regulations (that is the economic and social regulations) fail to govern the market and the institution, mainly due to the fact that the system that embeds the technical regulation tools is not functioning. Therefore, in line with the second stage health reform, chapter nine to ten have examined the system, which are the state and civil regulatory systems, as well as the norms and the compliance system. As both the regulatory and the compliance system are in the early stages of reform, an initial assessment has indicated that local governance and the public trust in state institutions are two critical factors affecting the system in transition. While local governance and state institutions are embedded in social institutions, the Chinese reform program is historically unprecedented.

Given the social institutional challenges and the reform objectives projected for 2010, managing the transition to a market-based healthcare system with the rule of law requires careful design of regulatory strategies, in line with the system constraints (which were explored in chapters nine and ten). This chapter aims to examine the possibility of applying technical regulatory tools (which were assessed from chapters six to eight) to the transitional system in order to govern the market and institutional performance. Following the analytical framework (Table 5-4, p. 82), the analysis is applied at the system or market level, the institutional level and the individual level. The system constraints are viewed as challenges for future reform. Various options and regulatory strategies are proposed.

The challenges identified are: differing views on reform that are explained by the research assumptions (that is, the understanding of the reform depends on the positioning of the persons in the system, see chapter five); and the formation of local governance that affects the attainment of equity. In order to achieve the regulatory objectives by 2010, this thesis argues that, at the market level, the market-based governance structure should be developed; at the institutional level, a management-based regulatory strategy should be

implemented; and at the individual level, risk management programs should be derived following the MATO.

This chapter first reviews the evolving reform objectives; then it summarizes the progress of reform by 2004. Then, this thesis also proposes the regulatory options and strategies towards 2010; and finally, it analyses the regulatory challenges.

From the ‘healthcare system’ to the ‘healthcare market’

In retrospect, to promote institutional efficiency out of a planned system, the institution of a fiscal decentralization policy in the 1980s generated hospital autonomy and market incentives. Entering into the 1990s, the excessive entrepreneurial providers created high cost, high volume service patterns that spurred on cost escalation. With market-based management and financing systems, a ‘public identity, and private behavior’ healthcare system was born in the first stage health reform. The objectives of the second stage health reform are to control cost and to promote quality. A mixed public/private market has to balance equity-efficiency through regulating different market entities (see Figure 1-2, p. 4). These market entities are to be defined by the concurrent governing system reform (see Figure 4-4, p. 65). The reform is complex in that it considers cost and quality, equity and efficiency, and financing and governing system reform. As stated by an interviewee:

Control cost is a driving force of reform. It starts with demand-side reform, and then moves into supply-side and now regulation. The basic directions of reform are decentralising and de-linking as done for SOEs (Policy maker, NDPC).

To date, to control cost, regulating provider behavior has been central to health reform. This is a daunting task for MOH, for both financing and hospital corporate governing system has not been addressed yet. The idea is to have a mixed public/private market that can respond to need and the diversified market-driven demand. The reality is that cost containment, equity and efficiency can only be achieved sub-optimally during the transition. As stated by several interviewees, the realization of reform objectives is of a limited nature and that cost increases will continue, mainly due to the fact that the demand for healthcare is diversified – some cannot afford care while others look for luxury care – which is the nature of the transition from the ‘healthcare system’ to the ‘healthcare market’, in the absence of state intervention:

The public benefits less while paying more for health; this is a general reflection. The core of reform is to contain the behaviour of doctors (Policy maker, NPDC).

Vice Premier Li Lanqing said, the cost control objective is very difficult to achieve. It is the realisation of the objective of control mechanisms from the perspective of the supply-side. Even for the latter, it is still within the framework of limited objectives (Official, health department).

The purpose of reform is to control health expenditures' rapid rising rate. To control is inevitable, cost rising is also inevitable. Why? Cosmetics, beauty salons, health tonic products are all reflecting that people are seeking quality of life. But how is this related to government affordability and social affordability (MOH policy maker)?

The demand-side is also in change. For psychiatric services, nutritional services, hospitals could also be involved. Psychiatric health gets increasing attention, say psychological counselling and issues related to the aged services are becoming increasingly important...So the demand is multi-layered and in various forms. As income gap is widening, urban health services are also varied, for those better-off patients who want quality services in large hospitals, there is a need to develop special hospital beds. While I was as secretary of Minister Zhang, there were so many telephone calls asking for going through 'back doors' to enter into special services. So the demand is there (MOH policy maker).

Then, in what way should the state intervene to bridge the gap of demands among segments of the population? For a country with a vast rural population and poor economic infrastructure, the state policy-makers in China neither believe in developing the healthcare system in a direction similar to the regulated market in the U.S., nor do they believe in developing towards a planned market, because there are no sound market institutions and healthcare is not an entitlement in China. China therefore is something like between the 'healthcare system' and the 'healthcare market'. As one policy maker said, 'the best political objectives still need an economic basis to support them. You cannot surpass the development stage to look for development':

China is unlikely to evolve into a U.S. hospital services system; at least the large hospitals would not. The U.S. emphasises freedom, and choice, but also equity, which is realisable at their level of economy. China has no conditions as U.S. has. There is a culture difference; the value and concept are not the same. U.S. is individualistic and individual heroic; China is collective and cooperative... U.S. is aiming at game and rule of game; China is aiming at disciplines and collective cohesiveness (MOH policy maker).

The Chinese market could not be like the States market. The institution economics emphasises the pathway reliance, that is, the new form is out of the older form but still has the elements of the older form. A large public hospital sector in China could not suddenly become a private sector that looks like the States market (MOH think tank).

If the regulated market in the U.S. is a private healthcare system with contract-based or technology-based regulatory system, and suppose the planned market in most OECD countries is a pro-public healthcare system with tax -based or performance-based regulatory system, then, the 'public identity, private behavior' healthcare system in China might be reformed towards, at best, a planned and managed market, for instance, a mix of planned and managed healthcare market in Shenzhen (see Figure 6-1, p. 102). At worst, the healthcare system could evolve towards a laissez farie market such as the case in

Shenyang. The regulatory approach, in the view of the researcher, can only be a management-based regulatory approach swinging between social and economic objectives, coupled with performance-based and technology-based regulations where and when possible. As assumed in Figure 5-4, this time-bounded hybrid regulatory system is grounded by the reality of diversity in China (as discussed in chapter six).

With management-based regulation, regulating cost-quality compromise tries to contain the incentives and interests of the regulated and the regulator (as summarized in chapter two and illustrated in Figure 5-3). This requires the reform of the governing structure of NFP hospitals as well as developing arms-length governing system between health departments and NFP hospitals (as described in chapter eight). The reform has to spell out incentives and interests into tangible and transparent rules, procedures, and mechanisms in order to enforce it.

Institutionally, to achieve social optimum reform objectives, the design of reform programs has to disintegrate the ‘public identity, private behavior’ system by splitting financing from provision, detaching hospitals from government affiliation, and conducting the reform on the management system and governing structure; and the implementation of the reform depends on the local authorities.

Therefore, this thesis argues that China’s healthcare system is between the ‘healthcare system’ and the ‘healthcare market’, and the pace of governing structure reform and rule-based administration reform is the key to achieve a mixed public/private market with the attainment of trade-off equity and efficiency. The position of interviewees accords with the above views:

The basic rules are that of clarity of property (ownership) rights, management to be based on law, limited government, and legal status of any individuals or collectives (MOH policy maker).

In the future 10 –15 years, first, I would say the thought and concept would change tremendously; second, there is a steady moving forward of the reform program. The backwardness of Chinese is their outdated concepts. We should avoid the distorted part of the market, say the equity issue in US and the efficiency issue in UK. Our reform program is an incremental reform: small steps but to walk fast. Overall this is not definitely slow (MOH policy maker).

Reform progress on regulating health service and its influence factors

Ideally, the reform should be through the state purchaser and planning to balance need and demand, equity and efficiency in the market, in order to reach the social optimum (see Table 7-2). In reality, the mandate for MOH is to regulate quality, the tools, such as tax policy, price, financing and personnel policies, are not given to MOH (Table

9-1). The state regulatory system is therefore fragmented. With the fragmented administration, MOH policy is to have a civil regulator to regulate cost-quality compromise, and to have HIC to enforce laws. While the capacity of both civil regulators and the HIC is under development, the key instruments to regulate incentives of staff and the interest of the surrogate regulator are not in place. The progress of reform on regulating health services is therefore uneven (see chapter six). Managing the transition in practice is a muddle-through process that depends on the place and time, as assessed in chapter six to eight (Table 11-1).

Table 11-1 Assessment of Reform Achievement by 2004

Mix	Demand-side Regulation	Supply-side Regulation
Private:	<p><u>Planning and market entry:</u> Fully opened to private foreign health insurance company in 2004 according to conditions of WTO accession; Regulated by NDPC, MOLSS, and SAIC.</p>	<p><u>Private hospitals planning and market entry:</u> Planning and market entry law ready; Regulated by NDPC, MOH, and SAIC; Implementation method is ready. Issues are those provinces are still under development of implementation method such as Inner Mongolia.</p>
Social:	<p><u>Supplementary insurance:</u> The idea is on piloting; Managed by MOLSS, presumably with provisional management method; Inpatient supplementary insurance and outpatient supplemental insurance is under piloting.</p>	<p><u>NFP hospitals:</u> Further reform is under piloting. Managed by MOH, no general consensus on principle for further reform, except the detachment of hospital affiliation from health department; The practices of local health departments are: Planning approach such as in Shanghai, ownership approach such as in Shenyang, and entrepreneurial state practice such as in Shenzhen. To regulate towards social optimum. The NFP hospitals are further divided by, social objective-oriented hospitals, networked hospitals, and share-holding hospitals. The issues remaining are arms-length governing mechanisms between health department and NFP hospitals, and NFP hospital corporate governance.</p>
Public:	<p><u>State purchaser under MSA:</u> Social Protection Law ready; MOLSS is purchaser after splitting financing from provision. Issues are no established payment method, and financing to extend coverage for uninsured. No quick solution exists. The incentive to have high volume practice cannot be contained due to no clinical protocols existing as review base.</p>	<p><u>State regulator:</u> Health Law not ready. MOH proposes government to finance public hospitals; Various state regulators manage price, tax, financial and accounting system, audit, and personnel. MOH only manages quality under new administrative restructuring. Issues: MOH policy is to develop civil regulators to manage cost-quality compromise to correct high cost, high volume practice. No quick solution exists. A transitional regulatory arrangement is to have hospital director as surrogate regulator – the conflict of interest comes as blurred public/private governing structure.</p>

Note: the thesis is not concerned with the demand-side regulation overall, except the MSA insurance.

The factors influencing health service reform are those sub-markets, such as, the insurance market, the pharmaceutical market and medical technology, and labor markets¹¹⁷. These sub-markets are outside the purview of MOH but they are the important determinants on health service costs. In addition, China has committed to open these sub-markets after WTO accession which will further complicate the regulation of the health service market¹¹⁸ (Liu, 2002, p. 12-32). For instance, the medical technology import in the 1990s has resulted in the total CT scanners in Beijing being similar to that of whole of Europe (Zhao, 2000); and the private sectors will stimulate the pent-up health demand of middle to upper income groups in urban China (Killingsworth, 2002, p. 22).

Options and strategies identified to achieve regulatory objectives 2010

In line with the reform objectives and the assessment of reform progress by 2004, and in line with the international practices regulating healthcare, as well as the perceptions, views and feelings expressed by the interviewees, the follow section synthesizes the options and strategies to regulate toward the mixed public/private market.

System level perspective: A market-based governance system

With the changing and diminishing role of the state, the role of the state is policy-making and policy implementation, financing and regulation, and promotion of service quality and competition through mediation on private sector entry into market (MOH, 2003).

¹¹⁷ On the labour market, by 2003, China has 0.74 billion workers, more than an aggregated total of 0.43 billion of established economies in Europe and American; each year there will be an additional 10 million people joining in the workforces, and 14 million people are either laid off or without job, and there are roughly 0.12 billion people coming into urban towns for labour from rural each year (Xinhua News Agency, 2003b). Such pressure will keep on until 2010 (Xin, Li et al., 1999). The MOLSS oversees the workplace health and safety and welfare privileges. The MOP oversees the skilled workers registration and their relations to the institutions. At institutional level, both ministries largely dilute their functions due to reform on the public sector. On social protection, reform includes pension reform, unemployment reform, and essential living protection system for laid-off workers, minimum living protection system for urban residents, and medical insurance system reform. In 2001, Social Protection Law was in pilot. The taxation items include essential pension, essential medical care, and essential unemployment. The pilot social protection program in Liaoning province was ready for national expansion (Zhu, 2003). By 2001, 60% of urban residents enrolled into pension and medical insurance, of which wage labour accounts for 75% and non-wage labour accounts for roughly 20% (Li, 2001).

¹¹⁸ For health services and dental care, there is no limit on cross border supply, consumption abroad; less than 70% of foreign financial share in the joint ventures for their commercial presence and in accordance to the healthcare need. For the temporary movement of natural persons, upon the certification made by MOH, the licensed foreign doctor can practice medicine in China for less than a year. For health insurance market, by 2004, the healthcare market will be fully open to foreign health insurance companies. For pharmaceutical and medical equipment, customs duty will be reduced to 5.5%-6.5% by 2003, roughly 10% reduction from 2001; pharmaceutical market by 2003 is already open, this includes procurement, storage, sale services; medical equipment import tax reduces to 10% by 2003, a 10% reduction from 2001.

The role of the state also includes setting up a legal framework for the market¹¹⁹. For instance, in the next five years, the laws related to health which are to be enacted by NPC are: Election Law, Local Organization Law, Civil Servicemen Ordinance, Administration Fee Collection Ordinance, Administration Enforcement Ordinance, Primary Healthcare Ordinance, State Assets Law, Anti-monopoly Ordinance, Social Relief Ordinance, Labor Contract Ordinance, Administrative Procedure Law, Government Information Disclosure Ordinance, and Inspection and Supervision Law (see Appendix E). Although law enactment does not mean the creation rule of law, it does formulate the legal framework (Robert, 2002).

The strategies towards a ‘good’ healthcare market

Almost all the interviewees from the central level and some interviewees from the provincial level described a ‘good’ market as having good policy, planning, and financing for essential care, law and law enforcement, and a civil regulator to take care routine quality issues. Further, they wish that social regulation should be strict, and economic regulation should be flexible, that is, to deregulate so as to create competition:

The strategies for a better market, a) ‘policy program’: system and legal institutions should be gradually improved, rules or regulations should be improved; b) Assurance of government financing is the key issue or main strategy. The direction of public financing should be on basic health services and prevention. The government uses the taxpayer’s money, then they should use the money for the payer; c) measures for implementation should be well thought. There are many commonly called ‘leader’s project’; and d) strict implementation of law and enforcement of law. This relates to conscience of action and intensity of execution (MOH think tank).

The government now promotes regional health planning, within the framework of planning to hold competition. Market supervision now relies on laws, such as medical institution decrees, doctors and nurses’ management methods and market entries, criteria that should be scientific and integrate into international practices. Social groups (doctors, nurses and hospitals) and market intermediators are to handle professional issues. The later needs perfecting and self-disciplines (Official, health department).

Regarding the 2010 health service market, it should be a market with governing. The governing is divided into social governing and economic governing. The social governing should be stricter, in the past the social governing relied on administrative measures, it is not strictly performed and hence chaotic. With the entry system in place now, the after-entry management [service performance] should be stricter; the government should be responsible for the public. On the other hand, the economic governing should be flexible, allowing competition between

¹¹⁹ Since the amendment of the Constitution in 1982, with aims to develop a rule of law society, a wide range of legislation among civil, commercial, administrative and criminal areas covering contract, corporate, securities, insurance, labour, land, tax etc. have been enacted at central, provincial and local levels. Yet the enforcement of law in diversified social and economic localities is a great challenge in the past decade. Overall, low compliance to law relates to the nascent status of legal culture, and understanding of the laws. There is yet rising rights consciousness with the growing private property around the turn of the century as of the rapid economic development (Cohen, 2001, pp. 403-410).

institutions with different ownerships, and leave the people to make choices on using institutions (MOH think tank).

The strategies described by interviewees towards a ‘good’ market are:

a) To develop a law enforcement system and supervision system:

The system is crucial. China should develop professional hospital directors, and develop law and regulations. One is a system, and one is rule of man. These two are difficult issues for China’s reform program. All the previous reform measures are of dealing with peripheral issues but not the hardcore issues: so, system, law and regulation, and professional hospital directors (Official, Jining health department).

b) To develop public governing system out of traditional ‘state-society’ relations:

The central government now is clear but there is seldom (applied) social sciences research. People want reform; the people’s understanding is improving. For example, although patient doctor relations are poor, yet all the individuals are good, so it is the system not working, pretty much like a sandwich (MOH policy maker).

c) To develop corporate governance for the NFP hospital:

The next step is the issue of the board of directors, who are those members? They should be from the society, legal workers, and persons with financial knowledge, community representatives, and hospital representatives (MOH policy maker).

d) To develop professional bodies to manage the quality of healthcare:

On medical professional groups, the profit-seeking behaviour is normal. How the government is to normalise them is an issue, this will be slow (MOH policy analyst).

There should be a transfer to the hand of the masses to manage; government should change to small as long as their head grows righteously (Official, Shenyang health department).

e) To develop the private sector, such as the hybrid approach in Shenzhen;

f) To develop payment methods between MSA and hospitals:

The extra services provided relate to the reimbursement method. The operational link between the service protocols and insurance payment is difficult; it requires high-level management. Possibly eventually the two could be connected. But presently it cannot see, no way to operate. In Shanghai now the insurance payment is based upon unit payment, this is a ‘thick line payment’. Hopefully, it will gradually become a ‘thin line payment’ (MOH policy advisor).

g) To develop methods to appoint hospital directors as surrogate regulators.

In summary, a ‘good’ market should have a mix of policy, planning, financing, law and law enforcement, and civil regulators. The credible public governing system, statutory corporate governance, and contract and regulation to exert arms-length governing between the public and corporate governing systems are essential for transition. For “...both contract and regulation have moved centre stage, ...a myriad of complex

rules and procedures” are critical to the formation new social institutions in order to support the transition (Harlow and Rawlings, 1997, back cover, editor's comment).

A ideal market model: ‘To have birds flying freely in the cage’

The interviewees from the government now regard NFP hospitals as a social sector. The aim of regulation is for the social optimum (Salamon and Anheier, 1994; Gray, Dey et al., 1997). Their idea is that the government, together with Medical Association, should develop a market-based governing system, or a cage. That is, the government should specify the responsibility of NFP hospitals for the purpose of equity. NFP hospitals then are free and anonymous to balance the social optimum – for profit seeking is the nature of the design of mixed public/private market. As stated by interviewees from hospital directors and health policy analysts:

The Medical Association or government decide the responsibilities of the hospital. The board of directors [in managing government assets] puts forward the requirements for hospital directors. It is then the hospital directors who handle the issues of social benefit and market suitability (Director, hospital).

The government should establish some responsibility system for such hospitals, e.g., for infectious disease surveillance and reporting, and satisfaction of ...targets and indicators (Director, hospital).

The government should build a cage. Within the cage there is a city zoo, the incentive of animals is very simple. What is profit seeking and what are constraints (MOH policy analyst)?

The market operates in the framework of rules. The departure point of rules is equity, which is also the departure point of government. Equity leads rules. As long as equity is there, one can earn money with legitimacy (MOH policy analyst).

In conclusion, the key to achieving the regulatory objective is to set up a market-based governing system. Of which, equitable rule making and transparency in dealing with conflict of interest are essential for a trusted regulator. Yet the problem with such an ideal market model is that China has no social audit program, so this model may well turn into one of compromised social efficiency, in the absence of anti-monopoly laws against NFP hospital concentration, of laws for information disclosure, and arms-length governance systems.

Institutional level perspective: A management-based regulatory strategy

With ‘self-governed’ hospitals operating for more than a decade, almost unanimously, all the hospital directors prefer to have internal management other than external control – that is, the surrogate regulator prefers self-regulation. This thesis argues that this approach

is impossible, because of the regulator capture, and because, in a blurred public/private governing system, the arms-length governing mechanism has not been developed so far. Instead, both internal and external management should be followed, and institutional rules should be spelled out clearly. As stated by officials from cities:

On internal and external regulations, both should exist. Governments should be more macro. Institutional rules should be more specific. But this could not be reached within 50 years. 'Civilian self-governing' is not realistic, that needs a generation's time at least (Official, Jining health department).

On realisation of managing hospitals, from past administrative management to market-oriented management, the crux is management tools. The health department has developed a set of medical protocols, which should be the major tools for internal management I think. On external management, we have developed a 'quality evaluation system'. This system draws from the medical protocols. They are major tools for us to 'manage' the hospitals (Official, Shenzhen health department).

Thus, this thesis argues that, with institutional rules spelled out, the management approach then should be evidence-based, that is, the government needs to develop hospital information systems that reflect the need for financial incentive and clinical management. In particular, the hospital information system should satisfy the need to conduct external hospital financial audit programs and clinical accreditation programs. The situation is that, most health departments have no management program, only a very small proportion of advanced cities, such as Shenzhen, where some sort of 'quality evaluation system' has been developed. As stated by the interviewees:

The government has no management on hospitals. It only manages infrastructure plus entry that's all (Director, hospital).

In Shenzhen, with its strong role of the state, they developed the so-called 'quality evaluation system' and financing policies (official, Shenyang health department)

In line with the above analysis, this thesis has proposed a management-based regulatory strategy, which is a combination of internal regulation with external regulation – that is, the enforced self-regulation where the state regulator exerts a pressure to enforce self-regulation. In some advanced cities, activities of enforced-self regulation are already observed as described by an interviewee:

In Shanghai City, eleven hospitals have come up with some loosely organised clinical image quality review committees. Each hospital has identified one leading expert with academic reputation to take the lead in a specific image quality review committee, and then the rest of the hospitals participate in the special image quality review sessions. The image film's affiliation with any hospital is deleted on purpose so no one is to lose face. Then for those bad quality films, all the participants discuss the way to improve things. Naturally, those hospitals with bad quality films know themselves, and they go back and do some homework to improve their staff's performance. The Shanghai Health Department has not provided any financial support for such activities. The supervision should include both internal and external supervision; external

supervision would help to push the internal supervision. The government's push for clinical supervision could actually obtain more cooperation from the hospitals (MOH policy maker).

Another case – Standardisation of writing of patient history in Shanghai City by use of expert reports. An expert group among hospitals forms to evaluate the patient history writing quality, if there is an issue, the expert group deals with the staff individually, and reports to the hospital management. If the issue is common, a plenary session is convened to discuss it collectively, without taking care of losing-face, the result is sent to all the hospitals. Now such meetings are gradually reduced. For those not willing to change their writing style, first the hospital director has a talk with them, if no change, then the health department staff has a talk - this is the administrative intervention. The pressure is to make change within a stated time frame, and 'to take care' of the persons selectively. So, it should have both internal and external regulations and integration of the two would be better (MOH policy maker).

In conclusion, enforced self-regulation is a preferred model, given that the other state regulators have taken away all the important regulatory instruments from MOH. From a long-term perspective, the government needs to develop hospital information systems so as to conduct external financial audits and clinical accreditation programs.

Currently, government tools are: appointing the hospital director, hospital capacity management, salary, tax and price. In the future there may be fewer tools. The government capacity needs research (MOH think tank).

Individual practice level: Risk management program to be based on MATO

With MATO, the healthcare quality is legally defined, which links to tort law. With hospitals being increasingly alerted the legal responsibilities of malpractice and medical disputes, this thesis argues that NFP hospitals need to develop hospital risk management systems, to replace the traditional health department-based or administration-based handling of medical disputes.

Regulatory challenges

The fundamental challenge for China is that social development and economic development should be coordinated. As explained by interviewees:

The 1997 health reform decision paper has drawn the blue picture. The issue is implementation; the key is to have economic strength. The best political objectives still need an economic basis for support. You can't surpass the development stage to look for development (MOH policy maker).

Changing of concepts relate to political systems. The mode of government management has its intangible change. There are contradictions between superstructures and economic bases, but eventually it is the economic base that determines things. The effort should be directed to the economy not politics. Many see the contradiction but do not see the consistency (Chairman, private hospital group).

From planning to market, the main dilemma of reform in China lies in the fact that ownership reform cannot keep abreast with the market-oriented system reform, and the political reform cannot keep abreast with the economic reform (Huang, 1994, p. 230). With desynchronized reform, a state corporatism is created, and so resulted in the ‘public identity, private behavior’ healthcare system during the first stage health reform. In relation to the implementation of the second stage health reform, apart from the above challenge, other major challenges are the understanding of the role of the state; to institute check and balance mechanisms to counteract the perverse interests of stakeholders arising from local governance; and the development of corporate governance.

Revisit the role of the state in the market

Reform needs to build coalition and social capital in order to win the support of key stakeholders. Yet the main issue in China now seems to be public trust of the state. Systemic issues and trust are common terms used to describe that the government itself is not a rule-based administration, as one provincial official said, ‘the concept of handling business without resort to regulations exists widely’.

In theory, the role of the government is to correct market failure. Now the government fails to promote the competition, which means the government needs to reform, for instance, to disclose information. Much of the problem can be traced to the understanding and concept of the state that relates to culture. As the social institution theory explains, there is interrelatedness between predisposing factors and normative and regulatory mediating factors (see Table 4-1, p. 59). The hierarchical bureaucracy system developed over the past two thousand years is, in essence, a culture of obeying the top, rather than a culture of exchange. The concept of the state in the modern sense is less than a hundred years old. For people immersed in daily life in Chinese society, and for people who make policies for change towards a market-based governance system for China, it is a struggle to change the way of life and to change the culture. As one policy maker said, ‘to set up a modern market system is to face a confrontation with traditional culture concepts’ (MOH policy maker). Therefore, it is fundamental to change norms, and social routines.

Local governance forms localized interest groups under incremental reform

“Although the rules are the same, the enforcement mechanisms, the way enforcement occurs, the norms of behaviour...are not” (North, 1990, p. 101). For Chinese, the issue of

central local relations is historically rooted – this is one of the reasons for the rise and fall of the past dynasties – ‘from above comes policy; from below comes strategy to counter the policy’. For instance, one policy analyst mentioned that for reform, ‘the issue is how to normalise the central local relations’. The main problem lies in how to institute checks and balance system both vertically and horizontally to contain the abuse of power of the state institutions. For instance, vertically, which level of government has the approval power for licensing, which level of government has the power to set the price for drugs and services; and horizontally, how to make the divisions of responsibility between the government organs? As stated by several policy analysts:

To regulate what aspects of the hospital, and power are to be decentralised or re-centralised and to what level are two issues. The MAD is responsible for qualification and behaviour, while the medical market inspection division of provincial HIC is responsible for the entry of individual private practice. The lowest level of entry approval is held at county level while the veto power for announcing the license to be invalid is at prefecture level so as to counteract the power of the county level (MOH policy analyst).

The structure of power should be designed, as the market system is a decentralised system. Vertical decentralisation is concurrent with what should be resorted to at a lower level and what should be retained at a higher level. For this relates to fee schedules of both drugs and services. Drugs policy should not decentralise, it should control the volume of utilisation (MOH think tank).

After the separation/decentralisation of government power, the pending issues involve several ministries or departments to handle the same issue and they are mutually affected. The responsibility of each government is not clear (MOH policy analyst).

Because of the unclear responsibilities of government organs both vertically and horizontally, policy-making needs to consider local variations and policy implementation is a negotiated process in China. The interpretation and modification of central policies is a matter for local governments. To achieve the objective of equity efficiency trade-off depends on the size of state financing, which also depends on local governments. As stated by an interviewee:

But it is not the issue of rational thinking of reform by local government; it is the issue of government input. Broad-based financing channels are the consideration of local governments; balance among sectors is another issue. The affluent provinces have choices but the poor have no choice. The level of excitement is not on the same platform. So the future trend is not easily discernible (MOH policy analyst).

With poor provinces having fewer financial choices, the challenge to have an appropriate balance between state purchasers and out of pocket consumption is difficult to meet. The understanding between growth and development and what the development means to people is therefore fundamental for the development of market socialism. The

reform is therefore a case-by-case situation due to local governance, as described by an interviewee:

The reform is to look at the local government, which varies at great degrees. The progress would be where the rich places would change much faster and in a directed way. Yet the trend is that as it is poor in poor places, government finance would be loosely treated. It is believed that in poor places, as one cannot manage well, so the opening up will be wider. As the economy is changing, the speed of marketisation becomes faster, and more and more issues will come (MOH policy analyst).

Lack of rules to regulate risk, incentive and interest: Corporate governance matters

The success of market socialism needs political reform, as one interviewee said, ‘legal governance reform needs political system reform. This relates to how hospitals will develop in the future’. In 2004, the State Council spelled out that the share-holding system will be the main realization of public ownership (Wen, 2004). This has paved the way to reform the dual regulating institutions for NFP hospitals – a corporate governing structure for hospitals may generate, it is then possible to have rules specified, and arms-length mechanisms developed to govern between health departments and hospitals.

Summary: Regulatory challenges lie in norms and social institutions

Based on the elucidation of the Chinese health policy makers and review of policy documents, this chapter synthesizes the reform objectives, regulatory options, and regulatory challenges. China is developing a mixed public/private healthcare market. The issue is how to conceive a market-based governing system – is it a multi-power centered market¹²⁰ or a social market? This has implications for the regulatory tools chosen, that is, to have contract and regulation prevail or to have a planning system culture to coax the bird to fly.

An important element of market-based governance is accountability (Institute On Governance, 2003). The key of accountability is to make choices between intensive accountability and extensive accountability¹²¹ (Donahue, 2002). “The central design challenge, for institutions of accountability, involves this trade-off between extensiveness and intensity. Mechanisms of accountability that tilt toward extensiveness are called governance. Mechanisms of accountability that tilt toward intensity are called market

¹²⁰ Multi-power centered refers to a pluralist relationship between society and state (Olsen, 1987). In the Chinese context, it refers to different stakeholders’ interests in formulating hospital regulatory policy.

¹²¹ Intensive accountability demands a spectrum of values embraced by the constituencies; Extensive accountability entails balancing of multiple missions claimed by agents of constituencies (Donahue, 2002).

(Donahue, 2002, pp. 6-7). Therefore, the strategy towards the market is to design accountable public governing systems and corporate governance, and the interrelationship of the two governing system. For China, with the blurred public/private governing system during transition, the central issue is how to regulate the capture of the regulator.

This thesis argues for management-based regulation at the institutional level, it argues for spelling out rules to contain clinical risks, incentives of staff and the interests of the surrogate regulators, for instance, the government needs to develop an information system so as to initiate external financial audits and clinical accreditation. This, however, concerns a fundamental issue in China, that is, to build the corporate governance system.

This Chapter also presents challenges on the reform, the understanding of the role of the state in the market, the formation of local governance, and corporate structure development. Local governance touches another fundamental issue of the healthcare system: the local governance decides the balance between equity and efficiency. It is clear that challenges are rooted in social institutions. Therefore, regulatory mediation has to consider the predisposing factors. The effectiveness of regulation is therefore compromised by the social routine and the system of norms. The next chapter concludes the research results from chapter six onwards to chapter eleven, and makes some recommendations.

CHAPTER TWELVE

CONCLUSIONS AND RECOMMENDATIONS

China once proudly announced that it used 1% of its health resources to solve health problems of one-fifth of the world population in era of planned economy (World Bank, 1993). Two decades later, across the world, China's healthcare system performance ranks 144, and fairness in financing for health ranks 188 (Appendix, A 4; WHO, 2000b, p. 152). The 'public identity, private behaviour' healthcare system that emerged from the first stage health reform has led to deterioration of the equity in the healthcare system, along with public distrust in the healthcare system. It raises the issue of the role of the state in the context of marketisation.

The second stage healthcare system reform aims to develop a mixed public/private market by 2010. The policy goals are to have the state as a purchaser for healthcare, open competition among NFP hospitals, and a market-based governing system. An assessment of reform progress indicates that, healthcare is still operating outside a regulated market system, health departments still manage health development with tools used during the era of planned economy, and NFP hospitals are still monopolistic providers but now experiencing viability problems (MOH, 2003). The findings and conclusions in this research support the assessment that high cost, high volume competition is continually protected by public entities and regulation failure exists. The three main reasons for failure to regulate excessive entrepreneurial behavior are that:

- a) The state financing regulatory tool is crippled;
- b) The market price is distorted; and
- c) The hospital governance structure is unclear.

As everything is changing during transition, a total solution that could be effective in correcting market failure is impossible to identify, due to divergent considerations and perceptions of policy-makers across the country. Instead, an optimal solution tailored to the stratified and diversified markets in different cities is preferred.

This thesis explored the possible regulatory tools for the achievement of a reasonable balance between equity, quality and cost in the establishment of the mixed public/private market by 2010. This chapter first lists the findings and conclusions of the research. Then, with projections of scenarios about competition patterns, this chapter presents

recommendations. Further, it analyzes the challenges and possible failures to adopt the proposed regulatory strategies. Finally, it concludes with the future research agenda.

Research findings

This study has found that: state financing for health and the governing arrangements for the NFP hospital sector are two fundamental issues that determine the functioning of China's healthcare system. The level of state financing has stratified the healthcare market and the governing arrangement has diversified the healthcare market. These two factors shape the nature of the emerging healthcare market in China. More specifically:

a) At the market level, the state financing tool is crippled, the price signal is distorted, and the NFP hospital sector is monopolistic with severe information asymmetry and planning as a regulatory tool faces governing structural barriers. This reflects the fact that the design of the regulatory system in China has to be management-based, rather than technology-based or performance-based.

b) At the institutional level, the legal imposition on market entry is just starting. There is no credible performance regulation, which is the reason for high cost, high volume practices under marketisation. There is no hospital accreditation program across hospitals to examine the service patterns and the use of resources, nor clinical protocols or pathways to guide the clinical practice. The external financial audit program is less visible, mainly because the NFP hospital is still regarded as a government institution, rather than a legally corporate entity.

So, the current relationship between NFP hospitals and health departments is not clear at all. There are no explicit rules spelled out to deal with the incentives of staff and the interests of the surrogate regulator. This is largely due to doubts and mixed feelings on hospital detachment policy initiatives. With nearly two decades of local state corporatism, the hospitals are used to being protected. Now the patronage is withdrawn, replaced by the new role of monitoring and inspection on hospital performance and management audits. This policy initiative has been bewildering to both local health departments and hospital managers. Similar to the internal market reform of NHS in the U.K., norms seem pivotal in understanding the implementation of the reform program (Smith, 1776).

c) At the individual protection level, medical disputes increase as the medical profession drifts into operating as businesses. The promulgation of MATO has linked the quality and risk of clinical services to tort law. Yet, there is no tangible risk aversion

program initiated by the hospitals. The past social routine still prevails due to the fact that the governance arrangements between hospitals and health departments are still unchanged at the operation level.

Research conclusions

This research concludes that:

- a) The first stage health reform has created a ‘public identity, private behavior’ healthcare system:
- b) With a fiscal decentralization program and local governance, China’s healthcare system is developing towards a stratified and diversified mixed public/private healthcare market;
- c) Therefore, local conditions and local stakeholders are decisive factors in achieving the objectives of equity-efficiency balance and effective regulation.

The implications are:

- d) Both the financing of the health and governing system reforms are two fundamental issues which need to be dealt with in the ‘public identity, private behavior’ healthcare system in order to attain the second stage health reform objectives;
- e) The governing system and social structure, and the system of norms (to understand the reform issues) are playing important roles for the effective implementation of regulation;
- f) Without social support (under the context of diminishing role of the state for health) and comprehensive reform (to develop the domain of civil society, and the civil regulator), the control of high cost, high volume competition is impossible because there is a lack of means to attain the ends.

To interpret the above conclusion, as a matter of fact, the ‘public identity, private behavior’ NFP hospitals are competing for price/product and quantities due to lack of rule-based competition on quality and price (For example, the clinical protocols and service payment method). Therefore, for China, marketisation needs not only to promote competition or economic regulation as shown in the established economies but also to develop social regulation with respect to the standard settings and rule of law. So, the regulatory objectives and regulatory tools need to centre on the attainment of the social optimum, as illustrated in Figure 12-1.

Figure 12-1 shows the regulatory pathway for China. At present, China has just started the market entry regulation to attain service safety and to define clinical risks. China has adopted the health planning approach to attain equitable distribution of health resources (cost saving) yet, access to care is not a social entitlement. China has a continuously developing the pricing system and the competition so far is not based on the price (or quality) due to its distortion but to volume-based competition (quantity and product innovation). So, cost-quality regulation is central to regulating towards the social optimum. While regulating on information disclosure has no legal base so far in China, with the medical profession drifting into business mode (with concurrent change of norms), the cost-quality compromise is largely a decision of individual doctors. Their preference determines the attainment of social objectives of balance between social efficiency and dynamic efficiency. As the traditional indoctrination approach is ineffective to their financial incentives, management of the healthcare system transition has to examine the alternative framework between the risks of clinical practices, incentives of their business operations and the interests of their manager.

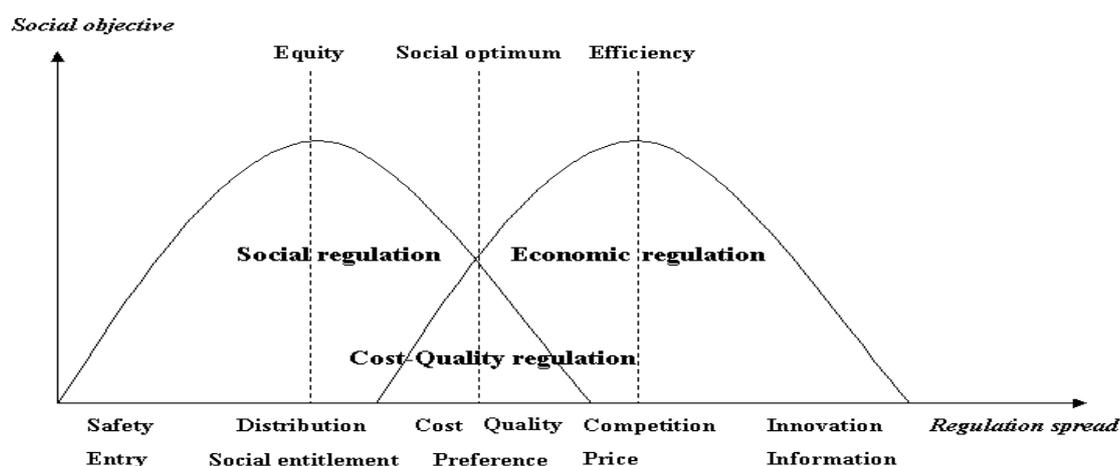


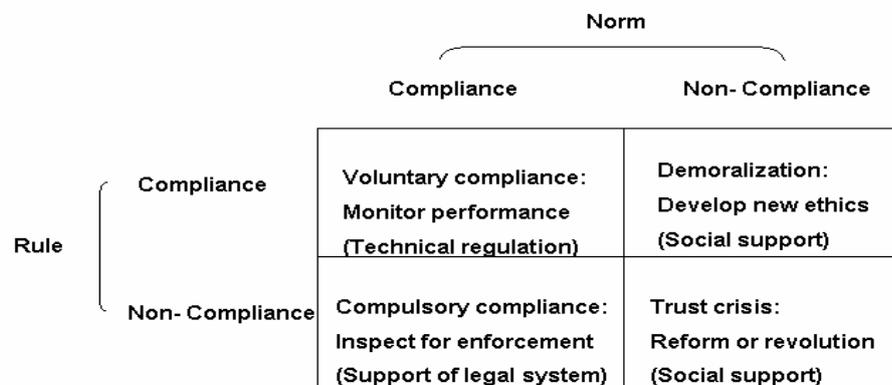
Figure 12-1 Regulatory Tools Spread along Marketisation in China

There are effective economic and social regulatory practices in the established economies, for instance, licensure, accreditation and certification are used in the regulated market and the planned markets. Table 12-1 suggests a mix of regulatory tools to be used in China. Yet, the market-based governance demands rule of law, which is not yet in place to support the institution of the technical regulations in the transitional economies.

Table 12-1 Proposal for Managing Transition in China

By level	Risk	Incentive	Interest
Individual	<u>MATO</u> , clinical protocols and service payment methods.	<u>Regulatory process</u> : internal financial and management audit programs	<u>Performance</u> : To conduct the monitoring program and to cull the outliers in relation to the standard (e.g. the accreditation program)
Institution	Risk aversion program: to identify the critical points listed as institutional rules	Code of conduct; Professional ethics; and Corporate business operation objectives (e.g. by-law of professional association)	Statutory statement between the staff and the surrogate regulator (e.g. clinical governance), management-based regulation
Market	State/legal regulators to assure the safety of services (e.g. the licensure regime)	Civil regulator to assure the social optimum of services; External audit program (e.g. the certification program and peer review system)	Arms-length governance between the hospital and the health department (e.g. service agreement, and rectification procedures for the surrogate regulator)

However, the social structure, public institutions and the development of civil society seem critical if the above technical regulations are to be effective as depicted in Figure 12-2. The key issue is the interrelatedness between rules, norms and compliance. If social capital exists in the society, that is, there are generally accepted rules and norms (or high possibility of compliance exists, see Chapter Four), then, the development of a data system to monitor the performance seems to be an important regulatory tool. The legal and regulatory system then is forced to cull the outliers who might be judged to display opportunistic behaviour. If there is a mismatch between the norm and rule, then regulatory implementation is either compromised or demoralised. If there is no acceptance of both the rule and the norm, then there is inspiration for fundamental change: to reform the whole system in order to avoid total failure.

**Figure 12-2 Relationship between Technical Regulation and Social Support**

Thus, the transitional options and challenges for China are not simply to consider the technical regulations; rather, norm and social institutions are keys to the understanding and ensuring of the effectiveness of the regulation. While both financing and governance are fundamental issues to be addressed in order to correct the ‘public identity, private behavior’ healthcare system, Clarity on the role of the state as both purchaser and regulator with respect to the emerging local governance and its diversification in individual cities is equally important to understand the complications during the transition. A tactical progression should be started with management-based regulation.

Striving for social agreement and social capital can make a difference in the making of social change, which is the driver for making reform move forward steadily in the incremental reform. Both legal and social forces are important, “any legal system, for legal arguments to make full justificatory sense, exist in a community in which there is some semblance of justice...sufficient adherence to principles of justice, in a community, to provide the sense and will for following the guidelines of improvement”¹²².

Projection on market competition scenarios and regulatory responses

In 2003, MOH issued a detailed time table for the establishment of a market-based governing system (MOH, 2003). The objectives are to establish the health law enforcement and inspection system within three years and to establish the market-oriented health management system within seven years. The strategies to achieve these objectives are:

- a) To encourage private financing for hospitals, so to change the monopoly status by public hospitals and to encourage competition;
- b) To change the functions of health department management through the use of policy and regulatory tools;
- c) To further implement health economic and fiscal policies for public hospitals, as announced in 2000; and
- d) To standardize medical services and their fee schedule.

In terms of regulation and governing system reform, the above strategies imply establishing the NFP corporate governance system; developing innovative arms-length governing mechanisms between NFP hospitals and health departments; developing clinical protocols; and establishing prices based on cost. In accordance with the above

¹²² Stephen Guest 1997 Ronald Dworkin (2nd edition), Edinburgh University Press. Edinburgh. p. 251.

strategies, the research has developed the following market competition scenarios and regulatory responses:

Scenario I. Price competition among NFP hospitals and with FP hospitals

For this scenario, NFP would change their service price to compete with FP hospitals. The regulatory response then centers on the publicity of price, monitoring of price and periodic review of price. This is actually the policy response stated in the MOH policy document (see Appendix D, Policy 25).

Scenario II. Tax status competition: FP hospital seeks tax exemption

This is the state-mediated market competition, that is, the use of the catfish effect¹²³ to stimulate the market. The regulatory response is entry control through licensure and re-licensure, which is also stated in the MOH document (see Appendix D, Policy 25).

Scenario III. Quality or product competition among all NFP providers

This is to improve the dynamic efficiency of NFP hospitals. The regulatory response is a new service entry certificate, quality assurance and financial and managerial audit, and the development of service payment methods under MSA. The MOH policy document has partially touched quality, financial and managerial audit (see Appendix D, Policy 25). The service payment methods are still a pending issue.

Scenario IV. High cost, high volume competition

This is the scenario the thesis is concerned with as it could lead to lower social efficiency. The scenario IV is the most likely mode of competition among NFP hospitals, in the view of the researcher. The regulatory response needs to shift the system towards the social optimum and this requires reform in the governing system. The regulatory responses need to consider the role of the state as purchaser and regulator in the mixed public/private market where local governance decides the nature of the market.

More specifically, to consider the role of the state as purchaser and as regulator should be framed within the stratified and diversified market. For instance, the Shenzhen

¹²³ The economist argues that to have a catfish (which is a fish killer) in the fish pool could stimulate other fish to run for survival and thus the whole pool or the market becomes viable.

healthcare market is a mix of planned market and managed market, where the increasing government purchase role can be seen but it is not proactive. Shenzhen also has social-objective oriented hospitals that could evolve into public hospitals. The laissez faire market in Shenyang and developing market in Jining can hardly see any sign of active planned purchase, as the role of governments in both cities are diminishing. So, regulating towards the social optimum in the cities is decided by the two fundamentals – financing and governing structure. As the high cost, high volume competition directly concerns the supply-side, the following section discusses the two key issues on the reform of the governing structure of the supply-side.

First, there is buyer concentration and information asymmetry in the existing NFP sector (Fudan Hospital Group, 2004). With buyer concentration, large hospitals can easily obtain dynamic efficiency through the use of medical technology, yet it creates low social efficiency because of the overuse of services. In addition, the NFP hospitals are less likely to announce their service quality and price information. Information collected is mainly used for government decision-making, rather than for consumers (Yang, 2004, personal communication). Regulating information asymmetry is a major government failure for China has no antimonopoly law.

Second, within NFP hospitals, staff can easily capture the government appointed surrogate regulator. The regulatory response therefore is to develop generally agreed clinical practice guidelines directing clinical behaviours and service payment methods. This is the most fundamental and crucial regulatory instrument regulating cost-quality compromise (Lim, 2002).

In line with the above, I conclude that, to regulate the high cost, high volume practice, the supply-side reform policy needs to consider the introduction of a private sector to promote competition and to correct information asymmetry in the short run, and to develop clinical protocols and payment methods in the long run. In addition, the hospital governing structure needs to be piloted in accordance with the modern corporate governance system.

Research recommendations

This research reveals that, technically, at the market level, proactive policy purchase is needed to influence perverse market incentives (through state financing and the development of payment methods); at the institutional level, regulating clinical risks and perverse incentives of providers requires better definition of processes and procedures of

credible clinical audit programs, financial audit programs and management audit programs; and at the individual level, the hospital needs to initiate into clinical audit programs for risk management.

Yet the reality is that there is no peer review practice to judge the appropriateness of clinical procedures and risk due to the lack of a civil regulator; there are no decent management and financing systems to contain incentives due to the hospital corporate governance structure which has not been developed; there is no sound mechanism to control the interests of the surrogate regulator. The regulatory activities of the health department are rather proving to lip service at the top. Managing such a chaotic transition requires a compulsory regulation system and the credibility of the regulator so as to attain a reasonable balance between equity, quality and cost for the healthcare system.

Thus, this study recommends that the MOH should adopt the mandated self-regulation approach. This means that although the policy is to detach hospitals from health departments, yet a cautionary flag needs to be flown that the detachment is by no means without regulation by the health department. For instance, MOH should urge NFP hospitals to develop risk management programs within the hospitals and report to the health department. MOH should also ask each health department to formulate action plans to the Policy 25 and report to the health department.

To deal with the above workload, as an immediate regulatory response, each health department should establish a special task force consisting of technical and administrative personnel to assist the HIC to realize the Policy 25. Therefore, in line with the market competition scenarios and regulatory responses, this study recommends establishing a special task force affiliated to each health department to deal with the issues faced by the NFP hospital sector reform. Specifically, the research recommends that:

- a) For the short-term, the recommendations are to continue piloting on the NFP hospital governance structure, and the arms length governing mechanisms between the health department and hospitals;
- b) For the long-term, the government needs to strengthen the financing role of local governments for health at the market level, and to develop the clinical protocols and payment methods to contain the perverse incentives of the providers and to cultivate the role of civil regulators.

To achieve the 2010 reform objectives, the research recommends that:

- c) MOH should establish a policy think tank (for example, Healthcare systems Institute) to coordinate the roles played by various national institutions that

have stewardship functions for the development of the market (for instance, CHEI, HIC, HMA, IHM, and MQSA).

Similar to the roles played by the Center of Disease Control for public health and by the China Academy of Medical Sciences for medicine, the Healthcare system Institute should have the function of policy research and policy formulation so as to direct the implementation of the 1997 health reform decision paper. It should also have the function of coordinating with MOLSS and MOCA with respect to the financing policy formulation for the insured under MSA and for the poor that includes the new poor.

Only a think tank of such rank and such scope might cope with the issues faced by the reform, for the Healthcare system Institute should tackle the issues discussed throughout the thesis. For instance, from a system of norms and social institutions to social agreement and social capital build up, from political reforms concerned with health development to the governing system reforms and NFP hospital governing structure reforms, from the development of clinical protocols to the coordination with MOLSS on the development of MSA payment method, from the development of civil regulators to the development of civil society to promote health information dissemination, and lastly, health development with respect to the role of the state, the civil society and the market in the making of the well being of the people and the nation.

Fundamentally, the “break-through” attitude of ‘seeking truth from fact’ should be adhered as a way of life and a solid belief in dealing with challenges faced by the reform.

Future research agenda

This thesis has explored the issues and challenges the Chinese healthcare system faces and the options and strategies that may lead to a healthy market by 2010. During the research, numerous complicated issues emerged, of which, the following research topics are highly recommended to be listed in the future research agenda:

- a) To have detailed research on the NFP hospital governance structure, for instance, to evaluate all the existing pilot practices and to develop the national policy;
- b) To have research on governance mechanisms between the NFP hospital and the health department, for instance to review the international experiences of arms-length governance mechanisms and to look for application in China;
- c) To study the role of professional groups and way of participating in regulation jointly with the state regulator; and
- d) To examine the central local relationships in policy adaptation by studying one particular policy implementation process, for instance, MATO.

APPENDIX A1. CHINA: PROVINCES BY ECONOMIC BELTS, 2000

Region	Population	Urban	% Urban	GDP	GDP per capita
National	126583	45844	36	136679	10798
Costal:	53622	23916	45	57740	10768
Beijing	1382	1072	78	2479	17936
Tianjin	1001	721	72	1639	16377
Hebei	6744	1759	26	5089	7546
Liaoning	4238	2299	54	4669	11017
Shanghai	1674	1478	88	4551	27187
Jiangsu	7438	3086	41	8583	11539
Zhejiang	4677	2277	49	6036	12906
Fujian	3471	1443	42	3920	11294
Shandong	9079	3450	38	8542	9409
Guangdong	8642	4753	55	9662	11181
Guangxi	4489	1264	28	2050	4567
Hainan	787	316	40	518	6588
Central:	43940	14720	34	26266	5978
Henan	9256	2147	23	5138	5551
Hubei	6028	2424	40	4276	7094
Hunan	6440	1916	30	3692	5733
Jiangxi	4140	1146	28	2003	4838
Anhui	5986	1665	28	3038	5076
Jilin	2728	1355	50	1821	6676
Heilongjiang	3689	1901	52	3253	8818
Shanxi	3297	1151	35	1644	4986
Inner Mongolia	2376	1014	43	1401	5897
Western:	28666	7930	28	13203	4606
Chongqing	3090	1023	33	1589	5143
Sichuan	8329	2223	27	4010	4815
Guizhou	3525	841	24	994	2819
Yunnan	4288	1002	23	1955	4559
Tibet	262	50	19	117	4483
Shaanxi	3605	1163	32	1661	4607
Gansu	2562	615	24	983	3838
Qinghai	518	180	35	264	5089
Ningxia	562	182	32	266	4725
Xinjiang	1925	651	34	1364	7088

Sources: China Statistical Yearbook, 2001.

Note: Population is in 100,000; GDP is in 100,000,000 yuan.

**APPENDIX A 2. HEALTHCARE SYSTEM PERFORMANCE COMPARISON,
1997**

Country	Healthcare system Achievement						Per capita health expenditures	Performance	
	<u>Health</u>		<u>Responsiveness</u>		Fairness in finance	Overall achievement		Health level assessment	System performance
	Mean	Dis	Mean	Dis					
China	82	101	88/89	105	188	132	139	61	144
India	135	153	109	127	43	121	133	118	112
Russia	92	69	71	86	185	100	75	127	130
USA	24	32	1	3-38	54	15	1	72	37

Sources: WHO, 2000b, pp. 152-155.

Note: Dis means distribution.

**APPENDIX A3. CHINA: POPULATION AND HEALTHCARE SYSTEM
PROFILE**

Characteristics/indicators	Note/values
1. Total fertility rate, 2002	1.8
2. U5MR/1000 live birth in 2002	31/41 (male/female)
3. LE at birth, 2002	69.6/72.7 (male/female)
4. Health expenditure as % of GDP, 2002	5.4%
5. State health expenditure as % of GDP, 2002	15.2% (excluding urban MSAs)
6. Aging population (65 and over) by 2002	> 1,000,000,000
7. Total population, 2002	13, 020,000,000
8. Doctors/1000 by 2001	1.69 (decrease, compared with 1990s)
9. Beds/1000 by 2001	2.39 (decrease, compared with 1990s)
10. Total private hospitals by March, 2004	Approximately 1,400 country wide
11. Urban tumor mortality rate in 2001	13,559/1,000,000
12. Urban cerebrovascular mortality rate in 2001	11.1/1,000,000
13. Urban cardiac mortality rate in 2001	9.6/1,000,000

Source:

Items 1-3 and 7 are from World Health Report, 2003.

Items 4-5 are from CHEI (Bloom, 2004, personal communication).

Items 6 are from MOH (MOH, 2003).

Items 8-9 are from CHSI/MOH. Item 10 is from (Fudan Hospital Group, 2004).

Items 11-13 are from CHSI/MOH.

APPENDIX A 4. HEALTH RESOURCES IN DIFFERENT ECONOMIES

Country	Doctors per 1,000 (Average) 1990 - 99	Hospital beds per 1,000 (Average) 1990 - 99	Health expenditures per capita (Average) 1995 - 98	Health expenditures to GDP (%) (Average) 1995 - 98	Health expenditure of central government (%) 2000
China	1.7	2.4	40	5.1	11.0
India	0.4	0.8	20	5.4	5.3
Russia	4.2	12.1	133	4.6	14.5
U.K.	1.8	4.1	1675	6.9	14.9
Australia	2.5	8.5	1714	8.6	16.2
U.S.	2.7	3.6	4271	12.9	16.7

Source: World Development Indicators, 2002; World Health Report, 2002

APPENDIX B 1. OPEN ENDED INTERVIEWING GULDE

The interviewing questions are open-ended considering the nature of the study. The interviewees would consist of three groups, the central level policy-makers, the local level policy implementation executives and institutions as the target of the policies. There will be a core set of questions for all three groups and a subset of questions for each group. In addition there will be some optional questions to be asked at appropriate context.

Core Set of Questions

1. Educational background, work experience and managerial experiences;
2. What are the changes of health policies over the past twenty years and why (the change role of government)?
3. What is your assessment of China healthcare market in terms of features, evolving trend and issues relating a functioning market (market description)?
4. How is your perception of health provider (both public and private) response to policies and regulations (compliance)?
5. How would you envision the healthcare, and market 10 years later (future picture in relation to mission/objective/value)?
6. What are the strategies to achieve the future vision and why?
7. Will the population benefit from current public/private market development?
8. What will be the impact on different segments of the population?
9. What are your opinions about the policy risks – explain?
10. How about the equity impact of the current reform, such as the impact on the uninsured poor and who should be responsible for them?

Subset of Questions for Each Group

Central level policy-makers

1. What is your understanding on international approach towards regulated market?
2. What can China learn and what cannot, which factors affect the use of those regulatory tools?
3. How do you think the existing policies generally for governing both the public and private providers (list three problematic policies if possible)?
4. What are the additional policies needed (why?) and what impact it could bring (how constraints have been considered in their mind when thinking of impact)?
5. What is your perception of governing willingness and capacity; and what is your perception of policy compliance at institutional level?
6. Will the government like to spend more for better policy impact/compliance, or what are the alternative strategies to enforcement?

Local level policy converters

1. How would you frame your local circumstances to formulate implementation strategies, from what perspective?
2. What are the common deficiencies you think that would improve the centre's policy; and what are major difficulties you face in implementing the policies?
3. How would regulate the hospital behaviour in general (given that some hospitals are public and their directors are appointed by health departments)? What are effective tools and what are not?
4. What is your perception of governing willingness and capacity; and what is your perception of policy compliance at institutional level?
5. Will the government like to spend more for better policy impact/compliance, or what are the alternative strategies to enforcement?

Health institutions

1. What is your attitude towards current health reform policy on public private hospital division?
2. Will your hospital choose to be public or private? Why?
3. What is needed in order to be a financially viable and high quality hospital –external environment and internal requirements?
4. Do you see any difficulty in realising any of the above?
5. What do you think the government should do? And what should they not do – explain?
6. Which approach is better, external regulator or internal regulator, why?
7. Will the hospital benefit or be disadvantaged from current reforms? In what way?
8. What do you need to do to ensure your hospital benefits?

APPENDIX B 2. CONSENT FORM

项目题目：治理保健市场：管制中国保健市场的策略

高级研究员：林光汶教授，拉筹伯大学公共卫生学院教授

研究员：赵鸿雯，拉筹伯大学公共卫生学院博士研究生

政府在保障人民健康方面的作用在 1949 年新中国成立时的宪法中就列为一个主要目标。卫生保健系统随之得到了发展，象在城市实行的政府保险计划和劳动保险计划，同时政府提供健康服务和管理。这些都体现了政府在可得服务，可及服务及可承担的服务方面的作用。通过这些努力，中国在 80 年代控制了在农村和很多城市发生的传染病，成功地取得了第一次卫生革命的胜利。

80 年代初期开始的经济体制改革使服务提供和需求发生了深刻的变化。因为所有的经济政策都强调效率，所以国家财政权力下放的政策强调成本回收和经济责任，甚至对国有机构也是如此。

因为实行这样的经济政策，在 2000 年，个人消费总量几乎占到了健康费用总量的 60%。政府因此决定改革卫生部门，通过发挥市场的作用达到提高效益的目的。但是，因为没有适当的受制约的标准和管理不能有效执行的原因，卫生市场一直呈现出无序的混乱。理解市场的不足和制约因素并理解国际管理卫生市场的办法对中国的政策制定者来说是一个挑战。同时，从机构角度讲，如何使管制取得更好的效果是政策制定面临的另一个问题。

研究者致力于在一个广阔的社会和文化背景下调查以上问题

研究者希望得知：在中国什么是有效的管理政策，什么是评价标准。

研究者将通过关键知情者访谈，了解中国的卫生保健系统，并访谈卫生政策制定者，医院领导和地方的卫生管理部门领导人员，以便了解他们对于政策，政策需求以及政策后果的看法。

如果你同意参加这项研究，则将占用你 1 个半小时的时间接受采访并回答问题。

在采访期间，研究者将做笔记。你的名字将不被写进报告。因此除了研究者，你的名字将不会透露给别人。所有的笔记将被研究者安全地保存。除了赵鸿雯和林光汶之外，没有人可以接触到笔记。

您从这项调查中得得不到任何直接利益。但是，您的参与将会对研究如何管理卫生市场相关问题的中国政策制定者提供信息。但这将有助于政策制定，最终使您得到高质量保健服务。

您在任何时间都有权退出调查，有权要求从项目中除去您参与调查的所有痕迹，该权力在调查结束后五周内有效。

关于涉及该研究课题“治理保健市场；管制中国保健市场的策略”的任何问题，您可询问拉筹伯大学公共卫生学院林光汶教授，电话：61 3 9479 1717

需要申诉时，请联系：

人类伦理学委员会秘书组, 卫生科学院, 拉筹伯大学, 旁都拉

维多利亚 3086. 电话：61 3 9479 3573

我，_____已读并理解以上信息，我回答了我认为满意的答案。我同意加入此项目，并认识到我可随时退出调查。我同意本项目研究数据用于论文，科学报告会或杂志出版。条件是我的名字不被引用。

参加者：(签名) 日期：

高级研究人员：林光汶 日期：

研究人员：赵鸿雯 日期：

(Translation of Consent Form in English)

GOVERNING THE HEALTH MARKET: REGULATORY POLICY CHALLENGES AND OPTIONS FOR CHINA IN TRANSITION

Senior Investigator: Dr. Vivian Lin, Professor, School of Public Health, La Trobe University.

Researcher: Dr. Hongwen Zhao, Dr.PH student, School of Public Health, La Trobe University.

The State's role in ensuring people's health has been one of the major objectives documented in the new China Constitution in 1949. There were subsequent developments in the healthcare system, such as Government Insurance Scheme (GIS) and Labour Insurance Scheme (LIS) in urban area and Cooperative Medical Scheme (CMS) in rural area, along with health service provision and their administration. These all reflected the State's role in assuring the availability of the services, service accessibility to the population, and affordable services to the population. With all these efforts, China has proudly claimed the success of the so-called First Health Revolution, the control of infectious diseases in urban and most part of the rural areas in around 1980s.

The initiation of the economic reform program in early 80s however has profoundly changed the existing structure of the service provision and demand. As the overall economic policies emphasise efficiency, so the fiscal decentralisation policy emphasises cost recovery and institutional financial accountability even for the public institutions.

Up to now, there are no estimates on the scope and role of private practice. At policy level, there is still limited thinking on how to direct the future development of private practice, regulating of private practice is far behind of what it should be. The impact of the market force on health service of both public and private sector is unclear, as well as interlink between the market and the state.

The researcher will interview key informants such as health policy maker, hospital director and local health department administrator from the Chinese healthcare system in order to understand their views on privatisations and policy implications.

If you agree to participate in this research, you will be asked and be interviewed approximately 1.5 hours.

During the interview, the researcher will take notes. Your name will not be included on the written form for the research project. You will therefore remain anonymous to everyone apart from the researcher. All the notes will be kept in a locked cabinet in Dr. Chris Peterson's office, Room 319, Health Sciences Building One, La Trobe University. No one apart from Dr. Hongwen Zhao and Dr. Vivian Lin will have accessed to the notes.

The results of the project will appear in the Dr.PH thesis of Dr. Hongwen Zhao, in journal publications, and in presentations at conference, but your name will not appear in any of these reports.

You will not directly benefit from this project. However, your participation will provide information for the health policy-makers on the issues of private sector development in China, which will benefit to the development of appropriate policies on private sector development and regulations which in turn will benefit you in term of quality care.

You have the right to withdraw from active participation in this project at any time and, further, the right to require that all traces of your participation be removed from the project provided that this right is exercised within 5 weeks after the completion of the interview.

Any questions regarding this project titled "The Policy Perspective of Private Health Sector Growth in China: Need of Regulation & Understanding of Market in Transition" may be directed to the senior investigator, Dr. Vivian Lin of the School of Public Health at La Trobe University on the telephone number 61 3 9479 1717.

Further enquires and/or complaints should be addressed to the secretary of the Faculty Human Ethics Committee, Faculty of Health Sciences, La Trobe University, Bundoora, Victoria 3086, telephone 61 3 9479 3573.

I, _____, have read and understood the information above, and any questions I have asked have been answered to my satisfaction. I agree to participate in this project, realising that I may withdraw at any time. I agree that research data collected during the project may be included in a thesis, presented at conferences and published in journals, on conditions that my name is not used.

NAME OF PARTICIPANT (in block letters):

Signature:

Date:

NAME OF SENIOR INVESTIGATOR (in block letters): Vivian Lin.

Signature:

Date:

NAME OF RESEARCHER (in block letters): HONGWEN ZHAO

Signature:

Date:

APPENDIX C. CODING FRAMEWORK FOR TRANSCRIPTS

Marketisation

Market-driven demand

- Urban income increase
- Stratification of demand
- Demographic base expansion and epidemiological transition
- Implication for healthcare

Healthcare market nationwide

- Criteria for healthcare market
- Economic belts

Healthcare market in sampled provinces

Healthcare market in three cities

- Shenzhen
 - Managed market and planned market
 - Entrepreneurial state
- Shenyang
 - Laissez faire market
 - Networked state
- Jining
 - Developing market
 - Developing state

Delivery system organizational reform

- Planning approach
- Ownership approach

Social regulation for equity

Social regulation to reducing social harm

- Entry:
 - Legal stipulation
 - Physician law
 - Medical Institutions Decree
 - Implementation method
- Process
 - Clinical process:
 - Quality standards
 - Managerial process:
 - Quantity standards (Volume x quality)
 - Management accountability system in China
 - Institution bylaw
 - FFS payment method
- Protocols x cost x insurance payment
- Protocols x quality x MATO x tort law

Social regulation to improve equity

Role of planning

- Demand-side equity
 - Insurance payment method
 - Increasing coverage
 - Policy purchase in three cities
- Supply-side equity

- Hospital distribution adjustment

Social regulation on influencing norm

- Professional ethics
- Norm
 - Norm to incentive structure
 - Norm to social-legal concept development
- Clinical practice change due to incentive change
- Clinical practice change due to clinical management and financing system change

Economic Regulation for efficiency

Market structure

- Market order irregularity
- A level playing field

Market function

- NFP hospital networking and monopoly
- Service price
 - ◆ Pharmaceutical Price
 - ◆ Price fix (nominal high pricing)
 - ◆ Price setting
 - ◆ Price discrimination
- Labor market
 - ◆ Formation of labor market
 - ◆ Physician payment: base and bonus payment
- Insurance market
 - ◆ Governing challenges for payment method
 - ◆ Role of insurance as purchase to influence provider
- Competition practice
- Consumer complaints
- Information on price, quality and reputation

Institutional Regulation for effectiveness

Public Governance

- Structural constraints
 - Governing structure
 - Governing matrix
 - Policy as average
 - Negotiated policy delivery
- Changing management
 - Fiscal federalism
 - Local governance
 - Competitive governments
 - Weakening role of the center
 - Public financing and financing for functioning administration
 - Implications of reduced public financing
- Forces and actors limiting the effectiveness of policies
 - Opposition from doctors
 - Willingness of local government on reform
 - Influence of planning system culture
 - Influence of culture
- New role of MOH

- Health administration reform
- Governments departments concerned for health
- Health reform policy delivery in three sampled provinces and cities

Corporate governance

- NFP governing challenges
- Paradox of dual regulating institution for NFP hospital
- Arms length governing on NFP hospital
- Pilot schemes
- Market socialism: public identity, private behavior
- Residual claim right
- Loopholes between the public and corporate governance
 - Incomplete contract
 - Personal appointment system for the regulator
 - Surrogate regulator and regulator capture
 - Ownership and state assets
- Governance arrangement and accountability
 - Law enforcement apparatus under development
 - Mechanisms linking hospital to health department
 - Between CCP and state
- Conflict of interest management

Regulatory base: Legal and civil institution changing

Governing body challenges

Formal social institution

- Towards rule of law: To regulator the regulator
 - Administrative adjudication
 - Separation of law enforcement from policymaking
 - Rule-based administration: The bill of health law
 - Issues
- Towards civil society: Alternative regulator
 - MOH-led health professional association
 - Civil organization as regulator
 - Issues

Informal social institution

- Civil culture and social norm
 - Political and philosophical culture evolution
 - Planning system culture to new ethics, new governing culture

Formation of social agreement

Harmonization on two regulatory systems: Regulatory and normative

- Slow social institution change vs. rapid economic growth
- Mainstream norm
- Social capital for compliance
- Action judgment for compliance
- Managing transition

Market-based regulation

Evolving objective of the health reform

Conceptualised public private mixed healthcare market

- Private sector development
- Market structure first
- Private submarket by services
- Reformation, restructuring and governing system for NFP hospital

System level perspective: Market-based governance structure

- Role of state
- Role of civil society and rule of law in the civil society
 - Patient right and informed decision making
 - Rule of law: Legislation program in the next five years

Criteria for a “good” healthcare market

Key strategies towards a “good” healthcare market

- New management system
- Law enforcement and supervision
- Professional bodies to manage quality of healthcare
- Competitive private sector
- Insurance payment method
- Managerial capacity and method of employing hospital director
- NFP hospital corporate governance

Towards a social market: Shanghai model

- Having a bird flying freely within a cage

Institutional perspective: MR strategy

- Volunteer self-regulation
- Arms length control
- Enforced self-regulation
- External formal regulation: state regulatory tool
- External formal regulation: civil regulatory tool
- External informal regulation: norm and professional ethics
- How to appoint the surrogate regulator?

Challenges: Risk, incentive and interest

- Norm and compliance system
 - Perspective of thinking
 - Building social capital for consensus
- Formal regulatory system
 - Issues: governing matrix, central local relations and local governance
 - Civil organization as alternative regulator
 - Instituting check and balance system

Driving force for reform

Individual level perspective: Risk management

APPENDIX D. HEALTH POLICY, DIRECTIVE AND CIRCULAR LIST

Policy documents at planned economy (1949 – 1979)

Policy 1, Four Guiding Principles of Health Development, State Council 1952 (First National Health Conference) (Qian and Wang, 1996, pp.9-19)

Policy 2, First PRC Constitution 1954 (that to propose upholding equity, availability and accessibility) (Qian and Wang, 1996, pp.9-19)

Policy documents since the first stage health reform (1980 – 1999)

Policy 3, MOH 1980, Report to Allow Individual Practices (Lim and Yang, 2002)

Policy 4, MOH 1985, Report on Some Policy Issues of Health Work (CHEI, internal circular)

Policy 5, MOH 1988, Medical Professional Ethics Norm and Implementation Method (Yin, Wang et al., 1997, pp. 189-190)

Policy 6, State Council 1989, Directive on Expansion of Medical Services (CHEI, internal circular)

Policy 7, MOH 1989, Circular on Reeducation of Hospital Working Principles (Yin, Wang et al., 1997, pp. 310-311)

Policy 8, MOH, 1989, Hospital Accreditation Program Management Method (Yin, Wang et al., 1997, pp. 279-280)

Policy 9, MOH 1993, Circular on Strengthening Medical Quality Administration (Yin, Wang et al., 1997, pp. 279-280)

Policy 10, MOH 1994, Medical Institutions Ordinance Implementation Specific Articles (Yin, Wang et al., 1997, pp. 197-206)

Policy 11, MOH 1995, Large Medical Equipment Rationing and Application Management Method (Yin, Wang et al., 1997, pp. 197-206)

Policy documents since the second stage health reform (2000 – 2010)

Policy 12, State Council 1997, (Second National Health Conference) Health Reform and Development Decision Paper

Policy 13, State Council 1998, Decision on Establishment of Essential Medical Insurance System for Urban Employees

Policy 14, MOH 1999, Physician Registration Method (temporary)

Policy 15, MOH, NDPC, MOE, MOCA, MOF, MOP, MOLSS, MOC, NPFPC, STCMA 1999, Directive on Development of Urban Community Services

Policy 16, MOH, SATCM, MOF, NDPC 2000, Implementation Direction on Urban Hospital Classification Management

Policy 17, MOH 2000, Directive on Centrally Organized Pharmaceutical Purchase through Bidding

Policy 18, MOH 2000, Directive on Deepening Personnel System Reform of Government Institutions

Policy 19, MOF, NDPC and MOH, 2000 Directive on Public Facility Subsidy Policy

Policy 20, MOF, SAT, 2000 Circular on Taxation Policy for Medical Facilities

Policy 21, MOF, MOH 2000, Separate Management Method (temporary) of Pharmaceutical Revenues and Expenditures

Policy 22, NDPC 2000, Report on Reform Drug and Medical Service Prices Administration

Policy 23, State Council, 2002, State Development Policy (Wang 2002)

Policy 24, NETC 2003, Circular of Directive on 2003 Economic Operations

Policy 25 MOH 2004, MOH Circular on Strengthening Professional Ethics in the Health Sector

APPENDIX E. HEALTH RELATED LAW, DECREE AND ORDINANCE

Existing and effective laws

Law 1, NPC 1979, PRC Penalty Law (Revision in 1997)

Law 2, NPC 1987, PRC Civil Law

Law 3, NPC 1993, Consumer Right Protection Law

Law 4, State Council 1994, Medical Institutions Ordinance

Law 5, NPC 1996, PRC Administration Penalty Law

Law 6, NPC 1998, PRC Physician Law

Law 7, NPC 1999, PRC Company Law (Revision based on 1993 version)

Law 8, NPC 1999, PRC Contract Law

Law 9, NPC 2000, PRC Legislation Law

Law 10, NPC 2001, PRC Drug Administration Law

Law 11, NPC 2001, PRC Taxation Collection Administration Ordinance

Law 12, State Council 2002, Medical Accidents Treatment Ordinance (Revision based on 1987 Medical Accidents Treatment Method)

Law 13, NPC 2003, PRC Administrative Approval Law

Legislative program in the next five years (since 2004)¹²⁴

Law 14, NPC 2001, PRC Social Protection Law (draft in practice)

Law 15 NPC, Constitution Amendment Proposal (to be passed in 2004 NPC session)

Law 16 NPC Election Law

Law 17 NPC, Local Organization Law

Law 18 State Council, Administration Fee Collection Ordinance

Law 19 State Council, Administration Enforcement Ordinance

¹²⁴ Source: China NPC news, released on 18 Dec. 2003.
<http://www.people.com.cn/GB/14576/14957/2252949.html> (Accessed 6 Mar. 2004)

Law 20 State Council, Civil Servicemen Ordinance

Law 21 State Council, Primary Healthcare Ordinance

Law 22 NPC, State Assets Law

Law 23 State Council, Anti-monopoly Ordinance

Law 24 State Council, Social Relief Ordinance

Law 25 State Council, Labour Contract Ordinance

Law 26 NPC, Administrative Procedure Law

Law 27 State Council, Government Information Disclosure Ordinance

Law 28 NPC/State Council, Financial Transfer Payment Law

Law 29 NPC, Inspection and Supervision Law

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