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 Commence
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.