

Policy Study of China's Medical System Reform

——Fei HAN

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Abstract

This thesis lays its basis on a study over China's policies in the reform of medical system. With thorough selection of policies, the historical trajectory of China's reform of medical system is demonstrated. Due to specific historical and socio-economic background, the presentation of this trajectory is divided into four parts. Accordingly, the thesis will carry analyses of performance in each part.

The thesis finds that in the past three decades, China's reform of medical system has induced some disturbing consequences to the public while it has greatly improve the developmental level of medical industry. Above all, a large part of China's population has suffered economic difficulties in pursuing medical services and drugs; and some malpractices by medical professionals are detected. These phenomena have led to decline of availability and quality of medical productions.

What is more, during the past one and half decades, it is also observed that although private-owned hospitals became legal, they have not substantially developed to a scale where they are capable to compete with state-owned hospitals. Based on relevant theoretical analysis, the thesis finds out that China's reform of medical system creates a monopoly by state-owned hospitals. The thesis finds that this phenomenon is not unique throughout the world, however, what is unique in China is that the situation emerged with a combination of one-party rule, lacking of wide-covering public medical insurance system and insufficient governmental fiscal support and etc. These specific historical events jointly led to this monopoly.

This monopoly not only makes harms to the consumer (the patient in this case) but also undermines the improvement of supervisory mechanism. Without efficient supervisory mechanism, government failure would be apt to occur. That may be the reason why corruptive activities generally reside in China's medical system.

In order to root out the detected problems, it is suggested by the thesis at the end to establish independent asset management committee and expert selection committee to mend the relationship between government and state-owned hospitals; to give aid to the development private-owned hospitals; and to build up certain online complaint-filing system and communication forums to improve transparency.

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Clarification

Before the study of the thesis begins, it needs to be clarified as below:

1. Because an entire medical system general includes two major blocks —— medical services field and public health fields. Among these, the public health field refers to the nation-wide disease prevention system and public health crisis management. The public health, as observed in many states, are usually managed and funded by the government, which attributes itself as public goods. Thusly studies over public health may refer to theories in other expertise, so discussions over the public health will not be included in this thesis.

2. In China’s case, the national medical system actually is divided into two categories: the urban system and the rural system. These two systems differ much with each other. Like the urban system, the rural one has its own development trajectory. Thusly the thesis finds it too much extensive to include both urban and rural systems in one thesis; as a result, this thesis will only exercise researches over the urban system. However, what also needs to be clarified is that although China’s rural areas apply a different medical insurance system, it is configured in China’s MS that rural areas have no local general hospitals. Consequently rural residents as well need go to hospitals in urban areas. Hereby after when the thesis talks about the clients/patients who pursue medical treatment in hospitals, both urban and rural population would be involved. Hereby after, the “medical system” applied in the thesis will only refer to the urban system.

Abbreviations

The following abbreviations will frequently occur throughout the thesis

1. MS——Medical System
2. OR——Opening-up Reform

3. GF——Government Failure

4. PRC——People's Republic of China

Introduction

In the middle of October in 2010, the Political Bureau of Central Committee of Communist Party of China held the “Fifth Plenary Session of 17th Central Committee of Communist Party” in Beijing. The meeting drew up the “Twelfth Five-year Plan” for the socio-economic development of China. In this “Plan”, the Chapter 34 specifically pointed out that one focal work during the next Five-year period (2011-2015) is to establish a well-functioning medical system so as to cater to the social demand of medical productions.¹ This Chapter made explicit instructions that 5 highlighted works (including “establishing and improving the medical service system”, “promoting the development of public health system”, “improving the medical insurance system”, “improving the drug administration mechanism” and “supporting the development of traditional Chinese medicine”) would be the centrality of national medical affairs in the coming 5 years.²

It is founded by the thesis that after the Opening-up Reform, only the “Eleventh Five-year Plan” and “Twelfth Five-year Plan” have explicit and specific instructions over medical affairs.³ It seems that the development of national medical system has drawn much attention from the top of the government. We may wonder the reason why China’s central authority began to attach much attention to medical affairs yet after a thirty-year⁴ reform in the medical sector.

Besides, some other facts have also intrigued the interest of the thesis. On the one hand, it is reported that after a thirty-year reform, compared to 169732 in 1978, China’s has about 936927 hospitals in 2011; 47868000 hospital beds in 2010 which

¹ “Twelfth Five-year Plan”. Drafted by the “Fifth Plenary Session of 17th Central Committee of Communist Party” in October of 2010.

Available at: <http://www.ce.cn/macro/more/201103/16/t20110316_22304698_19.shtml> (2013-8-25)

² Ibid.

³ From the sixth to ninth “Five-year Plan”, the central authority of China mainly focused on the economic development; since the tenth “Plan”, instructions over the development of social affairs appeared, but there were no specific instructions on medical affairs then; From the eleventh “Plan”, instructions over medical affairs, as a part of social development, were included in.

⁴ It is commonly acknowledged that China’s reform of medical system officially began in the year of 1985. Historical events about this will be elaborated in the coming empirical part.

was 20417000 in 1979; 8207502 medical professionals in 2011 which was 788304 in 1979; and national medical expenditure has also escalated from 1261.9 billion yuan in 19 to 199213.5 billion yuan in 2010.⁵ Likewise, it was estimated by World Bank that the vacancy rate of high-value whole-body CT scanner in China has reached to 16% in 2004;⁶ the national average life expectancy has increased from 35 years in 1949 to 78 in 2010⁷; infant mortality increased from 47.0% in 1975 to 19.0% in 2005⁸. It is reasonable to say that China's medical system has encountered a substantial development in the past three decades and become more and more capable to accommodate the demand of the public for medical productions.

One the other hand, the thesis has also detected some disturbing cases. It is reported that in 2004, CHANG Wenshan, from Henan province, unfortunately contracted a sort of hemiplegia caused by hypertension, and spent more than 50 thousand which was actually more than what he possessed for the medical treatment, which forced him to be in debt and to suspend the education of his two daughters who were at the age of attending middle school then. What seemed more grievous was that in the same year it was investigated by local government that among 2707 poverty-stricken families, 1280 were caused by un-affordability of medical services⁹; in the same year, The Medical Bureau of Beijing, acting as the administrative and supervisory organ for local medical affairs, launched a campaign to root out corruptions in hospitals, which in total took over "Red Packages"¹⁰ worth of 854 thousand yuan from 1153 medical professionals¹¹; likewise, in another similar campaign, the supervisory organ also founded a prevalence of unreasonable prescription¹², especially there was certain a

⁵ "2011's Statistical Yearbook of China's Health Affairs".

available at: < <http://www.moh.gov.cn/htmlfiles/zwgkzt/ptjnj/year2011/index2011.html> >

⁶ SHI Guang and GONG Sen(2005). "An Analysis on the National Medical Expenditures of China after the Opening-up Reform". *Review of China's Development*. No.A01 (additional) for 2005:29-46.

⁷ Ibid.

⁸ Ibid.

⁹ "One third of China's Population Could not Afford Medical Treatment"

Available at: <<http://health.sohu.com/s2004/nongminkanbing.shtml>> (2013-8-25)

¹⁰ "Red Package" used to refer to a red package (or envelope) which contains cash gift. However, "Red Package" in China's medical field specifically refers to the cash bribery presented by patients (or their families) to doctors so as to implore better medical treatment from doctors.

¹¹ "Strict Investigations on Corruption in Hospitals: Four Problems in the Charging Mechanism of Hospitals".

Available at: <<http://www.39.net/focus/yw/74487.html>> (2013-8-25)

¹² "Unreasonable Prescription" refers to such a phenomenon where doctors, in the therapy, tend to apply some

top-class pandocheum prescribed 33000 of a sort of preparation that was worth of 56 yuan in three months while the hospitals did have alternatives that had same curative effect but lower price.¹³ Through this lens, no wonder that a doctor who has practically insisted on not to make unreasonable prescription in her twenty-five-year doctor career could be awarded an honor of “Trustworthy Doctor for City of JIANGCheng”.¹⁴

Based on the cases mentioned above, it seems conflicting that contrast to the remarkable development of China’s MS, there still exist some problems, like unaffordable medical treatment and corruption, that undermine the enjoyment of this development of the public. Thusly we may wonder that what China’s MS reform really is and what it has brought about. Only when we find out the answer for these questions, we may be able to grasp the possibility for future improvement.

medicines/equipments which call for unreasonable higher price than those medicines/equipment that are priced with low price, however, could create same curative effects.

¹³ Ibid.

¹⁴ “Prescription of 80 yuan could also curative”.

Available at: <http://www.hb.xinhuanet.com/zhuanli/2009-12/24/content_18675791.htm> (2013-8-25)

Problem Formulation

Based on the aforementioned observations, the thesis has created the following problem statement:

What problems has China's reform of medical system caused and what are the underneath reasons that lead to these problems?

Methodology

In this thesis, suitable theories and reliable empirical data will be applied to undertake an analysis enabling us to unravel the problems formulated above.

1. Scientific Approach

To answer the formulated problems cannot be purely a selection of empirical data but should be carried out with theoretical analysis. With this consideration, the thesis finds the “Deductive Method” applicable on such an occasion. To be concrete, the thesis will try to dissect China’s MS shaped by relevant policies from time to time and to unravel the internal relations between China’s MS and the discerned problems via relevant theoretical analysis.

Besides, in light of the distinctiveness of medical productions (this will be elaborated in the theory part), the thesis believes it necessary to introduce highly relevant theories about health economy, which also creates certain basis in understanding the outcomes of China’s MS reform. Indeed, the formulation of this basis can also be treated as a process of applying existing theories, which could be seen as applying the “Deductive Method”.

According to the hypothesis below, the thesis will go into examine selected cases thus to verify/falsify the hypothesis and thereby provide us a thorough understanding on China’s medical reform.

The so-alleged “Deductive Method” initiates a scientific process supported by relevant theoretical knowledge and embodied by studies in targeted subject. With a certain theoretical perspective, observations would create a realistic hypothesis. This

hypothesis should be able to disprove or prove via a scientific process——verification or falsification. During this process, both theories and empirical data will be applied. What is also worth of noticing is that this process cannot be a definite process because many factors can impact and even disrupt it.

2. Hypothesis

The hypothesis of this thesis is based on the aforementioned bewilderments that *what problems has China's reform of medical system caused and what are the underneath reasons that lead to these problems*. Pursuant to this bewilderment, it can be observed that the thesis assumes that the problems cited in the “Introduction” part have something to do with the Reform of China’s MS. With this thought, the thesis hypothesizes that these problems are systematically caused and there may exist certain connections between China’s MS reform and aforementioned negative cases. However, the thesis is insecure on exactly links between specific institutional arrangements and detected problems. And the thesis also needs to find out the possibly applicable solutions in light of the relevant analysis. During the analysis process, the thesis will hold a perspective that the public welfare is the foremost.

3. Empirical Framework

Based on the hypothesis stated above, the thesis is about to carry out a policy study over China’s MS reform, because the thesis deems that it is the most direct way to make a thorough understanding of the shifts of a system.

Due to their respective emphases, the thesis divides the policy study into 4 sections, each of those is represented by a group of policies. Within the same group of policies, policies are highly related to each other. These 4 sections respectively are

“1949-1979”, “1985-1997”, “1998-2002” and “2003-?”. It is explicitly implied that each section would study policies within certain a period of time.

Besides, in order to better support the analysis, at the beginning of each section, the thesis will make a brief but intensive introduction over relevant socio, economic and political factors. With selections, these introductions are deemed highly influential over the development of China’s MS.

What also needs to be clarified is that because the policy study in the thesis will cover the developmental trajectory of China’s MS over about 60 years, it would be confusing to make such a long piece of separate empirical data, thusly the thesis would combine the empirical data and analysis parts into one. At the end of each section, the thesis will make specific analysis over the policies in each section.

4. Theoretical Framework

Because of the speciality of the medical field, the thesis actually is going to apply two bunches of theories.

In the first bunch, the thesis will introduce several theories that create the theoretical basis to learn the attributions of medical productions (including medical services and drugs). Meanwhile, the thesis will also apply two theoretical models developed in relevant studies, these two models will be respectively used to outline the “value judgment” and structure of China’s MS during each of those four periods of time.

In the second bunch, the thesis will apply theories of institutional school, mainly focusing on the institutional shifts, because the thesis believes that the developmental trajectory of China’s MS can also be embodied as a series of institutional shifts. Accordingly the thesis deems that the institutional school will be applicable. Besides,

relevant theories about “government failure” will also be adopted, because the thesis thinks that these will be useful in analyzing the governmental behaviors which are involved in policy-making.

Theory

The thesis finds it difficult to separately apply one single theory in specific case. Thusly the part will break the typical formality so as to present the theoretical base behind the analysis of the thesis.

To begin with, we will turn to make a brief but intensive introduction about medical productions (drugs and medical services).

1. Medical Production —— private goods or public goods

Unlike the so-called private goods, like the general commodity people usually purchase, public goods is non-exclusive and non-rivalrous, which means that public goods on some occasions could bear “free-riders”.¹⁵ With an institutional school perspective, Ronald Coase argued that public goods belongs to certain a kind of entity whose property right is unsettled in a corresponding period.¹⁶ In our daily life, there exist various kinds of public goods, like street lighting, road upkeep system, sewage disposal and even the national defense. On the contrary, private goods, with clearly defined proprietary right, are exclusive and rivalrous.

Medical Services and drugs are always necessary for maintaining the health and lengthening lifespan. With an economic perspective, purchase of medical services and drugs can be treated as a kind of investment in personal health maintenance. Purchaser, namely patient, can always choose the scheme of medical production, for example, with higher payment, patients can get better treatment. What is more important, medical services produced in hospital and the drug prescribed are exclusive, which means that they cannot be obtained by someone else than the targeted patient.

¹⁵ Samuelson, Paul A and Nordhaus, William D (2010). *Economics*. 19th edition. McGraw Hill Higher Education: New York. pp.45-47.

¹⁶ Coase, Ronald H (1974). “The Lighthouse in Economics”. *Journal of Law and Economics*, 17(2):357-376.

With these two facts, it is reasonable to define medical services and drugs private goods. Besides, it is worth of noticing that in some countries, a nation-wide free medical care system is applied, which makes medical services “look” like public goods. However, although medical services are free in this case, its exclusiveness is not changed, because unlike streetlight, medical services’ outcomes cannot be shared. This mode is generally called the “public provision of private goods” (via a third-party payment mechanism).

2. Why on many occasions government participate in the provision of medical services and drug sales?

To answer this question, we need to gain a further understanding of medical productions.

Here, the thesis will apply the theory developed by Kenneth Arrow. Arrow pointed out that *“the most distinguishing characteristic of one’s demand of medical service is that it is not steady in origin as, for example, for food or clothing, but irregular and unpredictable...medical services, apart from preventive services, afford satisfaction only in the event of illness...”*¹⁷

This unpredictability can be caused by many factors. For example, on one hand, to be a qualified medical professional always need a long-term education. Causally medical professionals always possess a great amount of knowledge that patient would no way possess, which generated an absolute information gap between medical professional and patients. Although there would always be an information inequality between the producer and the purchaser, Arrow believed that physicians possess the information about the consequences and possibilities of treatment very much greater than that of

¹⁷ Arrow, Kenneth J. (1963). “Uncertainty and Welfare Economics of Medical Care”. *The American Economic Review*. 53(5): 941-973.

the patient so that to patient, the very outcome of treatment would be likely unpredictable; on the other hand, illness actually acts as a kind of risk. We usually do not know when and what illness we might get; likewise, because of the complexity of human body, it would be naturally uncertain that the outcome of treatment exercised as well. To sum up, Arrow concluded that two kinds of risks existed in the medical affairs: the risk of being ill and the risk of losing productive time and ability when getting ill.¹⁸

Arrow strongly argued that “... *uncertainty, in fact, significant elements in medical care hardly needs arguments. I will hold that virtually all the special features of this industry, in fact, stem from the prevalence of uncertainty.*”¹⁹

Consequently, in those markets where there lacks risk-bearing mechanism, someone’s welfare will be reduced because risks could be somehow transferred. Within this circumstance, it would discernible that a reduction in welfare would occur from current technology, in other words, a failure to approach the “Pareto Optimality”.²⁰

Arrow found that in this case, the market itself could probably fail to guarantee the maximizing the social welfare because the competitive preconditions would be voided and the equilibrium would not be reached, he further concluded that:

“...when the market fails to achieve an optimal state, society will, to some extent at least, recognize the gap, and nonmarket social institutions will arise attempting to bridge it...the doctrine that society will seek to achieve optimality by non-market means if it cannot achieve them in the market is not novel. Certainly, the government, at least in its economic activities, is usually implicitly or explicitly held to function as the agency which substitutes for the

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ “Pareto Optimality” stands for such an occasion where “no-one could be made better off without making someone else worse off.” Concretely, the distribution of resources is Pareto optimality, if it is not possible to change the distribution of resources so as to make some people better off without making others worse off. However, in fact, Whether the “Pareto Optimality” is achieved is matter of a value judgment. Relevant documentation is available at < <http://moneyterms.co.uk/pareto-optimal/>> (2013-8-22)

*market's failure. ...And it would useful to remark here that the preference for redistribution expressed...motivated much by distributional value judgment...*²¹

To sum up, Arrow believes that health market/industry is somewhere where the market failure inherently prevails. Thusly non-market institutional arrangements with specific value judgment, as risk-bearing mechanism, are called for to prevent reduction of welfare.

Besides, the thesis finds another noticeable feature of medical productions, that is, the prices of medical productions inherently grow faster than the general inflation rate. Theoretically, people are always willing to increase the input in R&D of medical equipment and drugs to advance the medical technology to provide better medical productions. As a result, a cost-push inflation would occur in the medical industry. Due to constant pursuit of health, the cost-push inflation seems long-lasting, despite of the influence of economic circles. It was commented that “...the U.S produced about \$10 billion worth of goods and services in the year of 2005, however, what was astonishing is that every six of these dollars would go to health care...By comparison, in 1960, American spent only \$1 out of every \$20 on health care... The primary driver of rising health-care costs has been medical technologies. We continue to develop expensive treatments and, equally important, apply them to broader swaths of the population.”²²

So to speak, the patients tend to increasingly pay for the medical productions they potentially need. In this case, the society needs to apply some social movements, like commercial medical insurance or medical insurance managed by the government to ease the economic burden.

²¹ Arrow (1963). op.,cit.

²² Goldman, Dana.P. (2005). “Pressure from Rising Health-Care Costs: How Can Consumers Get Relief?”. Online commentary available at: <http://www.rand.org/commentary/2005/10/23/PE.html> <2013-8-21>

So far, we have shown two reasons behind the governmental interventions in medical affairs. It is observed that because of speciality of medical production, governmental interventions are often called for to subsidizing both either supplier or consumer to prevent the decline of the availability of medical productions.

3. Value Judgment in Government's Policies in Medical Affairs

We may further wonder what the “Value Judgment” of the government is in its institutional arrangements in medical affairs. In order to solve this bewilderment, here we will apply LIU's theory.

LIU, in his book “Study on Related Policies of China's Health-care Reform”, emphasized that medical market is so much different from other market in general, where market failure prevails and various government's interventions are involved. With this perspective, government's interventions seem to solve the market failure, however, the truth is more complicated. Government's interventions in medical market practically go beyond the scope of rectifying market failure. In fact, government's interventions primarily aim at expanding the availability of medical productions to as much population as possible, which are not simple market adjustments.²³ In a manner of speaking, medical market is a special market where social institutional arrangements highly impact the well-being of the market.

Obviously, the discussion over the value judgment of government's policies in medical affairs will focus on the maintenance of fairness in the medical market. However, we also need to be aware of that the concept of “social fairness” has long been interpreted in many cases and in many ways. Contextually, we need to learn the specific “social fairness” in medical affairs; otherwise “the fairness” would be a hollow and confusing concept.

Based on observations over MS of various countries, LIU concluded that “fairness” in medical affairs for the government to maintain actually consist of three concrete “fairness”: the fairness in financing the medical expenditure, the fairness in the

²³ LIU,Junmin (2012). “*Study on Related Policies of China's Health-care Reform*”. pp:1-5. Beijing: Economic Science Press.

availability of medical services and the fairness in practice of the provision of medical services.²⁴

To be concrete, the fairness in financing the medical expenditure take the obedience to the principle that in paying the fees for medical services and medical insurance, the payment amount should positively related to the capacity of payment;

The fairness in the availability of medical services is the core, because it outlines the general task of government's intervention in medical market, that is, maintaining as much availability of medical services as possible;

The fairness in practice of the provision of medical services has two connotations; actually it represents the establishment of the supply pattern of medical services where both vertical and horizontal fairness should be obtained. The vertical fairness means that it is possible to accommodate the various demands of various groups of patients; the horizontal fairness stands for that as to those who have the same medical demand, they can be catered the same quality of medical services.²⁵

However, as stressed by LIU, the pursuit of fairness cannot be the only one aim of government in medical affairs, because the medical field is a compound of both social institutions and market mechanism. If the efficiency is ignored in the policies, medical resources would be possibly wasted and the enthusiasm of medical professionals would be suppressed.²⁶

Consequently, government needs to attach a certain amount of importance of expediting efficiency in medical market in its policies. To be specific, efficiency in medical affairs includes the "efficient utilization of medical resource", the "maintenance of satisfactory quality of medical services", the "diversification of

²⁴ Ibid. p.6

²⁵ Ibid.

²⁶ Ibid. p.7

medical services so as to cater various parts of population” and the “prevalence of competitiveness”.²⁷

With these arguments, we have gain the theoretical basic for judging the value judgment behind the policies in China’s MS reforms. In a word, as suggested by LIU, due the speciality of medical market where diverse pursuits of interest intertwine, the government should make a reasonable and prudent trade-off between fairness and efficiency in the preference of its policies²⁸.

²⁷ Ibid.

²⁸ Ibid.

4. What is the structure of a Medical System?

Policies, as institutional arrangements, will form up a regime, where system is regulated and operated. We have already included some theories to study policies in China's MS reform. In the sector, we will introduce another theoretical tool to parse the MSs in China from time to time.

This time, we need to apply a theory developed by XIA in his doctoral thesis. With observations over MSs of various states, XIA pointed out that a MS includes 5 major elements: 1. Financing; 2. Payment; 3. Organization; 4. Regulation; 5. Behavior.²⁹

However, these elements are concrete manifestations of MS. It was further indicated that MS contains two connotations as backbones which keep up the whole system. They are: 1. the distribution of interests, including the recipient of medical service, the proprietary relationship of medical entities and the sharing arrangement of medical fees; 2. the distribution of medical resources. With this understanding, XIA developed the chart below to demonstrate the causal links between these elements and connotations. Any changes exerted on the operative mechanisms of the system would cause changes in these elements, which finally would lead to the change in the performance of the system.

²⁹ XIA Mian (2010). "Study on the Game Behavior of Interest Group and Health Institutional Change in China". Doctoral Thesis. Huazhong University of Science and Technology. p. 28. (unpublished)

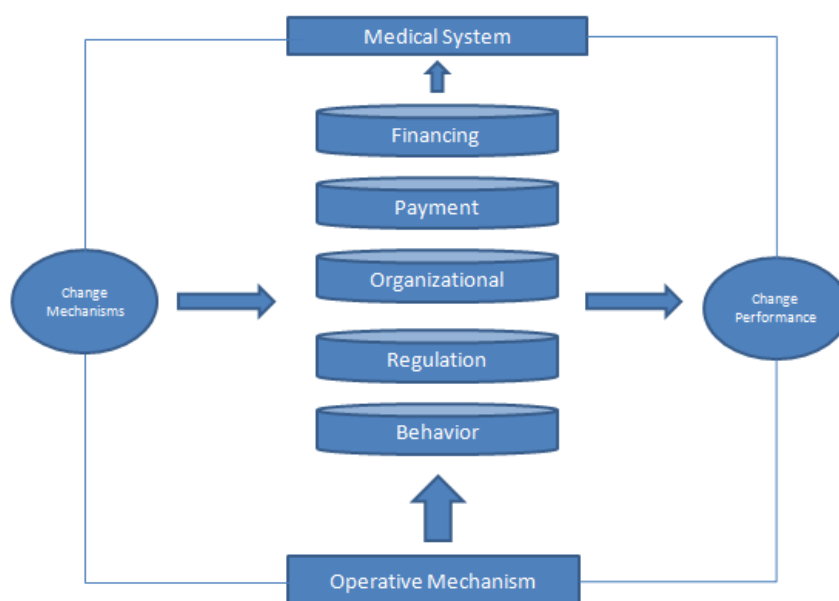


Chart 2.1 Linkages between the changes in mechanisms and in performances of a Medical System

It is concluded by XIA that a MS usually can be seen as a three-dimension structure, the prime or the core dimension is the interest-distribution mechanism, which decides the way to allocate transactions fees generated in the MS; the second dimension is constituted by “supply pattern of medical service”, “the financing manners for government’s medical expenditures” and “the supervisory mode”; the third or the peripheral dimension is concrete operative mechanisms, including the way of producing, organizing and supplying medical services, the way of pricing medical productions and the way of paying medical fees.³⁰

However, we cannot directly and concretely dissect the core dimension, because it is, on most occasions, hardly to exercise a quantitative research on the multifarious transaction fees and the aforementioned interest. Consequently, we have to make conclusions by virtue of analyses of the factors on second and third dimensions.³¹

³⁰ Ibid. pp 29-30.

³¹ Ibid.

What is equally important, we need to make a further illustration on the manifestations of “supply pattern of medical service”, “the financing manners for government’s medical expenditures” and “the supervisory mode”.

To begin with, the “supply pattern of medical service” here stands for the organizational relations of the producing and supplying of medical productions. It has two extremes, on the one hand, it is the absolute public provision; on the other hand, it is the provision by pure competition in market.³² The medical productions here include medical services produced in hospitals, drugs/medicines prescribed in hospitals or any clinics or out-patient activities and public health (not studied in this thesis).

In addition, the “financing manners for government’s medical expenditures” means financing and allocating the fund. In order not to involve the discussion about fiscal risk, here the thesis will simplify the structure of “financing manners for government’s medical expenditures” from XIA, that is, the “financing manners for government’s medical expenditures” determines “who to buy”, “what to buy” and “how to price”³³.

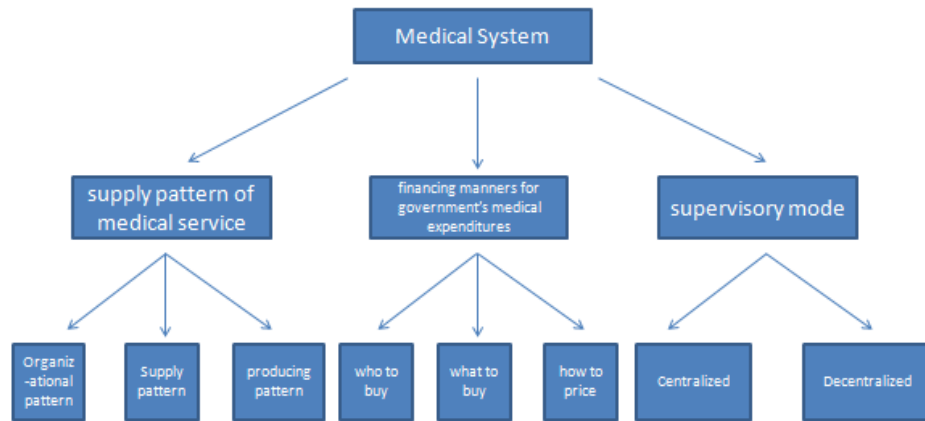
Finally, “the supervisory mode” can be divided into two classes, namely centralized supervision by government and decentralized supervision in market.³⁴

As the structure chart demonstrated, a medical system can be seen as below:

³² Ibid.

³³ Ibid.

³⁴ Ibid.



*Chart 2.2 The Structure of Medical System*³⁵

With this chart, the thesis will try to dissect China's MS reform in different period so as to clearly show the shifts in the system happened.

³⁵ *ibid.* p.31.

5. Institutional Shift Theory

Besides the analyses that are related to the theory displayed above, we also need to analyze the changing process of policies of MS reform in China. For this part of analysis, we will apply the institutional shift theory. The thesis believes it suitable, because institutional arrangements of MS reform, as a sort of endogenous resource, found the basis of the entire system, they play a decisive role in any shift of the system. With this perspective, analyses about the institutional shift in China's MS reforms would be meaningful for the thesis.

To begin with, we will firstly introduce the institutional shift theory that will be applied. The institutional shift theory is often times esteemed as the outstanding representative of the theories in the "neo-institutional school". Unlike the "neo-classical economics", the institutional shift theory treats institutions as endogenous variables. Taking "property right" and "transactional fees" into considerations, it aims at probing functions and influences of institutions by applying the basic assumptions of "neo-classical economics"—"rational choice", "maximum utility" and "equilibrium analysis".³⁶

It is argued by the Institutional school that the emergence of institutions stems from the desire to reduce transactional fees. And the motivation to pushing forward institutional shift is laid in the pursuit of potential incomes.³⁷ Potential incomes/benefits are something that is not covered by the "old" system and can be covered by the "new" system. Thusly, people tend to exercise institutional shift to cover the uncovered benefits. Because the institutions are not exclusive, they can be regarded as public goods. So when there is no demand for new institutions, equilibrium occurs.³⁸

³⁶ Malcolm Rutherford (2001). "Institutional Economics: Then and Now". *Journal of Economic Perspectives*, 15(3):173-194.

³⁷ Davis, Lance and Douglass North(1970). "Institutional Change and American Economic Growth: A First Step Towards a Theory of Institutional Innovation". *The Journal of Economic History*. 30(1):131-149.

³⁸ Davis, Lance and Douglass North(1971). "Institutional Change and American Economic Growth". *The Journal*

However, the statement above seems too much “economic” and “abstract”. In this case, it was once pointed out that Institutional shift can be also treated as the outcome of game playing between interest groups.³⁹ Different interest groups have different preferences in status, power and interest distribution, thusly they would have different assertions in institutional choice.⁴⁰ It was metaphorized by North that if the institutions are game rules, interest groups are actors. As a result, claims of different interest groups would check and balance the path of institutional evolution. With the perspective above, it is observed that the institutional shift may be decided by the contention between interest groups. If there exists only one leading interest group, it is conceivable that this interest group would tend to keep the current system unchanged.

There are two types of institutions: formal and informal; relevantly, there are three kinds of institutional shift: spontaneous, imposed and induced. Opposite to the spontaneous institutional shift, induced ones usually represent government’s reactions to the social desire of new institutions.⁴¹ In these cases, due to the intervention of government, political regime and ideology would play a hand in the establishment of new institutions.⁴² With the compulsive interventions of government, institutional shift became something more than the “initiative contractual game rule”.⁴³

Justin YF LIN also made a thorough research over the induced and compulsive institutional shift. He argued that physical conditions, technological conditions, economic efficiency and externality would together determine the persistence of institutions.⁴⁴ What is more important, ideology in itself can reduce the transaction fees in institutional shift, because ideology keeps up certain a cognitive system where

of *Economic History*, 31(1):118-125.

³⁹ Becker, G.S(1983). “A Theory of Competition Among Pressure Groups for Political Influence”. *Quarterly Journal of Economics*. 98(3):371-400.

⁴⁰ Posner, R.A.(1974). “Theories of Economic Regulation”. *Bell Journal of Economic*. 5(2):335-358.

⁴¹ Davis and North(1971). Op.,cit.

⁴² Douglass North (1991). “Institutions”. *Journal of Economic Perspectives*. 5(1):97-112.

⁴³ Ibid.

⁴⁴ Lin, Justin Yifu (1989). “An Economic Theory of Institutional Change: Induced and Imposed Change”. *Cato Journal*. 9(1):1-38

people to some extent agree with each other.⁴⁵ Consequently, ideology and institutions would exert influences over each other, which sometimes could be embodied as a kind of path-dependence.⁴⁶ Four factors would arouse the possibility for institutional shift, including technological changes, changes in alternative institutions, constant changes of prices of productive factors and other relevant institutional shift.⁴⁷ He also epitomized that 5 factors would lead to the failure of policies, they are:

1. Preference of government;
2. Rigidity in Ideology;
3. Inefficiency in bureaucracy;
4. Conflicts between interest group;
5. Boundedness in the development of social science.⁴⁸

⁴⁵ Ibid.

⁴⁶ Coase, Ronald and Ning WANG(2012). *How China became Capitalist*. New York: Palgrave Macmillan.p.121

⁴⁷ Lin(1989). Op.,cit.

⁴⁸ Ibid.

6. Government Failure

In addition, the thesis will also apply a very essential concepts in many political-economic theories—— “government failure”.

“Government Failure” was created as an analogy to the “market failure”. It stands for the government interventions that cause no efficient solutions than without governmental interventions. Wolf. Charles once metaphorized that government success is just some prescribed therapies by the market failure.⁴⁹ In other words, it is indicated that like the existence of market failure, government failure also prevails in each society.

Many scholar have studied the GF, the thesis cannot make a thorough review over all of them. But what needs to be clarified is that GF is not some phenomenon that only occurs when the market failure happens. Actually, it is concluded by Charles Wolf that bureaucratic organization inherently tends to reach inefficiency and unfairness.⁵⁰

GF can be categorized into 4 classes:

1. GF can be embodied as that government’s intervention achieves no established goals; GF can also refer to the circumstance where the established goals are completed but the cost is higher than the benefit; GF can as well stand for that government’s intervention reaches the set aims with the cost that is lower than the benefits, however, this arrangement causes too much negative externalities to afford.

2. It is the expansion and growth of government would possibly cause GF. Because government doesn’t belong to productive entities, government functionaries turn to

⁴⁹ Wolf, Charles Jr (1979). “A Theory of Nonmarket Failure: Framework for Implementation Analysis”. *Journal of Law and Economics*. 22(1):107-139.

⁵⁰ Ibid.

pursue the expansion of the power instead of economic gains. However, a constant expansion of government may not be a rational choice for the society nor a reasonable utilization of resources.

3. It is because that the phenomenon mentioned above would also lead to inefficiency, so along with the expansion of government, the inefficiency gets further spread, especially in its policies about public affairs.

4. It was pointed out by Buchanan that any government functionary can be also treated as the “economic man”. They might turn to make usage of their power to pursue economic gains, which can be seen as the “rent-seeking”. This “rent-seeking” probably favors the individual benefit rather than the public’s interest. Conclusively, “rent-seeking” may lead to policies that are not designed for maximizing the public welfare but for the interest of specific interest group, which can be regarded as the failure of government.⁵¹

Furthermore, theoretical researches over GF also believe that 4 major reasons cause the GF. They are:

1. Lacking of competition eases the constraints over government;
2. Categorical hierarchical structure distorts the information flow;
3. Time lag in government’s reactions;
4. Lacking of supervisory mechanism plants the seed for improper policies, delayed remedies and “rent-seeking” activities.⁵²

⁵¹ CAO, Guoan and LI Jiwen (2005). “A Comparative Study between Government Failure and Market Failure”. *Journal of Hubei University of Economics*. 3(6):86-91.

⁵² WANG Yang (2008). “Government Failure and Solutions in the Management of Public Crisis”. *Science and Management*. No.3 for 2008:85-87.

Empirical Data and Analysis

1. The Trajectory of China's MS Reform

After the foundation of PRC, the whole society was gradually shaped into a binary system to fit the basic need of communist regime——exploiting agricultural sector to support industrial sector. This binary system practically manifested itself as a system where urban and rural systems paralleled⁵³. Consequently, socio-economic disparities were generated between urban and rural areas in China.

However, the development of China's MS was deeply rooted in the formulation of socio-economic structure at the time. Contextually, the MSs differed much between urban and rural system. Under this circumstance, it is deemed reasonable by the thesis that we should establish specific discussions over the trajectories of China's MS in the urban areas so as to reflect the socio-economic shifts behind properly. The coming sectors, as stated in the Clarification, will try to shed a light on the trajectory of the development of MSs only in China's urban areas before the OR.

1. 1 China's Medical System in urban areas before OR

The establishment of the MS in the urban area of China between 1956 and 1979 was originated with duplication of the former USSR's MS——regarding the MS as a part of social welfare system. Under this circumstance, the main feature of China's MS in urban area was embodied as a sole distribution system by the government, namely the provision of medical service solely belonged to the government⁵⁴.

With the outcomes of the first and second “National Conference on Medical Affairs”

⁵³ WU, JL. *Understanding and Interpreting of China's Economic Reform*. Shanghai: Shanghai Fareast Press, 2010. pp.79-81.

⁵⁴ XIA(2010). Op.,cit.

that were held in the year of 1950 and 1952 respectively, China's government had settled the "Four basic principles of national medical affairs" for the newly founded PRC. These four principles were "Serving the Worker, the Peasant and the Soldier", "Highlighting Disease Prevention", "Combining foreign and Chinese medication" and "Bonding medical affairs with public campaigns".⁵⁵ In 1957, the "Guidance on the Strengthening of the Leadership of the Administrator of Medical Organs at Primary Levels" firstly claimed that the development of national medical affairs shall abide with communist creeds and thusly aim at promoting the social welfare.⁵⁶ The formulation of this document was based on the completion of the "socialist transformation" which was carried out between 1950 and 1955 throughout the country. This transformation converted private-owned capitals into the public-owned form and created the foundation of a communist state.⁵⁷

While settling the principle of medical affairs for the newly founded PRC, the government also designed a three-dimension MS. The three dimensions were decided to the political and administrative affiliating relations between governments at various levels. They were Provincial dimension, Municipal (or XIAN) dimension and Village dimension.⁵⁸ The first two dimensions referred to the MS in the urban area that we are here discussing about. The establishment of this three-dimension system began with the issuance of "Guidance on the Medical Treatment at State Expense for the employees of Government Organs, Public Organizations and State-owned Enterprises" in the year of 1952. This "Guidance", together with the "Regulations on Labor Security" which was issued in 1951, attached the responsibility of payment of medical

⁵⁵ Ibid.

⁵⁶ "Guidance on the Strengthening of the Leadership of the Administrator of Medical Organs at Primary Levels". Seen at the "Bulletin of the State Council of China".
<<http://www.cnki.com.cn/Article/CJFDTotal-GWYB195735007.htm>> (2013.8-20)

⁵⁷ Between 1950 and 1955, China's government launched a campaign called "socialist transformation", aiming at turning China into a soviet-style communist state. This campaign consisted of three sub-movement: "socialist transformation in agricultural sector", "socialist transformation in handicraft industry" and "socialist transformation in capitalist commercial sector". Via confiscating private lands, establishing productive cooperatives and non-violently redeeming private capitals, China's government gradually turned nation-wide capitals into the public-owned form. As a result, a communist regime was build up around year of 1955.

⁵⁸ Development Research Center of the State Council(2005). "Evaluations and Suggestions on the reform of China's Medical System". *Health Policy*. No.9 for 2005:4-10.

service to every state-owned entity.⁵⁹ Furthermore, the responsibility of financing of the construction of hospitals befell on them as well. Thusly hospitals became affiliations of various socio-economic entities.⁶⁰

This situation actually made the MS in urban area something more than a three-dimension system. It fragmented the MS in urban areas of China at the time into two paralleling systems——‘Lao Bao’(labor security including medical insurance) and ‘Gong Fei Yi Liao’(state-funded medical system), the first one was applied for those who worked or had worked for the state-owned enterprises (productive organs) and the latter one was applicable for those who worked for public unproductive entities⁶¹.” What needs to be clarified is that a portion of urban employees’ salary was deducted as a sort of premium for medical insurance. For those who worked for state-owned enterprises, the reserved ratio (to monthly salary) was 6% in 1950s and increased to 11% in 1969; for those who worked for unproductive organs, basically the organs affiliated to the Party and government, it was 18 yuan per year before 1961 and gradually increased to 70 yuan in 1979 (The salary system applied in productive sector differed from that in unproductive sector from time to time; consequently the reserved deduction mentioned above had respective manifestations in the two sectors).⁶²

Meanwhile, the coverage of the expenditure on employees’ medical treatments also evolved from time to time. Pursuant to the “Regulation” and “Guidance” mentioned above, between 1952 and 1966, fees for employees’ medical treatments, including registration fee, diagnosis fee, home-visit medical service fee, surgery fee and the expenditure on non-high-value drugs were covered by the state-based MS. High-value

⁵⁹ “Regulations on Labor Security”, issued in 1951-2-26.

Available at <<http://www.cnki.com.cn/Article/CJFDTotal-TJZB195122003.htm>> (2013-8-20)

⁶⁰ “Guidance on the Strengthening of the Leadership of the Administrator of Medical Organs at Primary Levels”. Op.,cit

⁶¹ YAO Li (2010). “A Historical Study of urban Medical Insurance System in PRC”. *Literature of the Communist Party*. No.3 for 2009:94-99.

⁶² GONG Sen (2005). “A Review of China’s Urban Medical Insurance System”. *Review of China’s Development*. No.A01 (additional) for 2005:63-77

drug, in principle, shall be paid by the patients themselves at the expense of cost-price, however, under some extreme circumstance (like where the patient were entrapped by poverty and couldn't afford the needed drugs), it can be as well paid by the government.⁶³ Not because of the Cultural Revolution but the "6·26" talk of the Chairman MAO (elaborated at the footnote 64)⁶⁴, the distribution of state's medical expenditure were re-arranged and more resources were re-navigated towards rural areas. As a result, the "coverage" for employees who worked and lived in the urban area shrank. The registration fee and the fee for home-visit medical treatments were no longer covered by the medical insurance.⁶⁵ What is more, this MS in the urban area also took the responsibility for the payment of medical services of urban employees. The "guidance" regulated that "the fees for medical treatments of the relatives of the employees (including those who had already retired) of any socio-economic entities should also be covered by the government's fund conditionally". It was specifically listed that "diagnosis fee, fully covered; registration fee and the expenditure on normal drugs, half covered; and high-value drugs, the fee for home-visit medical treatments and surgery fee, not covered."⁶⁶

It is also noticeable that the salary system of the employees of China's hospitals in urban areas before OR was a unified-criteria one. Employees of hospitals were categorized into two sorts——medical professionals and non-medical employees. Each kind implemented its own salary system. Taking the salary system of medical professionals as example, a professional was rated with a corresponding job title pursuant to one's qualification and the record of performance, like clinical novice, physician and chief physician. The salary increased along with the title promoted. So to speak, the salary was bonded with the title. However, the salary of professionals

⁶³ Ibid.

⁶⁴ "6·26" talk refers to a speech made by MAO Zedong. In 26th of June, 1965, MAO Zedong pointed out that "...the national Ministry of Health had only worked for those who lived in cities and not paid enough attention to the rural medical affairs...85% of China's population is still entrapped in poor medical conditions...we need to shorten the schooling terms for training doctors...and infuse more resources into rural medical affairs." This speech aroused drastic re-distribution of national medical resources into rural areas, more medical resources were navigate to rural medical system.

⁶⁵ GONG(2005). Op.,cit.

⁶⁶ Ibid.

with same title was unified and fixed, which means this fixed salary regard of no working performance. This inflexible system had prevailed until the middle of 1980s.⁶⁷

According to relative statistics, this system had never covered more than 20 percent of the national population. In the year 1956 when the communist transition was basically finished and most labor forces were recruited by the public-owned socio-economic entities, 25 million urban employees which was about one-third of the entire population who lived in urban areas, were covered by the MS described above. Till the year of 1966, it was estimated that between 70 and 80 percent of the population who lived in the urban area were covered by this system.⁶⁸

On the other hand, between the year of 1949 and 1978 in the urban area, the total number of hospitals was increased by 24 times and the hospital beds for per thousand people were increased by 8.9 times.⁶⁹ With this development of medical investment, the average life expectancy drastically grew from 34 years in 1949 to 57 in 1957 and to 68 in 1980.⁷⁰ Correspondingly, the national “Human Development Index (Known as HDI)” of China increased from 0.159 in 1951 to 0.47 in 1979⁷¹. It is observed that the establishment of the MS after the foundation of PRC had contributed hugely to the improvement of physical conditions of the public.

The Dissection of China’s MS before OR

In this part, the thesis will try to outline the MS in urban areas before 1978 by

⁶⁷ YAO,Zhongxin, Ning MA, et.al(2006). “A Study of the Distribution Mechanism of the State-owned Hospitals”. *Chinese Hospital Management*. 26(1):16-18.

⁶⁸ Ibid.

⁶⁹ DING Ningning (2005). “Economic Reform and China’s Medical Affairs: the Economic, Political and Social Background of China’s Medical Reform”. *Review of China’s Development*. No.A01 (additional) for 2005:15-28.

⁷⁰ Ibid.

⁷¹ HDI index by Country, available at the database of International Human Development Indicators in the website of United Nations Development Programme.
<<http://hdrstats.undp.org/en/tables/>> (2013-8-21)

applying the theories introduced in the theory part.

First of all, we need to make clear the guiding ideology of the MS described above. Because it was stated that “... national medical affairs shall abide with communist creeds and thusly aim at promoting the social welfare...”, we may know that during this period of time the MS in China’s urban areas was treated as one affiliation of the communist state apparatus and its establishment was based on communist “orthodoxy”. As a result, the guiding ideology of building this system was to build a public medical system to cover the urban areas and the employees hired by the state-owned entities. It attached much importance to maintaining the fairness throughout the urban society.

For the “fairness in the availability of medical services”, the system basically succeeded in providing anyone who was covered by the “LaoBao” or “GongFeiYiLiao”, but it is noticeable that the system didn’t cover the entire urban population, after 1966, there was still a fraction of urban population not covered by the system, the reason that these people were not covered may be complicated, say, they were not skilled enough to be hired. But the point to recognize this part of uncovered population is to illustrate that China’s urban MS between 1949 and 1978 was not a MS like that in the U.K.⁷² but a sort of “medical insurance system” provided by the employer——namely the government here; as to the “fairness in financing the medical expenditure”, the system also loyally took the obedience to the principle of fairness, namely the “proportional charges of medical subsidies” that was elaborated above made sure that the payment amount of medical subsidies was in direct proportion to the capacity of payment.

Compared to the guiding ideology of fairness, the medical system at the time did not

⁷² The UK exercises a kind of unified public medical insurance system which covers all the citizens. Ages, educational levels, occupations and etc would not determine whether the citizen would get the medical insurance. This system is generally called National Health Service (abbreviated as NHS). It would be better elaborated in the coming chapter.

focus much on the efficiency. With the unified and inflexible salary system, the medical professionals would get the same salary however much contribution they make, which radically eroded the incentives to stimulate the working enthusiasm; more medical resources flocked in the urban areas and couldn't be properly utilized so as to cover more population (see at the footnote 64). In a word, the system laid more attention in maintaining the availability of medical services for those who were already covered.

If we make a one-to-one correspondence with the system to the Chart 4.1 in the theory part, we may get a sketched structure of this system:

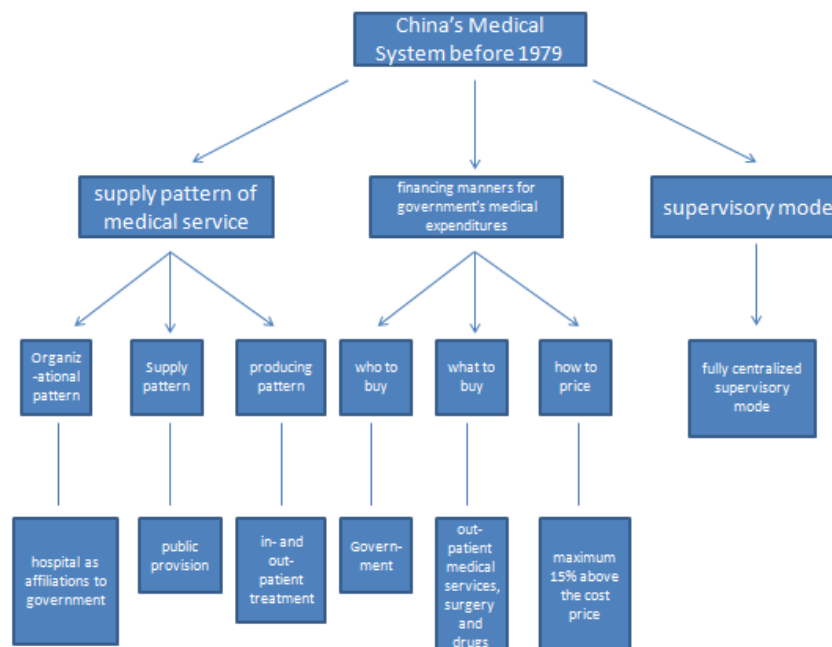


Chart 4.1 The Structure of MS in China between 1949 and 1978

As to “organizational pattern” in the Chart, due to the communist regime, all urban hospitals and other medical institutions were entirely funded and operated by the government; as for the “supply pattern”, because the hospitals belonged to various governmental entities, the medical services were produced by the government, put it another way, the “supply pattern” then can be defined as “public provision”; likewise, because no private-owned or individual-operated medical institutions were licit at the

time, all kinds of medical productions were produced by government-operated entities.

Correspondingly, the government was the actual purchaser of medical productions. As stated at Page 31. , government would pay for urban employees' and their families' registration fee, diagnosis fee, surgery fee and a part of needed drugs. According to the non-profit principle, the price-markup mechanism had little influence over the availability of medical productions.

Finally, within the communist socio-economic regime, it is easy to conclude that the “supervisory mode” in medical field can be defined as a centralized mode where all medical institutions were supervised by local medical administrative department.

1.2 China's MS between 1980~1985

The evolution of China's MS between 1980 and 1985 was not conspicuous, because there were few profound-affecting policies issued in that period. However, the thesis deems that due to its ramifications, it is necessary to make a brief introduction over the changes in MS in that period.

Meanwhile, the socio-economic foundation of urban MS in China had encountered changes between 1978 and 1985. Three factors played a strong hand in these changes. To begin with, the “Up to the Mountains and Down to the Countryside Movement” campaign which was initiated in Cultural Revolution and required “educated youths” to go and work in the countryside ended right after the conclusion of Cultural Revolution.⁷³ According to certain statistics, more than 30 million “Educated Youths”

⁷³ “Up to the Mountains and Down to the Countryside Movement” refers to such a social movement which was initiated by MAO Zedong at the beginning of the “Cultural Revolution”. This movement was prevalent throughout the state during the late 1960s and early 1970s. This movement was defined as an “Anti-bourgeois” movement, because MAO Zedong thought that urban educated youth were privileged and should be sent to countryside to get rusticated in order to learn from farmers and workers. Relevant Documentation is available at:

which accounted for almost 20% of urban population at the time backed to urban areas. However, urban economy had no adequate job vacancies for these “Educated Youths”.⁷⁴ An army of the unemployed immediately flocked into China’s urban areas in China and generated a substantial threat that may lead to a potential social crisis. China’s government had to deregulate the constraints over private economy. Since then, “private economy” or “self-employed business” became legal again in PRC. To accommodate this change, the state council of China granted the “Application for the Permission of self-employed medical professionals and businesses”.⁷⁵ Consequently, “private-owned business” became licit in the urban MS. However, this so-called “private-owned/operated business” only referred to the qualified “individual practitioner” or “individual physician” while any forms of private-owned medical institutions were still banned.⁷⁶

In addition, because urban hospitals applied the aforementioned salary system, a widespread lacking of working enthusiasm prevailed at the time in urban medical professionals, which directly led to a decline of supply quantity of medical services. Nevertheless, the public demand for medical service had never declined (or could not decline): especially China in the early 1980s encountered a second time baby-boom since the foundation of PRC (shown as the chart below)⁷⁷. The urban public medical service system (including both Labor Security and Public Medical Service here) had to cover more and more population, which stood for a greater need for medical service provision. This situation substantially generated an undersupply of medical service.

< http://news.ifeng.com/history/zhiquing/comments/200909/0907_6852_1337767.shtml > (2013-8-21)

⁷⁴ Coase and Wang(2012). Op.,cit.

⁷⁵ Ibid.

⁷⁶ XIA(2010).op.,cit.

⁷⁷ Editorial Board of *China Statistical Yearbook*, led by MA Jiantang(2011). *China Statistical Yearbook 2011*. Available at: < <http://www.stats.gov.cn/tjsj/ndsj/2011/indexeh.htm> > (2013-8-21)

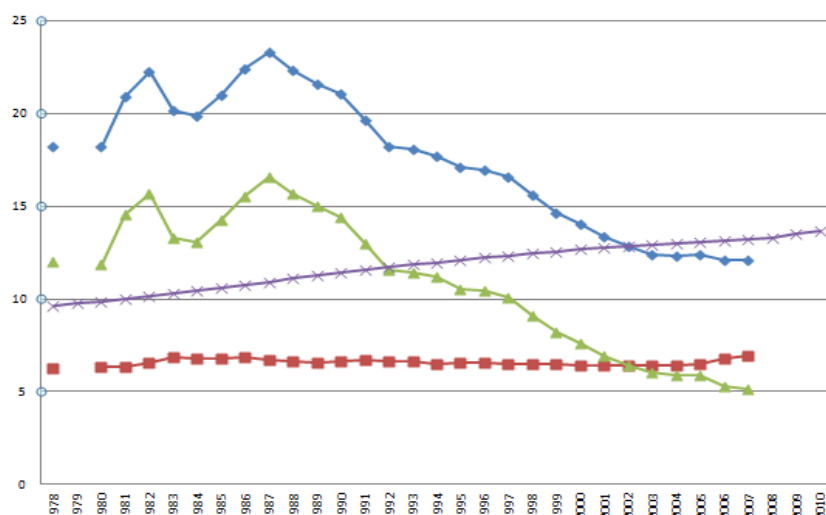


Diagram 4.1 The Demographic Change of China between 1978 and 2010

Legend: —◆— Birth Rate; —■— Death Rate; —▲— Natural Growth of Population; —×— Total Population

Last but not least, the social demands for medical expenditure gradually outran the bearing capacity of national finance. Due to the specific developmental mode then, China's government launched a campaign called "Great Leap Forward: Western Learning" around 1978, which led to a bunch of intensive investments in heavy industries⁷⁸. Gradually national finance found it hard to proliferate its expenditures besides enlarging input in critical heavy industrial enterprises, therefore, sectors like education and health had experienced a crunched financial support from the central government.⁷⁹ We may see from the table below that before the MS reform of 1985 was launched, the government's fiscal support decreased on a yearly basis.

Alongside, the mainstream of China's economy——state-owned enterprises got trapped into downturns since the 1980s. By 1988, only about one-third of state-owned enterprises annually gained profits.⁸⁰ Hospitals that were affiliated to those enterprises may also suffer a downturn in economic support.

⁷⁸ WU, JingLian and Guochuan MA(2013). *Re-launch the Agenda of Reform*. Beijing: SANLian Bookstore Publishers. p.192.

⁷⁹ Ibid.

⁸⁰ Ibid.

Under these circumstances, the Ministry of Health of China circulated “Notification on the Solution of the Economic Loss of Urban Hospitals”, it suggested that urban hospitals could carry out a “dual-track” charging system where those whose medical expenditures were covered by state-expenses (namely “LaoBao” and “GongFeiYiLiao” systems) could be charged about the “cost price” of some medical services (including diagnosis fee and drugs prescribed in hospitals); and those who are not covered by any public medical service systems should be charged at a concessional price.⁸¹ Since then, a modified urban MS gradually emerged. This modification mainly aimed to create more revenues for hospitals and thus to match up the provision of medical services with the demands while solve the trouble where government couldn’t sustain medical expenditures.

1.3 China’s MS between 1985-1997

The thesis finds what was uttermost relevant to the developmental trajectory of China’s MS during 1980s is the evolution of China’s fiscal system, because governmental expenditures on public affairs, on most occasions, belong to fiscal expenditures, the configuration of national fiscal system is highly related to the expending ability of government’s investments in public affairs. This section will begin with a brief introduction of China’s fiscal system in 1980s as the background information.

China’s fiscal system has evolved twice since 1978. Between the year of 1980 and 1994, the fiscal system of China was carried out in a form of “Fiscal Contracting System”.

China’s government decided to lay a reform on its fiscal system since 1980. At the time, this reform’s foremost task was to offer better incentives to local governments

⁸¹ “Notification on the Solution of the Economic Loss of Urban Hospitals”, issued in 1981-2-27
Available at: <<http://www.people.com.cn/item/flfgk/gwyfg/1981/112708198101.html>> (2013-8-11)

and state-owned enterprises.⁸² Basically this reform established a system where central and local governments shared all the revenue. Within this system, a pre-settled budget expenditure quota was consolidated exogenously on the basis of negotiation between central and local governments. Sequentially, various sharing rates were set to cover this expenditure and to accommodate differing local conditions.⁸³ To guarantee the expenditure that local economies needed, China's central government also offered that if the local yearly revenue was more than the quota, the surplus could be detained in local coffers; if the revenue was less than the quota, the difference would be offset by financial support or loans from central governments.⁸⁴ It is commented that this is an ambitious reform aiming at overhauling the whole fiscal system.⁸⁵

It is observed that the prime advantage of this system was that it generated incentives for tax collection at local levels. However, the outcomes of this reform were highly complicated. This bargaining mechanism between central and local governments oddly led to an extremely low level of retention of revenue to the central government. Although the sharing ratios were fixed, the local governments spared no efforts to increase revenue and to reserve as much as possible into the local coffers. As a result, a vast fiscal income loss happened to the central government. In the increment of fiscal income, only 3.3% belonged to the central government in the year of 1988 and 4.8% in the year of 1989. Local governments began to perform for its immediate interest. It was astonishing that during the late 1980s, the central government of China failed twice to "borrow" money from local governments.⁸⁶ In a word, the central government of China in 1980s was running out of money and the whole fiscal system was fragmented.

Within this fiscal framework, most of governmental expenses on medical affairs

⁸² WONG, Christen.P.W(1992). "Fiscal Reform and Local Industrialization: The Problematic Sequencing of Reform in Post-Mao China". *Modern China*, 18(2):197-227.

⁸³ Ibid.

⁸⁴ Ibid.

⁸⁵ Ibid.

⁸⁶ WU and MA (2013). Op.,cit.

belonged to local fiscal expenditures. However, local government assumes many other tasks of supporting public affairs. Investment in public affairs like health, education, environment and etc mainly depended on the local fiscal expenditures. What is more important is that within this fiscal system, local government had different pursuits of interest with central government. Obviously Making effort to increase local fiscal income seemed more appealing to local policy-makers, because thusly they were able to control more financial funds. As a result, local government would be more willing to invest in, like secondary industry, to generate more revenues, which no doubt subdued the intentions to invest in the health sector.

Besides, what is also worth of noticing is the prevalent reform pattern in various sectors in 1980s. During that period of time, “contracting mode” was repeatedly applied in many reforms, especially the reform of state-owned enterprises. As recorded, in the year of 1982, the “Central Economic Working Conference” emphasized that “contracting” the annual productive task to the president of state-owned enterprise may delegate more autonomy to the enterprise thus to stimulate the working enthusiasm.⁸⁷ Eventually, “contracting mode” was broadly applied. It referred to certain a mode where the government would not interfere with specific productive activities and the enterprise only need to fulfill the appointed productive task. If the yearly revenue excelled the appointed workload, the difference could be retained as the net incomes of the enterprise.⁸⁸

Back to the MS of China in 1980s, we may wonder how China’s MS was developed after the period between 1978 and 1985. Here we start the discussions of this section with a quotation (translated) of the text of the “Report of Policies on the Reform of Medical Affairs”, which was launched in 1985 and esteemed as the initiator of China’s MS reform, to answer the question.

⁸⁷ WU (2010). Op.,cit.

⁸⁸ Ibid.

“Since the foundation of PRC, we have witnessed certain a success of the development of national MS. Up to the end of 1983, more than 196 thousand medical entities have been established; 2.11 million hospital beds have been set up; we even have 4.09 million medical professions...A health-promoting network covering both urban and rural areas has been preliminarily set up so that social morbidities have been dramatically decreased...However, we must realize and admit that the development of national medical affairs still cannot match up with the social demand of the provision of medical services. Until the end of 1983, the “hospital beds per thousand people” were only 2.07; “medical professionals per thousand people” were just 1.03. The social demand of medical services cannot be adequately accommodated... a typical example is that many of those who need to be hospitalized could not get hospitalized...”⁸⁹

It was further stated by this “Report” that we believe that *“two major factors have given rise to this disturbing situation: first, it is the underinvestment in medical affairs that impede the development of national MS. Along with this underinvestment, during 1960s the charging standard of urban hospitals had been thrice lowered, which caused a widespread economic loss in urban hospitals; second, it is the rigid policies that constrain the exercise of subjective initiatives of medical professionals and suppress the innovation of various medical entities.”*⁹⁰

With the above quotation, we now get a glimpse over the situation faced by China’s MS around 1985. Two features should be highlighted: the repressed supply and constantly increasing demand. This situation decisively influenced the path of the coming reform.

The report explicitly pointed out that *“...the future reform shall not only lay its*

⁸⁹ “Report of Policies on the Reform of Medical Affairs”, issued at 1985-4-25

Available at: <<http://www.people.com.cn/item/flfgk/gwyfg/1985/112708198501.html>> (2013-8-21)

⁹⁰ Ibid.

foundation on the increase of government's investment but also continuously probe about more manners to stimulate medical practitioners' enthusiasm so as to meet the social demand of medical services."⁹¹ It was believed by the government that the rigid regulations are the sources of the sluggish supply of medical services. With this guiding ideology, eight specific measures were asked to take, five among these were related to the urban MS. As listed below, they were:

1. Diversifying the ownership of hospitals;
2. Deregulating—Delegating autonomy to hospitals;
3. Encouraging medical practices by individual;
4. Encouraging medical employees to take usage of their spare times to increase personal revenues;
5. Encouraging business expansion of hospitals so as to progressively increase the charging standard.

Because of the issuance of this report, the year of 1985 was titled as the first year of China's MS reform. With this report, the previous national MS was reshaped—more proprietary relations became accessible. Moreover, because the government was no long the only supplier of medical services, a medical care market thusly was founded. The "Report" and the reform that was initiated by the report echoed with the statement made by the president of the Ministry of Health at the time—economic laws should be applied in medical affairs.⁹²

With the tendency that was launched by the "Report", in the year of 1988, the state council required that any state-owned enterprises that have affiliated hospitals should change the administrative mode from direct to indirect⁹³; likewise, in the November of the coming year, the state council of China issued the "On the Enlarging the Supply of Medical Services", this directive asserted that in order to keep up with the OR, the charging mode of medical services should be altered; the "contracting mode" should

⁹¹ Ibid.

⁹² SONG, Lin(2012). "Retrospection and Reflection of China's Health Reform". *China's Market*. No.31, 2012:143-144

⁹³ "Chronicle of Events of the reform of China's Medical System: 1985-1992". Available at: <http://www.ce.cn/xwzx/gnsz/gdxw/200909/03/t20090903_19934082.shtml> (2013-8-22)

be promoted; medical institutions would be granted a three-year tax exemption; it is allowed to develop repayable medical services.⁹⁴

In the year of 1992, another policy——“Guidance on the reform of MS” was enacted. The “Guidance” was deemed as the other founding pillar of China’s reform of MS after 1978. ⁹⁵

The “Guidance” came down in one continuous line with the “Report”. It was regulated by the “Guidance” that the compensating mechanism between government and hospitals should be altered into certain a mode where stipendiary services are not prohibited. What is more, the personnel affair management and salary system were also required to be adjusted so as to cater to the principle of “enthusiasm mobilizing”⁹⁶; on the other hand, financing channels for hospital constructing were, at the same time, broadened, where bank loan, private investment and etc got off the ban list⁹⁷; as to hospitals themselves, it was advocated by the “Guidance” that “nowadays hospitals could and should apply the mode of “avocation-assisting” which means that hospitals become able to gain more revenues by business incomes (avocation incomes); as to governments at various levels, they should support hospitals via policies not fiscal expenditures.⁹⁸

The “Guidance” specified about 10 avocations, including “Specialist Outpatient”, “Advanced Ward”, “Special-requiring Nursing” and etc.⁹⁹ Concretely, the “Guidance” suggested that except basic medical services that are meant for the guarantee of the public’s health, hospitals are allowed to develop their own special services to expand revenues.¹⁰⁰ Thusly, medical services produced in hospitals were categorized into two

⁹⁴ “On the Enlarging the Supply of Medical Services”. Issued in the 1989-1-15
Available at: <http://www.110.com/fagui/law_891.html> (2013-8-21)

⁹⁵ “Guidance on the reform of MS”. Issued in the 1992-9-23
Available at: <<http://www.people.com.cn/item/flfgk/gwyfyg/1992/236001199202.html>> (2013-8-22)

⁹⁶ Ibid.

⁹⁷ Ibid.

⁹⁸ Ibid.

⁹⁹ Ibid.

¹⁰⁰ Ibid.

kinds, namely basic medical services and special services. According to the “Guidance”, basic services should be charged about the cost price to guarantee the availability; but the special services could be charged by the “market price”.¹⁰¹ Likewise, the “Guidance”, together with the “Policy on the Price Markup of Drugs” which was issued in 1954,¹⁰² founded the “markup mechanism” of drug in hospitals in 1990s. This mechanism allowed hospitals making sort of “markup” to the cost price of drugs so as to make more revenues. Meanwhile, the “Guidance” nailed the allocation of responsibility between central and local government: investment in local medical affairs should be taken charge of by the local government.¹⁰³

Consequently, a reformed MS occurred in China. Compared to the previous one which was established in the planned-economy era, this system is more complicated. Hospitals are authorized to charge more than 15% of cost price for supplying medical services. The salary and personnel system became more flexible. All these measures were taken to stimulate the enthusiasm of hospitals and medical professions, which aimed at improving the supply of medical services. Just as proposed by the “Guidance”, *“...to patients, it is the time to share medical expenditures by government, employers and patients themselves; to hospitals, it is time to broaden the financing channels—constructing by government but operating by hospitals themselves”*.¹⁰⁴ With this guiding ideology, it is reasonable to say that the previous communism-oriented public medical service system in urban areas was disintegrated.

However, what needs to be clarified is that the “GongFei”(public medical security for those who worked for the governmental entities) and “Laobao”(medical fee at state expenses for those who worked for the state-owned enterprises) mechanism were not abolished. Instead, they were still the major elements in the “sharing mode”

¹⁰¹ Ibid.

¹⁰² The “Policy on the Price Markup of Drugs” was actually initiated in 1954, before the completion of communist transition. However, due to the communist-oriented MS before 1982 (because 1982 with the “Notification on the Solution of the Economic Loss of Urban Hospitals”, state-owned hospitals were delegated more autonomy in pricing the medical productions), this policy had not exerted much impact over the society as it did after 1985.

¹⁰³ “Guidance on the reform of MS”(2012). Op.,cit

¹⁰⁴ Ibid.

mentioned above¹⁰⁵. Without other medical insurance system covering the majority of population, this “sharing mode” was only accessible to a limited part of the population, namely those worked for the government and state-owned enterprises.

During the same period, we could also witness a withering tendency of governmental investment in national medical affairs. As shown in the table below, the absolute value of government expenditures had constantly increased. However, the portion that it accounted for had contrarily decreased throughout those years. Correspondingly, the proportion made up by individual medical expenses increased to about 60% from 1985 to 2000.

*Table 4.1 The Composition of National Medical Expenditures*¹⁰⁶

Year	National Medical Expenditures (billion yuan)	Proportion made up by Government Investment (%)	Proportion made up by Socio-economic entity (%)	Proportion made up by Individual Expenses (%)
1978	11.02	32.16	47.41	20.41
1980	14.323	36.24	42.57	21.18
1985	27.90	38.58	32.95	28.46
1990	74.73	25.06	39.22	35.73
1995	215.513	17.97	35.63	46.40
2000	458.663	15.47	25.55	58.99

Compared to other middle-income countries, the proportion of national medical expenditures made up by governmental investment in China had been lower than all OECD members by the end of 1990s (seen as table below).

*Table 4.2 The Comparison between China and OECD member on the composition of national medical expenditure*¹⁰⁷

¹⁰⁵ YAO Li (2010).op.,cit

¹⁰⁶ SHI Guang and GONG Sen(2005). “An Analysis on the National Medical Expenditures of China after the Opening-up Reform”. *Review of China's Development*. No.A01 (additional) for 2005:29-46.

¹⁰⁷ The Table 4.2 is compiled by F.HAN, the Arthur of this thesis.

Relevant Data was selected from the “2011’s Statistical Yearbook of China’s Health Affairs”. available at: < <http://www.moh.gov.cn/htmlfiles/zwgkzt/ptjnj/year2011/index2011.html> > (2013-8-20)

Country	Medical Expenditure to GDP (%)	Proportion made up by Government Investment to national Medical Expenditure (%)	Proportion made up by Individual Expenses to national Medical Expenditure (%)
China	4.6	38.3	61.7
Australia	8	66.2	33.8
Austria	9.9	76.8	23.2
Belgium	9	67.5	23
Canada	8.8	70.4	29.6
Czech Republic	6.5	90.3	9.7
Denmark	8.3	82.4	17.6
Finland	7.2	71.1	28.9
France	10.1	79.4	20.6
Germany	10.3	79.8	20.2
Greece	7.9	60	40
Hungary	7	70.7	29.3
Iceland	9.8	78.9	18.4
Ireland	6.1	75.3	24.7
Italy	8.1	72.5	27.5
Japan	7.7	81.3	18.7
South Korea	4.8	45.5	54.5
Luxembourg	7.5	69.8	14.5
Mexico	5.1	46.6	53.4
Netherland	8	63.1	32
New Zealand	7.7	78	22
Norway	8.4	76.2	17
Poland	5.5	70	30
Portugal	8.8	72.5	27.5
Slovakia	6.6	85	15
Spain	7.2	71.6	28.4
Sweden	8.2	94.9	15.1
Switzerland	10.2	55.4	44.6
Turkey	4.9	62.9	37.1
The United Kingdom	7	79.3	20.7
The United State	13.4	43.0	56.8
Chile	6.6	52.1	47.9
Estonia	5.3	77.5	23.5
Slovenia	8.3	74	26
Isreal	7.7	63.8	26.2

On the other hand, it is worth of noticing that between the period of 1990~1998,

expenses on medical services (including governmental, social and individual expenses on in and out-patient service) accounted for from 39.89% to 50.70% of national medical expenditures (in-patient service, from 25.91% to 33.60%; and out-patient service, from 13.98% to 17.10%); expenses on drugs (prescribed by out-patient service) made up for from 35.60% to 31.70% of national medical expenditures¹⁰⁸; between 1985 and 1994, revenues made by drug sales of hospitals rose 5.6 times (in the year of 1994, 55.3% of hospitals' annual revenues were from drug sales) . Meanwhile, expenses on disease prevention accounted for no more than 10% through the 1990s.¹⁰⁹ This is to say that during that period of time, expenses on medical services and drugs accounted for the majority of national medical expenditures.

Based on the available data from OECD, till the end of 1990, the average proportion of the expenses on drugs (prescribed by out-patient service) to total national medical expenditures of in all OECD members was 16.4%; among those members, the state had highest proportion made up by the expenses on drugs was South Korea, the index was 30.0%; the lowest was Switzerland, 7.4%.¹¹⁰ It can be concluded that compared to other states (OECD members here), with decreasing governmental support, Chinese citizens, on the whole, bore a heavier economic burden for expenses on drugs and medical services.

In other word, the period between 1985 and 1997 assumed a fade-out tendency of government financial support and a fade-in tendency of individual expense on medical affairs. We may further wonder what influences these changes have on the public.

Here we found some data to answer the question. The Table 4.3 below shows that from 1984 to 1997, the proportion of medical expenditures to GDP grew from 3.4% to 4.3%, which stood for that the national medical expenditures increased faster than the

¹⁰⁸ SHI Guang and GONG Sen(2005). Op.,cit

¹⁰⁹ Ibid.

¹¹⁰ Ibid.

GDP of China (this difference also indicate that the expanding rate of medical industry was higher than the average growth rate of national economy). From 1984 to 1997, the average growth rate of medical expenditures was 19.11%, which was higher than that of GDP——17.78%.¹¹¹ Combining this table with Table 4.1, we may find that the average growth rate of individual medical expense was 28.58% which was obviously higher than that of GDP——14.1%. During the same period, the average growth rate of individual medical expense per capita was 24.50% higher than that of GDP per capita¹¹². It is reasonable to say that all these evidences support that the public directly began to bear an increasing economic burden in purchasing medical productions.

Table 4.3 Changes in China's medical expenditure between 1984 and 1997¹¹³

Year	National Medical Expenditure (billion yuan)	GDP (billion yuan)	The proportion made up by National Medical Expenditure to GDP (%)	Medical Expenditure per capita (yuan)
1984	24.21	717.1	3.38	23.2
1987	37.964	1196.25	3.17	34.73
1990	74.74	1854.79	4.03	65.37
1993	137.78	3463.44	3.98	116.35
1997	319.67	7446.26	4.29	258.58

What was worse, this increasing economic burden of the public turned to be grievance. Between 1984 and 1997, the personal disposable income of urban/rural residents increased by 544%/393%. However, during the same period, the total amount of in and out-patient medical services fees grew by 998% and 965%.¹¹⁴ For granted many of Chinese then could not afford the medical services and drugs they needed. The table below shows that there existed a notable portion of China' population that couldn't afford medical services they needed.

¹¹¹ Ibid.

¹¹² The average increase rate of GDP per capita during the same period can be reckoned based on the index in the Table 4.3. Between 1984 and 1997, China's GDP per capita growth rate (average) was 16.77%.

¹¹³ SHI Guang and GONG Sen(2005). Op.,cit

¹¹⁴ Ibid.

Table 4.4 A Comparison between the price of Hospital Medical Service and Disposable Income per capita between 1990 and 1997¹¹⁵

Year	Price of Out-patient Treatment	Price of In-patient Treatment (PI)	Disposable Income per capita in Urban Area (DIU)		Disposable Income per capita in Rural Area (DIR)	
			Amount (yuan)	PI/DIU (%)	Amount	PI/DIR
1990	10.9	473.3	1510.2	31.3	686.3	69.0
1995	39.9	1667.8	4283.0	38.9	1577.7	105.7
1996	52.5	2189.6	4838.9	45.2	1926.1	113.7
1997	61.6	2384.3	5160.3	46.2	2090.1	114.1

As shown in the Table 4.4, we may find that as the time went by, expenses for medical services had occupied an increasing portion of individual's yearly disposable income. Especially in the rural area, those who have serious illness and need in-patient services may pay more than what they could dispose in a year. No doubt that purchase of medical services became an actual burden for Chinese families.

Table 4.5 The proportion made up by those who cannot afford medical treatment in 1993 and 1998¹¹⁶

The proportion made up by those who cannot afford out-patient treatment(%)							
Year	Large City	Middle City	Small City	A Villages (where annual income per capita over 3000 yuan)	B Villages (where annual income per capita between 2000-2999 yuan)	C Villages (where annual income per capita between 1500-1999yuan)	D Villages (where annual income per capita less than 1500 yuan)
1993	3.21	2.40	9.58	15.10	21.36	19.55	24.42

¹¹⁵ GU Xin(2012). *The New Round Reform of China's Medical System and Public Welfare*. YUNNan Education Press: KUNMing. p.3

¹¹⁶ Ibid. pp.4-5.

1998	36.69	2348	42.96	30.09	31.67	42.29	38.72
The proportion made up by those who cannot afford in-patient treatment(%)							
Year	Large City	Middle City	Small City	A Villages (where annual income per capita over 3000 yuan)	B Villages (where annual income per capita between 2000-2999 yuan)	C Villages (where annual income per capita between 1500-1999yuan)	D Villages (where annual income per capita less than 1500 yuan)
1993	34.09	33.87	53.47	47.95	63.15	61.14	67.72
1998	53.12	58.43	70.77	63.80	54.12	70.26	69.38

It is observed that the index in the Table 4.5 generally grows against the local GDP per capita. Put it another way, poorer the area is; more people could not afford medical services, especially in-patient services. What is also worth of noticing is that against the steady growth of national GDP in the same period, the index increased. This phenomenon agreed with the conclusion we reached before.

According to certain research from the Ministry of Health in 1998, the two-week morbidity¹¹⁷ in urban and rural area was 49.9% and 33.2%; those who chose not to go to hospital for medical treatment took self-treatment as alternative; however, among these people, there was still 12.5% for urban and 34% for rural didn't take any measures as medical treatment; 42% of the discharged patients in both urban and rural areas were the ones who initiatively asked to be discharged.¹¹⁸

However, the reform did spur a bourgeoning development of China's medical industry, hospital beds increased from 832 thousand in 1982 to 1.96 million in 2000¹¹⁹; the national medical expenditures increased from ¥ 24 billion in 1985 to ¥ 320 billion in 1997; and the medical expenditure per capita was increased by 9 times (see at p50.).

¹¹⁷ "Two-week Morbidity" is such an indicator which is often applied in medical investigations. This indicator manifests the potential demand of medical services in the investigated area. The "Two-week Morbidity" is calculated by the formula: "Two-week Morbidity"= the number of morbidity cases in two weeks/the number of the investigated population. Higher the "Two-week Morbidity" is, more medical services are needed.

¹¹⁸ SHI Guang and GONG Sen(2005). Op.,cit

¹¹⁹ DING Ningning (2005). Op.,cit.

However, we may also detect that during the same period of time, the improvement of physical conditions of the public of China lagged that of many other developing states, let alone the developed ones. The average life expectancy and infant mortality rate are the two major indicators to measure the development of public physical conditions. Between 1982 and 1998, the average life expectancy in low-income states increased 3 years; in middle-income states increased 5 years; in high-income states increased 4 years. However, China's average life expectancy during the same period only increased 3.5 years. Between 1980 and 1998, the infant mortality rate of China only declined 6.3‰ which was much less than 23‰ in middle-income states, 29‰ in low-income states and 9‰ in high-income states.¹²⁰ Based on the above statistics, we may know that the developmental rate of China's public physical conditions between 1980 and 1998 fell behind many other states.

Dissection of China's MS between 1985 ~ 1997

It has been repeatedly stated in the two sectors above that the policies for medical affairs carried out around the year of 1985 were designed to solve the problem of lacking of working enthusiasm among medical professionals and the perennial economic losses of hospitals, which led to the undersupply of medical services.

Actually, the "Report of Policies on the Reform of Medical Affairs" that was issued in 1985 aimed at delegating more autonomy to hospitals to stimulate working enthusiasm of medical professionals in urban hospitals while increasing investment to keep the previous urban MS functionary. However, due to the historically specific fiscal system in 1980s, the reform launched in 1985 turned to be a reform relying more on, as quoted, "economic laws".

¹²⁰ Development Research Center of the State Council(2005). Op.,cit.

And that the “Guidance” issued in 1992 inherited the guiding ideology of the “Report”, further developed the pattern of autonomy delegating and established the price markup mechanism of medical services and drug, which solidified the developmental pattern that was initiated in 1985.

All these taken measures were carried out to energize the whole medical industry. Although the “LaoBao” and “GongFeiYiLiao” mechanism were not abolished, the socio-economic background behind was changed and these two mechanisms could not representatively cover the majority of urban population. The diversification of economic forms then hugely changed society and national economy, a noticeable proportion of urban population were not covered by any traditional type of medical insurance system. Thusly the availability of medical services could not be guaranteed. To sum up, the reform of urban MS between 1985 and 1997 was based on a value judgment of “delegating autonomy” and “marketization”, which favored the improvement of efficiency in medical industry but, with the withering influence of the previous urban medical insurance system, overlooked the maintenance of fairness (embodied as the decline of availability of medical services, see at the Table 4.4). Especially on the issues of “efficient utilization of medical resource” and “diversification of medical services”, the reform then made a recognizable achievement.

Without unified urban medical system, the “fairness in financing the medical expenditure” vanished, those who still enjoyed medical insurance obviously bore lighter economic burdens; with the dramatically increasing price of medical productions (see at p14. and p49., the thesis has both theoretically and evidently proved this statement), the availability of medical services remarkably declined; with no risk-bearing mechanism, neither the vertical nor the horizontal fairness in the “practice of the provision of medical services”.

With the application of XIA’s model, here we may have the chart below:

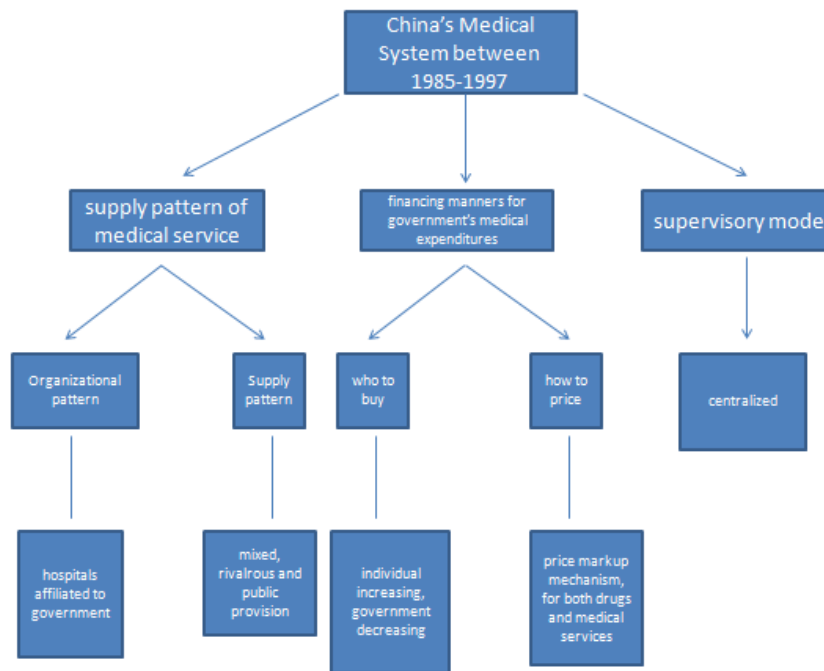


Chart 4.2 The Structure of MS in China between 1985 and 1997

With the emergence of individual authorized medical practitioners, the organizational pattern of China's MS was no longer unified. It became mixed by both the state-owned medical institutions and individual medical practitioners. However, state-owned medical institutions were still taking an absolutely leading position because of their scale and influence. What was also change was the "supplying pattern", it is founded that various factors contributed to this change. Shrink of the coverage of either kind of urban medical insurance system, invention of the "special-requirement" treatment and the withering fiscal support from the government all played a hand in. Pricing mechanism became more influential in the market. Thusly the previous "public provision" pattern was disintegrated, a sort of "rivalrous" supply pattern occurred.

Correspondingly, individuals, compared to the government, began to bear an increasing economic expense on medical productions. Government was no longer the sole purchaser of medical productions. And the pricing mechanism also began to play an increasingly strong hand in the medical affairs. As shown by statistics, price

markup mechanism gradually led to a decline of availability of medical productions.

The “supervisory mode”, compared to the previous system, still can be seen as a kind of centralized mode.

1.4 China’s MS between 1998~2002

Gradually, negative phenomena came into notice. In the 1997, the first national conference of medical affairs after the OR was held in Beijing. The special meaning of this conference was that it for the first time pointed out the necessity of the establishment of a medical insurance system which could cover all of national population. Likewise, the conference admitted that “...*although the previous reform had achieved much, especially in increasing the productivity of the medical industry, it also neglected the maintenance of the commonweal...The future reform should transfer the working centrality to promoting the public welfare...the focus should be laid on the establishment of a medical insurance system and the further transition of state-owned hospitals.*”¹²¹

Since then, China’s MS reform turned to its first turning point. In 1997, the state council of China also issued “Decisions on the reform and development of medical affairs”. The “Decisions” explicitly pointed out that the development of national medical affairs must agree with the promotion of public welfare. It also required to establish a medical insurance system to cover urban areas and to change the operating mechanism of state-owned hospitals.¹²²

Unlike the previous reform, the “Decisions” blended “the promotion of public welfare”

¹²¹ JIANG Zemin and LI Peng(1997). “Speech on the first National Conference of Medical Affairs”. Two speeches were respectively published in *China’s Rural Medicine*. No.1 for 1997:4-7; and *Management of China’s Rural Medical Affairs*.No.1 for 1997:7-11.

¹²² “Decisions on the reform and development of medical affairs”. Issued in 1997-1-15
Available at: <<http://www.people.com.cn/item/flfgk/gwyfg/1997/112708199730.html>> (2013-8-21)

into the MS reform. Based on the introduction made before, we may find that the “Report” of 1985 and the “Guidance” of 1992 belonged to the same kind of tune. However, the 1997’s “Decisions”, as a self-examination, indicated that *“alongside the achievement we have made during the MS reform...we must confess that the current developmental stage of national MS still cannot meet the demand of social and economic progress... geographical inequality, lacking of disease preventions in rural areas, lacking of medical insurance, lacking of government’s financial support, dramatic increase of prices of medical services and drugs...all these phenomena challenge the social development, which requires further and deeper reform as remedial measures...”*¹²³

The “Decisions” pointed out that to guarantee the quality of medical services and the ‘value for money’ for patients is as much important as to stimulate the enthusiasm of medical professionals; “President Responsibility Mechanism” should be thoroughly carried out, more autonomy should be delegated to hospitals; on the other hand, we should pay equal attention to both increasing governmental financial support and broadening financial channels for hospitals.¹²⁴

The “Decisions” also emphasized that it is significant to establish a medical insurance system to cover urban areas. This system could base itself on the combination of “social pooling” and “individual account”; and on a scientific-designed sharing allocation among local governments, employers and labors themselves. The “Decisions” clearly indicated that on the one hand, we will spare no effort to increase the national medical expenditures to 5% of national GDP by the end of this century; on the other hand, we need to increase the availability of ‘basic medical services’ throughout the country by the establishment of a steady- and well-functioning medical insurance system.¹²⁵

¹²³ Ibid.

¹²⁴ Ibid.

¹²⁵ Ibid.

Afterwards, in 1998, the state council issued the “Decisions on the Establishment of the Urban Medical Insurance for Basic Medical Services”. Unlike the public medical insurance system before 1979, the expected medical insurance system blueprinted in 1998’s “Decisions” would not be only applicable for the employed because of the ongoing socio-economic shifts.¹²⁶ It was the first time in PRC’s history that an official directive explicitly required to establish an indiscriminate medical insurance system to cover all the labors in urban areas.¹²⁷

However, without detailed executive schedule, this system had not been successively set up between 1998 and 2003. A survey showed that 70.3% of high-income urban residents, in 2000, were covered by some medical insurance (provided by government, employers or commercial insurance institution), in comparison, the index was 63.7% in 1998; 43.0% of low-income residents were covered, in comparison, the index was 49.8% in 1998.¹²⁸ It is surprising that as time went along, the group in the low-income resident who were covered by some medical insurance shrank. By the end of 2013, only 0.107 billion urban labors were covered by any medical insurance systems; nevertheless, the number of urban employees was estimated between 0.167 to 0.289 billion.¹²⁹ It is observed that only about 50% of urban labors enjoyed the medical insurance managed by the government.

Meanwhile, the proportion made up by individual’s medical expenses to the government’s medical expenditures culminated at 63.2% in 2000¹³⁰; according to the “*World Health Report 2000*” from WHO, in 2000, China’s “fairness in medical affairs” ranked fourth from the bottom, beating only Sierra Leone, Brazil and Burma.¹³¹ So to speak, although government decided to build up a wide-covering public medical

¹²⁶ “Decisions on the Establishment of the Urban Medical Insurance for Basic Medical Services”. Issued in 1998-12-14

Available at: <http://www.sdpc.gov.cn/jyysr/zcfg/t20050714_35644.htm> (2013-8-21)

¹²⁷ Ibid.

¹²⁸ GONG Sen (2005). Op.,cit.

¹²⁹ Ibid.

¹³⁰ 2011’s Statistical Yearbook of China’s Health Affairs. Op.,cit.

¹³¹ World Health Organization(2000). “World Health Report 2000”. <http://www.who.int/whr/2000/en/whr00_en.pdf> (2013-8-21)

insurance system, positive outcomes of the system had not been yielded before 2003. With the Table 4.6, we may find solid support for this statement. After 1997, it is demonstrated that medical expenses tended to occupy almost 50% of urban individual disposable income and 150% of rural individual disposable income.

Table 4.6 A Comparison between Disposable Income per capita and Price of Hospital Medical Treatment in 1998-2003¹³²

Year	Price of Out-patient Treatment	Price of In-patient Treatment (PI)	Disposable Income per capita in Urban Area (DIU)		Disposable Income per capita in Rural Area (DIR)	
			Amount (yuan)	PI/DIU (%)	Amount (yuan)	PI/DIR (%)
1998	68.8	2596.8	5425.1	47.9	2162.0	120.1
1999	79.0	2891.1	5854.0	49.4	2210.3	130.8
2000	85.8	3083.7	6280.0	49.1	2253.4	136.8
2001	93.6	3245.5	6859.6	47.3	2366.4	137.1
2002	99.6	3597.7	7703.0	46.7	2475.6	145.3
2003	108.2	3910.7	8472.0	46.2	2622.2	149.1

Alongside, private-owned medical institutions turned to their germinating and rapid evolutionary period. With the “Regulation on the Administration of Medical Institutions” that was initiated in 1994, private-owned medical institutions became legal in China. The “Regulation” contains statutes on the application, accreditation and supervision of private-owned medical institutions.¹³³ Moreover, with China’s accession to WTO, foreign capitals became legal to invest in China’s medical affairs (relevant directive was “Interim Measures on Administration of hospitals funded by Sino-Foreign Joint Venture” which was issued in July, 2000)¹³⁴. By 2003, more than 40% of hospitals in China were private-owned; about 10% national medical

¹³² GU(2012). Op.,cit.

¹³³ “Regulation on the Administration of Medical Institutions”. Issued in 1994-2-26

Available at:<<http://www.people.com.cn/item/flfgk/gwy/jkww/w940226.html>> (2013-8-21)

¹³⁴ “Interim Measures on Administration of hospitals funded by Sino-Foreign Joint Venture”. Issued in 2000-5-15
Available at:< <http://www.people.com.cn/item/flfgk/gwyfg/2000/11401000222N.html>> (2013-8-21)

professional worked in private-owned hospitals.¹³⁵

However, in 2003, only 2.7% of patients had medical treatment in private-owned hospitals; medical transaction fees generated in private-owned hospitals only accounted for 3% of national medical expenditure of the year; cases of hospitalization in private-owned hospitals was only 2.5% of total cases of hospitalization of China.¹³⁶

In addition, since 2000, various local governments made trials of transferring the proprietary relation of state-owned hospitals. City of SUQian was the pioneer, in 2000 the People's hospital of SUQian sold 63% of stock equities to a medicine company——JINLin.¹³⁷ Therefrom, successive similar cases happened in various cities. Three manners of transferring, including “trusteeship”, “shareholding mechanism” and “overall transfer of stock equity”, were applied. As thus, medical institutions in China got diversified.

It is observed that the period between 1998 and 2003 was a period of time where the organizational mode of hospitals became diverse, which reflected certain an acceptance or pursuit of the market mechanism in China's medical affairs. Although different cases may have difference causes, what we may witness is the emergence of non-state-owned hospitals in China's medical market.

Dissention of China's MS between 1998~2002

Through the decisions made on the “national conference of medical affairs”, it is discernible that the government of China realized the necessity for the development of MS. The “Decisions on the reform and development of medical affairs” reflected the

¹³⁵ “2004's Statistical Yearbook of China's Health Affairs”. Available at:
<<http://www.moh.gov.cn/mohwsbwstjxxzx/s7967/201307/0e45985cc44f4a318956632cd92e825c.shtml>>
(2013-8-21)

¹³⁶ Ibid.

¹³⁷ ZHAN Guobin(2008). “Comparative Study of the Privatization of State-owned Hospitals”. *Journal of Public Management*. 6(4):61-68.

ideological shift of policy-makers, ensuring the availability of medical services and re-launching the MS reform in rural areas featured the “Decision”.

It is reasonable to say that as to the value judgment of the policies for medical affairs, the “fairness” had been re-blended in. However, the “fairness” could not epitomize the guiding ideology of the reform then. The thesis believes that China’s government favored to proceed the market-oriented reform between 1997 and 2003, which led to a bunch of cases of property right switch of state-owned hospitals. With an economic perspective, encouraging the diversification in proprietary relations of hospitals would generate a lasting competitiveness in the market. Conclusively it is observed that China’s government, unlike the guiding principle of the reform between 1985 and 1997, advocated the maintenance of social fairness in medical affairs.

For the urban MS between 1998 and 2003, we may have:

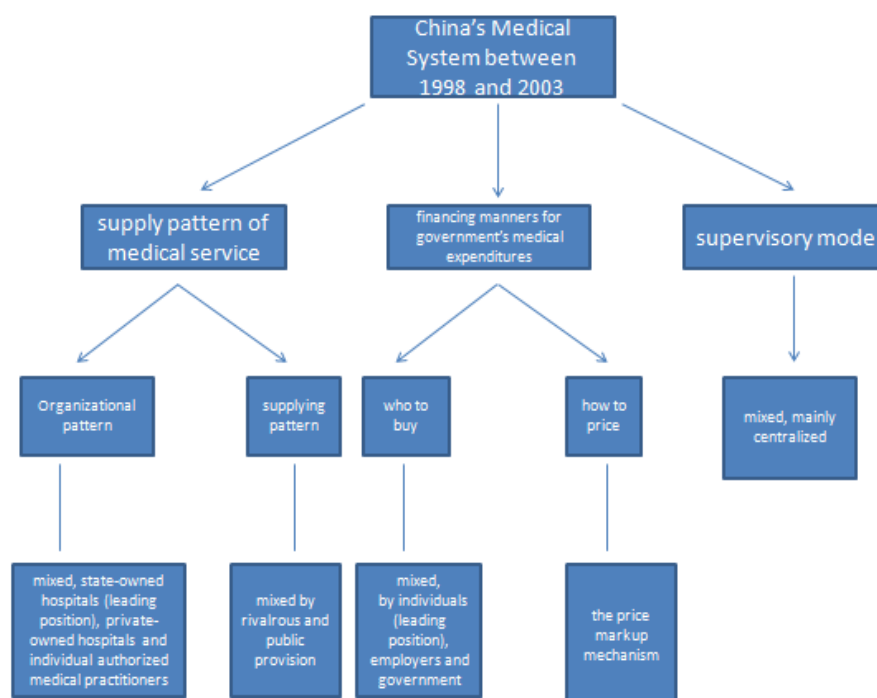


Chart 4.3 The Structure of MS in China between 1998 and 2003

With the “Regulation on the Administration of Medical Institutions” which was issued in 1994, private-owned hospitals (including hospitals funded by joint ventures)

emerged. Thusly the organizational pattern consisted of more constituents——state-owned hospitals (leading position, see at p58.), private-owned hospitals and individual medical practitioners were all involved.

As shown by relevant statistics (see at p.56-57), the public, as before, still bore an increasing economic burden in purchasing medical productions. However, due to the “Decisions on the Establishment of the Urban Medical Insurance for Basic Medical Services” issued in 1998, medical insurance system managed by either government or employers also play a hand in. Accordingly, the pricing mechanism remained the same.

With more and more private-operated medical institutions, competition might have a fade-in influence in the medical field. Consequently a sort of supervisory force¹³⁸ rooted in the competition may be formed. The “supervisory mode” may be no longer a solely centralized one but a mixed one.

1.5 China’s MS from 2003-?

Actually, although the thesis believes the reform of China’s MS from 2003 till now differs from that between 1998 and 2003, it is also reasonable to say that the reforms in these two different periods share a commonplace, that is, an emphasis on the maintenance of public welfare, which could be seen in various official policies (as mentioned above and will be mentioned in the coming paragraphs). The reason why this thesis defines them different from each other is that compare to the reform between 1998 and 2003, the following reform was manifested itself as a government-leading reform. The coming paragraphs will try to demonstrate the trajectory of this phase of reform.

¹³⁸ This “supervisor force” stands for that consumers would be able to “punish” the supplier if it provides unreasonable or unsatisfactory productions by choosing other suppliers, creating social pressures and etc. This sort of “supervisory force” is highly related to the degree of development of market.

In order to gain a better understanding of this reform, we will again make a brief introduction of the socio-economic background of the past decade. With the access of WTO, China's economy turned to a constant burgeoning period during the past decade. In these ten years, the national GDP average growth rate were 10.7%, which topped the list of states world-wide.¹³⁹ During the same period, due to the effectuation of the "tax-sharing system", the fiscal income of China increased at an average growth rate of 20.91%, which represents that the government of China has become more capable in fiscal expenditures.¹⁴⁰ Meanwhile, since 2003, a tectonic shift took place. The new leading body of China's government issued "Decisions on the improvement of Socialist Market Economy" soon after it came into power. This "Decisions", for the first time, explicitly advocated the "harmonious development" of society, which meant that the economic growth was still a major pursuit of the government while the societal development shall not be ignored.¹⁴¹ It is reasonable to say that China's government was more prepared both ideologically and economically to start off a new round of reform of national MS.

Let us turn the sight back to the medical field. In fact, the MS reform of China in this period began with a directive—"On the Consolidation of Morality in Medical Affairs". This directive pointed out that with the huge contribution made by those "Angels in white", national medical industry has made considerable progress, especially in the battle with SARS; however, immoral activities, like taking "Red Package" bribery¹⁴² or unreasonable prescription¹⁴³, exercised by medical professionals have greatly eroded the morality in medical industry, which would lead

¹³⁹ China Statistical Yearbook 2011. Op.,cit.

¹⁴⁰ WU, JingLian and Guochuan MA(2013). Op.,cit.

¹⁴¹ "Decisions on the improvement of Socialist Market Economy". Issued in 2003-10-21
Available at: <http://www.gov.cn/test/2008-08/13/content_1071062.htm> (2013-8-21)

¹⁴² "Red Package" used to refer to a red package (or envelope) which contains cash gift. However, "Red Package" in China's medical field specifically refers to the cash bribery presented by patients (or their families) to doctors so as to implore better medical treatment from doctors.

¹⁴³ "Unreasonable Prescription" refers to such a phenomenon where doctors, in the therapy, tend to apply some medicines/equipments which call for unreasonable higher price than those medicines/equipment that are priced with low price, however, could create same curative effects.

to damages to social orders.¹⁴⁴ The directive explicitly pointed a finger at the immoral activities committed by medical professionals, especially the bribery in various forms. Further, the directive urged the works of medical professionals should be based on the interest of patients; briberies in any form shall be forbidden and the discipline shall be held firmly.¹⁴⁵ This directive, which kicked off the reform since 2004, laid more attention to the social construction of medical industry instead the economic development of medical industry.

In 2005, a report from the “Development Research Center of the State Council” announced that the previous reform of MS could not be defined as a success.¹⁴⁶ It was indicated by the report that because of lacking of governmental interventions, the previous reform failed to match up with social demand while it did push forward the development of medical industry.¹⁴⁷ This report provoked a hot debate on the government’s role in the MS reform. In the same year, the vice-president of the Ministry of Health publicly stated that marketization will not be the future path of China’s MS reform.¹⁴⁸

In the next year, the state council of China announced that a new round of MS reform is being launched, 4 expert panels would be established to collect proposals from the society at large and to formulate the schedule of the reform.¹⁴⁹ In the same year, the National Development and Reform Committee and the Ministry of Health initiated the “Guidance on the Establishment of ‘Community Health Centre’”, which aimed at establishing government-funded clinics to provide the public “basic medical services”.

¹⁴⁴ “On the Consolidation of Morality in Medical Affairs”. Issued in 2004-4-21
Available at: <<http://www.china.com.cn/chinese/PI-c/567946.htm>> (2013-8-21)

¹⁴⁵ Ibid.

¹⁴⁶ Development Research Center of the State Council(2005). Op.,cit.

¹⁴⁷ Ibid.

¹⁴⁸ Editorial Department of *China Community Physician*(2005). “The Ministry of Health: Future Reform of Medical System will not be Market-Oriented”. *China Community Physician*. No.14:2005:2

¹⁴⁹ GU Xin(2012). Op.,cit.

In 2007, the 17th National Congress Meeting of China laid much stress on the development of national medical affairs and defined the core tasks of the second-round MS reform——“Ensuring the availability of basic medical service for everyone”, “Insisting on promoting public welfare in medical affairs” and “Consolidating the role of the government in medical affairs”.¹⁵⁰ The meeting ascertained the direction of this reform, some scholar called this direction “Building the basic, Ensuring the Basic, Serving the public”.¹⁵¹

In the 23rd of July, 2007, the state council of China also issued the “Guidance on the Establishment of Urban Medical Insurance for Basic Medical Services”. This 2007’s “Guidance” required to build up 79 pilot cities in 2008 to try out the feasibility of this Medical Insurance System and if feasible, to cover the entire nation by 2010.¹⁵² It was regulated in this “Guidance” that compared to the policy issued in 1998, it is time to expand the coverage of urban medical insurance system especially to cover teenagers and those who are not employed; the principle of voluntariness is the basis and the collection of funds must cater to the need of families; all the collected funds will be pooled into the “Social Security Funds” to make overall arrangements; part of state-owned hospitals and qualified pharmacies will be defined as designated medical institutes, patient can only enjoy the medical insurance in those designated institutes.¹⁵³

In 2009, the state council further issued the “Measures on the Establishment of the Essential Drugs System”, “Regulations on the Establishment of the Items of Essential Drugs” and “The Items of Essential Drugs”. It was regulated that patient’s purchases of essential drugs in designated pharmacies will be fully covered by the insurance¹⁵⁴.

¹⁵⁰ HU Jintao(2007). “Speech on the 17th Congress Meeting of China”. Made in 2007-10-24
Available at:< http://news.xinhuanet.com/newscenter/2007-10/24/content_6938568_7.htm> (2013-8-21)

¹⁵¹ LIU,Junmin (2012). Op.,cit.p.186.

¹⁵² “Guidance on the Establishment of Urban Medical Insurance for Basic Medical Services”. Issued in 2007-7-23
Available at:< <http://law.51labour.com/lawshow-84196.html>> (2013-8-21)

¹⁵³ Ibid.

¹⁵⁴ “Regulations on the Establishment of the Items of Essential Drugs”. Issued in 2009-8-18
Available at: <<http://finance.sina.com.cn/g/20090818/17446633218.shtml>> (2013-8-21)

Thusly China's urban medical insurance system succeeded in including both medical services and drugs. The significance of these measures is that they manifested the tenet of this second-round reform is, unlike the previous reform, in a form of "Consumer-subsidizing".

In 2009 and 2010, the state council of China successively issued "Guidance on Deepening the Medical System Reform", "Implementation Plan of Focal Work in recent Medical System Reform (2009-2011)" and "Guidance on the Reform of State-owned Hospitals". The first two policies were pitched the same tone——5 key reforms. They are:

1. Deepening the development of urban medical insurance system and the rural cooperatives of medical system;
2. Establishing the "Essential Drugs" system to increase the availability of medicine;
3. Establishing a network of urban community health centers;
4. Reforming the operative mechanism, compensation mechanism (between government and hospitals) and supervisory mechanism (between government and hospitals) of state-owned hospitals and Encouraging diverse capitals to invest in hospitals;
5. Improving the "Public Health" system through the society.¹⁵⁵

These three directives from the central authority even required, between 2009 and 2011, governments at various levels to invest 850 billion yuan in medical affairs (including 350 billion from central government).¹⁵⁶ Furthermore, these directives explicitly made adjustments in the compensation mechanism and price mark-up of

¹⁵⁵ "Guidance on Deepening the Medical System Reform". Issued in 2009-3-17

Available at: <<http://www.sda.gov.cn/WS01/CL0611/41193.html>> (2013-8-21);

"Implementation Plan of Focal Work in recent Medical System Reform (2009-2011)". Issued in 2009-4-23

Available at: <<http://www.moh.gov.cn/zwgkzt/pzcqgh/201204/7d5a2d6f9f2548a4a43652a2e63a7e1e.shtml>> (2013-8-21);

"Guidance on the Reform of State-owned Hospitals". Issued in 2010-2-11

Available at: <http://www.china.com.cn/policy/txt/2010-02/24/content_19464497.htm> (2013-8-21)

¹⁵⁶ "Implementation Plan of Focal Work in recent Medical System Reform (2009-2011)"(2009). Op.,cit.

drugs mechanism. It was regulated that mark-up part of medical service fees must be less than 10% of the cost price; the price mark-up mechanism of drugs would be abolished; annual incomes from special-required medical services shall be no more than 10% of state-owned hospitals' total incomes; encouraging the separated management between medicines and clinics.¹⁵⁷ So far, the price mark-up of drugs had been eliminated and that of medical services had been evidently constraint. Actually, as stated in the “Guidance on Deepening the Medical System Reform”, these directives aimed at demolishing the price mark-up mechanism that could spur up the price of drugs and medical services; and creating competitions between state-owned hospitals and hospitals of other property right relations to stimulate the enthusiasm of medical professional so as to provide better medical services to the public.¹⁵⁸

Overall, since the first half of 2000s, with the improvement of the public medical insurance system and relevant policy adjustments, as shown in the table below, the government expenditures have accounted for an increasing proportion of national medical expenses. Likewise, medical expenses made by social organizations reached more than one third of national medical expenses (compared to record in 2000), which implies a decline of medical expenses borne by individuals themselves. In a way, the economic burden of the public in purchases of medical productions has been decreased. Through this lens, the establishment of urban public medical insurance system has yielded certain expected outcomes. According to the speech made by CHEN Zhu, the former president of the Ministry, by the year of 2012, 95% of urban resident are covered by some social or public medical insurance, which represents that, as quoted, the “universal coverage” of medical insurances has been basically realized.¹⁵⁹

¹⁵⁷ “Arrangements on the Deepening the Reform of Medical System for the year of 2012”. Issued by the General Office of the State Council on 18th, April 2012.

Available at: <http://www.china.com.cn/policy/txt/2012-04/18/content_25174201.htm> (2013-8-21)

¹⁵⁸ “Guidance on Deepening the Medical System Reform”(2009). Op.,cit.

¹⁵⁹ CHEN Zhu(2012). “Speech on the World Health Assembly”. Made in 2012-5-21
Available at: <http://news.xinhuanet.com/2012-05/22/c_112009925.htm> (2013-8-21)

Table 4.7 Government Expenses on Medical Affairs between 2003 and 2010¹⁶⁰

year	Governmental Medical Expenditure (abbreviate for GME) (billion yuan)					GME to national fiscal expenditur e	GME to national medical expenditur e	GM E to GDP
	Total	For Medical Service	For Medical Insurance	Administr -ation Fee	Family Planning and Birth Control			
2003	111.694	60.302	32.054	5.157	14.182	4.53	16.96	0.82
2004	129.358	67.972	37.160	6.090	18.136	4.54	17.04	0.81
2005	155.253	80.552	45.331	7.253	22.1.8	4.58	17.93	0.84
2006	177.886	83.4.82	60.253	8.459	25.692	4.40	18.07	0.82
2007	258.158	115.330	95.702	12.395	34.732	5.19	22.31	0.97
2008	359.394	139.723	157.710	19.432	42.529	5.74	24.73	1.14
2009	481.626	208.109	200.151	21.788	51.578	6.31	27.23	1.41
2010	568.864	NA				6.35	28.56	1.43

It is demonstrated that government expenses on medical affairs has steadily increased since 2003, especially after 2006. Expenses on medical services and medical insurance now accounted for more than 80% of government medical expenses. Compared to the Table 4.1, we may find that the proportion made up by government medical expenses to total national medical expenses is still lower than that of 1980s; and governmental medical expenses are still not prominent to the national GDP.

Compared to other OECD states, as we did before, the table below shows that the portion made up by governmental expenditures on medical affairs to national medical expenditures of China is still lower than many other states (including developing ones), which represents that the economic burden for medical expenses of the public in China is still relatively high.

¹⁶⁰ “2011’s Statistical Yearbook of China’s Health Affairs”(2012). Op.,cit.

Table 4.8 The Comparison between China and OECD member on the composition of national medical expenditure in 2008¹⁶¹

Country	Medical Expenditure to GDP (%)	Proportion made up by Government Investment to national Medical Expenditure(%)	Proportion made up by Individual Expenses to national Medical Expenditure(%)
China	4.3	47.3	52.7
Australia	8.5	65.4	29.1
Austria	10.5	73.7	20.9
Belgium	11.1	66.8	20.3
Canada	9.8	69.5	30.5
Czech Republic	7.1	80.1	17.5
Denmark	9.9	80.1	15.3
Finland	8.8	70.7	24.5
France	11.2	75.9	11.4
Germany	10.5	74.6	22
Greece	10.1	60.9	30.1
Hungary	7.2	68.9	28.5
Iceland	9.2	81.5	16.5
Ireland	8.7	76.9	23.1
Italy	8.7	76.3	23.7
Japan	8.3	80.5	18
South Korea	6.5	53.9	40.2
Luxembourg	6.8	74.8	15.9
Mexico	5.9	46.9	53.1
Netherland	9.9	75.3	16.5
New Zealand	9.7	80.2	19.5
Norway	8.5	78.6	15.6
Poland	7	67.4	26
Portugal	10.6	67.4	28.5
Slovakia	8	67.1	28.1
Spain	9	69.7	26.9
Sweden	9.4	78.1	16.8
Switzerland	10.7	59.7	40.9
Turkey	6.1	73.1	26.9
The United Kingdom	8.7	82.6	17.4
The United State	15.2	47.8	52.2

¹⁶¹ This Table is also made by F.HAN. Data Selected from the “2011’s Statistical Yearbook of China’s Health Affairs”.

Chile	7.5	44	56
Estonia	6.1	77.8	20.6
Slovenia	8.3	68.6	26.2
Isreal	7.6	58.4	41.6

Specifically, if we examine the composition of income of state-owned hospitals, we may find that about 89% of their yearly incomes consist of business income from sales of services and drugs (the sale of drug accounted for 44% and the charge of service accounted for 46%).¹⁶² Correspondingly, the thesis also finds out that in the recently issued official directives, although price markup mechanism of drugs has been asked to be cancelled, new adjustments over price markup mechanism of medical services are not explicit. Furthermore, compared to the 1990s, the “contracting mode” has disappeared in these directives while the “president responsibility” remains. To some extent, the thesis deems that recent reforms more focus on the adjustments at operative level not the institutional level, those reforms that refer to like the transition of the supervisory mechanism have not been unveiled.

Meanwhile, the development of private-owned hospitals turned to a downturn. In 2011, although the numbers of private-owned hospitals has increased at an average rate of more 23% (seen at the table 4.7), 91% of nation-wide assets of hospitals still belong to state-owned hospitals (seen at the table 4.8); 99% of large-scale pandocheum are state-owned (seen at the table 4.9); averagely 93% of cases of in- and out-patient treatment took place in state-owned medical institutions (seen at the table 4.10). All these statistics show that state-owned hospitals are still firmly holding the leading position in the medical market while private-owned hospitals have to flock into small-scale clinics. Especially on the issue of cases of in- and out- patient treatment, we may find that private-owned hospitals have not gained much progress since 2003. However, right after the expiration of the three-year tax exemption initiated in 2000, many private-owned hospitals were entrapped in difficult situations. A local report revealed that more than 60% of private-owned hospitals in the city of

¹⁶² “2011’s Statistical Yearbook of China’s Health Affairs”. Op.,cit.

NANJin had deficits since the year of 2005. Many investors were, therefore, scared away¹⁶³. Lin, the owner of a private-operated hospital “Shuguang”, complaint that *we (private-owned hospitals) are trying our best to keep the business running, but since the break-out of SARS, clients have tended to go to state-owned hospitals, because they seems more competent; without tax abatement, we can only enjoy increasingly less profit. He also complained that when you have problems in business, it would be more difficult attract investment let alone expanding the hospital.*¹⁶⁴

*Table 4.9 Number of Hospitals in China, from 2005 to 2010*¹⁶⁵

Category	2005	2006	2007	2008	2009	2010
Total	2445012	2560402	2675070	2882862	3120773	3387437
Among these						
State-owned	2300910	2368877	2444714	2609636	2792544	3013768
Private-owned	144102	191525	230356	273226	328229	373669

*Table 4.10 Brief Balance Sheets of Hospitals in China, 2010*¹⁶⁶

Category	Total Assets (ten thousand yuan)			Liabilities (ten thousand yuan)	Net assets (ten thousand yuan)
		Current Assets	Fixed Assets		
Total	176133693	60193354	113645963	56552830	119580863
Among these					
State-Owned Hospital	156313642	53434570	101655028	48918572	107395070
Private Hospital	6926580	2089128	4120807	2470078	4256502

*Table 4.11 Hospitals sectionalized by the amount of beds, 2010*¹⁶⁷

Category	Total	0~49	50~99	100~199	200~299	300~399	400~499	500~799	800or more
Amount of hospitals	20918	8644	3750	3496	1691	968	582	1069	718
Among these									

¹⁶³ The Guardian of the East(2006). “Private-Owned Hospitals are at downturn”. Available at: < <http://news.sohu.com/20060407/n242691381.shtml> > (2013-8-21)

¹⁶⁴ *ibid.*

¹⁶⁵ “2011’s Statistical Yearbook of China’s Health Affairs”. Op.,cit.

¹⁶⁶ *Ibid.*

¹⁶⁷ *Ibid.*

State-owned	13850	3896	2273	2911	1557	922	560	1024	707
Private-owned	7068	4748	1477	585	134	46	55	45	11

Table 4.12 The Amount of Cases of Medical Treatments, from 2005 to 2010¹⁶⁸

Year	2005	2006	2007	2008	2009	2010
Total	1386533401	1471012912	1637695812	1781669786	1921938815	2039633314
In State-owned hospitals	1320029575	1385765389	1526500365	1649114479	1768900941	1873811426
In Private-owned hospitals	66503826	85247523	111195447	132555307	153037874	165821888

Dissection of China's MS since 2003

It is clearly stated in the paragraphs above that the establishment of urban medical insurance system and the establishment of the “Essential Drugs” system and the reform of state-owned hospitals pillar the reform between 2003 and 2013. Furthermore, an explicit schedule of increasing government's medical investment distinguishes this reform from the previous one. In addition, according to the frequency of issuance of official directives, it is detected that government's concerns about medical affairs have increase.

And that the current urban medical system seems more extensive than that in the period between 1949 and 1979, because teenagers and the unemployed could be covered by the system. And the establishment of “social pooling account” represents that this system would to some extent break the barriers that were set up by the former “employer medical insurance”.

¹⁶⁸ Ibid.

As we quoted that this reform can be defined as a “consumer-subsidizing” reform. On one hand, subsidizing consumers aims at enhancing the availability of medical services, which would help maintain the social fairness; on the other hand, not subsidizing producers tends to alleviate the discriminative treatment that state-owned hospitals may get, which would help boost the efficiency in the market via competition reserving. So to speak, the thesis recognizes the value judgment of the urban MS reform between 2003 and 2013 is a better combination of fairness and efficiency.

The proportion of individual expenses on medical productions to national medical expenditures, with the increase in government’s support and the expanding coverage of urban medical insurance system, has been steadily decreased, which finally pushes forward the maintenance of “fairness in the availability of medical services”. With the serviceability of China’s urban MS, the vertical fairness may be guaranteed; however, the horizontal fairness may have not been fully realized, due to limited coverage of public medical insurance system.

In the light of the urban medical insurance system, we may have the chart below:

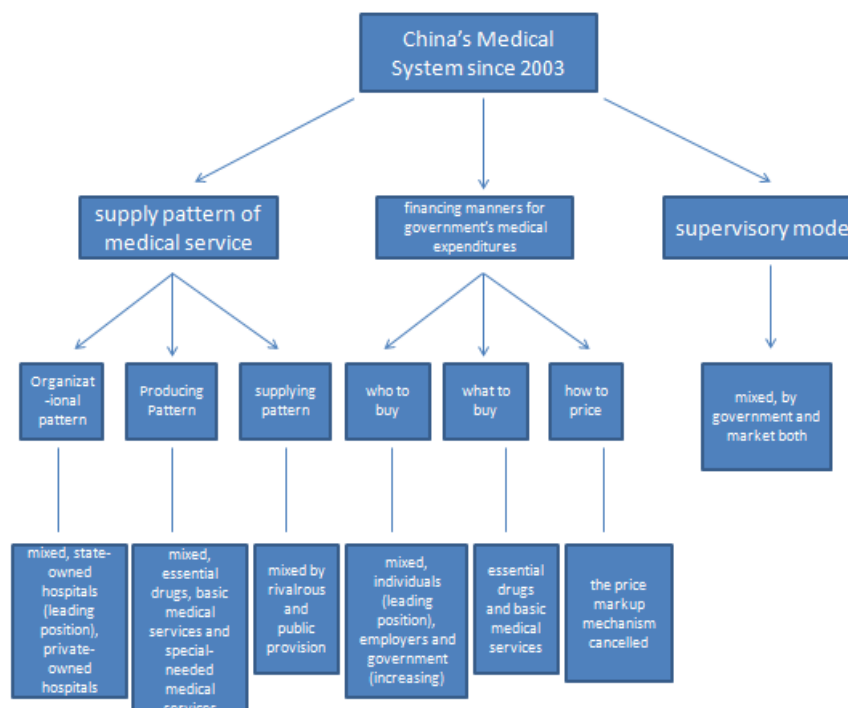


Chart 4.4 The Structure of MS in China since 2003

With policies intensively issued in recent years, China's urban MS has been reformed again. Although the organizational pattern has remained the same, the government has enriched the "public provision" in medical field by establishing a wide-covering medical insurance system. Accordingly, the government provides some free medical productions (basic medical services and essential drugs) to the majority of population again.

Although more than 35% of national medical expenses were assumed by individual medical expenditures, it is also detected that the government has made an escalating contribution in funding the public's purchase of medical productions (see at p66.). With the urban medical insurance system, basic medical services and essential drugs were covered. And fortunately the price markup mechanism that had contributed to a dramatic decline of availability of medical productions was cancelled. As a result, medical productions (services and drugs) were priced at the cost prices.

With an undeniable development of private-owned medical institutions, almost half of China's urban medical institutions belong to private investors. A stronger competition is fading in. Thusly the "supervisory force" that stems from market competition may be more influential. Correspondingly the current "supervisory mode" of China's urban MS can be treated as a mixed one where both centralized and decentralized "supervisory mechanism" could take effect.

Sub-conclusion

So far, the thesis has combed major relevant policies in China's reform of MS. First of all, what we have witnessed is that the developmental trajectory of China's MS is profoundly influenced by various social, political and economical factors. Back in the beginning of the foundation of China's MS, the system was designed with communist creed; as to the reform launched in 1980s, it was restraint by the limited fiscal support

from government; with a growing population that was covered by neither the “Laobao” nor “GongFeiYiLiao” system, the up-roar prices of medical productions led to a remarkable decline of availability of medical productions, which exerted a far-reaching impact on the evolutionary path of reform in the next decades; with a progressively opened market, increasing capital inflows in medical field induced the government to make specific policy on the administration of hospitals funded by joint ventures, which may promote the development of private-owned hospitals; with the tectonic shift in 2003, new ruling ideology emerged and laid the ground for reshaping the value judgment of the MS reform.

In return, the MS reform also influenced the overall development of the society. For example, unreasonable prescription and “Red Packages” may change the values of those students who major in medicine or erode the public trust in hospitals and doctors; likewise, those who don’t enjoy medical insurance may tend to deposit more than those who are covered by some medical insurance, thusly the gross consumption of the national economy may be reduced and the economic growth would lose certain dynamics.

It is concluded by the thesis that policies and institutional arrangements do not stand alone. They are produced by political power; and they are acting as “junctures” between different phases in socio-economic development. This also embodies the meaning of this policy study, that is, creating the “skeleton frame” of China’s MS by demonstrating those “junctures”.

It is also argued by the thesis that it is just because policies (institutional arrangements) have such a relation with social, political and economic factors that they cannot be neutral. Consequently we may be able to recognize certain value judgment embedded in policies.

With this perspective, here the thesis will try to sketch the developmental trajectory of China's MS so as to create a whole picture of this reform. Thusly the thesis has created four charts as below

Chart 4.5 The changing path of value judgment of China's reform of MS

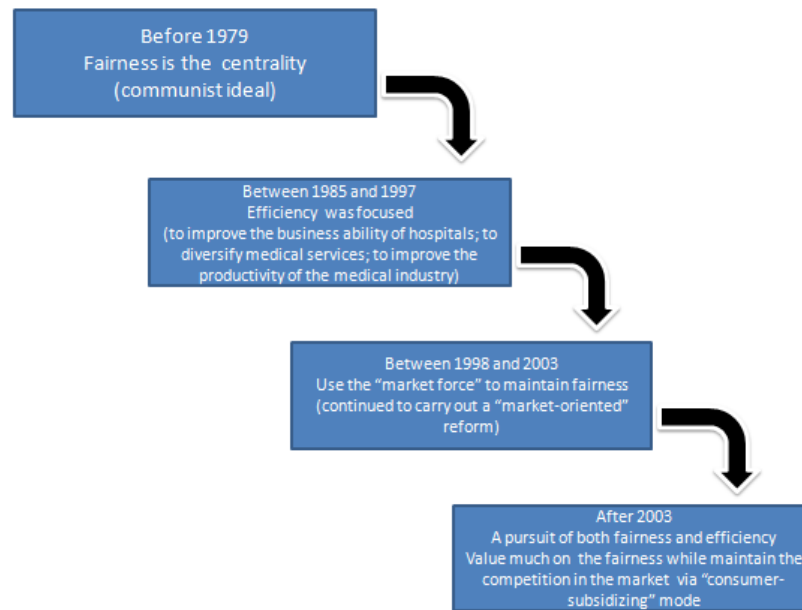


Chart 4.6 The development of China's medical institutions

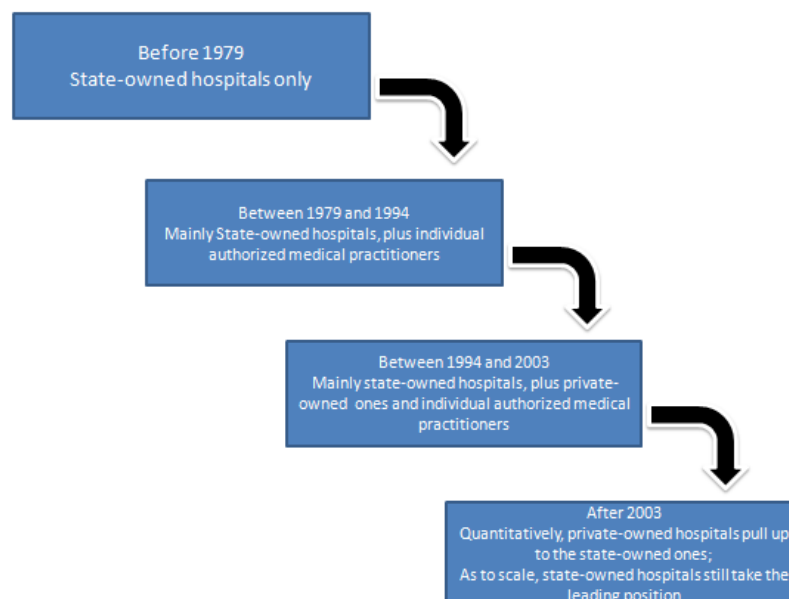


Chart 4.7 The development of pricing mechanism and medical productions

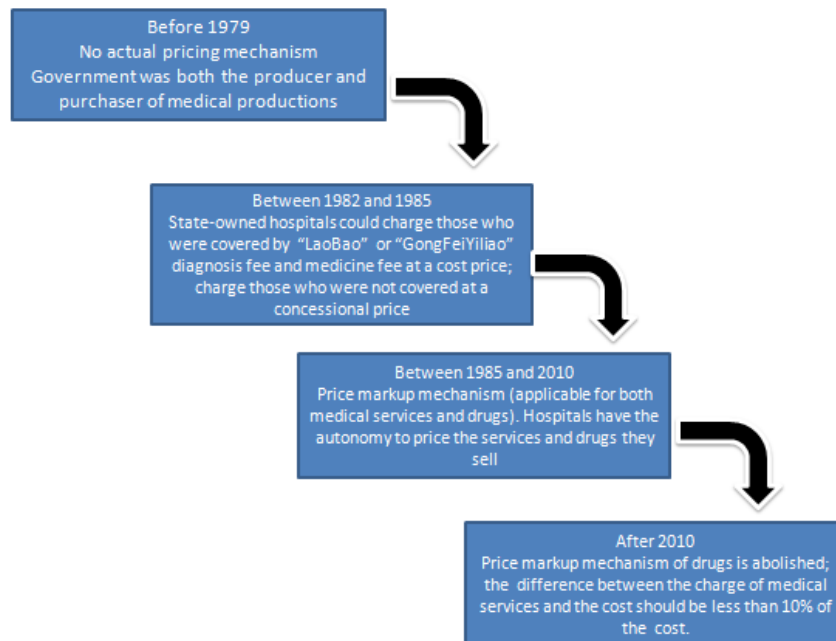
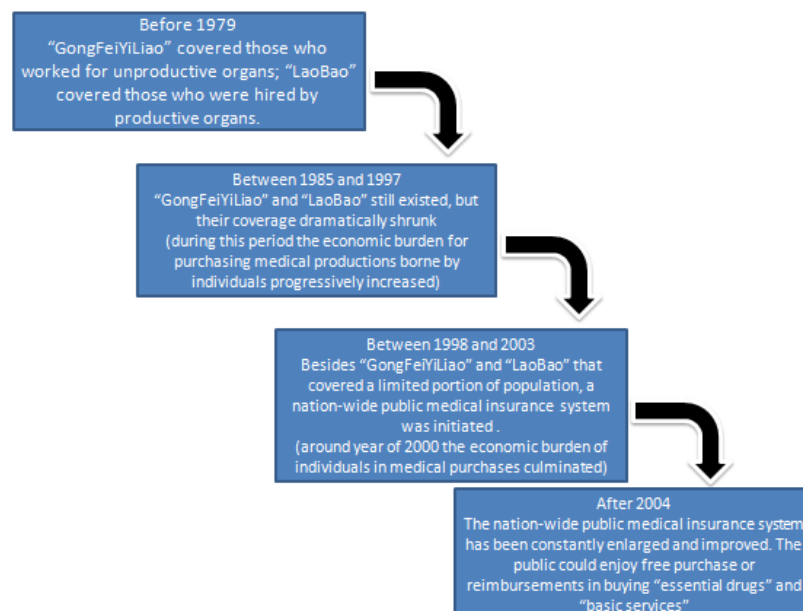


Chart 4.8 The developmental trajectory of medical insurance systems in China



2. What causes incur the problem in China's MS reform?

2.1 Why it is difficult for the public in China to get medical productions?

This question is actually quoted from a speech made by CHEN, the former president of China's Ministry of Health. He summarized that *the saying "hard and expensive to see a doctor" indeed reflects two generally acknowledged phenomena incurred by China's reform of MS, that is, prices of medical productions exceed the affordability of a vast part of population and the quality of medical services is undermined by malpractices committed by medical professionals.*¹⁶⁹

Actually, these phenomena described by CHEN are just what the thesis has demonstrated so far. Contextually to answer the formulated "Problem-statement", it is concluded that China's reform of MS incurs two far-reaching problems: first, a dramatic decline of availability of medical productions throughout the society; second, "value for money" of patients is undermined by corruptive activities.

What needs to be clarified is that the phenomenon of up-roar prices of medical productions is not China-specific. For example, the U.K. has the same problem (the nation medical expenditure of the U.K increased from 1010 million pounds in 1960 to 101509 million pounds; individual medical expenditure was 144 dollars in 1970 to 3076 dollar¹⁷⁰), however, the availability of medical productions is maintained by a nation-wide public medical insurance system. Likewise, corruptive activities may happen in other MS of other states. But the corruption residing in China's MS, which

¹⁶⁹ "Responses on the 'hard and expensive to see a doctor' from the President of Ministry of Health".

Available at: < <http://www.chinanews.com/jk/2011/02-18/2854438.shtml> > (2013-8-26)

¹⁷⁰ DING Chun(2009). *A Comparative Study on Iconic Medical Insurance Systems in the World*. University of FUDan Press:Shanghai. pp.151-152.

induced specific official directive that aimed at put the situation on hold, can be defined phenomenal.

As shown in the Table 4.1, a crescendo tendency where individuals began to bear the major part of their medical expenses occurred in the 1990s, which means that the “public provision” of medical services that prevailed before the OR vanished. It was because that the government took a “market-oriented” reform and failed to provide adequate fiscal support when it was subject to the fiscal system.

Within this circumstance, the state-owned hospitals actually acted more like the state-operated profitable medical institutions. Because without the revenues made from business incomes that took more than 80% of China’s state-owned hospitals annual incomes, those hospitals would be entrapped deeply in economic losses.

And as stated before, OR dramatically changed the economic structure of society, state-owned economic institutions no long were the only licit ones, an increasing part of population were engaged in non-state-owned economy where the “LaoBao” and “GongFeiYiLiao” systems didn’t exist. It is reasonable to say that during that period of time, a considerable proportion of population was not covered by the public medical insurance system.

For another thing, according to what we have demonstrated, it is observed that state-owned hospitals dominated an overwhelming majority of sales of both medical services and drugs. And they also enjoyed to pricing power of medical productions. In this way, patients would be easily positioned at a disadvantageous place. They might spontaneously suffer from the price markup of drugs and the reducing of service quality (bad service attitudes, less reasonable prescription and etc).

To sum up, the thesis believes that it is the monopolizing position of the state-owned hospital that aroused the two problems stated before. What needs to be clarified is that

the monopoly mentioned here is not conflicting to the “market-oriented” reform. In a way, monopoly stands for the monopolizing force in the market. However, with the presence of monopoly, competition is suppressed; and interest group is apt to occur. As to China’s case, what the so-alleged “market-oriented” reform actually created was monopoly. And the thesis finds this monopoly strong and resistant, because it was supported by political factors¹⁷¹.

With no targeted social arrangements for subsidizing either the producer or the consumer of medical productions, the medical market had no risk-bearing mechanism, risks would be transferred to those who have less information —— typically the patient. Consequently, the availability of medical productions would decline.

However, what needs to be clarified is that although the thesis defines the MS of China in 1990 was a market captured by monopoly forces, this “accusation” doesn’t point its finger right to the institution of “public-owned/state-owned hospitals” itself. Instead, a MS which is backboneed by state-owned hospitals can be of diverse forms, among those monopolizing the market is just an exceptional case.

In order to support this argument, the thesis here is about to make a brief introduction over some other MSs that are pillared by state-owned hospitals, which might reflect the speciality of China’s MS.

NHS, namely the National Health Service, is the national “public medical service” system for the U.K. The NHS provides each British citizen free medical services through their lifespan. Nevertheless, free medical services are only available in state-owned hospitals which make up about 1400 hospitals of the 1600 hospitals that the U.K has. Along with state-owned hospitals, there are more than 36000 “general

¹⁷¹ The political factors here refer to the ideology that the government may more trust state-owned hospitals; the fact that state-owned hospitals in China have been affiliated directly to the government, because the government not only funds state-owned hospitals but also take charge in appointing senior managers, like president, for state-owned hospitals.

practitioners” in the U.K. who are hired by the state to provide patient free and basic medical services¹⁷². State-owned hospitals at various level and general practitioners constitute the three-dimension supplying pattern of NHS. Either the state-owned hospital or the team of “general practitioner” is funded and operated by the government. In 2000s, about 75% of capital inflow of state-owned medical system belonged to pure fiscal expenditures from taxation; around 15% belonged to various public funds.¹⁷³ State-owned medical institutions are not engaged in commercial sales of drugs. Nevertheless, patients are allowed to pay extra fees for customized medical services in both state-owned and private-owned hospitals; in this case, state-owned hospitals are also allowed to make profits.¹⁷⁴ As thus, NHS basically becomes a fully national operated system where medical productions are supplied by the government, which may be interpreted as a “welfare state-oriented” arrangement. Patients, whether taxpayers or not, do not bear any medical expenses when they pursue medical services in state-owned hospitals.

In Singapore, patients, unlike their British counterpart, do not enjoy totally free medical services. However, they also have a broader-covering medical subsidizing system. Each Singapore citizen could enjoy the same subsidizing standard in either state-owned hospitals or private ones (75% reimbursed for those who are younger than 18 or older than 65; 50% for the rest).¹⁷⁵ What is important is that neither the government nor the state-owned hospitals has the right to price medical services. It was relinquished to the market.¹⁷⁶ By competition between state-owned hospitals and private hospitals, the prices of medical services are decided by the law of “supply and demand”. The government constantly funds the state-owned hospitals, especially in the investments in high-value equipments and building constructions, so as to make state-owned hospitals more competitive and to lower the price.¹⁷⁷ This arrangement

¹⁷² Ibid. pp.115-134

¹⁷³ Ibid. pp.145-155

¹⁷⁴ Ibid.

¹⁷⁵ Ibid. pp. 312-320

¹⁷⁶ Ibid.

¹⁷⁷ Ibid. pp. 320-326

impels private-owned hospitals to follow up on the issue of pricing. On the other hand, with the “threat” from private-owned hospitals, state-owned hospitals couldn’t lower the quality of medical services when they are not capable of charging high.

The first case show that when the monopolizing state-owned hospital have no actual pricing right towards the patient, the welfare of the public may not be reduced either; the second case of Singapore tells us that with the presence of state-owned hospitals, the “value for money” of patients could also be guaranteed.

The thesis believes that the state-owned hospital is just a kind of proprietary arrangement. Their influence and functions are decided by other supporting institutional arrangements. State-owned hospitals can be either fully controlled by an extreme centralized public medical service system, like NHS, or compatible with market and competition. But what is certain and should be firmly hold is the aim of government’s operating the medical system, that is, promoting the public welfare, because the thesis believes that *the market shall not make life or death decisions*. In China’s case, with the monopoly of state-owned hospitals distorting the market mechanism and without relevant remedial arrangements subsidizing the public, it is hard to achieve the certain goal.

However, as revealed in previous sections, the reform which was launched in 1985, due to the historical specific conditions, was not primarily positioned as a welfare-promoting one. The reason why the reform couldn’t start with a pursuit of balance between fairness and efficiency may be historically specific. It is fortunate that China’s government has realized the significance of this pursuit and re-navigated the ongoing reform already.

2.2 The role of market¹⁷⁸

It is worth of noticing that by the year of 1993, there was already a considerable amount of population could hardly afford the medical services. Indeed, a potential demand for institutional shift may occur. However, the negative situation even continued through the coming 7 years (see at Table 4.6). We may wonder why the situation could not be put on hold timely.

During this period, a large amount of benefits gained by monopolized sale of medical productions flew into the state-owned hospitals. Thusly a specific interest group may be hatched. With the intervention from interest group, we have already known that the institutional shift would be obstructed. When the interest group is founded by monopolizing incomes, it is difficult to expect a self-abnegation. As thus, remedial institutional shift may face a higher cost to realize. Just as what we demonstrated before, private investors may have not much confidence in investing in hospitals because most market shares are taken by state-owned hospitals. This may lead to a vicious circle: the state-owned hospitals may stay mighty; then policy-making would be impacted because state-owned hospitals may have stronger speaking-right; remedial policies may be difficult to take effect; finally the monopoly may be consolidated.

Meanwhile, policies, like “president responsibility mechanism” (as a contract-out mechanism which was prevalent in the 1980s in the reforms of state-owned enterprises), reflected certain a “path-dependence”, which might be caused by the ideological rigidity or the preference of government. In fact, this mechanism actually still gains government’s preference, as stated before, it cannot be detected in recently

¹⁷⁸ Actually the “government failure” in this section may refer to the malpractices made by both the administrative organ and state-owned hospitals, because government not only funds the state-owned hospitals but also grasp the right to make important personnel decisions for state-owned hospitals. In this way, state-owned hospitals may be seen as the extension of the government.

issued official directives that the “president responsibility mechanism” should be repealed.

Last but not the least, China’s MS then was a system lacking of efficient supervisory mechanism, because the medical administrative organs are not only the supervisory institution of state-owned hospitals but also the designator of the senior officials of them. In this case, to some extent, the supposed “judge”——supervisory department in government was also the “athlete”——operator of hospitals. As a result, “rent-seeking” would bear less risk (for example, the transparency would be reduced), more medical professionals would like to be engaged in bribery (the “Red Package” phenomenon was a suitable illustration).

All these cases demonstrate that within such a system that is captured by monopolizing force, malpractices would be bred. Actually, from the recently issued MS reform policies, we may find that the government repeatedly urged to make actual deeds in the reform of state-owned hospitals, especially its proprietary relationship, the thesis thinks that China’s government also finds that the current proprietary relationship between government and state-owned hospitals was a major obstacle for the establishment of an efficient supervisory mechanism.

What we have also known is that the trials of transferring the proprietary relationship of state-owned hospitals launched in 2000, as a pity, didn’t successfully solve the problem, because what they did was not trying to find an applicable way to establish an efficient supervisory mechanism with the retention of state-owned property right.

All these phenomena described above, in fact, reflect “government failures” in the MS reform. “Potential interventions from interest group”, “ideological rigidity”, “rent-seeking” and “lacking of supervisory mechanism” all lead to the potential reduction in the social welfare, which can be seen as a kind of improper governance——government failure.

Let us turn our sight to the NHS again. Even if the NHS is a well-functions medical system, defects can also be detected, some are even serious. For example, with the constant and vast fiscal support, the availability of medical production in NHS is guaranteed, however, British patients usually have to wait for a surprisingly long time before they can get any treatments. In the UK, it is demonstrated by relevant statistics that the average waiting time for getting any treatment from either general practitioner or state-owned hospitals was above 80 hours.¹⁷⁹ It was also proved by some other statistics, the UK transplant revealed that in 2000, the number of people on the waiting list for getting kidney transplant was 4.2 times of those who got the transplant treatment in that year.¹⁸⁰ Through this lens, it is reasonable to say that the British government has built a unified public medical services system which provides the society free medical services at the expense of timely treatments.

Without surprises, private-owned hospitals had got the chance to develop. During the 8 years between 1990 and 1998, 29 new private-owned hospitals were established and the growth rate was about 15%.¹⁸¹ On many occasions, patients are willing to pay extra fees for getting treatment timely, especially for surgeries like abortion or cataract extraction which contributed more than 20% of business incomes in 1990s.¹⁸² A unitized system like NHS, to those who need medical treatment done timely more than for free, seems to be not a suitable one. Imagine that what if the U.K had no capable medical private-owned hospitals, patients may perhaps face a longer waiting time to get needed medical treatments. So to speak, the private-owned medical institutions are important constituents of the NHS.

Compared to NHS, the thesis indicates that China's MS needs the well-being of market mechanism as well. Although a long waiting time for getting medical

¹⁷⁹ Ibid. pp.155-175

¹⁸⁰ Ibid.

¹⁸¹ Ibid.

¹⁸² Ibid.

treatment may not occur in China, China's system, like its English counterpart, is dominated by state-owned hospitals. What is so worth of noticing is that China's MS is formulated in a different socio-economic background.

Politically, China is a one-party ruled state. Without the challenges from the opposite Party (or Parties)¹⁸³, certain corresponding supervisory mechanism would not exist, thusly malpractices in governmental organs would more easily occur; likewise, one-party ruled regime may be apt to have "path-dependence" because of lacking of challenging thought. Socially, with the dominance of state-owned medical institutions, the public actually becomes dependent on state-owned medical institutions. Thusly any malpractice committed by them may lead to a distrust of the system. Legally, it is of no doubt that China's legal system is not as much advanced as the British one. It would be easier to exercise "rent-seeking" and other corruptive activities. Economically, although the drug price markup mechanism is cancelled, targeted and detailed policies about the pricing markup of medical services have not appeared, consequently it is still possible that medical professionals may tend to unreasonably apply "high-value" equipment to charge higher (these examinations may not be covered by the "basic medical services item"), which is actually more subtle and difficult to detect and measure. Correspondingly state-owned hospitals may still have a decisive influence on the pricing of medical services in the market, which helps maintain its monopolizing position.

Taking all these factors into considerations, we may find that China's MS is developed within such a background where government failure is apt to occur. Thusly we may say that to prevent potential GF from happening may need a kind of remedial/restraint mechanism, say, market¹⁸⁴.

With state-owned hospitals' leading position in the industry, the leading position of

¹⁸³ Here the thesis tends to make no discussion over the legitimacy of one-party ruled regime.

¹⁸⁴ The market here does not refer to a general market which may include oligopoly and monopoly but a level-playing arena where competition is prevalent.

government in the MS is not deniable. Furthermore, based on the lessons of history of China's MS, governmental supports (fiscal support, policy support and etc) seem critical in maintaining the availability of medical productions. So what the thesis advocate is not to reduce the influence of government but to increase the role-playing of market forces to improve the performance of government's behaviors.

It is indeed doable. For example, in Singapore, the assets of state-owned hospitals are not managed by the supervisory department of government but by a separate Hospital Management Committee that independently acts as the asset manager, which disable the supervisory department to exercise interventions in operative affairs of hospitals and enhance the ability of supervising by reducing the possibility of interest conflict.¹⁸⁵ Besides, it is also suggested by the thesis that policy-makers may take effort to remove those policies which seems discriminative to private-owned hospitals (for example, patients could only enjoy the public medical insurance; although NHS applies same arrangement, the thesis believes that this removal may have its specific significance in China) to help them grow, which may result in cultivating competitive force in the market against monopolizing force.

Combining the discussions in the above two sections, it is concluded by the thesis that China's MS is apt to breed government failures: monopoly price would "plunder" the interest of the public, especially in a medical market where consumers/patients are always positioned in disadvantageous places due to the uncertainty and informational gap; monopoly would accommodate the desire to make malpractices because of lacking of efficient supervisory mechanisms; monopoly would suppress the reforming forces because of the dominant interest group; furthermore, monopoly would restrain the ideological changes, which may lead to excessive "path dependence".

Especially for the MS of China, increasing the influence of market may marginally play a positive role. For example, with more competition from competent

¹⁸⁵ Ibid. pp. 320-326.

private-owned hospitals, state-owned hospitals may have fewer opportunities to exercise malpractices, like “Red-Package” extortion and unreasonable prescription, because patients could just go to private-owned hospitals to “punish” these behaviors. These positive outcomes would transmit positive signals back to the society and policy-makers, as a result, the competition may be consolidated and strengthened. In other words, it may be the competition that could rectify the problems incurred by this monopoly. As stated before, the recent MS reform took the form of “consumer subsidizing”. The thesis believes that this would be an ice-breaking opportunity to break up the monopoly of state-owned hospitals in China. And the thesis has repeatedly emphasized that competition, via creating a level-playing field, intends not to demolish the state-owned institutions but to push them to produce better medical services for the public.

Above all, the thesis holds that the aim of developing the MS is to serve the public while promote the productivity of the industry—a balance between “fairness” and “efficiency”. The role of market is not about a solemn challenger on the behalf of “efficiency” to the government —the spokesman of “fairness” but a sort of compatible institutional basis for the maintenance of social justice. In the medical market, there would both market failure and government failure, combining the advantages of market and government may be the way to overcome the two kinds of failures. And establishing a system where both market mechanism and governmental interventions could prevail may be a way to fulfill the balance of fairness and efficiency. We cannot say that MS with prevalent private-owned hospitals are universally applicable, but to China’s MS where various GFs have been detected, a diversified system may help.

Conclusion

What should be firstly pointed out here is that institutional arrangements are highly intertwined with various factors (social, political and economic). Put it another way, the policy-making and institutional shifts may be always bounded to the very socio-economic background.

The thesis has repeatedly reflected this point. For example, between 1949 and 1979, the establishment of MS had to agree with the communist system; after 1985, the reform was designed to solve the problem of undersupply of medical productions that occurred since 1980 via stimulating the enthusiasm of medical professional and delegating profits to hospitals; and after 2003, with the new governmental administration and the growing fiscal capacity, more social concerns were blended into the MS reform, thusly the completion of medical insurance system were highlighted so as to improve the availability of medical productions.

The thesis also argues that because institutional arrangements are highly related to socio-economic conditions, they must be also obedient to certain value judgment. Taking a perspective where the public welfare is ultimately important, the thesis believes that the value judgment for medical affairs should always be a constant pursuit of the balance between fairness and efficiency. During the communist era, Chinese system over-valued the fairness, which led to a loss of enthusiasm among medical professionals and an ubiquitous economic loss in hospitals; as a result, the reform which was launched in 1985 was navigated to rectify these problems by delegating autonomy, however, although the undersupply was eliminated, prices of medical productions went beyond the affordability of the public. It is observed that these reforms attached undue attentions to either fairness or efficiency, which caused damages to the other.

Especially after 1985, the reform even created a monopolizing situation in the medical market, with no competing forces, the state-owned medical institutional controlled the pricing right of medical productions, incurring an increasing proportion of the public that couldn't afford the medical productions and various kinds of malpractices committed by medical professionals.

Actually, policies like these can also be deemed as a sort of GF. Because even if the established goals of certain policies (like policies referred to in the last paragraph) are reached, this is done at the expense of reducing the public welfare, taking a perspective where the public welfare is ultimately important, these policies may make higher cost than benefit.

As pointed out before, the government may be fettered by claims of interest group, by the ideological rigidity, by the corruption or even by the defection that it spontaneously has. As a result, the government should make less effort to subdue the development of challenging forces, like market. The coexistence of the government leading and market based mechanism may provide broader financing channel, or a comprehensive supervisory mode, or diverse views for overcoming the ideological prejudice, or even the counterbalance force to interest groups. Even if China's MS would evolve into an entirely government-leading system, like NHS, but the thesis is still inclined to advocate a therapy for China to support private-owned hospitals so as to strengthen the competition in the medical field. In fact, it should not be seen as a biased support to the private-operated medical institutions but as an outmaneuvering measure to subdue the GF in a unitized system.

Policy Implication

Based on the discussions above, the thesis also makes several specific policy

implications for the improvement of China's urban MS:

1. To mend the relationship between government and state-owned hospitals, the thesis suggests establishing independent asset management committee and expert selection committee, which may separate the supervisory activities from asset-managing and personnel-appointing affairs so as to guarantee the justice in the relevant supervisory activities;
2. To give aid to the development private-owned hospitals, the thesis suggests authorizing some qualified private-owned hospitals to provide services that could covered by the urban medical insurance system to the public, which would eliminate the advantageous of state-owned hospitals somehow and boost the competition in the market. All in all, the government should focus on erasing those policies that may have discriminative effect on private-owned hospitals;
3. To suppress the possibility of occurrence of unreasonable prescriptions, it is suggested to build up certain online complaint-filing system and communication forums for both doctors and patients, aiming at comprehensively strengthening the supervisory mechanism.

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