

Challenges in China's health system reform: lessons from other countries

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Abstract. We are very pleased to have been invited to edit the inaugural virtual special issue for the *Australian Journal of Primary Health*. This virtual issue will present a set of recently published papers from the *Australian Journal of Primary Health* that have been selected for their relevance to issues faced in China. It will be launched on 11 September 2017. We have written this Editorial to set the scene for the special issue, and as a general overview of issues affecting one of our most influential neighbours in the region.

China commenced market reform in the late 1970s and over the succeeding decades has experienced rapid economic development. During this time, population health status has continued to improve although inequalities in health status have emerged: across regions, between rural and urban and across social class in the cities (Asia Pacific Observatory on Health Systems and Policies 2015).

Over this time, the landscape of health care delivery in China has also changed dramatically. China used to be a global role model for its primary health care system, characterised by universal access, public funding, public delivery, emphasis on prevention, and a predominance of low technologies. A key feature of Chinese health care during this period was its organisational base in the 'work unit' or enterprise (rural communes, factories, departments, etc.).

With the transition to a market economy, enterprise-based welfare (including housing, education, retirement support as well as health care) was seen as a drag on economic productivity and the enterprise was progressively released from the obligation to provide such services. As the funding which had previously flowed through the enterprise dried up, the economic planners proposed that resource flows for health care could be generated through user-pays financing, and health care organisations were encouraged to compensate for reduced budget funding through user charges. Although user charges for labour intensive services were tightly controlled, the prices for diagnostic services involving high technology equipment and the prices for the newer medicines were allowed more flexibility. By the mid-1990s hospitals were financially dependent on the net revenue gained from the sale of medicines (including intravenous infusions) and the provision of high tech services. While the basic salaries of medical staff were tightly controlled, a system of bonus payment emerged, on top of basic salaries, with a view to incentivising clinicians to generate much needed revenue.

The aggregate effect of these developments was the rapid development and modernisation of tertiary hospitals in the

cities (but continued resource limits in primary care and in the rural areas) and increasing financial barriers to accessing health care and an increasing risk of medical impoverishment. Concerns about over-servicing (e.g. antibiotics, intravenous infusions, computed tomography scans) and financial barriers to health care assumed greater prominence in policy discussions.

The development of social health insurance slowly assumed priority on the policy agenda from the late 1990s, but from 2009 there has been a huge increase in government funding through three government sponsored health insurance schemes, covering over 96% of the population. However, there remain significant inequities between the schemes, high out-of-pocket charges for many services, much tighter expenditure control on primary as opposed to tertiary care services, and many of the remuneration incentives driving over-servicing remain in place (Asia Pacific Observatory on Health Systems and Policies 2015).

Further challenges facing health system reform in China arise from the rapidly aging population; challenges that are exacerbated by the one-child policy and increasing geographic mobility. Services to the elderly have also been affected by the collapse of the enterprise welfare model and the challenges of building a 'stand-alone' aged care 'system' in its place.

Arguably, the biggest winners to date in adapting to the changing health policy environment, have been the tertiary hospitals. Although per-capita health care expenditure in China is only one-sixth that of Australia, China has a similar hospital bed ratio and similar admission rates to Australia. The most recent statistics show that China has an average of 38 hospital beds per 10 000 population and 16% of the population is admitted to hospitals every year (Ministry of Health of China, see <http://www.moh.gov.cn/>), compared with 39 hospital beds per 10 000 population and 16.7% hospital admission per year in Australia (Australian Institute of Health and Welfare, see <http://www.aihw.gov.au/>).

Notwithstanding the 2009 reforms, there remain several intractable challenges facing health care policy makers in China.

These include efficiency, both technical and allocative; equity, including distribution of resources and access to care; clinical governance, with implications for quality of care and public trust; and system integration, including the relations between primary, secondary and tertiary levels and between medical care and social care.

Particular challenges lie ahead for primary care development in China. Unlike hospitals, the primary care sector in China is much weaker compared with its Australian counterpart. There are ~5 primary care physicians for every 10 000 population in China (see <http://www.moh.gov.cn/>), less than one-third of that (16 for every 10 000) in Australia (see <http://www.aihw.gov.au/>). The shortage of nurses in China is even more serious: 10 nurses per 10 000 population in China (see <http://www.moh.gov.cn/>) compared with 109 nurses in Australia (see <http://www.aihw.gov.au/>). Under the national essential medicines list system (NEML), primary care institutions are only allowed to stock and dispense medicines listed in the NEML (~500 products) and are restricted to a zero mark-up. Evidence shows that the availability of medicines in primary care institutions is limited. Commercial pharmacies have a small share of the market, and people may depend on hospitals to fill out prescriptions they need. The overuse of antibiotics and other medicines remains a serious challenge (Asia Pacific Observatory on Health Systems and Policies 2015).

The Australian case-mix funding system for public hospitals has attracted enormous attention from China. There is hope that it may prove to be an effective tool for the government to regain control over the growth and distribution of hospitals as well as forcing hospitals to improve efficiency. The case-mix funding system, if designed properly, can also exert a downward pressure on hospital provision of primary care services, diverting patients with minor illness and some with chronic conditions to primary care. This would be expected to provide primary care providers with more opportunities to expand and improve their services.

In a broad sense, China and Australia share some similar challenges in health reform. Equity, efficiency, safety and

quality of health care are ultimate goals of health reform in both countries. In relation to primary care: quality, efficiency, system integration, patient centredness and prevention are goals which are common to both China and Australia.

Without doubt, we can learn from each other. In some degree, we can learn about the dynamics that drive health system functioning by watching how other health systems operate and about the policy strategies and institutional mechanisms that can facilitate or obstruct healthy outcomes. However, there are more general benefits from understanding how foreign health systems function and how foreign policy makers are approaching their challenges. Understanding how other systems operate enables us to reframe the familiar in new ways and to see afresh the features that we have hitherto taken for granted, for example, the links between health care utilisation and culture; or the links between health care funding and the wider economy.

In the virtual issue to be released in September, we have brought together 12 articles about different primary health challenges that have particular relevance to China. These include challenges associated with delivering healthcare to aging populations, the potential for well-coordinated primary care to reduce demand for emergency and hospital care, the value of collaboration between health professionals within and across sectors, and the importance of consumer engagement and community health literacy.

The Victorian government recently launched an international health initiative, promoting health partnerships between Victoria and China. Mutual understanding is essential for such partnerships and collaborations. We hope that the virtual issue will lay a solid foundation for promoting dialogue and learning between the two countries.

Reference

- Asia Pacific Observatory on Health Systems and Policies (2015) People's Republic of China HiT (2015). (WHO Office for the South-East Asia Region: New Delhi, India) Available at http://www.wpro.who.int/asia_pacific_observatory/hits/series/chn/en/ [Verified 15 August 2017]