
Health Care Transformation in China—the Privatisation and De-Privatisation of Health Care in a Chinese County

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Abstract:

The Chinese health system has experienced dramatic changes over the past decades from the historically socialist health-care system, the drastic marketised transformation, to the new socialist characterised health care reform. Since 1949, the health sector changed from most private services to all public ones in the collective era, experienced a transition from fully state run and financed system toward more private financing and delivery of health care in the post reform era, and recently turn to the expansion of public health service in the new health reform. The thesis examines the transformation of Chinese health sector in a specific county to show the privatisation and de-privatisation process of health care services over the past decades.

Key Words: Privatisation, De-privatisation, Health Care Transformation, China

1. INTRODUCTION

In recent decades, health reforms have happened all around the world. Decades ago, a number of advanced market economies (e.g. U.S., Britain) and Eastern Europe countries have implemented structural changes and privatisation of health services. The experience in the industrialized countries strongly influenced the design of health reform in low and middle income countries. Private health care grow rapidly in many places. However, before that, health policy in most countries has emphasized the development of public health services that largely financed by the government. Especially the command economies and ex-colonies countries in Africa and Asia, most of their public health services have functioned as bureaucratic state enterprises although some also had formal and informal sector private providers (Bloom and Gu 1997). In fact, many developing countries have established similar systems of peripheral clinics and health workers, integrated community health centres, and a tiered system of public hospitals under the recommendations of international agencies like WHO (Hanson and Berman 1998). But in recent years, the appropriateness of this organizational model is increasingly being questioned. Many countries have embarked to reform the relationship between government and health service providers (Cassels 1995).

With the transition from a planned economy to a market economy, China has also reformed its health sector, experienced rapid health care privatisation in the last decades. It is fascinating and important to see the Chinese health care evolution—‘first in establishing centrally planned and managed health services, and then in changing the organization of these services radically’ (Bloom and Gu 1997). Recently the new health reform shows tendency of de-privatisation of some privatised health facilities and expanding public health services. The unique Chinese privatisation and de-privatisation experience in the last decades could hopefully give substantial rethinking of health care strategies in the lower and middle income countries, and contribute to the reform of health care system in other countries. The paper focuses on the health care transformation in a specific county—S¹ in southern China. There are over 2000 counties in China. The experience in S county could not represent healthcare transformation in other places, but is hopefully to show some generally trends of transformation that happened in Chinese health sector over the past decades.

2. THE EXPAND OF PUBLIC HEALTH SECTOR- HEALTH CARE ARRANGEMENT PRIOR TO 1980S

Prior to 1949, the provision of health care in China was dominated by private sector (Meng *et al* 2000; Liu *et al* 2006). After 1949, the founding of the People’s Republic of China, the ministry of health was responsible for all healthcare activities, and public health care system was set up. In this period, private practice and private ownership of health care facilities were considered incompatible with socialism and were put on the agenda of elimination. After 6

¹ The county is shortened as S for anonymity. For the province that S county located, I use S province.

years' socialism, in 1956, all private hospitals, including 243 private mission hospitals, were transferred into public ones, and doctors engaged in individual private practices in urban areas were also gradually recruited into the public health facilities (Liu *et al* 1994). The nationalization of medical human resources progressed through two lines: the absorption of private practitioners into state employment, and the complete control of education and employment of new practitioners by the state (Yang 2010). The Cultural Revolution, started in 1966, accelerated the speed of eliminating private sector. By 1967, the private health sector including individual and group practices and private hospitals had been completely eradicated as capitalist residues (Liu *et al* 1994). The predominant role of the private health sector was totally replaced by publicly owned health system. The government owned, funded and ran all hospitals from large specific facilities in urban areas to small clinics in the countryside to supply universal medical coverage (Blumenthal and Hsiao 2005).

In S county, according to the county annals and local medical chorography, before 1949 and the following few years, all rural health professionals and the majority urban health practitioners were private. They used traditional Chinese medicine to treat common illness and frequently encountered disease in S county (SCCEC 1990: 934). Since 1949 after the long-term chaos, the local society began to revive in every aspect including health care. In 1951, there were 241 medical shops in the County—229 Chinese medicine shops and 12 western medicine shops—most of which had doctors over the counter (*zuotang yisheng*) specially prescribing drugs and giving medical advices to patients². Among these medical shops, 46 were located in the city. Then a series of political movements and reform measures were carried out, aiming at reducing private profiteering activities and eliminating capitalism function. That led to the rapid decrease of private medical practices. In rural areas, individual private clinics were gradually replaced by joint clinics; since 1957, private medical practices began to be forbidden in the whole county. (SCCEC 1990: 934) Private doctors in the rural area were largely recruited into the public or collective system. In the city, the 46 private medical stores reduced to 21 in 1953, 16 in 1956, by 1959 only 8 were left all of which were transferred to public ownership. In 1962, the local health authority designed *The Interim Measures on Management of Medical Workers* (*yiwu renyuan zhiye guanli zanzing banfa caoan*) to further enforce the administration and banning on private medical practices. (SCCEC 1990: 944) Officially, the legalized private health sector had all been eliminated in the county, but illegal private medical practice was secretly operated underground. It even progressed somewhat with many reported fraudulent behaviours when the 'Cultural Revolution' (1966-1976) took great social disorder and government dysfunction. Only after 1980s with the market reform, private medical practice was legally permitted.

While the private health services rapidly reduced, the public system developed quickly. In 1950, the county health centre—the only public health institution in the county had only 8 health professionals, 8 beds, and 31.8 outpatients per day. Later the county health centre was renamed

² The medical shops at that time were one of the major forms of private medical practices. They operated like private clinics by selling medicine and treating patients at the same time.

as the People's Hospital, some private health institutions and doctors were integrated into the hospital, the hospital buildings were enlarged, new medical equipment were imported, soon it became the biggest health institution in the county. In 1985, it already had 381 health professionals, 300 beds, and the daily outpatient number reached 928.3. Besides, the Hospital of Traditional Chinese Medicine (TCM Hospital) was founded in 1958 by 6 traditional medical doctors. In 1962, it increased to 28 health professionals, 15 beds, and 145.6 outpatients per day. Till 1985, there were already 162 health professionals, 200 beds and 725 daily outpatients. The TCM Hospital became the second biggest health institution in the county. (SCCEC 1990: 932) Moreover, in the city, the Maternal and Child Health Centre was established in 1953, and a County Red Cross Hospital was founded in 1958 (SCCEC chapter 8, unpublished). In the rural area, township health centres and village health stations were widely established. Until 1985, 84 township (commune) health centres were founded and village health stations were broadly established in every village. It is worth to note that after the Cultural Revolution, the village health professionals came to a peak in 1977 with 1868 'barefoot doctors' and 4880 primary health workers in the county. In general, the public health system in S county has expanded dramatically from only 1 health institution, 5 beds, and 6 health professionals in 1949 to 720 health institutions, 1983 beds and 3332 health professionals in 1979 (SCCEC 1990: 935-936). Health professionals in this period varied from paramedical workers and barefoot doctors in the villages to fully trained and qualified physicians in the county hospitals. With the development of the county hospitals, township health centres and village health stations, a three-tiered health network was formed linking the village, township and county health units vertically together. Before the 1980s, China had developed an extensive public health care system, under which, health services were provided to virtually all people at very low cost.

3. HEALTH CARE PRIVATISATION SINCE 1980S

In China, the term privatisation is called *siyinghua* (privatisation of operation) or *siyouhua* (privatisation of ownership). Before the 1980s, privatisation was a taboo and was regarded as the consequence of capitalism, incompatible with the communist society. In the west 'private' was commonly linked to the idea of autonomy, of actions pursued by individuals and groups outside the reach of the state. But in China 'private' had connotations of selfishness and disregard for the public good. 'To privatise' suggested an acceptance of capitalism and bourgeois liberalization, and hinted at abandonment of governmental responsibility (Wong 1994). Because of such sensitivities, 'private' did not find its way into the official lexicon. The private medical institutions in general were called social medical institutions (*shehui yiliao jigou*) or people-operated medical institutions (*minyong yiliao jigou*). Private clinics were officially named as individual-operated or solo-operated clinics (*geti zhensuo*).

The (re)emergence of the private health sector in China started in the 1980s and the 1990s. The motivations for the privatisation of health care were different in the 1980s and the 1990s. In the early 1980s, there was a big shortage of health care services (Wang 2003). After three decades of command and paternalistic management, health care stayed at very low level, the technology

and products were outdated, health service did not have economic effectiveness. The transition of health sector was driven by several significant forces: the increasing medical expenditure that the state could not afford; the change of demographic factor (more and aging population) led to the rise of health care needs; the emergent needs to establish health services to peasants with the dismantle of rural cooperative medical system; and the economic growth brought about increased spending on health care and diversified demands for health services (Wu 1997). Needs were far too numerous for the state to tackle by itself. The state tried to expand the supply of health services. In this period joint responsibility and diversification became the guiding principle in the provision, funding, and regulation of services (Wong 1994). Private medical practices were officially allowed as supplement to public health services.

In the 1990s, needs have been largely satisfied. The reform goal by then was to set up the market economy (Wang 2003). Health sector went through the marketization process with the aim to modernize China's healthcare system, to alter the structure of health services, and to decentralize the central government's responsibility. The state retreated from financing, organizing, and delivering of public health services, leading to an underfunded and fragmented public health care system. Without enough public finance, hospitals at both county and township level were urged to become self-sufficient. At the primary level, a plurality of ownership and competition among health care units was encouraged. (Zheng and Hillier 1995; Chen 2009) Privatisation then was seen as a solution for the state to discharge public obligations, and enhance both efficiency and public satisfaction of health care. As a result of the transformation, the Chinese health care has undergone wide-scale privatisation. In S county, the local government has implemented a series of reforms in health sector since the mid-1980s.

3.1 Privatisation in Service Provision and Financing

The privatisation of health services went first in the rural areas. In the countryside, the abolition of the collective production system and the commune in the 1980s destroyed the collective finance to the cooperative medical system in most localities in China. The coverage of this system reduced from 80% of rural residents in 1975 to less than 10% by 1984 (Aldis 1989; Hillier and Zheng 1990). Village health stations were sold or contracted to individuals; township hospitals were forced to become self-sufficient in the market. Most of the unfinanced rural health workers became private practitioners or changed profession. The 'market reform' across China in the 1990s further encouraged the former 'barefoot doctors' and surplus medical practitioners to open their own clinics in supplying basic health care. In the urbanization process, more and more private doctors concentrated into the cities and towns, leaving villages with few health personnel. Since 2000, the local county government further encouraged the reform of health property rights (*weisheng chanquan zhidu gaige*). Many township hospitals were closed, sold, or operated in great difficulty. Health stations in 526 villages of the county's total 591 villages have been transferred to individual operation, most townships health centres have disappeared except 11 central township hospitals (out of the 84 township health centres in 1985) (SCCEC chapter 4, unpublished). Public or collective health facilities in the rural area

reduced quickly with rapid expansion of private medical care. Health care in the rural area was largely under private control, but the numbers and quality of health-care facilities and personnel were inadequate, and the three-tiered rural health system collapsed.

In the city, since the 1980s, the state has been trying to decentralize the government system on public health providing. With the decentralization of financial responsibilities, cuts have been made in subsidies to public health service from the central government. There was also a reduced involvement of the local government in health expenditure coverage, especially in less developed places like S county. Financing in major hospitals was greatly reduced although the public hospitals have absorbed the majority of health resources and funds. Prior to the market reform, government subsidized about 50 to 60 percent of the costs of public health facilities (mainly calculated to pay for the salaries of health personnel), but the subsidies decreased to approximately 10 percent in the 1990s (Yip 2010). The health sector stepped up the exploitation of new sources of funding. The provincial government required public service unit to try ‘multiple channels, multiple owners, and multiple means’ (*duo qudao, duo zhuti, duo xingshi*), encouraging public personnel to go into personal business³. The county government also allowed the private finance invested into the public health institution⁴. Greater economic and staffing autonomy was given to public health institution. Some spaces were created to allow public doctors to move to private sector. They contracted health units and clinics in the public hospitals, or opened a clinic in the market under the name of their hospitals. But the commercialization of hospital service in this period has not fundamentally changed the ownership structure of China’s hospital sector. Less than 2 percent of public hospitals were privatised between 1995 and 2005 (Tam 2010). For the urban community health facilities, they were unstructured, poorly resourced, and staffed by under-trained personnel in large cities. But in small cities like S, urban community health stations were never established. The primary health care in the city were generally provided by private clinics that newly emerged in the post-reform era. Private hospital in S county is a recent phenomenon which only emerged after 2000s. Thus in the post-reform era, health care in the city is also privatised, broadly including commercialized health care in the public hospitals and private basic health care in the private clinics.

Without sufficient public funding, local hospitals generally experienced great difficulty in operation except the People’s Hospital and the TCM Hospital. Most public hospitals and the 11 central township hospitals in S county were heavily indebted. All levels of public health facilities relied mainly on user fees to support their operation. Now in rural areas of the county, the collective financing of health care has given way to predominantly private payment. The majority of rural households needed to pay out-of-pocket money for health services. Urban

³ ‘Policy Suggestions to Further Accelerate Private Economy’ (*guanyu jinyibu jiakuai mingying jingji fazhan ruogan zhengce de yijian*), by CPC S Provincial Committee and S Provincial Government, July 1997.

⁴ ‘Implementation Measures on the Transformation of Health Units’ Internal Management Mechanism’, (*S xian zhuanhuan yiliao weisheng danwei neibu jingying tizhi de shishi banfa*), S County Health Department Report, May 1994.

residents without insurance also relied heavily for out-of-pocket payment for health care. Thus, the burden of financing health care was largely shifted from public providers to household individuals.

3.2 Granting of private medical practice in regulatory legislation

The advent of privatisation in health service provision and financing reflects changes in policy orientation and preference. The growth of private sector in health care was resulted not only by the privatization of the public or collective medical facilities, but also the increase of newly founded individual medical practice since the market reform.

In the beginning of 1980s, the local government has allowed the private medical practices. Followed the issue of *Report on the Granting of Permission for Solo Private Medical Practice* in 1980 which legitimized the private medical practice at the national level, the provincial government published the *Interim Measures on the Administration of Individual Medical Practices in S Province (S sheng geti kaiye xingyi ren yuan zanxing guanli banfa)* in 1981, which restored the legalization process of private health practices. In implementation, S county health bureau ratified some qualified private medical practitioners to open individual clinics. The local authority allowed the ratified medical practitioner to work in fixed place taking specified medical practices, but was not allowed to sell medicines; pharmacies could employ certificated doctors (*zuotang yisheng*) to prescribe drugs and treat patients. (SCCEC 1990⁵) In 1983, all health professionals were required to take examination, through which 367 health practitioners became licensed ‘village doctor’ and 1201 got certificate as primary health worker (out of the 1868 barefoot doctors and 4880 health workers in rural area in 1977) (SCCEC 1990: 933). Some of these licensed health professionals went into the private medical sector. Till 1985, the county had 267 registered individual private medical practitioners including 24 who operated in the city (SCCEC 1990: 934).

However, it was not easy to pass all the examinations, particularly for the non-institutionally trained medical practitioners. This prevented some old doctors, barefoot doctors and rural medical practitioners from publicly opening their clinics. Most of these doctors and medical workers then changed their profession or took private medical practices illegally. Due to the incomplete legislation and unregulated market, many travelling medical peddlers (*youyi*) also re-emerged in the market since the 1980s. In the city alone, there were about 40 to 50 ambulatory medical stalls every market day with unevenly skilled practitioners and unqualified medications, not to say the uncountable numbers in the rural areas (SCMB 1988: 102). While forbidding these unqualified medical peddlers, the local health authority also embarked to openly give examination to all those who apply to open private clinics from 1989. In 1990 they set up the personal records archives for all the private doctors and tried to eliminate those

⁵ From S County Chorography Edit Committee (SCCEC) (eds.), *S County Chorography (S Xian Zhi)*, 1990, volume 25, Chapter 3, Section 5. Since the page number is missed in the scanned material, I denote the section of the source here.

without licence. In 1993, the local health department further stepped in to relax the approval of private health practice, and there were already 327 solo-operated private clinics in the county.⁶ On the other hand, the local government allowed limited space for public doctor to operate private clinics. Although the national reform proposed to give greater staffing autonomy for public health facilities and encouraged public personnel to go into individual practice⁷, in the local county it still strictly forbade public health professionals to open private clinics or work in private medical institutions. Those who open private clinics would be regarded as resigned from the public employment, and would never join the public system (SCCEC chapter 13, unpublished).

In 1990s, two significant national policies were released. First, *The Medical Institution Governing Regulation*⁸ in 1994 required all health institutions to get the Medical Institution Practice Licence. The local county began to examine, approve and register every medical institution in the county, and issue the Medical Institution Practice Licence for the qualified ones from the following year. Second, *The People's Republic of China Medical Practitioner Act*⁹ in 1998 launched the doctor license system which clearly indicated all doctors were required to get the Medical Practitioner Licence before taking part in medical practice. It clarified the requirements of the license examinations, licensing procedures, as well as the rights and obligations of doctors. Since then, only the private clinic with both Medical Institution Practice Licence and the Medical Practitioner Licence could legally operate in the county. State medical workers were still explicitly prohibited from private medical practices¹⁰. Besides, a health supervision team was organized in the same year to supervise the health related services and remove the unlicensed private medical institution. In 2005 alone, 53 unlicensed private clinics were cleared out in the county (SCCEC chapter 6 and chapter 13, unpublished).¹¹ In 2007, the provincial government suggested the local authorities to further open the health market to private sector.¹² The policy generally tends to relax the public control and encourage private investments while tightening the supervision on private medical practice.

⁶ From the 1994 published report by the local health bureau (protected Reference).

⁷ 'Policy Suggestions to Further Accelerate Private Economy' (*guanyu jinyibu jiakuai mingying jingji fazhan ruogan zhengce de yijian*), by CPC S Provincial Committee and S Provincial Government, July 1997.

⁸ *The Medical Institution Governing Regulation* (*yiliao jigou guanli tiaoli*), available at http://www.gov.cn/banshi/2005-08/01/content_19113.htm, accessed May 13, 2010.

⁹ *The People's Republic of China Medical Practitioner Act* (*zhonghua renmin gonghe guo zhiye yishi fa*), available at http://www.gov.cn/banshi/2005-08/01/content_18970.htm, accessed May 13, 2010.

¹⁰ In *The Medical Institution Governing Regulation* released by the Ministry of Health in 1994, Article 12 clearly forbids the health professionals who still hold the public post, get early retirement due to illness, or are on unpaid leave to apply setting up medical institution.

¹¹ In 2005, a provincial announcement came down to suggested local level government tightened the supervision and administration of medical institutions and professionals, control illegal medical practices, from 'S Provincial Health Department notice on further strengthening the practice approval, supervision and management of medical institutions and health professionals', 2005.

¹² The regulation could be found on Section 1, Item 2, in 'Policy Suggestions to Further Promote the Development of Private Enterprises' (*guanyu jinyibu cujin mingying qiye fazhan de ruogan yijian*) by CPC S Provincial Committee, S Provincial Government, 2007.

As a conclusion, in S county, there was a termination of public health service provision (including village health stations and township health centres). The public hospitals in the city also commercialized their services. The financing of health care has largely changed with reduced state and collective funding, increased private investment and out-of-pocket payment. Besides, the policies tend to relax on the private medical practices, grant licence to the qualified health institution and qualified doctors while strictly regulated the illegal medical practices and public health professionals. In general, there was a shrinking role of the state, and rapidly enhancing role of the private sector in health care.

4. THE COEXISTENCE OF PUBLIC AND PRIVATE HEALTH CARE IN THE NEW HEALTH REFORM

The privatisation and commercialization of health care since the 1980s transferred the health care responsibility to individual patients. Health care became a heavy burden for many people. But the state has not established an effective regulatory system to minimise the unfavourable impacts of health care privatisation. The outbreak of SARS in 2003 further exposed the problem. Since then, the government has begun to reassert its role in public health care, particularly the de-privatisation of hospitals below the county level (Tam 2010), and rebuilding public primary health system.

The most notable change was the release of the 2009 health care reform plan¹³ that aimed at universalising basic healthcare and insurance coverage. In the 2009 health reform blueprint, one way to improve the equity and accessibility of health care is to “improve services of grassroots medical institutions, especially hospitals at county levels, township clinics or those in remote villages, and community health centres in less developed cities”¹⁴. Huge investments are put to facilitate the rebuilding of public health institutions. The number of township hospitals in S county increases from 11 to 31 with one township hospital each town, and the 11 central township hospitals are refurbished and expanded. Village clinics are also rebuilt. At least one village clinics are set in each village to take primary health care and public health work. Four community health centres are opened in the city to improve health care at the grassroots level. Investment in county hospitals has also increased. Besides, the government set to raise the health insurance coverage such as the establishment of ‘New Cooperative Medical Scheme’ to rural population and Medical Insurance for urban residents. Funding came down from above to achieve universal basic health insurance. The insurance costs are mainly borne

¹³ ‘Opinions of the CPC Central Committee and the State Council on Deepening the Health Care System Reform’ (*zhonggong zhongyang guowuyuan guanyu shenhua yiyao weisheng tizhi gaige de yijian*), 6th April 2009, available at http://www.gov.cn/jrzq/2009-04/06/content_1278721.html, accessed 27th January, 2011. An English version is available at http://www.china.org.cn/government/scio-press-conferences/2009-04/09/content_17575378.htm, accessed 5th February, 2011.

¹⁴ ‘China Passes New Medical Reform Plan’, available at http://news.xinhuanet.com/english/2009-01/21/content_10698501.htm, accessed April 24, 2009. Also see ‘China Health Reform to Give Every Village a Clinic’, available at <http://news.bionews.com.cn/news/130/ARTICLE/2123/2009-04-12.html>, accessed April 23, 2009.

by different levels of government while small parts are contributed by individuals. In general, there is a significant expansion of public funded and public provided health care in the county.

While public health sector is expanding, private medical providers are also increasing. The new health reform denotes “qualified doctors will be allowed to work in more than one health facilities and open their own clinics”¹⁵. The new health reform encourages private and foreign investment into health sector and gives policy incentive for the development of private medical facilities¹⁶. It aims to develop diversified types of health care, supplied by both public and private sector. The private medical institutions began to be regarded as ‘important part’ of health sector, instead of the previous ‘useful supplement’ of public health institutions. It further confirmed the equal status of private and public health services. In S county, private hospitals began to emerge after 2000s with four in 2008, eight in 2012, and the number is continually increasing. Besides, private hospitals are incorporated into the national health insurance system. Patients could use their medical insurance in private hospital as that in public ones. It greatly encourages local health professionals’ willingness to found and invest in private hospital. The private health sector is still small in terms of the scale of services it provides. It is yet to form a mature market, and there are multiple challenges for its further development. However, it can be expected that the private sector in health care area will expand rapidly over the following years.

5. CONCLUSION

In short, prior to the 1980s, medical facilities increased rapidly in the public sector while reduced greatly in private sector. In the post-reform era, health care organizations increased mainly in private sector, while public health facilities in the rural areas were heavily dismantled. In the new health reform, medical institutions keep increasing in both public and private sector, and a double process of privatisation and de-privatisation coexist, which is significant to China’s health care transition. Now China is at the crossroads in transforming its health care system in order to make it more effective, efficient, and accountable. Under the new health reform, it is hopeful to find a suitable way of public/private mix and a balanced and shared role of the state/market that best fits to the society.

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¹⁶ ‘Notice about suggestions on further encourage and guide social capital to operate medical institutions’ (*guanyu jinyibu guli he yindao shehui ziben juban yiliaojigou yijian de tongzhi*), available at http://www.gov.cn/zwgk/2010-12/03/content_1759091.htm, accessed 8th April 2013.

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