Leadership failure in health care and China's system of hospital price regulation

Alexandra Fox

Today, China faces a leadership crisis that is plaguing its health care system. Leaders' failure to adequately address the problems in health care or take responsibility for public health funding have been coupled with misguided policies to produce a perverse incentive structure and price distortion of medical goods and services. This system now poses a major challenge to the government's own efforts to control the rapidly increasing costs of health care. Reform efforts have thus far failed to critically self-analyze, and so have not eliminated the waste and inefficiency surrounding China's health delivery system. Leadership failures in coordination, implementation, and regulation across different levels of government and between bureaucratic divisions and health administrators have allowed a system of price regulation to transform hospitals into profit-making entities. The acknowledgment of the waste and economic burden produced by such a system should encourage leaders to reassess the current methods of hospital financing, and reform efforts in hospital management and performance evaluation undertaken to encourage appropriate policy implementation and combat profit-seeking incentives.

The first failure in leadership that has spurred China's health system to its present state is simply leadership neglect. During China's economic rise, health care was marginalized as an issue, sidelined in the pursuit of economic growth. Thus, in the period after Mao's death, declining government support pushed health care facilities to find other ways of generating revenue and remain afloat. While recently

the government has indeed made significant efforts to improve public funding for healthcare, government spending as a percentage of total health-care spending reached only 24% in 2010 (Huang, 2011), and is still low compared to OECD economies. Government spending as a percentage of total health-care spending in the United States is 44% (CDC, 2009), and 78 percent in France (KFF, 2009). Similarly, out-of-pocket payments as a percentage of total health expenditure have declined recently, but remain high at 78.9% (World Bank). In terms of fairness of financial contribution, based on the fraction of a household's capacity to spend that goes toward health care, China ranked among the least fair along with Sierra Leone, Myanmar, and Vietnam (WHO, 2000).

Inadequate public funding means that the central government covers only about 30% of total funding for public health, with the remainder of the burden falling on local governments. The ability of local governments to allocate resources towards healthcare, however, varies greatly between urban and rural areas. Though local authorities frequently become burdened with the task of funding public health, this responsibility is again skirted. Because cadre performance is often rewarded based on delivery in areas such as GDP growth, local officials follow the lead of those above them who are preoccupied with GDP growth, and similarly become largely unmotivated to invest significant attention or resources in health care.

The lack of government support has thus forced hospitals to find ways of generating their own revenue. Government subsidies in total cover only about 10% of the costs health care providers face (WB, 2010). The remaining 90% must be generated by health care facilities themselves in order to continue providing

medical services. To do so, hospitals rely on the sale of over-priced drugs and high tech diagnostic services, which the government allows them to mark up to a 15% profit margin. The government policy of price regulation exacerbates the need for hospitals to rely on sales of high-profit goods and services. The government maintains basic services and appointment fees at 40-50% of their actual cost, creating a large gap between the average unit cost and the regulated fee of the majority of health services. The price setting approach produces a leveraging effect in which hospitals must sell 7 USD in order to earn back 1 dollar profit (Yip, 2009). With a cost-recovery rate of 50% on most medical services and government subsidies constituting only 10% of hospital costs, health facilities must cover 40% of their costs by other means. The need for providers to make up the loss incurred in providing basic services combined with the potential for revenue in selling high-priced drugs and diagnostic tests creates a perverse incentive structure in which health care facilities oversell profitable services. There is a heavy reliance on drug sales to recover costs; drug revenues make up over 40% of gross income in Chinese hospitals, compared to a range of 15 to 25% for OECD countries (Mu, 1996).

The failure of leadership to appropriately address the growing costs of health services ultimately means that the responsibility of paying for health care lands heavily upon the patient. Because a large portion of the population has little or no insurance, patients must bear the costs of expensive tests and treatments. The government policy of price regulation has essentially turned health care facilities into profit-driven entities, which strategically over-sell drugs and services with high profit margins. The incentive to participate in such behavior can lead to the

unnecessary provision of treatments, at the patient's expense. In China, 79% of hospital patients are prescribed antibiotics, more than double the international average of 30% (Yip, 2009). Similarly, the significant fall in the number of positive cases of patients who undergo CT testing similarly suggests that such high-priced diagnostic tests are ordered unnecessarily. The number of positive cases for patients who underwent CT testing was between 10-20% in 1995, compared with 50% in 1988[1] (Mu, 1996).

This profit-seeking behavior, encouraged by misguided government policies, is allowed to run rampant in the absence of any directed efforts to curb or control it. The Ministry of Health (MOH) plays the main role in shaping policies in public hospitals; health authorities also directly appoint public hospital administrators. Aside from these appointments, however, health administrators themselves are minimally involved in day-to-day hospital activities, and there is a large lack of external oversight. Public hospitals have full autonomy when it comes to the purchasing of drugs and medical equipment. While the government monitors the cost and sale of these items, evidence of distorted service provision, under-the-table payments, and law-enforcement issues with charges of services costs above the regulated price point to the failure of the State Pricing Commission and central government to control these activities.

These regulatory failures are compounded by systemic structures that further encourage the overprovision of certain drugs and services. Within hospitals, personnel autonomy is low, and performance assessment is often focused on subjective evaluation (WB, 2010). Bonuses have become an important part of

doctors' salaries, and physicians in public hospitals are rewarded for revenue-generating activities. Thus hospital leadership passes along the incentive to participate in profit-seeking activity, which is implemented by physicians and other providers. Across hospitals, the fee-for-service payment model additionally encourages physicians to over-provide often unnecessary treatments, promoting quantity over quality of care. Finally, because health authorities have also been unable to integrate or coordinate China's fragmented health care delivery system, wasteful procedures are unnecessarily order when patients move between hospitals. Many facilities will treat or hold patients when they should be referred to a different level of care, and tests are often repeated when patients do move between providers.

The inability of officials to target these systemic deficiencies and address the distorted pricing structure has now led to a rapid increase in total health care expenditures. Annual health care spending more than doubled between 2007 and 2010, with continued double-digit growth (Frost and Sullivan, 2011), and drug expenditures grew at an annual rate of 15% between 1990 and 2001 (Meng *et al*. 2005). While some instances of reforms moving away from fee-for-service systems have had some success, attempts to combat the increases in health expenses through drug price regulation reform have not. Wagstaff *et al.* (2009) report that hospitals were able to circumvent reform attempts by shifting to drugs whose prices are not controlled, or simply further increasing drug sales.

While CCP leadership has now clearly recognized the need for large-scale health care reform, the politics in China's administrative agencies and the

sometimes-divergent bureaucratic interests pose a challenge to the scope of reform. The number of departments in the Ministry of Health has grown, each with its own administrative capacities. There is a diffusion of political power, which consequently makes it easier to shirk political responsibility, especially in the area of public health financing. The opportunities for political advancement often means that Chinese officials are most pressingly concerned with the expectations and demands of those above them, and not, foremost, to the general public. Because cadre performance has so consistently been measured by the delivery of economic growth, there is little incentive for local authorities, when burdened with the task of improving local healthcare, to follow through. In order to really address the issues in healthcare and adjust or control the effects of the government's regulated pricing policy, bureaucratic agents and individual actors must be held accountable for their respective responsibilities in funding and improving the health care system.

Additionally, measures should be taken to realign bureaucratic and individual interests with party interests, and with the public interest. Bureaucratic interests may further conflict with the stated goals of the politburo due to entrenched interests in the bureaucracy. The MOH largely represents the interests of public hospitals, physicians, and health-care workers, and the institutional collusion between the MOH and public hospitals means that the opportunity for corruption, misallocation of government funds, and inefficient payments are likely to persist. In the absence of external oversight or regulatory committees, the MOH has not and is unlikely to curb profit-seeking behavior. As mentioned above, attempts at drug price regulation reform have failed because providers were able to

circumnavigate the new policies. There is additionally collusion between providers and pharmaceutical companies, and hospitals will often receive kickbacks for prescribing certain drugs.

Without appropriate monitoring agencies and regulatory oversight, such behavior can run unchecked and very negatively impact the population when hospitals are encouraged to sell drugs not only high in price, but low in quality. In the absence of citizen groups to check and report on government misbehavior, the government should itself establish an independent evaluation agency to monitor the use of public funding for health care and implementation of health policy. Administrative agencies and local governments can then be held responsible for health outcomes. Constructing an independent supervisory structure is one way in which to restore a system of checks and balances, and assure that cooperation between policy-makers and implementers are not managing public funds inefficiently. Without monitoring system to effectively supervise policy implementation, increased public funding for healthcare and attempts to reform hospital price distortions may have little effect.

The failure of Chinese leadership across and between government levels and institutions has produced healthcare system in which providers have become profit-seeking machines, driving up total health care expenditures and exacerbating the problems of unaffordable healthcare and medical impoverishment. The CCP's own need for legitimacy makes it difficult for them to shift prices for basic health services closer to their actual costs, as doing so could exacerbate the public's perception of unaffordable and inaccessible health care, spurring social unrest. The distorted

pricing structure, however, has resulted in rampant health spending and is ultimately unsustainable. In order to reform the healthcare deliver system, the central government must seriously reassess its own leadership and performance criteria in evaluating the policies and behavior of health authorities and local governments, in order for policymakers to seriously consider the issues in health care, and assume responsibility for public financing and policy implementation. Additionally, new leadership is needed in the area of monitoring and regulation to combat the current distorted pricing structure that has produced distorted provision of medical services and rising economic burden.

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