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Public hospital autonomy in China in an international context

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SUMMARY

Following decades of change in health care structures and modes of funding, China has recently been making pilot reforms to the governance of its public hospitals, primarily by increasing the autonomy of public hospitals and redefining the roles of the health authorities. In this paper, we analyse the historical evolution and current situation of public hospital governance in China, focussing the range of governance models being tried out in pilot cities across China. We then draw on the experiences of public hospital governance reform in a wide range of other countries to consider the nature of the Chinese pilots. We find that the key difference in China is that the public hospitals in the pilot schemes do not receive sufficient funding from government and are able to distribute profits to staff. This creates incentives to charge patients for excessive treatment. This situation has undermined public service orientation in Chinese public hospitals. We conclude that the pilot reforms of governance will not be sufficient to remedy all the problems facing these hospitals, although they are a step in the right direction. Copyright © 2013 John Wiley & Sons, Ltd.

KEY WORDS: public hospitals; autonomy; China; governance; reform

INTRODUCTION

As Yip and others (Yip and Hsiao, 2008; Yip *et al*., 2012) point out, the Chinese healthcare system is at a crossroads. It has been acknowledged by the Chinese leadership that the transformation of the health system from a centrally planned one to a market-orientated one since the late 1970s had a deleterious effect on access to healthcare for many people (Cao *et al*., 2012). In the new millennium, the government responded to this problem by committing itself to increase government funding for health care by between 1 and 1.5% of GDP, aimed at providing universal basic healthcare (Feng, 2006), and indeed, between 2006 and 2007, the central government increased its healthcare budget by 87% (Ministry of Finance, 2007).

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But it is not enough simply to increase spending on healthcare; it is also necessary to reform the healthcare delivery and payment systems to achieve efficient and effective healthcare for all (Yip *et al.*, 2012). Following the announcement of a major health reform programme in 2009, there has been a series of major policy initiatives attempting to improve aspects of the Chinese health system (CPC Central Committee and the State Council, 2009). First, a new cooperative insurance scheme has been set up to provide rural residents with a financial safety net to cover catastrophic healthcare expenses, as the former rural insurance schemes collapsed in the late 1970s when rural communes disappeared. Many varieties of these schemes exist all over China with different benefit packages and administrative arrangements (Wagstaff *et al.*, 2009). Overall, 97% of rural residents are now covered by health insurance (albeit with much less than total reimbursement), and 89% of urban residents are also covered by other schemes (Parry, 2012). Second, primary care is being strengthened in the cities by the introduction of community health centres, which are designed to redirect patients from hospital services (Wang *et al.*, 2011). Third, public hospitals were told to shift their emphasis back from commercial priorities, which had been thrust on them during the introduction of market based reforms to put the public interest first (CPC Central Committee and the State Council, 2009). This paper will consider an aspect of this third policy initiative concerning the changes in the governance and orientation of public hospitals. The relevant policy relates to the increase in autonomy for some Chinese public hospitals. The policy is in its early stages, and there is very little evidence yet available from Chinese hospitals. We can investigate the policy by using a tool designed by Harding and Preker (H&P) (2000) to analyse hospital organizational reform (Harding and Preker, 2000) and by drawing on the experience of other countries that have also been experimenting with changing the governance of their public hospitals to increase autonomy. We begin by setting the scene for policies aimed at increasing public hospital autonomy across the world. Then we explain how public hospital governance in China has changed over the past 60 years, and use the H&P tool to analyse the recent attempts to increase autonomy. We then relate these current experiments to developments in other countries and what they have learnt. We then return to the Chinese situation to consider the likely effects of current policies there.

PUBLIC HOSPITAL GOVERNANCE REFORM ACROSS THE WORLD

China is not alone in reforming the governance of its public hospitals. In many countries, including China, public hospitals traditionally operated under a ‘command and control’ model, where many decisions were made at a governmental level higher than that of the hospital itself. One of the problems identified by critics of this model of governance was the inability to separate local operational decisions inside the hospitals from the overall policy responsibility of politicians (Duran *et al.*, 2011); and the slowness and unresponsiveness of local decision making (Allen, 2006). This is regarded by some as an example of general problems of inefficiency caused by bureaucratic and monopolistic public management (Buchanan and Tollison, 1984). To deal with the problems perceived to be caused by ‘command and control’

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structures, the goal of increasing autonomous management for public hospitals has been pursued in many countries across the world since the late 1980s (Saltman *et al*., 2011).

In this context, autonomization can be understood as 'autonomy from oversight in the form of goal setting or supervision over operational decisions and therefore denotes greater discretion in tasks and function' (McGrath, 2001). Clearly, no hospital will be fully autonomous, as there will be government and regulatory frameworks to which it must adhere. Autonomy can be seen as a continuum, which involves degrees of delegation of responsibility for the operational management of hospital services (and sometimes strategic management too) from central ministries of health to hospitals themselves (Pearson, 2000).

In many cases, a range of measures has been introduced, including internal incentive systems; introduction of boards of trustees/supervisors; senior managers becoming non-politicized professionals rather than party members; operating surpluses being rolled over by the hospital to be used by the hospital in the next budget year; and capital being raised from the private sector (Saltman *et al*., 2011).

These reforms can be seen as part of a wider trend in the management of public services to introduce mechanisms found more usually in the private sector (Hood, 1991). It is often referred to as an aspect of New Public Management (NPM) (Clarke and Newman, 1997), which uses the introduction of different levels of institutional autonomy and some degree of market incentives in an attempt to improve public services. The objectives of these reforms often include improving the internal efficiency of the public organizations, improving user satisfaction and improving public accountability and transparency (Pearson, 2000). The economic theory behind these policies is that autonomy of public organizations (especially in the context of a degree of market competition) improves performance by creating stronger incentives for managers to perform better and that decentralized decision making is swifter and more responsive to local needs (Allen, 2006).

> '*In the same way that the private sector is often efficient in maximising profits, it is argued that by recreating elements of the environment found in the private sector, public hospitals can be encourage to maximise* [*a range of*] *objectives. In short, performance is enhanced by adopting a more business like approach.*' (Pearson, 2000, page 7).

The process of granting public services has increased autonomy and has also been designated as a form of 'corporatization' (Harding and Preker, 2000).

EVOLUTION OF PUBLIC HOSPITAL GOVERNANCE IN CHINA

In the light of trends in public hospital governance, we now turn to the unique evolution of public hospital governance in China. Public hospitals form the backbone of healthcare services in China. The number of public hospitals amounts to 66.2% of all hospitals but 95% in terms of hospital beds (Ministry of Health, 2010). The doctors/assistant doctors and nurses working in public hospitals account for 89.7% and 91.0% of the total manpower, respectively (Ministry of Health, 2012).

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The Chinese communist nation was established in 1949 on the basis of a socialist ideology and planned economy. A command and control model was applied to the government, to industry and to public services. Public hospitals were established by the government at different levels (central and local) to provide healthcare to its citizens with full fiscal subsidies, and the government at each level played a full role as sole financer, administrator and regulator (Wang, 2009). The president and major managerial staff were typically appointed by the government, and they were directly accountable to the government (Li, 2006). The government also strictly enforced a salary schedule, as well as a fee schedule lower than the marginal cost of the drugs and services provided (Yip *et al*., 2010). The purpose of this fee regulation is to guarantee the affordability of basic healthcare to all citizens.

China's undeveloped economic status and the political unrest during the Cultural Revolution era in 1960s increased problems in healthcare delivery. Deficits of public hospitals was already becoming a prominent issue (Li, 2006). Meanwhile, the infrastructure and equipment in public hospitals were hardly able to meet demand for care (Li, 2006). Healthcare delivery became increasingly difficult for the government to sustain. The initiation of the market economy reform officially ended the welfare health era in China in 1978 (The Third Plenary Session of the 11th Central Committee of the C.P.C. 1978), and significant changes were made in the public hospital sector as a consequence. Under the principle of market economy, as a result of the government's retreat from financing public hospitals, these hospitals had to find a new way to survive financially (State council of China, 1985). In 1986 legislation was enacted, which gave public hospitals the status of 'public legal persons' (Civil Law, 1986). This symbolized the beginning of autonomization for public hospitals. Despite their legal person status, public hospitals have not been granted the rights of autonomous legal persons. In spite of the policies promoting financial autonomy, the government retained control over the appointment of most key managers, continuing the 'command and control' model in this respect. Overall, public hospitals are still accountable to the hierarchical authorities (Li, 2006). They are subjected to multiple bureaucracies including the Ministry of Health, the National Development and Reform Commission, the Ministry of Finance, the Ministry of Human Resources and Social Security and the State Food and Drug Administration (see details in Yip, *et al*. 2012). Public hospitals still have no discretion over human resource management, including salary rates. And the government enforces a fixed fee schedule for many healthcare services that is still quite similar to the planned economy era (despite being after 30 years of market economy reform). Operational intervention from the hierarchical authorities has been reducing gradually, but most ministries still exert major power over public hospitals.

On the other hand, the government has been encouraging public hospitals to maximize revenue and be financially self-sufficient, primarily by producing financial incentives for hospital staff. In 1992, Ministry of Health issued a document entitled, 'Several Suggestions on Deepening Health Care Reform' (No. 34 document) (Ministry of Health of China, 1992), which officially endorsed more financial autonomy for public hospitals. According to this policy, public hospitals began to be allowed to retain financial surpluses they generated and to be obliged to bear all debts and operating losses. Importantly, public hospitals were permitted to

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distribute their financial surpluses to their staff. This has been considered by the government as an incentive to improve efficiency, as well as compensation to appease unrest among health professionals caused by their low salaries set by the government. These salaries are significantly lower than those of health care providers from the US, which are 5 times higher than the average wages, being only 1.2 times average wages (Liu, 2012). And the government officially allowed a 15% mark-up on prescribed drug prices. Together with the fee-for-service payment schedule, health care providers in public hospitals became heavily dependent on service volume and drug sales (Lui and Mills, 1999; Reynolds and McKee, 2011). Clearly, this created perverse incentives for providers. Almost all independent research and official data have shown that over 80% of hospital revenue was from sales of services and medicines (Hsiao, 2007; Yip *et al*. 2010). In the meantime, basic health care prices were set below cost, while prices for new and high-tech diagnostic services were set above cost (Ma *et al*., 2008), and cross-subsidization was soon spread throughout the system.

Commentators have seen the illegitimate mix public and private mechanisms as the root cause of much of China's rapid escalation of healthcare expenditures, inefficient use of resources, poor quality and erosion of medical ethics (Hsiao, 2007).

In the past three decades, the governance of public hospitals in China could be characterized as a distorted semi-autonomous model. The 'command and control' model had not been entirely overturned, and autonomy had not been fully established.

RECENT DEVELOPMENTS IN PUBLIC HOSPITAL GOVERNANCE IN CHINA

One of the major objectives of the latest healthcare reform in China since 2009 has been to alleviate the lack of affordability and accessibility of health care. Public hospital reform was highlighted as one of the key areas, together with universal health insurance coverage, grassroot health institutions and an essential drugs system. The relevant objective is clearly defined as the goal of restoring 'not-for-profit' status for public hospitals (Chen, 2009). Different reform measures were included in the 'Public Hospital Reform Pilot Plan' enacted by the central government (Ministry of Health, 2012). The central government encouraged hospital and local initiatives. Among these, governance reform (in many cases including increasing hospital autonomy) has attracted most public attention, as it is hoped that economic efficiency, care quality and social solidarity could be achieved through this means.

The core reform policies were known as 'four separations', and all of them were related to public hospital governance. The first is 'separation between not-for-profit and for-profit hospitals'. This foresees completely different policies in respect of private, for-profit hospitals. There are very few independent not-for-profit hospitals, so the policy is mainly aimed at public hospitals. The second is 'separation between drug sales and hospital revenues'. This envisages that

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the perverse financial incentive of drug sales being a major contributor to hospital revenues should be removed. The third is 'separation of governmental administration from hospital management'. This envisages that the political authorities to which the public hospitals are accountable should not intervene in the internal management and operation of public hospitals. This is meant to reduce the hierarchies, make the governance structure flatter and increase the autonomy of hospitals. The fourth is 'separation between ownership and regulators' (Ministry of Health, 2010). This envisages that the owners of public hospitals (which include the Ministry of Health, or other public bodies, such as local government, universities or the military) should take a hands-off stance to rebuild regulatory legitimacy. This is necessary as the Ministry of Health is both the primary owner and the primary regulator in the current system.

In this context, pilot reforms of public hospital governance were officially initiated in 2010. Some hospitals have actively participated in these reforms, while others have reacted passively. In February 2010, 16 cities (from eastern, western and middle China) were announced as pilot sites (Ministry of Health, 2010), and Beijing was announced to be the pilot site in 2011 (Mao, 2011). The reforms have been primarily driven by local initiatives at the municipal level and each city has adopted different individual reform measures (Yip *et al.*, 2012). There have been a few local attempts towards full privatization,[1] but most of the rest have adopted governance reform following the central government's guidance and have begun to change their governance structures (Yip *et al.*, 2012)

The pilots have been running 2 years. There are two leading models. The first has embraced the objective of 'separation between ownership and regulation', and the second has been trying to make the operation of public hospitals more independent from the government. The application of these two measures varies from city to city.

We will start by discussing the governance models that separate ownership from regulation.

In Shanghai and Wuxi, as shown in Figure 1, arm-length bodies 'Centres of Hospital Management/Development' (CHM) have been established as the owner and direct hierarchical superior to the public hospitals. The CHM is equivalent to the local health bureau with regard to its administrative level and is directly accountable to the local municipal government. CHMs are responsible for strategic planning, major asset supervision and investment, appointment of hospital presidents and performance evaluation on behalf of the municipal

[1]Privatized hospitals are not subject to the fee or salary levels imposed on public hospitals and may distribute any profit to their owners. To increase funding available for healthcare in China, privatization of public hospitals first appeared in the late 1990s. The first case took place in Suqian in Jiang Su Province in 1999. But the outbreak of SARS led to a halt in the process, as the Chinese government was concerned to preserve the public health protection network. Because the 2010 public hospital reforms were introduced, some local governments have obtained financing from capital markets to reduce their own financial burden. For example, in Suqian, the government transferred nearly all public hospitals to private hands through auctions and employee share ownership. And in Xinxiang (Henan Province), the government sold 70% of its assets in public hospitals to a state-owned company (Huayuan).

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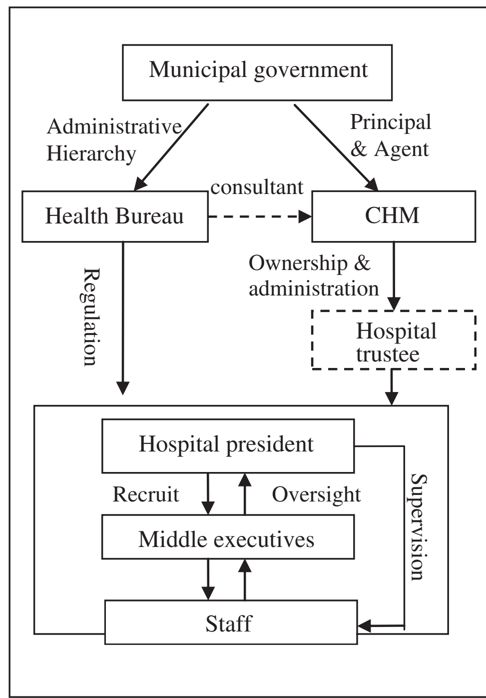

Figure 1. Governance Model in Shanghai and Wuxi.

government. The local health bureau retains its right of supervision of public hospitals.

The governance structure and mechanisms for these two cities are quite similar despite the fact that Shanghai established an additional organization, in the management hierarchy, being the hospital trustee. This difference implicitly indicates that the CHM in Wuxi is a government-like agency, whereas the one in Shanghai is more similar to a corporate one. This difference is also reflected in their respective driving forces for governance reform, organizational structures and human resources. The major driving force for the governance reform in Shanghai was the need to expand financing channels for public hospitals. The CHM in Shanghai was actually converted from a state-owned enterprise for health care *investment* named Shenkang; whereas in Wuxi, the central government reform guidance has been followed. Shanghai has put improvement in hospital management and operation as the first priority, whereas Wuxi focuses on rationalizing the power of the government. Regarding organizational structures, the CHM in Shanghai has a department for supervising the use of assets and a department for investment and construction. On the other hand, in Wuxi, there is no specific department for investment, and the function of supervising assets is merged into the accounting department.

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Some of the staff of the CHM in Shanghai used to be employees of the investment enterprise, whereas one third of the staff in Wuxi's CHM is from the local health bureau (Fang, 2010).[2]

Beijing was the last of the 17 cities to begin its governance reform pilot. The experience from its predecessors has shown that coordination between the CHM and the health bureau generates additional costs. And there has been resistance to changes of employer by some former health bureau officials who ceased to be government employees when they joined the CHM. In light of these problems, the CHM in Beijing is subordinated to the local health bureau (as shown in Figure 2). However, many scholars and practitioners suspect that the overlap between ownership and regulation and dual appointments for staff working in the CHM may linger (Fang, 2012).

Now, we turn to the governance models that separate government administration from hospital management. In cities such as Suzhou and Weifang, the government has been making efforts to withdraw from managing public hospitals. These models are designed to achieve more autonomous public hospitals. The local government delegates full rights of internal management and operational decision making to the hospitals. These consist primarily of human resource management (recruitment, salary levels and promotion), asset management, management of facilities, as well as administrative management. The government's responsibility of supervision is achieved through contracts with the hospital presidents (every 3 years) (World Bank, 2010). Specific organizational aims such as 'people-centred care' and focus on quality are included in the contracts. Performance indicators are also defined in the contracts. For example, performance evaluation in Suzhou is based on five dimensions: social function, efficiency, operation of assets, sustainability and employees' satisfaction. Performance evaluation is linked with financial incentives for the hospital president. Most pilot sites provide an annual bonus for hospital president the payment of which is dependent on the hospital achieving the targets set at the beginning of the financial year. The amount varies from pilot site to site. In Suzhou, a CHM has been also established; however, it is a private not-for-profit organization rather than a governmental or quasi-governmental agency. This CHM set up a management council, and the members are elected by a staff representative committee under government supervision (Huang, 2010).

In Weifang, seven major public hospitals have been converted into public institutions as full legal persons, no longer part of the government administrative agencies. And the problems caused by the dispersal of power throughout the various

[2]In almost all public hospitals in China, there are two groups of employees. One group has formal public-employment status (public hospitals and public universities are classified as public institutions in China); this group primarily consists of employees who joined their hospitals before 2000 and employees who have postgraduate degrees. The other group of employees has employment contracts with the individual hospitals, and they are not public employees. The hospital president is able to fire the latter group, but not the former. The reason why there are two groups is that the government controls the number of public employees and the hospitals have quotas, which are not large enough to staff them adequately. Officially, there are trade unions for hospital employees in China, but their bargaining power is very limited, as is the case for all unions in China. Thus, the unions have not been significant partners in decisions about the employment status of hospital staff.

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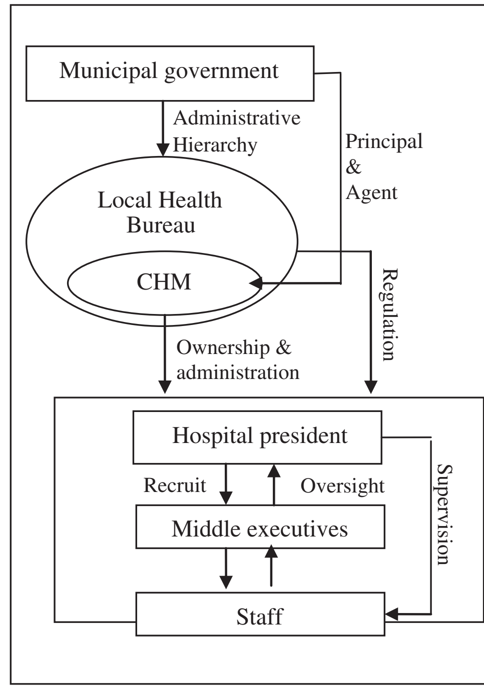

Figure 2. Governance Model in Beijing.

government bureaucracies are being addressed (Yip *et al*., 2012). A CHM affiliated to the health bureau has been established to coordinate the multiple government bureaucracies to which the public hospitals used to be subjected. These bureaucracies are in the process of withdrawing from administering these public hospitals.

ANALYTICAL FRAMEWORK

Having described the different models of increasing public hospital autonomy in China, we now introduce a useful analytical model for understanding these diverse models. This was proposed by Harding and Preker (2000) (The 'H&P framework', refer to Table 1).

In this model, governance of public hospitals can be presented as a continuum according to the extent to which so called 'private mechanisms' (i.e. NPM or even market) are involved. The continuum is characterized as moving from the most 'public' form of 'command and control' through 'autonomization' and 'corporatization' to actual 'privatization'. The H&P framework also sets out the structural changes made in governance and how these changes contribute to the incentive regimes in each organization.

The first aspect is about decision autonomy itself. Decision rights can be transferred to the hospital management. These can be over matters such as inputs

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Table 1. H&P Framework

Level of autonomy HP framework	Command and control	Autonomization	Corporatization	Privatization
Decision rights	None	Transferred operational rights to hospital managerial level	Legal person; full decision rights within budget constraints or other financial constrains; fully responsible for financial risks	Full
Residual claimant	Public	Retain surplus within global budget but only for another budget items	More flexibility to retain and use surplus, while responsible for loss at the same time	Distribute to owners
Market exposure	None Financing through budget allocation	Allowed to expand revenue from service provision in addition to budget	Setting financial targets; have to maintain and increase asset value by obtaining revenue	
Accountability	Up through the public administration hierarchy	Mainly accountable through the public administration hierarchy; also subjected to benchmarking of financial performance sometimes. Could have a board in place to govern daily operation	Board	Contract; regulation
Social function	Mandated to provide healthcare services regardless of ability to pay to whole population, but without additional financing (within the budget)	Clarified social function by the government; Specific financing	Fulfilled through government purchasing, insurance policy, consumer payment or political mandate	Fulfilled through government purchase, insurance policy or consumer payment

Source: April Harding and Alexander S. Preker, Understanding Organizational Reforms: the corporatization of public hospitals, Health, Nutrition and Population (HNP) Discussion Paper, Washington, 2000.

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(including human resources and procurement—Pearson, 2000), financial management, scope of activities and strategy. The degree of autonomy can be seen on a continuum between vertical hierarchy and management autonomy. Second, there is the question of the residual claimant, which is thought to affect the incentives operating on the staff. The theory is that greater incentives are produced for staff if they can keep some of the profits of the hospital. The continuum is seen as running from the public purse to the private individual. In this paper, we also want to distinguish consideration of the autonomy of hospital management to make decisions from the more specific right of the hospital management to distribute any profit made to the staff. Third, market exposure is important. The theory is that incentives will be enhanced if revenue for the hospital is earned in a market, rather than direct budget allocation. Fourth, accountability is important: as the market elements increase, accountability is thought to be promulgated through regulation and market mechanisms, as opposed to being enforced in a direct line through the bureaucratic hierarchy of the government. If the government is the purchaser of care, accountability can be enhanced through the use of contracts. There is no direct contradiction between increasing autonomy and increasing accountability—it is a question of how that accountability is promulgated. Finally, the ability of the hospital to carry out social functions is important. This means whether it delivers services to patients at a price less than cost. The increasingly strong financial incentives introduced by other aspects of the H&P framework are likely to undermine the capacity to do this, as it becomes increasingly necessary to break even. Thus, there is a continuum between what H&P call 'unspecified mandates' and those which are specified. By this, they mean the extent to which is it possible for the hospital to cross-subsidize care or find other ways of not charging full cost to users.

ANALYSING CHINA'S HOSPITAL AUTONOMY POLICY

We now use the analytical framework proposed by H&P to characterize current policies in respect of the governance of China's public hospitals. In respect of decision making autonomy, in spite of the variations in the extent to which the decisions are made locally, decision autonomy in all public hospitals in pilot cities has been increasing substantially, especially in the areas of human resource management and investment of assets. In fact, local decision making by the presidents and other executives, and investment in hospital infrastructure and equipment had been in place prior to the current reforms (because the government stopped subsidizing hospitals) but now these autonomies have become legitimate. This progress is more significant in the pilot cities such as Suzhou and Weifang, where the reforms are made to separate internal management of the hospitals from the governmental administration.

Accountability relationships for public hospitals have been streamlined in all the pilot cities. The CHMs, to which the public hospitals are accountable, are supposed to take over the responsibilities of ownership from the hands of the other bureaucracies. The problem is that, as we mentioned before, some of the CHMs are still comprised of staff from the governmental agencies, even the local health bureau.

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And currently in most parts in China, the hospital presidents and other senior staff still hold administrative titles as governmental officials.

Importantly, little impact has been made by the latest governance reform on the source of hospital revenue and the illegitimate financial incentives. There have been no indications of the government's commitment to provide more financial support for public hospitals, despite the fact that the government has made major investments in the community health care (Wang *et al.*, 2011). Public hospitals still have to survive by earning revenue from patient care. Thus, they are subject to market exposure. As a result, discretion for profit distribution at hospital level is still a major cause of supplier-induced demand and the soaring health expenditure.

Public hospitals in China traditionally have strong social functions, including response in the event of a social emergency, provision of disaster relief and public health. And in fact, public hospitals contributed greatly during the SARS outbreak (Xinhua News Agency, 2003) and the earthquake in Sichuan (Xinhua News Agency, 2008).[3] However, there is no explicit budgetary funding for the fulfilment of social functions. Particularly, the hospitals' interests in increasing revenues have weakened their social role. Although the government now provides medical relief to people who are uninsured or underinsured, the amount provided is insufficient. Most public hospitals have found it difficult to afford to provide free services to those who are unable to pay. Most of the pilot cities have not resolved this problem. In Weifang, the two public hospitals in the pilot programme have been officially relieved of their social responsibilities.

If we locate China in the organizational spectrum with respect to government and market mix according to the H&P model (2000), we find inconsistencies lie in the governance of public hospitals, which are a reflection of the mix of three governance models: the 'command and control', the 'autonomous model' and the 'corporatized model' in the current public hospital system in China. Characteristics of H&P's different models of governance exist concurrently in these pilots. The reform model 'separation between ownership and regulation' focuses more on rationalizing the roles of the health authority. Increasing autonomy is a by-product or a second priority. The pilot hospitals that adopt this reform model in respect of the domains of decision rights and accountability appear to resemble autonomous units. On the other hand, the reform model, 'separation of government administration from hospital management' focuses more on increasing internal hospital autonomy. Hospitals have more flexibility regarding their decision rights, financing and profit distribution (these pilot hospitals are officially permitted to distribute profits to staff, unlike other public hospitals that do so without such formal permission).

Thus, we can see that some public hospitals are gradually becoming free from hierarchical control, but governance reform of Chinese public hospitals is in its infancy. We do not know yet whether it will achieve its aims. Some early research has shown that operational costs have been decreasing; pilot hospitals have more freedom to recruit or lay off their staff; and hospital revenue has been increasing.

[3]During the SARS outbreak, 3600 beds for patients were offered by16 public hospitals in Beijing, and 63 public hospitals in Beijing set up fever clinics to receive suspected cases. After the Sichuan earthquake in 2008, public hospitals participated in emergency rescue and medical treatment

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However, there has been no evidence of improvement in care quality or social function, and illegitimate financial incentives continue (Fang, 2010).

In the following sections, we draw on other countries' experiences of similar reforms.

PUBLIC HOSPITAL REFORM ACROSS THE WORLD

Having analysed China's recent policies concerning public hospital autonomy, we will now consider what is known about other countries' attempts at similar reforms, using H&P's framework.

European countries

We can start with the European experience, which has been summarized recently in respect of eight European countries (Saltman *et al*., 2011). This book did not attempt to use H&P's framework, but we now do so here to investigate how the evidence relates to the Chinese situation. As far as decision making autonomy goes, this varies between European countries from a large degree of management autonomy in the Netherlands (where, in fact, the hospitals are non-profit private concerns and not public hospitals at all) to much more restricted management decision making in most other countries (e.g. Norway, Portugal and Estonia). England and Spain are seen as having a middling degree of management autonomy between the two extremes. In all these countries, command and control notions of direct political authority no longer exist. But, the authors note that all eight health systems show a tendency for political actors to try to reassert greater control over the hospitals over time. One reason for this is that (except in the case of the Netherlands) the hospitals are all still owned by the government, and in all cases, public funds are being spent to provide care. '[T]hus, there is considerable public concern that funds should be spent in a manner consistent with broader political and social objectives' (Saltman *et al*., 2011, page 67).

As far as the question of the residual claimant is concerned, none of the European countries allows actual distribution of profits to staff. But in some countries (not all), there are performance-related incentives for the autonomous hospitals' staff. Incentive systems are either defined by means of a consensus of the organization as a whole (in respect of some non-profit hospitals in Israel and some government-owned hospitals in Portugal) or agreed with individual staff members (Israeli government owned hospitals). The degree to which the autonomous hospitals in Europe are exposed to market competition varies, however, mainly depending on their geographical positions. In principle, most of the European countries in the study are committed to some level of competition between providers of care.

As far as accountability is concerned, the degree to which the direct line of control through the bureaucratic hierarchy has been broken varies between countries. In some countries, politicians sit on the hospital boards or appoint some of the members. In some countries (notably England), there continue to be powerful hierarchical accountability mechanisms (such as annual guidance from the

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Department of Health) in addition to more market-orientated regulatory and contractual mechanisms. Direct citizen participation to improve accountability at local level is generally absent in Europe, except for England, where local residents and patients may become members of the supervisory board (often known as the 'council of governors'). The social function can be fulfilled in these countries, as all residents have access to care funded by the government (or sickness funds).

There is little evidence from European countries about whether increasing public hospital autonomy has actually led to improvements in efficiency; responsiveness to patients or increased patient satisfaction; or improved accountability, as the increase in autonomy was meant to achieve (Saltman *et al.*, 2011). Reasons for this include the fact that the models of autonomy vary and, equally importantly, the institutional context and changes to that context also vary, so that it is difficult to untangle the effects of autonomy per se. Evidence from a later study of autonomous public hospitals in England (called 'NHS Foundation Trusts'—FTs) (Allen *et al.*, 2012a and Allen, 2006) indicates that these improvements have not occurred, in fact. One reason for not finding increases in efficiency is that only the more efficient hospitals were allowed to attain FT status in the first place. There was no significant increase in accountability to local people, despite new governance mechanisms to promulgate this. But Allen *et al.*'s study did find that FT management appreciated their greater decision making autonomy and were able to make decisions about changing service delivery and investments more quickly at local level.

Low income and transitional countries

We can also consider the experience of public hospital autonomy in low income and transitional countries. In respect of decision making autonomy, in many autonomous hospitals in poor countries, boards of directors have been created whose task is to focus on internal hospital management, rather than having a single hospital manager who simply follows rules, procedures and detailed budget allocations set out at higher levels of the hierarchy (Pearson, 2000). A management team with enhanced roles for financial and personnel management has often been established as well. Decision making over financial resources has been increased by giving hospitals block grants, instead of funding by line items, although this has not usually extended to autonomy in respect of capital expenditure (Pearson, 2000). But most have made little change in respect of personnel management. In general, staff has remained on civil service terms and conditions (for example, in the Northwest Frontier Province in Pakistan—Abdullah and Shaw, 2007). As noted in respect of Europe (Saltman *et al.*, 2011), politicians and senior civil servants are reluctant to give hospitals a significant degree of autonomy, because of the sensitive and politicized nature of healthcare. In fact, in Tunisia, structures usually adopted to increase autonomy had the effect of increasing central government control (Achuri and Jarawan, 2003). And in Hong Kong, the creation of an autonomous hospital funding and management authority as a non-profit public corporation in 1991 had the effect of rendering individual hospitals more subject to its central control, rather than increasing their individual autonomy (Yip and Hsiao, 2003).

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The residual claimant has continued to be the government in these poorer countries. Performance incentives have not usually been introduced (one exception is Malaysia, where significant financial incentives have been introduced for staff. But only one hospital has been given autonomy in Malaysia, which is the newly established tertiary heart centre; Hussein *et al.*, 2003). The degree to which autonomous hospitals have been subject to competition varies between countries (for example, in Hong Kong, the financing system was left unchanged, whereas in other countries it was not.)

In all places, a key aspect of autonomy has been an attempt to improve accountability by introducing more explicit objectives for the autonomous hospitals, which form the basis for plans to be made by the hospitals, and thereafter monitoring and supervision by the funders (typically still central government). In some places, there are formal contracts and in others, less detailed memoranda of understanding. There are very rare examples of direct citizen participation at local level to increase accountability—one has been identified in a pilot project in the Punjab in Pakistan (Abdullah and Shaw, 2007). Autonomy and associated reforms in poor countries can lead to a decrease in the capacity of public hospitals to carry out their social functions and treat the poor. This is likely to occur where incentives to increase user fees to increase overall revenue, and the possibilities to cross-subsidize the poor therefore decrease. Performance against social obligations has to be monitored by the hospitals' supervising bodies, which may not be able to do this effectively.

Pearson (2000) reports that it is equally difficult to assess the effects of hospital autonomy in poor and transitional countries, as we find it in Europe. He does note that there is little direct evidence of improved efficiency, but the situation may have improved in some places in respect of better maintenance. The example of Andra Pradesh in India is given as a place where the down time for equipment fell from 6 months to 2 weeks. Ssengooba *et al.* (2002) report positive changes in Uganda in respect of management of the drug supply, improved human resource management and better cost recovery. But McPake (2003) could find no evidence for increased productivity or improvements in quality in Columbia. Pearson (2000) also states that accountability has been improved in terms of timely and accurate financial reports to government, but that there has been no change in accountability to local communities (Abdullah and Shaw's 2007 findings concerning Pakistan may be an exception). Local managers have found that they have more freedom in terms of day to day management, at least. As Lieberman and Alkateri (2003) note, in many underdeveloped countries, such as Indonesia, an important reason for significant improvements not being evident after hospitals were granted autonomy is that the changes made to internal governance and the external environment were limited and inconsistent.

COMPARING CHINA'S AUTONOMY POLICY WITH OTHER COUNTRIES' EXPERIENCE

Analysis using the H&P framework has shown that the notions of a public hospital and the policies for increasing autonomy have some similarities between China and

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other countries. Like many other countries, public hospitals have a unique legal status between the market and the state. Because the latest reforms, the hospital management has been able to make more decisions locally, albeit supervised by the CHM. True management autonomy has not been achieved in most Chinese hospitals, as presidents and other senior staff are government officials under strong government control. Accountability in China is similar to other countries—the upward accountability remains much stronger than any accountability at local level, despite the fact that CHMs are meant to include a wider range of stakeholders, such as patients and the public.

There are two significant differences between China's public hospitals and many of the autonomous public hospitals in other countries. First, the issue of funding is crucial for the operation of public hospital autonomy. All hospitals in China need to find 90% of their income from revenue-generating activities, rather than block funding from central government (Wagstaff *et al.*, 2009). This means that autonomous hospitals in China are still obliged to recover most of their income from complex procedures for which more than cost price can be levied, as the price for basic procedures is set below cost. As noted earlier, this creates perverse incentives for hospitals to over test and over treat patients. Second, public hospitals in China can distribute significant amounts of profits to their staff. When the funding structure is combined with the unique Chinese policy on residual distribution, problems are bound to arise. There is a very strong incentive for staff to continue to over prescribe and over test, as they will personally gain from profits made by the hospital in doing so. Although some other countries have introduced some financial incentives for staff, none has allowed the same degree of distribution of profits as in China. In this sense, Chinese hospitals are very 'business-like' and may well be aiming at maximizing profits, as Pearson (quoted earlier in this paper) claims that privately owned firm do (2000).

CONCLUSION

We have shown that the broad notion of increasing the autonomy of public hospitals hides wide variation in the structure and implementation of this term across different countries. Although the changes in many health systems are examples of policies reacting to criticisms of a 'command and control' public sector, and of the introduction of the techniques of NPM, they vary significantly, especially in respect of the extent to which changes in the direction of creating institutions with 'private' elements have been proposed.

Reforms in the governance of public hospitals in China are still evolving; it is too early to judge their success. Nevertheless, it is clear that three specific issues need further attention. First, the organizational structure and function of CHMs in some cities need further clarification. The overlap between CHMs and health bureaux make it difficult for CHMs to function as independent institutions. The concerns about costs of coordination between CHMs and health authorities should not be addressed at the expense of the independence of either CHMs or health authorities. The model in Shanghai and Wuxi seems to deal with this best. Second, one of the

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objectives for CHMs is to involve more stakeholders and coordinate different interests. However, CHMs are still primarily comprised of governmental officials. The voice of other stakeholders, especially the general public, is weak. Third, despite the introduction of almost universal social health insurance, it is unlikely that the government will be able fully to subsidize public hospitals. One of the effects of this problem is that Chinese public hospitals cannot currently fulfil their social functions. The current distorted fee schedule produces perverse incentives, and thus the economic incentives for public hospitals need urgent attention.

The comparison of public hospital autonomy in China and other countries makes it clear that allowing distribution of profits to staff in China was a step too far. Allowing distribution of profits to staff creates very strong incentives to maximize the revenue of the hospitals and, in the process, to over provide services on which a profit can be made. A more cautious approach should be taken in relation to autonomous hospitals. The latest healthcare reform in China has focused on, among other aspects, hospital autonomy, in the hope of improving efficiency through local autonomy instead of profit-seeking incentives. The major issue for China now is to maintain a balance between efficiency and public service orientation. But, it may be easier for the public sector to make profits than to encourage public sector hospitals to maximize other objectives, despite Pearson’s view of the advantages of adopting a business-like approach quoted earlier in this paper (Pearson, 2000).

If one wishes to promote public sector values such as value for money and equality of access to care in public services, our analysis of public hospital autonomy in China compared to other countries leads us to conclude that there is a limit to the amount of change towards the end of the continuum seen as more similar to ‘private sector’ characteristics (using H&P’s model), which is appropriate. Public hospital reform was less likely to be a success if there is a lack of levers to create appropriate hospital budget constraints. The issue of the residual claimant appears to be crucial. The example of England demonstrates that it is possible to use the policy of increasing autonomy to strengthen the financial incentives under which a public hospital operates (mainly by allowing it to retain surpluses for the benefit of the hospital) without causing undue harm to either value; whereas the example of China demonstrates the damage that can be caused by designing financial incentives to operate too strongly on individual members of staff. In China, more appropriate hospital remuneration arrangements and hospital management autonomy are needed. Medical staff should not receive any income directly from prescribing drugs or referral for diagnostics. And the management should have full rights to set compensation and incentive schedules, as well as full autonomy to recruit medical and managerial staff, and the boards of the hospitals should be able to alter management pay to reflect performance.

Finally, turning to another aspect of H&P’s analytical framework, there is no evidence from other countries that the increasing use of market competition on the supply side has been harmful per se—it is the way in which funding is generated and how competition is regulated that matters. In the case of most European countries, the funds are raised through general taxation or sickness funds and allocated down through the public system to state run purchasers or sickness funds. Patients are not required to participate in the financial aspects of the market to any

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great extent. In the case of China, the establishment of universal social health insurance coverage aims to make insurance the largest financing source replacing individual payments, but this has not been achieved yet. To date, marketisation in China has had a direct effect on patients' financial access to care. The types of mechanisms the social health insurance schemes decide to adopt to enhance competition and produce positive incentives are crucial. In China, carefully designed regulations and institutions to enforce them are needed for competition to be capable of promoting efficiency and improving quality. Without these, for-profit behaviour may continue in public hospitals and among doctors. Thus, it is clear that China's policy concerning public hospital autonomy must be integrated with wider institutional reform.

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