Governance and Regulation: An Alternative to the Stalemate in Health Reform Program in China

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本文认为，治理与规管的研究是中国目前医疗卫生研究的薄弱环节，需要特别引起重视。文章从基本卫生与新医新药的双轨制造成治理和规管的难题入手，运用规管的视角，分析了投入不足、医疗保险低覆盖、药品和医疗机械价格不合理、公立医院的体制障碍和卫生行政部门监管不力等5个使医疗卫生陷入困境的论点，提出放弃治理与规管不但导致所有的现行问题更加严重，而且也使修正的行为变得没有意义或具负面效应。最后，作者讨论了中国规管失效的一般性原因，提出建立独立于行政机构的公立卫生服务规管机构可能是推进中国医疗卫生公平、实现全民初级卫生保健的一种规范性选择。

Thanks to the reforms of the last two decades and more, China's health care resources have multiplied. Medical technologies, capacity, and proficiency have improved following the growth of human resources, increase in hardware input and greater opening up to the outside world. In the meantime, health care policies have undergone several reforms. Still, in the rating by WHO of public health systems of the 191 UN member nations in 2000, the overall status of China's health care and sanitation was ranked 144th. In terms of the equitable financing of national health care, China stood the last but three of all the 191 member nations, preceding only Brazil, Burma and Sierra Leone. China now reverberates with a huge public outcry — coming not only from the urban but also the rural areas — against the inequity and excessive cost imposed by the existing system of medical care — a system that is decried almost by everybody. The unconscionable behavior of medical circles is being criticized nationwide. Social life in China is permeated by an animosity between the general public and medical circles. Since they have lost public trust, any new reform proposals for the health care system will have difficulty winning over and appealing to the public.

We can say that the health care issues now confronting us are no long in any way a technical problem or one of structure and total quantity in the economic sense. They are more of a problem of social health care in the sense of social policy. The whole of society is clamoring with one voice for social justice and equity. In this grave situation, the time is ripe to seek a breakthrough in a new developmental model and strategies for

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future health care reform through comprehensive discussion and debate.

This paper seeks to enrich the ongoing discussion from the perspective of governance and regulation.

I. Why Has the Question of "Regulation" Come Up?

In recent years, research findings relating to China's health care system have proliferated. However, when it comes to the issue of monitoring, such findings are uniformly stereotyped in that they remain firmly committed to a simplistic linear approach and concentrate only on who should be doing the monitoring. Moreover, most findings criticize the government as the main culprit in the failure of monitoring. They broach the topic of monitoring but leave out such questions as "What is monitoring?" "How should it be carried out?" How can such findings help promote China's health care reform?

We cannot discuss monitoring without bringing in governance and regulation. Governance hinges on "subjects." Different subjects call for different scope, methods, and principles of governance. "Regulation" means managing in accordance with a system of regulations. What is pivotal here is the legal status of such a system. It is necessary to formulate clear, quantifiable, and workable objectives and procedures. While governance relies on regulation for realizing the subjects' intentions and policy goals, regulation needs a rationalized "framework of governance" to work. When governance is combined with regulation, the quality of public service will be further enhanced. In recent years regulation has been drawing more intensive attention from the international community. This has led to much progress in research in such fields as the subjects, goals, processes, and methods of regulation.

Regulation differs from monitoring or oversight, which is simply a function. Although monitoring as a function can be performed by any individual or organization, it is more often taken for granted that it is a task incumbent upon government, whereas regulation is management enforced through the legislative system and is thus at the highest level of standardization. From the perspective of regulation, monitoring in the first place requires the delegation of authority and clearly defined limits to authority. A great number of monitoring tasks can be carried out only by specialized management agencies. It is only when a specialized management agency acts as a third party within the bounds of its formal authority, and has supervisory authority and corresponding responsibilities in relation to all stakeholders, that the requirements of regulation are met.

In the field of health care, the fact that the objects of regulation, namely hospitals and practitioners, have very much the advantage in terms of information places regulators under considerable pressure. The execution of regulation in this field calls for a much higher level of professionalism than in any other, including other fields of public service. It requires that the regulators should be independent within the governance framework, should be highly expert, and should have adequate resource inputs.

In raising the topic of regulation, we need to begin with the double-track price system. The so-called "double-track price system" refers to the situation where on the one hand,

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the government decrees that hospitals offer basic health care services to the public at prices lower than the actual costs of such services so as to maintain social stability and fairness, while on the other, the government allows hospitals to offset the losses arising from this practice through self-determined pricing of any new treatment or medicine in order to improve operating efficiency. This "double-track price system" was introduced nationwide over two decades ago. All health care institutions across China —from large and comprehensive urban hospitals to small township health centers —have owed their survival and growth to the "double-track price system."

It is apparent that the system was engendered by a "dual-goal project" with conflicting goals. It involves an attempt to uphold social equity by providing low-priced basic health care services while making profits from non-basic health care services. These diverse goals call for diverse forms of regulation, but these diverse forms of regulation have to be applied to one and the same health care institution or health care worker.

Requiring doctors to prescribe nothing but basic medicines for their patients or to issue no prescriptions, or fewer prescriptions, for high-profit medicines, amounts to asking doctors and hospitals to act against their own interests. If hospitals are to survive, they have to sell high-profit drugs and offer high-cost medical consultations. Less than twenty years ago, local government' s annual budgetary appropriations to hospitals —especially comprehensive urban hospitals — in China was already reduced to only three to five percent of the total sum of salaries, not including the hospital' s regular operational costs. If we take the operational costs into consideration, the percentage of government can be regarded as zero. This gives great impetus to over-servicing. As mentioned above, there is an information disparity between the providers and the consumers of health care services. The former has the advantage in terms of information. In many cases, demand is induced by doctors and hospitals rather than coming from patients. Impelled by the lucrative practice of prescribing high-cost medicines or peddling pharmaceutical products, the cost of health care service has been rising at an alarming rate.

The "double-track price system" was originally intended to give free rein to hospitals in fixing the prices of new medicines and therapeutic equipment that are unrelated to basic health care services. This was to balance the objectives of providing basic health care service to the middle and lower social strata with that of harvesting revenue from the health care services offered to those capable of paying for them. This wishful thinking has gone badly astray in practice.

The basic health care services provided by medical institutions under the "double-track price system" have demonstrated an obvious side effect that contradicts the initial policy intent. The situation is even worse in poorly equipped, remote, and grassroots-level hospitals. Generally speaking, so long as lower-end hospitals maintain a certain price differential between themselves and high-end hospitals, they too can climb on the price rise bandwagon. People who can afford them prefer high-end hospitals due to the quality of their services. This means that inferior hospitals have fewer patients, and so fleece everyone who comes through the

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door. Consequently, farmers who use lower-end services are forced to bear the costs of high-end consumption and price rises. Thus, rather than improving the quality and widening the coverage of basic health care services, the "double-track price system" is making ordinary people' s access to the health care system more difficult and seriously undermining social equity.

The "double-track price system" has been in practice for over two decades and has fully demonstrated its negative aspects. According to "An Analytical Report on the 3rd Nationwide Health Care Survey," in the ten years from 1993 to 2003, the percentage of persons confined to bed by illness in all the income groups in China' s urban areas rose by nearly half, while the percentage of those seeking medical advice and being hospitalized continually for two consecutive weeks fell by nearly half in the same period. The only exception was that the percentage of persons who were hospitalized in the highest income group rose slightly over the period. The drastic slump indicates an increasingly worsening situation in which patients put off obtaining health care services, while there has been a corresponding rise in serious illnesses (those confined to bed).

Why did the government adopt the "double-track price system" in spite of its salient defects?

Table 1 Need for and actual use of health care services among China's city and town population classified into 5 income levels

	The lowest income level	The low income level	The middle income level	The high income level	The highest income level
Persons confined to bed (%)					
1993	2.22	2.04	2.15	2.04	2.09
1998	1.94	1.75	1.59	1.74	1.73
2003	3.69	3.32	3.12	3.39	3.33
Changes 1993-2003	+66.2%	+62.7%	+45.1%	+66.2%	+59.3%
Persons seeking medical advice continually for 2 weeks (‰)					
1993	21.80	19.60	22.80	22.30	26.90
1998	16.50	16.60	15.50	18.50	20.30
2003	10.10	10.20	12.00	11.80	15.00
Changes 1993-2003	-53.7%	-48.0%	-47.4%	-47.1%	-44.2%
Persons who were hospitalized in the year preceding this survey (‰)					
1993	4.53	5.13	5.26	4.86	5.32
1998	3.07	3.07	3.67	4.26	4.20
2003	3.36	3.03	4.55	4.66	5.56
Changes 1993-2003	-25.8%	-40.9%	-13.5%	-4.1%	4.5%

Source: Health Statistics and Information Center of under MPH, *Examining China's Health care services: An Analytical Report on the 3rd Nationwide Health Care Survey*, Peking Union Medical College Press, 2004, pp. 87-88.

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For the government, this institutional arrangement was mainly motivated by financial considerations. At the time the government lacked financial muscle and could not take on the continually climbing health care costs caused by the upswing of market prices in general. In such circumstances, the government had no choice but to allow hospitals to offer high-profit services on their own initiative, providing them with a source of income in well-off patients in addition to their fiscal appropriations. This would cover the deficit caused by the provision of basic health care services at a low price. Moreover, the policy was also influenced by the fact that at the time the state was relinquishing part of its control over state-owned enterprises and especially by the new pricing policy, i.e., the state exercises general pricing control over important products only, leaving the pricing of ordinary products to the market. It has only been in the last two years that our society reached a consensus that such public goods as health care and education are not private goods and cannot be subject to arbitrary market prices.

However, whether at the time when this policy was introduced or now, the "double-track price system" survives because it meets the needs of government as well as those of hospitals. Hospitals want to make money and the government wants to save money, while at the same time attaining equity and efficiency. However, the government has only been concerned with balancing its books and achieving its policy goals as quickly as possible, without taking into account the fact that employing the "double-track price system" to accomplish its dual goals was asking too much of the governance and regulation of health care services. This was impossible for China to achieve in the conditions prevailing over twenty years ago, and this remains the case even today. Because, over the last twenty plus years of health reform, the government has been unaware of the need for and undecided over the establishment of an efficient governance and regulatory system, leaving the drawbacks to fester unchecked. Hospitals in China have already gone too far along the path of "subsidizing basic health care by prescribing high-priced drugs." This chronic malfunction has led to today' s dilemma.

A great number of public hospitals have been encroaching upon the interests of the general public by outmaneuvering the "double-track price system." Although everybody has witnessed and condemned this phenomenon, it seems nobody can do anything about it. Why? In our opinion, this stems from the fact that we have little knowledge of and little comfidence in governance and regulation in the domain of public health care services. When confronting the problem, everybody looks to the government, expecting it to change its policy, fix the price of medicines, and place requirements on hospitals. However, they don' t have many ideas about how government should regulate hospitals, or what sort of framework or measures it should employ. Before the government has had the chance to understand the complexity of the regulatory endeavor or make decisions about it, public opinion and academic research have already leapt into the fray with questions of interest groups and bureaucratism. In fact, governance and regulation is a highly specialized field that can and must be researched independently. So

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far China has been lacking in such studies. Hence we have no choice but to strengthen our study of the issue and learn both from other countries' experience and our own.

II. Health Care's Present Dilemma Stems from the Absence of Governance and Regulation

A lot of policies and projects aimed at promoting reform of health care have appeared in the last ten years, but most have not been treated seriously. For example, in October 2002, the State Council promulgated a resolution on improving health care work in rural areas. The resolution deals with problems in seven categories and contains twenty-five articles. Its essence was that farmers should receive guaranteed basic health care through systematic and comprehensive reform of the health care network, personnel, system and institutional arrangements. Of the twenty-five articles, only three deal with establishing a new rural cooperative health care system that insures against severe illness or with special medical assistance for poor rural families. In the three years following, these were the only two initiatives to be designed and implemented, and they were only incremental additions to what already existed. The other proposals, such as "strengthening disease prevention in rural areas and adhering to the policy of giving priority to prevention," "promoting reform in township (or town) clinics," "creating a socialized rural sanitation and health care network," and "improving the monitoring of health services in rural areas according to law" —were mostly shelved. This accounts for the fact that even though the central government used all its executive powers in an unprecedented effort to create a new rural cooperative health care system, its efforts actually went nowhere.

In the course of the debate across the country, a lot of insightful ideas have emerged as to the causes of these problems. Yet we believe that given actual social circumstances, unless governance and regulation are given a central role, not only will our present health care problems be exacerbated, but the government's moves to adapt its existing policies to suit the circumstances will be rendered meaningless or even backfire. Only through governance and regulation can good institutions and policies be protected; otherwise harmful institutions and policies will play havoc with our society.

To deepen understanding of what is meant by governance and regulation, we have summarized under five headings society's views on the causes underlying our health care problems and discussed them from the viewpoint of governance and regulation.

1. Insufficient inputs

According to this view, it is because of insufficient investment in health care that the government has had to give free rein to medical institutions' making profits to balance their budgets.[1] As a result, the general public has been left to acquiesce in their aberrations. However, would these distortions be reversed if investment were poured into medical institutions? If they had adequate government appropriations, would they then be willing to refrain from making profits either for themselves or individuals through expensive consultations or medicines? In the last two years, the state has provided generous support and continuing investment for

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both medical institutions at the bottom and the rural cooperative health care system. However, little has come out of such investments. Moreover, in the absence of governance and regulation, it is quite possible that the more abundant the input, the further the deviation from the policy goal. For example, the government has in recent years directly funded township hospitals or village clinics. However most village clinics now exist only in name, with village doctors becoming in word and deed independent actors who make a living subsidizing their medical services by the sale of high-cost drugs. As for town and township hospitals, since most of their proceeds come from the market, they choose to invest as much as possible in facilities and buildings, disregarding the health of the rural population. This has resulted in subjecting the rural population to a heavier financial burden arising from the increasing cost of these institutions. This phenomenon is widespread today, but the relevant authorities only announce how much the government has invested in rural areas, without redressing these obvious departures from policy objectives and goals.

2. Low coverage of medical-service insurance

This view also talks about insufficient inputs, but it believes that responsibility for financing lies not only with the government but also with communities and individuals. We agree with widening the coverage of medical insurance, but can this widening alone definitely solve the problem? If enlarging the coverage of medical insurance is intended simply as a means of pooling funds so as to relieve some of the government' s financial burden, leaving the regulation problem unsolved, it will not necessarily bring fair benefits to those insured.

Some of the advocates of this view believe that widened coverage would help public medical insurance agencies monitor medical institutions and doctors. In other words, as a third party in the chain of health care services, such agencies would be able to oversee the conduct of medical institutions or practitioners. On this point, they demonstrate an understanding of the need for regulating health care services. However, at present all that public medical insurance agencies monitor is macro-statistics; they have no way of controlling the desires of millions of individuals or the concrete actions of doctors even if something goes wrong, because the evidence is so elusive. Obviously, this is not a question of whether monitoring is necessary, but of how it is to be implemented.

3. The Unreasonable price of medicine and medical equipment

Advocates of this view believe the key problem lies with distribution, namely how to divide up the health resources pie. In using the term "divide up" we are making a distinction between the division and allocation of resources. The resources are divided among directly or indirectly interested parties —such as hospitals, medical practitioners, dealers in pharmaceutical products, manufacturers of medical apparatus and instruments, distribution agents, and even the government department in charge of pricing and agencies supervising sanitation and medicinal products. The only people excluded from the division are the patients.

In such circumstances, when hospitals are ordered to lower medicine prices, they can raise fees for consultations, diagnosis,

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etc. in response, because the mechanism of "dividing up the resources" works like a seesaw. If one side goes down the other goes up. Under the premise of a fixed budget and profit maximization in the absence of valid regulation, a reduction in the prices of medicines or consultations will undoubtedly lead to an increase in fees for diagnosis or treatment. How then can medical resources be divided and shared equitably among the parties concerned? We simply do not know. However, from the perspective of regulation, centralization rather than decentralization of the supervising authority is one of the regulatory principles. In the absence of an authoritative organization able to make judgments and decisions and implement them consistently, there would be chaotic strife among different interest groups. In such a case public interests are destined to suffer. Only a proper governance framework and regulatory system can provide a fair and reasonable dialogue between different interest groups and a level playing field.

It can be seen that the regulatory perspective can throw light on the apparently technical problem of the so-called conflict between the total amount of health care resources and their structure.

4. A Dysfunctional public hospital system

This view argues that the current system of decentralization of operations and responsibilities to various departments is a great obstacle to the development of health care in China. Over the years, China's administrative hierarchy has been epitomized in the saying: "A thousand threads above, a needle point below." Placed under the joint jurisdiction of a series of government administrative bodies, local government organizations are chastised at every turn by their contending superiors. Since a hospital is a specialized and complex institution, the problem is even more serious there. A public hospital's capital construction and fixed assets are handled by the development and reform commission of the local government; budgetary subsidies come under its financial office; appointment or removal of the head of the hospital comes under the local Chinese Communist Party organization department; and the local public health office is in charge of approving and monitoring of the medical profession and technology. Since leadership or jurisdiction over public hospitals is divided among so many areas, any of them can put themselves forward as the leadership or superior authority of the hospital, which has to bow to every directive issued by any of them. Since the hospital's personnel matters, medical apparatus and instruments, and policy formulation are controlled by the local government, a public hospital is fully justified if it chooses not to hold itself accountable for its own acts. In such circumstances, neither the mechanism of incentive nor that of restraint can function properly.

From the regulatory point of view, the trouble here lies in the fact that the powers and duties that should have belonged to a public hospital, as an entity in its own right, are now confused with third party monitoring. To put it another way, things such as personnel management and distribution that should naturally have been under the jurisdiction of a public hospital are withheld from it, while things such as standardization of health care procedures, prescription

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procedures, and control of quality that should be regulated have either been transferred to public hospitals or left unheeded by all parties concerned. To sum up, the powers and functions of a public hospital as a health care entity have been confused with the regulatory function of monitoring.

5. Poor monitoring by health care administrative bodies

Some insightful observers have already pointed out that the authorities in charge of the health care sector have not yet formulated or enacted feasible rules for monitoring medical institutions across the country, have never created an assessment system suitable for evaluating the performance of individual medical institutions, have not established a procedure for scrutinizing the performance of heads of public hospitals, and have never disciplined anyone for the shameful bribe-taking and kickbacks that have long been the scourge of our public hospitals. At the same time, the development of professional associations has been lagging behind. Neither doctors' associations nor hospital leagues have grown to be really independent organizations. Medical circles as a whole still exhibit an unwillingness to embrace self-discipline.

The factors behind this situation are complex. One is that medical institutions often have close ties and common interests with public health departments in terms of personnel, finance and history. Another is that medical institutions are now like the pre-reform state-owned enterprises, keeping people on their books to maintain stability. Health departments and hospitals not only safeguard their common interests but also contribute to political stability. Yet another factor is that since public hospitals have multiple leadership, health authorities alone have no way of controlling them.

From the regulatory point of view, it is evident that public medical institutions have never been able to act as a full agent of the owner (the state). Thus public health departments have had to take their place. Though public medical institutions are not independent, they have to behave independently to look after their own interests through market exchanges and thus become interests in themselves. However, an interest entity without full independence is quite formidable, because no matter what goes wrong, it can always shuffle off its responsibilities to others. In this regard, it is like state-owned enterprises prior to reform.

Thus some people have recommended reform of the ownership of public medical institutions. One is the categorization of all hospitals into non-profit and for-profit. This expedient aims at conferring a fully independent identity on all hospitals. However, registering a hospital under one of these categories and making it nominally a legal person does not mean that the hospital in question really acquires the full status of an independent actor (most hospitals in China are already registered as legal persons). Moreover, if hospitals acquire independence and become entities with legally protected interests, but regulation fails to keep up with these developments, the fierce scramble for profits we see today may well be exacerbated. Effective regulation presupposes that the institution to be regulated behaves rationally and consistently and is not saying one thing and doing another. A hospital may not need independence in the sense of being a

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legal person, but it needs to have an independent legal status, do what it says it will, and be able to take legal responsibility for its behavior.

Another question is "Who is most suitable to be in charge of regulation?" The public health department? As part of government, its main functions are planning and policy implementation, while regulation is a highly specialized task. To properly fulfill the task requires the exclusion of all involvement with interested parties. The public health department is one of the parties with a direct interest in health care institutions. Moreover, in China relationships within the system are linked to policy. The two sides are linked by common interests. Therefore, however one looks at it, the public health department is not a suitable regulator. The regulator needs to be established independently, especially in China. In order to protect public interest, public health departments should be isolated from the task of regulation.

According to the practice of advanced health care systems abroad, the role of government public health departments is that of planner, determining the goals and macro-level planning of health services. Moreover, in various domains of specialized health care services, regulation, redress of complaints, and administration should also be specialized and relatively independent of the government. Although these branches are subject to the public health department, this subordination is defined by relevant laws. For example, in Britain and Hongkong, it is the bureau of hospital administration, an independent and professional organization established in accordance with the law,[2] rather than the public health department that directly administers hospitals. Such an organization is usually funded by government and has its functions defined by law. Its goal is to raise efficiency, with social equity as a precondition. This has the following obvious advantages: clear assessment goals for health care institutions; cooperative supervision by the government, health care institutions, and the general public; high transparency; and enhanced public confidence. At the same time, in regulatory work, the division of labor is clear and detailed: personnel qualifications, standardized equipment, and clinical procedures are all authenticated and supervised by a specialized body. Independent redress of grievances is not only the watchdog of regulation but also the ultimate and most direct channel the general public can resort to. In sum, diversified government agencies are responsible for different tasks; the division of responsibility is clear, and each is clear about legal jurisdiction and responsibility. In this way, not only can each agency fulfill its duty independently and successfully, but together they form a system of checks and balances, constraints and incentives.

III. A General Analysis of the Lack of Effectiveness in China's Health Care Administration

Public health administration in China is far from mature. This is because the whole society is permeated by the idea of the supremacy of officialdom, an ideology which is direct opposition to management science which recognizes only scientific exploration, facts, and efficiency. Moreover, the concept of business administration has so far been

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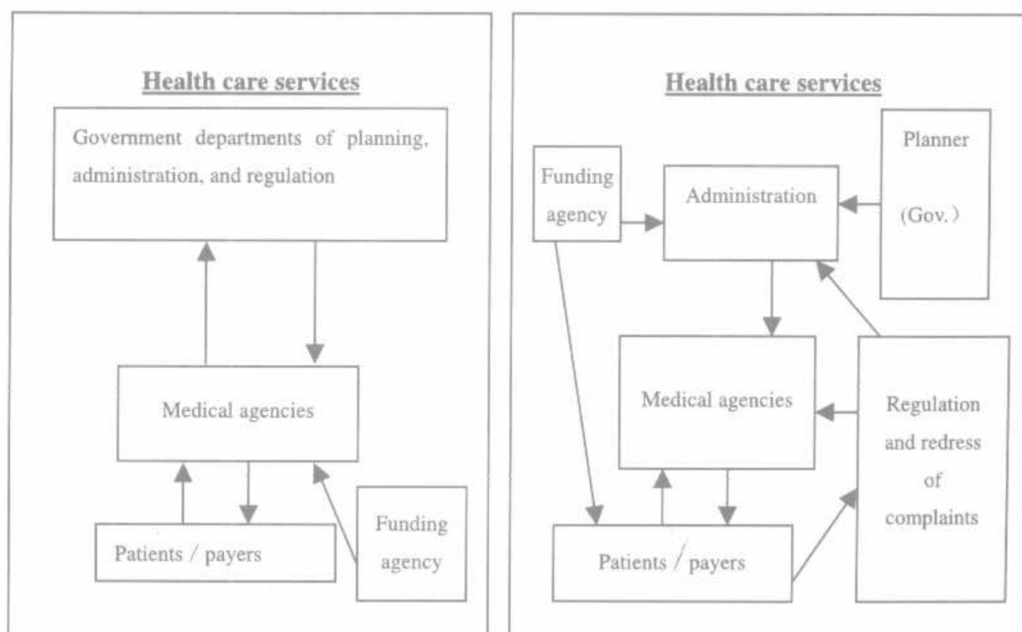
barely popularized in China. Additionally, public health administration is particularly specialized and complex. Therefore, the presence of ideological obstacles is not unexpected.

Up to now, jurisdiction at all levels of government has been determined by official rank, rather than by specialized functions. To make the matter worse, there is no scientific personnel management system in China at present to recruit truly qualified and talented persons to fill administrative posts. That is why the director of a health bureau may be incapable of exercising authority over hospital directors, why a local department of medicine inspection may be unable to control the pricing of medicine, and why a local public health bureau may be unable to supervise public health. When the relation between the parties exercising administration and those being administered is abnormal, regulation can only be futile.

The instances referred to above serve as an illustration of the most commonly seen mechanism underlying “dysfunctional regulation”: a defective governance framework. As neither the subject of regulation (hospitals) nor the regulator (a governmental agency) is fully developed, it is difficult to set up a framework of public administration, let alone regulation and management. Therefore, regulation must follow governance, and governance presupposes the development of the parties concerned.

Fig. 1 Entities involved in health care services and their relationships



The first step in regulation is a smooth governance relationship. After that, attention should be focused on major stakeholders — patients, health care institutions (including hospitals in cities, towns and township, and rural clinics), various supervisory agencies (including government organizations and intermediary outfits inside and outside the

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market), and investors (the government, social insurance institutions, commercial insurance institutions, and individuals). In a word, the implementation of governance should abide by the following guiding principles: (1) the actors involved ought to be clearly defined; (2) the scope of power or of responsibility ought to be clearly defined; (3) each defined goal is explicitly assigned to a department; and (4) each actor is assigned a specific task, with corresponding power and responsibilities.

Figure 1 presents two diagrams that serve to illustrate the interrelations of all the parties in health care. The diagram on the left is a conventional version of such interrelations, while the diagram on the right summarizes the interrelations between independent actors. The diagram on the right shows the thrust of health care governance in which funding bodies, managers, regulators and health care institutions are distinct, so that each of the four parties becomes an independent actor accountable for performance in relation to its assigned goal.

Table 2 Most commonly seen problems of unsuccessful regulation

1. regulatory defects	lack of accountability	Regulators are not fully responsible to the source of their power (legal or political structure). Though they are arbiters of the public interest, they actually only take care of their own interests or those of their department.
	dependency	Regulators and the regulated organizations have common interests, leading to the failure of the former in fulfilling the task of regulation.
	capture	Regulators or regulatory procedures can be exploited by partial interests (including the regulated organizations and other group or individual interests) to serve their particular interests.
2. initial stages	incompetence	Regulators with inadequate professional competence, information and resources are unable to fully grasp the actions of the regulated organizations, or to predict how regulation measures will affect the actions of the regulated body and the public.
3. over- maturity	goal displacement	The set goals of regulation are either replaced or eclipsed. In some cases the process becomes more important than the goals of regulation.
	proliferation	Regulation system keeps growing until its influence, complexity and costs are disproportionately large so that it is unable to concentrate on its goals.
	ossification	Failure to renew procedures leads to triviality and redundancy that restrain and hinder development and innovation.

Note: This table is borrowed from K. Walshe, *Regulating Health Care: A Prescription for Improvement?* Maidenhead, Open University Press, 2003, with adaptation and enrichment.

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The greatest obstacle to achieving this is administrators. In present-day China diverse government departments exercise various forms of control over the health sector. Power over investment, human resources and distribution boils down to management power. Why should entities with management skills be separated from hospitals? The separation means it's not possible to "gain power and have one's orders carried out immediately." At the same time, though hospitals may call for decentralization in a general sense, when they really need to take responsibility they often hide behind their managers to deflect criticism. Therefore it is important to clearly define hospitals' power and responsibilities in addition to establishing a clearly defined framework of governance. Only in this way can we resolve the first category of commonly seen problems of ineffective regulation, as listed in Table 2: lack of accountability, dependency and capture.

Apart from rationalizing the governance framework, the second category of frequently seen problems in the regulation of health care in China involves incompetence, whether this be in terms of professional competence, information and communication, or understanding. Because they lack the skills to manage the situation, managers are often deceived, and are unable to set standards for hospitals and doctors. Raising the level of competence is a long-term task, requiring systematic training and study. We should concentrate on exploring the best approach to regulation rather than wasting time on the game of systems and interests.

IV. Choice of Regulatory System in China's Health Sector

Choice of regulatory system hinges on the institutional choices of the health care sector. For example, the American health care system places a high value both on individual choice and market competition. Thus regulation is carried out through specialized agencies' assessment and certifying of hospitals and the constraints of consumer choice. In countries (such as the UK, Sweden, Norway, and Australia) or regions (such as Hong Kong) with a system of health care services that serves the whole population, the focus of regulation in the health sector is on both the costs and effects of health care provided to the general public. Regulation consists primarily in monitoring cost-efficiency and controlling the input of funds and the revenue of the hospitals to realize quality control.

Regulation entails very high operational costs, because it involves simultaneous control over the amount, quality, and pricing of health care services, entailing high information costs and an adequate supply of specialized regulatory personnel. Therefore it is necessary that the number of subjects of regulation be limited to a "manageable" range that is clearly defined in textbooks on management. Choice of regulatory mechanism is constrained by cost. In the US, regulation is widely dispersed, while a more centralized approach is adopted in the UK. British hospitals are under the management of a total of 300 health care foundations.

Systematic regulatory institutions have yet to be set up in the health care sector in China. The present system is the legacy of the planned economy and is characterized by rigid government control in the absence

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of specialized management. This legacy now clashes with the current health care system, where the outward semblance of a public institution masks the pursuit of private interests, so that its every act attracts criticism.

The establishment in China of a system of regulation calls in the first place for a choice for health care system and social policy to sustain this system. Should it be a completely market-oriented or semi-market-oriented system, or a unified nationwide state system? It does not look as if either would work in China. However, there is another alternative: universal coverage in primary health care coexisting with both public and commercial provision of other health care services. This choice presupposes two layers of medical service with two operational models, which requires a regulatory system suited to this dual character.

Therefore, it can be clearly seen that in the course of creating a regulatory system in China, the first difficult question consists in determining which type of health care institution meets China's needs. The second is the cost of regulation. For example, in constructing a rural primary health network, many experts have insisted that the government has to pay for the services of all rural doctors. However, the vertical regulation of millions of doctors in rural health institutions to achieve the not easily quantifiable goal of effective primary health care would cost an astronomical sum well beyond the capacity of local finance. Regulating dispersed individual farming households under a market system is totally different from managing barefoot (rural) doctors under the planned system.

To sum up, taking into account the factors constraining the creation of a regulatory system, if we choose a dual system of universal primary health service plus public and commercial health care services, we will need a corresponding low-cost regulatory system. This may be a normative choice to achieve the goal of health equity in China. The first step in reaching the goal is to define regulation legally and create regulatory institutions. It may be necessary to set up independent and specialized regulatory systems at the central, provincial and county levels. The next step is to reform the human resource system of public health agencies, making them independent subjects of regulation with full discretion in personnel affairs. The third step consists in structural reform involving survival of the fittest. The heads of public hospitals should be appointed by people's congress at various levels, rather than the government, so as to provide a legal foundation for regulation. The final step is to design and implement a set of regulatory rules and systems.

The establishment of an independent regulatory agency for public health care institutions facilitates governance in the following ways:

(1) It provides a platform for actors (government departments, health care institutions, social insurance organizations, and patients) to coordinate their interests, so that their respective responsibilities and goals in resource management may be clearly defined.

(2) With joint planning and clearly defined goals, the resources of government

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departments and public health care institutions can be pooled to develop service and managerial systems that can satisfy social and professional needs. Barriers between various public health care institutions may be eliminated to allow greater mobility for medical personnel.

(3) Setting up an accountability mechanism at a high level requires heads of regulatory agencies and public health care institutions to be responsible for the performance of their respective agencies.

(4) Setting up specialized competencies and communication mechanisms and collecting information will counteract the information advantage possessed by public health care institutions. The workload of public health care institutions will be determined and their performance assessed, with intervention if necessary. At the same time, relevant information will be provided to the public so that they can participate in supervision. There will be more information on the use of health care resources, leading to fairer and more efficient resource allocation.

The establishment of an independent regulatory agency for public health care institutions by no means implies carving off part of the existing health care department and giving it space and equipment, creating another organization. Rather, it should be an independent agency with the status of a legal person parallel to government administrative departments. The setting up of such a body does not have an explicit legal basis in China, although there are analogous organizations. They include market intermediaries such as law firms, accounting firms, and auditing firms. In order to protect the public interest, it is not appropriate to register them as enterprises, nor are they nonprofit or volunteer organizations. However, they are the core of civil society. Without them, the public interests of society would be left without real protection and the public would lose their confidence in society.

An independent regulatory agency for public health care institutions is a non-market organization committed to enforcing rules and regulations. Although this kind of independent organization has already existed in other countries for years, its transplantation into China involves organizational innovations that must be accompanied by policy and system innovations. In relation to correcting the marketization trend in health care it serves as a sword that, coming from outside, is yet able to pierce the vitals of the medical system. In a word, the absence of a regulatory system is not the critical factor bringing about the dilemma in China's health sector. However, the establishment of a regulatory system that fits in with a two-layer health care system but also operates at a relatively low cost may open the door to a new health care system not only for today but also for the future. Of course, this innovation will not be easy, mainly because the dominating ideology in China at present is not pragmatic "managerialism" but the pre-eminence of officialdom.

One last point we would like to make is that regulation is not omnipotent. In China in transition, innumerable complex factors add more unpredictability and uncertainty to health care situations and health care behavior that are already complicated enough. Generally speaking, regulation is a kind of

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managerial technique already in existence and continually evolving. It will not be able to exert a crucial influence unless it is integrated with elements of social policy such as the social environment, social culture and the participation of the general public.

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Notes

1. According to "the 3rd Nationwide Health Care Survey," investments made by the state in medical institutions across the country increased in the last five years, enlarging the total amount of health care resources. The percentage of hospitals benefiting from the increased investment also rose in the last five years. Findings from the survey indicate that the total amount of expenditure on health care by all levels of government nationwide in 2003 was 30% higher than in 1997. However, as a percentage of total expenditure on health care it fell from 89.9% in 1997 to 88.4% in 2002. These investments went mainly to hospitals, clinics and hospitals of traditional Chinese medicine. 80% of the health care investments of different levels of government went to the cities, and of this sum 80% went to large urban hospitals. But owing to financing difficulties, slow progress was made in areas such as preventive health care, basic health care services, and rural health, despite the fact that they provide greater social benefit.
2. Since there can be clashes of interests between health care services and preventive health care or health promotion, public health is placed under the jurisdiction of an independent government body.

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