Improving Policy Design and Capacity from Local Experiments: Equalization of Public Service in China’s Urban-rural Integration Pilot

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Reallocating Authority in the Chinese Health system: an Institutional Perspective

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**Abstract**

Affordability of health care is still a serious concern in China after the health reform in 2009. According to the literature of the economics of organization, allocation of authority in hospitals and social insurance is extremely important for improving affordability. The information structure and the degree of conflicts in tasks within an organization determine the optimal allocation of authority. However, the progress of the governance reform to reallocate the authority is relatively slow during the reform period. This paper argues that the slow progress is associated with ineffective coordination among government departments in China. Two institutional reasons are illustrated in this paper. First, there is no institutional arrangement to facilitate the horizontal coordination among ministries and bureaus. Second, the performance evaluation system for officials, which mainly addresses the vertical coordination between upper and lower level governments, has unintended consequences for horizontal coordination among local government departments. Future reforms should take into account these institutional aspects.

**Introduction**

China’s most recent set of health reforms have entered their sixth year of implementation in 2014. Between 2009 and 2013, the government expenditure on health reached RMB 3 trillion. More importantly, by the end of 2013, over 95% of Chinese citizens were covered by at least
one social health insurance programme. Government health expenditure increased from 15.5% in 2000 to 30.1% in 2013\(^1\).

While the universal coverage of social health insurance has been realized, affordability is still a concern. There has been double-digit annual growth in health expenditure in China for the past 10 years. Total health expenditure has reached RMB 3.16 trillion, which accounts for about 5.6% of Gross Domestic Product (GDP) in 2013\(^2\), compared to about 4% in 1997. It is estimated the share of health expenditure in GDP will reach 8.4% by 2030 (Ma, et, al 2012).

Out-of-pocket payment as a percentage of total health expenditure in 2013 was about 34%. More specifically, health care expenditure for a rural and urban resident reached RMB 513 and 1,063 in 2012 respectively compared to RMB 246 and 786 in 2008.

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In the literature of the economics of organization, the affordability issue can be addressed by reforming the governance structure by reallocating authority including delegating, centralizing and restructuring authority in an organization (Bolton and Dewatripont 2012, Gibbons, et al, 2012). In principle, the information structure and the degree of conflicts in tasks within an organization determine the optimal allocation of authority. As long as the incentives conflict between the principal and agents is not too substantial, agents with better access to information shall be granted authority. In this case, authority allocation is an instrument to take advantage of local knowledge/information. In addition, when there are

\(^1\) China health statistical yearbook, various years & Statistical Communiqué on Healthcare and Family Planning Development in China 2013, 
multiple tasks to be fulfilled, authority of dealing with interest-conflicting tasks should be allocated to different agencies. This is to avoid adverse impact of conflict of interests and also to improve accountability since it is easier to measure agencies’ performance with focused missions.

For the Chinese health reform, to improve affordability via reallocating authority for health insurance and hospital governance is pivotal since both social insurer and doctors are critical for health care decisions. According to the theory of economics of organization, there are two directions for reallocation authority in the health system. First, information structure matters for an efficient authority allocation. For instance, if a private insurer has better professional expertise of managing risks (i.e. better information), the task to manage social insurance fund may thus be reallocated from social health insurance to a private insurer. Second, authority for of interest-conflicting tasks should be delegated to different agencies. For example, the authority of managing social insurance should be assigned separately to the authority of health service provision, given that these two tasks, the provision and the purchase of health services, are of conflicting interests. It may be more desirable to let local social security bureau, rather than local health bureau, to manage rural social health insurances.

Although there have been some initiatives to reform the health care governance structure since 2009, inefficient allocation of authority is persistent in public hospitals and social insurances. The research question raised by this paper is that for what reason, the progress of governance reform to reallocate authority in both public hospitals and social health insurance has been slow since 2009.

The persistence of inefficient authority allocation in the health system is related to an
analytical framework in Chinese politics: “Fragmented Authoritarianism”, which claims that the decision-making bodies are fragmented and disjointed among different ministries as well as among different levels of governments (Lieberthal and Oksenberg 1988). This paper argues that there are two reasons for the slow progress of governance reform in this fragmented structure. First, while coordination among government departments is necessary for reallocating authority, there is lack of institutions for political actors to exchange support and enforce bargaining results. Second, performance evaluation system for government officials, which is an institutional response to the vertically fragmented structure of policy implementation, has unintended consequences for horizontal coordination among government departments. Local officials tend to allocate their efforts on those tasks which are more rewarding such as promoting economic growth and they are more likely to be accountable for the local party secretary rather than the ministry.

Policy implication then is to look for a second best solution for reallocation of authority in public hospitals and social insurance, given these constraints of the fragmented structure of policy making and implementation.

This paper belongs to a growing literature about political economy of Chinese health reform (Hsiao 2007, Huang 2013, Kornreich, et, al 2012). This paper differentiates from existing literature in two ways. First, this study interprets the health reform in China through the lens of reallocation of authority defined by the theory of economics of organization. Second, this paper highlights that there are institutional reasons associated with the framework of “Fragmented Authoritarianism” which results in a suboptimal allocation of authority in public hospitals and social health insurances. This paper does not simply apply the framework “Fragmented Authoritarianism” in the context of health reform. Rather, comparing with the
committee system in the U.S. congress, this study considers what institutional arrangements are necessary to achieve the coordination among political actors and compliance of bureaucracy. This paper shows that when these institutions are absent, the inefficient allocation of authority is persistent in the Chinese health system.

The rest of the paper is arranged as follows. The next section reviews status of the recent round of health reform. Then, why reallocation of authority matters and what kind of institutional arrangements can improve efficiency are discussed. Following a discussion on some initiatives in governance reform in the health sector, the difficulty to reallocate authority is shown as a result of institutional constraints in China. Finally, the policy implications and conclusion are drawn.

**Progresses and concerns in health reform**

Government indeed has taken the lead role in health reform in China. Between 2009 and 2013, one of the most outstanding achievements made by the health reform was the dramatic increase in government health expenditure. According to an official report in April 2013, accumulative government expenditure on health reached RMB 3 trillion during the five-year-period from 2009 to 2013.³ The share of government expenditure in total health expenditure reached 30.1% in 2013 compared to 15.5% in 2000.

By the end of 2013, over 95% of the 1.36 billion Chinese citizens were covered by at least one social health insurance programme (i.e. Figure 2). In 2014, the government paid subsidies in the amount of RMB 320 for each enrollee under the rural New Cooperative Medical Scheme (NCMS) and Urban Resident health Insurance (URI)⁴. Patients’ out-of-pocket health

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expenditure decreased from about 60% of the total expenditure in 2000 to 33.9% in 2013 (see Figure 3).

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However, the affordability is still a serious concern after the five-year reform. Between 2008 and 2013, out-of-pocket expenditure increased by 12.8% annually in average (Figure 4). Regarding to social health insurance, financial coverage is yet insufficient. For example, the upper limit of social health insurance for reimbursement is still low (i.e. about 4-6 times of local average annual income).

--- Figure 4 approximately here ---

Health care providers’ profit-seeking behaviour is believed to be the key reason for high health expenditure in China. In particular, public hospitals have the incentive to over-prescribe drugs since public hospitals are entitled to charge a price markup of up to 15% for drug prescription. There is little evidence showing that the incentive structure for public hospital physicians has changed much as yet, and the problems of inappropriate prescription still persist in many places. For instance, a recent study shows that over 60% of patients in the sample are prescribed antibiotics that are not compatible with their symptoms. Even for informed patients who understand that antibiotics are not appropriately-prescribed in their cases, 39% of these patients have still been prescribed antibiotics (Currie et al. 2011). Currie et al. (2014) also identify that the over prescription of antibiotics is largely a result of financial
incentives of doctors. Figure 5 shows that the share of drug revenue in general hospitals remained at 40% between 2004 and 2012.

--- Figure 5 approximately here ---

The incentives as well as the capacity of social insurers are substantially relevant to address providers’ profit-seeking behaviour. Although some localities have started pilot reforms of payment methods (Cheng 2013), the social insurers are short of capacity/professional training to improve affordability via purchasing health services from providers (Ramesh, et, al 2013). Also, many local social insurers’ objective is merely to balance the budget and not to explore potential payment method reforms in order to control health service costs.5

What is authority and how to allocate authority?

In this section, the implication of authority allocation in public hospitals and social insurance for affordability of health care are going to be discussed. According to the literature of economics of organization, “authority” is defined with a bundle of decision rights. These decision rights include the power to initiate projects, ratify and approve actions, monitor subordinate’s performance as well as exact obedience (Bolton and Dewatripont 2012). As indicated in the literature, to improve efficiency, two determinants of choosing a certain way of allocating authority are information structure and the degree of conflicts in tasks.

Vertically, if the incentive conflict between the principal and agents is not too substantial, the authority should be (re)allocated to the agent who has more information (Gibbons, et al, 2012, Laffont and Martimort 2009). Some tasks are with more uncertainty and some are more

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5 For example, a recent document released by Gaoan city of Jiangsu province in 2011 highlights the importance of the balance in the insurance fund but not much was mentioned about the negotiation mechanism to reduce the treatment fee in the hospital. See http://www.jxhrss.gov.cn/view.aspx?TaskNo=008&ID=105554, accessed 4 August, 2014.
difficult to be measured. In this case, the agent with more/better information is more likely to make efficient decisions. For example, according to recent empirical studies on management performance, managers with MBA training may have more information on what are the best practices to run a firm and may make more efficient decisions (Bloom, et. al. 2014) than those who have no such trainings.

Likewise, an individual agent may need to fulfil multitasks and the objectives of these tasks may be in conflict with one another. It is likely for an agent to spend more effort on those rewarding tasks and less effort for other tasks. To fulfil all tasks more efficiently, the authority for tasks in conflict may need to be assigned to different agents. For example, many researches interpret the role of the local government in economic development as a firm in the market (Oi 1992). Local economic development is a critical task for local officials in China. However, local officials are also assigned with some other tasks which may be adverse to local economic development. For example, in Wu, et al (2013), local officials are not willing to spend on environment infrastructure for pollution control since it is not directly helpful in local GDP growth. It is debated in China now that local environment protection agency should be independent from local government.

Governance reform in the health sector, including various initiatives to reallocate authority such as delegating, centralizing, restructuring authority in public hospitals and social insurance, is critical to improve affordability of health care. These reforms include reorganizing the governance structure of public hospitals, integrating management of social insurance, contracting out insurance service to private insurers, etc. Given that affordability is associated with behaviour and incentives of public hospitals and social insurers, with various governance reforms to reallocate authority, the affordability issue can be addressed by

changing the behaviour of providers and insurers.

For example, for social insurances, an integrated social health insurance plan may have a better bargaining position with hospitals, compared to fragmentarily managed plans. For public hospitals, an independent government agency who regulates public hospitals can address the issue of doctors’ incentive to overprescribe drugs.

While the objective of social insurers and public hospitals (i.e. improving financial coverage and delivering more services with quality) may be different from the objective of a firm in the market, the principles for allocating authority in a firm can be applied to the governance of hospitals and social health insurance for two reasons.

First, similar to a firm in the market, hospitals and insurers have multiple tasks, which may be in conflict to one another, and hospitals and insurers also have asymmetric information structure. For example, hospitals need to make sure that their patients are treated properly while hospitals also need to generate enough financial revenue to sustain daily operations. For social health insurers, one task is to increase coverage and improve affordability while the other task is to keep budget balanced. The task of local health bureau is associated with service delivery while the task of social insurers is to provide financial coverage for these services. More and better services delivered imply more expenditure from social insurers. These tasks are in conflict with one another. In addition, for a given task, some agents are informed and some are less well informed. For example, compared to social security bureau, which have more experiences in managing social insurance, local health bureau, who manages rural health insurance, may be less familiar with risk management.
Second, hospitals and insurers, similar to a firm in the market, have incentives to improve efficiency. For example, hospitals are keen to minimize the operation costs to treat more patients, given the quality of health services. Insurers want to keep the health expenditure minimum for a given treatment process.

For the above two reasons, the allocation of authority is relevant to improve affordability in the health sector. The governance reform in public hospitals can address the concerns of conflicting tasks and asymmetric information by reallocating authority. For a long time, local health bureaus regulate and manage the operation of public hospitals (Qian and Blomqvist 2014). However, regulating the health service quality and its price is a task in conflict with the task to manage and operate a hospital. In this case, it is more efficient to allocate the authority of regulating and managing to different agents (“guanban fenkai”).

Regarding to the reform on social health insurance, information structure is important to determine the allocation of authority. Currently, fragmentarily managed social insurers are short of capacity of managing financial risks. It is better to reallocate authority to private insurers with the authority of managing social insurance since they have better information structure. Similarly, an integrated local social health insurer for rural and urban residents and employees can take advantage of better information since the integrated insurer can access to more sufficient information about demand and utilization of local health services.

**Slow progress of governance reforms in social insurances and public hospitals**

A number of pilot projects on how to reform governance structure of public hospitals and the social health insurances have been initiated since 2009. The governance reform in public hospitals has taken place in various forms. One way is to reform governance structure within
the public hospitals. Public hospitals in Shanghai, Ma’an shan, Kunming and Xiamen have been corporatized by establishing independent board of directors and supervisory board. Another direction of governance reform is to reorganize the structure of health care service provision. For example, some cities such as Beijing have established a new government agency (‘‘Yi Guan Ju’’) to regulate public hospitals and public hospitals in these cities are corporatized. In Shanghai, an independent agency to manage public hospitals (i.e. Shen-Kang Hospital Development Center) is allocated with the authority of operating hospitals and local health bureau has been allocated the authority of regulating. As a conglomerate with 24 hospitals, this new agency may have better information about demand from patients and can make better investment decisions on infrastructure building and resource planning.

For social insurances, one reform direction is to integrate social health insurance plans. By 2014, there are seven provinces integrating the NCMS and URI. In these provinces, integrated social health insurances are managed by a single government agency. Usually, it is the local social security bureau that manages this integrated social health insurance. The administration cost is saved when these insurance programs share the same health information system and redundant investments on the information infrastructure are avoided. In addition, under the integrated plan, insurers are likely to have better information for health care service utilization and it is more effective for social insurers to purchase health care service.

Another direction of governance reform for social health insurances is to engage with private insurers for improving affordability of health care. In August 2012, a government guideline

7 China Reform, No. 8, 2013
about the “Catastrophic medical insurance program” (“Dabing Yibao”) was released\textsuperscript{12}. The catastrophic medical insurance program is a supplementary insurance program aiming to extend the coverage of insurance by increasing both the rate and the upper limit of reimbursement. In this guideline, social insurers are suggested to reinsure with private insurance companies to improve the coverage while government will take the lead role in designing and managing the “Catastrophic medical insurance program”. In 2014, the “Catastrophic medical insurance program” has covered about 400 million people in 28 provinces\textsuperscript{13}.

There are two major reasons to initiate the catastrophic medical insurance. First, the affordability of health care services is a concern. The catastrophic medical insurance, which focuses on relieving financial burdens of the patients who are swamped by catastrophic medical expenditure, is going to improve the depth of the insurance coverage by increasing both reimbursement rate as well as the upper limit of the reimbursement. Second, the professional skills of private insurers are complementary to social health insurer\textsuperscript{14}. There are large amounts of accumulated surpluses for social insurance. In particular, the accumulated surpluses of Basic urban employee Health Insurance reached over RMB 810 billion in 2013, compared to RMB 127 Billion in 2005\textsuperscript{15}. Many local social insurers are financially sufficient but they have no adequate knowledge/skills to figure out the financial risks when designing health insurance policies for catastrophic health care spending. By reinsuring with private insurance companies, social insurers take advantage of their professional expertise.

While there are some initiatives in governance reform, inefficiency in the governance of

\textsuperscript{14} Sun Zhigang, "The catastrophic medical insurance as the key point of improving affordability of health care", \textit{Administrative Reform}, 54-7, Dec 2012. Note, Mr. Sun is the director of the health reform office in the State Council.
\textsuperscript{15} China Human Resources and Social Security yearbook, various years
hospitals and social health insurance is persistent. For example, in most cities/counties, there are still three different types of social insurance plans managed by two different government agencies: local health bureau and social security bureau. Inefficiency is associated with the fragmented insurance system. It is reported that currently over 100 million Chinese people have joined more than one social health insurance plan and that over RMB 20 billion are subsidized to people who have enrolled with more than one social health insurance plan\textsuperscript{16}. There are two types of inefficiency: first, the government subsidizes an enrollee more than once. Second, an enrollee contributes premium for multiple health insurance plans, while he can only be reimbursed by one insurance plan for health care expenditure.

For the newly initiated catastrophic medical insurance, although authority should be allocated to private insurers with better expertise and information about risk management, private insurers instead play a very limited role in managing the insurance. Given that the principle is that government takes the lead role, private insurance companies do not have much discretion about insurance policy design. Private insurers are usually paid with commission fee for managing the fund while the amount of the commission fee is proportional to the premium of health insurance. For example, in Xiamen city, private insurers are paid at most 3\% of the premium contributed to the social health insurance and government will subsidize private insurers to keep the budget balanced should there be any financial losses for the scheme\textsuperscript{17}. In some cities such as Hangzhou, it is the social insurer who directly manages the catastrophic medical insurance\textsuperscript{18}.

Governance reform for public hospitals is not very effective either. In most cities/counties, public hospitals are still regulated and managed by local health bureau and the authority of

\textsuperscript{17} See Qiu and Huang (2014).
\textsuperscript{18} Ibid.
regulation and management are not separated. By 2014, only 6 out of 17 national pilot sites for hospital reform have separated their regulation and management authorities\textsuperscript{19}. Some cities initiated the regulatory agency for hospitals under the name of “hospital management bureau” (“Yi Guan Ju”), but this regulatory agency is still part of health bureau (e.g. in Beijing city, hospital management bureau is a subordinate of health bureau\textsuperscript{20}). Decisions made by health bureau are not very credible if these decisions conflict with public hospitals’ interests since public hospitals are managed by local health bureau. One illustrating example is the number of medical malpractice disputes is increasing by over 20% since 2002\textsuperscript{21}. More people now look for a third party “People’s Mediation” (“renmin tiaojie”) to sort out the disputes since People’s Mediation, which reports to local justice bureau, is independent from health bureau\textsuperscript{22}.

**Reallocating of authority in a fragmented political structure**

The research question for this paper is that given the serious concern of affordability, why the authority is still not allocated efficiently in the Chinese health system? The following discussion will show that the persistence of inefficient authority allocation is a result of the difficulties to reallocate authority in the context of Chinese health reform. To change allocation of authority within a firm depends on the decision of the owner who has the property right. The owner is the residual claimer of a firm and he can decide who have authority for certain risks (Hart 1996).

However, changing *status quo* allocation of authority within a government-owned/controlled organization such as public hospitals and social health insurances is even more complicated. It


\textsuperscript{21} From a recent report in *Southern weekend*, Nov 6, 2014, Chinese Hospital Management Association estimates the number of medical malpractice has increased by 22.9% annually since 2002. See http://www.infzm.com/content/105341, accessed Nov 18, 2014.

\textsuperscript{22} One example of the quick development is Beijing city. The number of cases was increased by 40% between 2011 and 2012. See http://www.bjsf.gov.cn/publish/portal0/tab68/info14149.htm accessed Nov 18, 2014.
depends on whether different government departments involved with management or operation of social health insurances and public hospitals can reach an agreement to do so. It also depends on how the coordination among different government departments can be enforced after reaching an agreement. Furthermore, since health care is a “resource dependent” and “nonproductive” sector, health reform, compared to reforms in other policy areas, is even more likely to depend on the coordination amongst various government departments (Huang 2013: 136). For example, there are at least 11 ministries outside health system involved with the health reform in China (i.e. table 1). The departmental interests for these ministries are much diversified (Hsiao 2007).

--- Table 1 approximately here ---

As the most influential model to explain Chinese politics, the “Fragmented Authoritarianism” literature highlights the critical role in policy making and implementation process of the fragmented and decentralized structure of authority. This fragmented structure can be referred as the fragmentation among government departments (i.e. horizontal) or the fragmentation between central and local level governments (i.e. vertical). Policy making in this context may be ineffective since each government department or different levels of government will bargain with one another in defend of their own interests.

But why does this fragmented structure make it so difficult to reallocate the authority? One quick explanation can be that the number of players is large in this fragmented system. With a large number of players, it is more difficult to have collective actions among various departments with diversified interests (Olson 1965). Following this rationale, given diversified departmental interests in the health reform, it is difficult to reform the hospital
governance structure since there are 16 ministries involved in the health reform. However, as Liu (2011) reveals in the case of allocating authority for collecting social security contribution, coordination failures are still there when the number of players is relatively small. There are only two government departments who are involved for collecting social security contribution: tax bureau and social security bureau. Although it is more efficient to reallocate the authority to a single agency to collect the social security contribution, it takes more than 15 years to allocate the authority because these two bureaus refuse to compromise (Liu 2011: 155).

**Institutions supporting horizontal coordination**

This paper argues that it is the institutional reasons that explain the persistence of inefficient governance structure in Chinese context. According to the literature of new institutional economics, to achieve coordination and sort out the diversified interests among political actors, similar to a transaction in the marketplace, some institutional arrangements are necessary to facilitate the coordination/exchange of interests.

There are two conditions to be fulfilled for these institutional arrangements. First, an institutionalized platform is needed; where exchange of support among political actors can take place credibly. These institutions reduce the uncertainty for political actors by creating a stable structure of exchange (North 1990). Second, there must be some institutions to make the political actors’ coordination credible by limiting the discretion of bureaucracy (Moe 1990). These institutions make sure that the bureaucracy will not shirk in the process of implementing policies made by the political actors.

This paper uses the U.S. committee system as an example to illustrate the above-mentioned

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two conditions for the following reasons. First, with very diverse interest in such a large country, political actors in U.S. have to deal with the exchange of interests and enforcement issues. For example, legislators have heterogeneous interests since they represent interests located within their districts. Committee system therefore is an institution to coordinate these diverse interests. Second, the committee system is well discussed in the literature as an institution to facilitate exchanges of interest among political actors.

The committee system is pivotal in the policymaking process in U.S. Niskanen (2001) argues that the committees are powerful enough to dominate in the legislature in the American political system. In the congress, every committee is associated with a particular policy arena, such as commerce, agriculture, banking, and etc. and every committee has monopoly power in its own policy arena (i.e. its jurisdiction) to change the status quo (Sobel and Pellillo 2013). There is a seniority system that a committee member can stay in the committee as long as he intends, conditioning on reelection. In addition, a bidding mechanism works in the congress. Once a member leaves the committee, other congressmen can bid for the seat. Since there is an upper limit for the number of committees a congressman can serve, one has to bid for the most valuable committee for his political interest.

Similar to the case that people make exchanges in the marketplace, legislators can exchange support with other legislators in the political market. For example, legislator A can support legislator B’s proposal while in exchange for B supporting A’s proposal. However, they are not sure whether the exchange can be made since this exchange may be not simultaneous and flow of benefits can be not contemporaneous.

The committee system facilitates the coordination amongst political actors for two reasons.
First, the institutional arrangements under the committee system can facilitate the exchange of support among political actors by providing a stable structure of exchange. The bidding system provides an exchange medium for political support so that a legislator has to bid for the most valuable committee for him. In other words, legislators are sorted by their preferences. In addition, the committees possess monopolized agenda setting power since only a committee is entitled to propose policy changes to legislature in its policy area. Furthermore, seniority system implies that a committee member can always have influence over policies as long as he wishes to stay in the committee. On top of that, bidding system, monopolized agenda setting power and seniority system are helpful to enforce the bargaining results since “the exchange is institutionalized, it need not be renegotiated each new legislative session” (Weingast and Marshall 1988).

Second, some institutional arrangements support the committee system by making the coordination among political actors more credible by limiting the discretion of bureaucracy. While bureaucrats/government agencies have a degree of autonomy, the congress minimizes the bureaucrats’ discretion via *ex ante* controls (e.g. administrative procedure) as well as *ex post* controls (e.g. budget review, sunset review) (McCubbins, et al, 1987). The administrative procedure requires the bureaucracy to publicize their policy aims *ex ante* and budget review rewards and/or sanctions the bureaucrats *ex post*. These institutions are useful to induce compliance of bureaucrats to meet the requirement of the political actors.

In short, while U.S. is not the best example for health reform, the committee system in the U.S. congress illustrates an institutional solution to coordinate political actors with diverse interests. The committee system fulfills two conditions for facilitating the coordination among political actors. First, the committee system provides a stable structure for legislators to
exchange support and enforce bargaining results. Second, some institutional arrangements support the committee system by making sure the coordination is credible in limiting the discretion of bureaucrats with various instruments.

“Fragmented Authoritarianism” and reallocating authority

Both conditions for coordination are not fulfilled in the context of Chinese health reform. A stable institution for coordination among political actors is absent and bureaucrats’ discretion is significant.

One should note that there is no clear cut difference between political actors and bureaucrats in China. The ministers/directors in a government department, similar to political actors in western countries, have some political agenda to fulfill. However, these officials are also part of bureaucracy who is responsible for the enforcement and implementation of policies. They are subject to performance evaluation system, in which various tasks are defined by the upper level government (Landry 2008).

The role of bureaucrats is critical in China for two reasons. First, the rules of regulation are set by bureaucrats, it is well recorded in the literature that public policy is a product of bureaucratic bargaining in China (Lieberthal and Oksenberg 1988:4). Compared to bureaucrats in Mao-era China, bureaucrats now are even more influential and have incentives to pursue their goals strategically in the process of policy making (Huang 2013:11). Second, bureaucrats have large discretion over the policy implementation in China. Bureaucrats are exempt from political controls of the legislature. Different from many other countries where executive branch is separated from politicians, “the executive branch has predominated in the formulation and implementation of regulatory laws and policies” in China (Tam and Yang
In this context, the horizontal coordination in Chinese political system is very difficult to realize efficiently for two reasons. First, at the central level, horizontal coordination among government departments is not institutionalized. There is no stable institution equivalent or similar to the committee system in the U.S. congress to exchange interests for coordinating and enforcing the bargaining results. Currently, at the central and local levels, one solution to coordinate different departments is to establish a small leading group or a coordination group (“lingdao xiaozu” or “xietiao xiaozu”). For the health reform, there are both central and local level (i.e. provincial and below) small leading groups. Group members are stakeholders for policy making and implementation. For example, there were 16 ministries siting in the coordination group at the central level for health reform, which were renamed as the small leading group for health reform in 200824.

However, unlike the committee system in the U.S. congress, this horizontal coordination mechanism (i.e. small leading group) is not very effective for two reasons. First, in a small leading group, preference structure is not stable. A small leading group consists of various ministries which are subject to frequent personnel changes25. For a given ministry, changes of personnel may imply shifts in the structure of exchange, if different ministers have different political agendas. For example, different health ministers may want to reform health system in different directions and they may have different health reform agenda (e.g. there are five health ministers since 2000). In other words, the structure of exchange of support among government departments is not very stable, given the possibility that political actors can be


replaced relatively more quickly for various reasons.

Another reason is that the operation of small leading groups is subject to external shocks. The objective of many small leading groups is to fulfill a certain task rather than to coordinate policy changes in general in a policy area. A new small leading group can be initiated if there is a new task to be fulfilled (e.g. the coordination group for health reform was established in 2006 after the State Council planned to have a major reform in health system). A small leading group can be dissolved after the task is fulfilled (e.g. 2008 Beijing Olympics coordination group was established in 2001 and dissolved after the organizing committee of Olympics took over in 2003). The task-oriented character for the small leading groups implies that this horizontal coordination mechanism is far from stable.

Second, at the local level, the performance evaluation system, as an institutional response to the fragmented structure in the vertical direction, has unintended consequences for horizontal coordination among government departments. Given that bureaucrats have large discretion over the policy implementation, as an institution for \textit{ex post} control, the performance evaluation system for government officials is designed to improve the policy effectiveness by motivating bureaucrats to fulfill policy targets set by the upper level government. Appointment, promotion and demotion of local bureaucrats are decided by whether they have fulfilled the upper level government’s requirements for various policy targets. It is also observed in the literature that under the performance evaluation system, local officials in China are likely to be promoted on the basis of growth rate of GDP and fiscal revenue (Landry 2008, Li and Zhou 2005, Shih, et al. 2012) and social policy targets are not as rewarding (Wu, et al. 2013).

The theory of bureaucratic behavior recognizes that bureaucrats usually need to accomplish multiple complicated tasks, or a single task which can have multiple dimensions to it (Wilson, 1989). Bureaucrats are likely to exert more efforts to carry out observable and rewarding tasks for the sake of performance evaluation (Holmstrom and Milgrom 1991). In this case, local government has strong incentives to allocate fiscal resources on local infrastructure to promote economic growth and broaden tax bases rather than on other less rewarding tasks, which may be in conflict with promoting economic growth. Indeed, local government is efficient in coordination with different local bureaus in terms of infrastructure building and attracting investment (Xu 2011).

The performance evaluation system, as an ex post control for bureaucrats, has therefore two unintended consequences. First, local officials are lack of incentives to implement governance reform in the health sector. Governance reform, for local government, is a task which is not as observable and rewarding as infrastructure building since governance reform in the health sector may be in conflict with economic development in the short-term. For example, it is observed that a dramatic increase of infrastructure building in public hospitals nationwide in the past several years. In 2008, there were only 394 hospitals with more than 800 beds while in 2012 there are 1032 public hospitals with more than 800 beds\(^{28}\) in the country. Governance reform in public hospitals implies a more restrictive regulation over financial decisions, and as a consequence infrastructure investment in public hospitals may be decreased. In this case, for local officials, the task of governance reform in hospitals contradicts the target of economic growth and they are lack of incentives to enforce the reform which may put institutional constraints on infrastructure building in public hospitals.

Second, with the performance evaluation system in which officials in local bureaus are

\(^{28}\) China health statistical yearbook, various years.
evaluated by local government leaders, local bureaus are likely to be accountable for the local
government leaders rather than the ministry when implementing the health reform (e.g. local
health bureau vs the National Health and Family Planning Commission (former Ministry of
Health)), which makes the coordination among government departments at the central level
even more complicated. In many other policy areas, it is observed that ministries have
problems to enforce policies at the local level. For example, there is a general insufficiency
of coordination between the local government and different ministries in revealing budget
information for earmarked transfers, even though these transfers are supposed to be
earmarked for particular projects (Wu and Liu 2010).

Discussions

Since 2009, there have been many achievements in the recent round of health reform in China.
Ongoing reforms on public hospitals and the new initiated catastrophic medical insurance
target at improving the affordability of the health care. Nevertheless, governance reform,
which is to reallocate authority in public hospitals and social insurance plans, is still a work in
progress.

Institutional constraints are the major reasons why the progress of governance reform is slow.
First, there is no institutional arrangement to address the horizontal coordination among
ministries and bureaus. Second, the performance evaluation system for officials may distort
horizontal coordination among government bureaus for some policy initiatives.

Both institutional reasons imply that government departments at the central level are not very
effective in making and implementing reform policies. Explanations for slow progresses of
governance reform in this paper are consistent with the observations in the existing literature.
For example, Huang (2013: 137) argues that it is the “health bureaucrats” and “local officials” rather than government department at the central level who play “a significant role” in the health reform.

To understand the importance of reallocation of authority for health insurance and public hospitals is also related to two other issues for the reform in the next phase. First, how to design a better system to take advantage of the interaction of market mechanism and the direct government intervention is an increasingly important question. In some cases, delegating the authority to players from private sector is a better option and in some others, a direct management by government is more desirable.

Second, the allocation of authority becomes an even more important concern regarding to the recent initiative about mixed ownership for public hospital reform. “Mixed ownership” refers to the situation in which institutional investors from either public or private sectors can invest on public enterprise including public hospitals. It is believed to be a win-win solution for both public and private sectors given that public hospitals have advantage in human resources (i.e. more qualified doctors and nurses) while the private sector has a larger financial capacity to invest in public hospitals.

In April 2014, a public hospital in Hunan province has been selected as a pilot for mixed ownership reform\(^{29}\). In this particular case, government holds 51% of the shares of this hospital while the rest of shares are held by the investors from the private sector. With more and more mixed-owned hospitals, how to reallocate authority among public hospital managers, local health bureau and institutional investors is an issue to be discussed in the next stage.

Policy implications in this context is that future reform initiatives regarding to reallocation of authority should take into account the fragmented structure of decision making in Chinese political system. The other option is to establish a stable institutional arrangement for horizontal coordination and reform the performance evaluation system for officials.

References


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Qiu, Y and Huang, G. 2014. “The mechanism for the Catastrophic medical insurance program: international and China experiences”, Zhouzhou xuekan, 1, 61-66


Figure 1: Health Expenditure and GDP in China

![Graph](image-url)

Source: China health statistical yearbook, various years & Statistical Communiqué on Health Care and Family Planning Development in China, 2013.

Figure 2: The number of enrollees covered by social insurances

![Graph](image-url)

Source: China health statistical yearbook, various years & Statement of social insurance in China, 2013
Figure 3: The share of government expenditure/out-of-pocket expenditure in total health expenditure

Source: China health statistical yearbook, various years & Statistical Communiqué on Health Care and Family Planning Development in China, 2013.

Figure 4: Growth of out-of-pocket expenditure in China
Figure 5: Average share of different sources of revenue in public general hospitals

Source: China health statistical yearbook, various years
Table 1: Ministries involved in the health reform*  

<table>
<thead>
<tr>
<th>Health sector</th>
<th>Non-health sectors</th>
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<tbody>
<tr>
<td>National Health and Family Planning Commission  (including State Administration of Traditional Chinese Medicine)</td>
<td>Ministry of Human Resources and Social Security</td>
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<tr>
<td>China Food and Drug Administration</td>
<td>National Development and Reform Commission</td>
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<td>Ministry of Finance</td>
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<td>Ministry of Civil Affairs</td>
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<td>China Insurance Regulatory Commission</td>
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<td>State Commission for Public Sector Reform</td>
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<td>Ministry of Industry and Information Technology</td>
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<td>Ministry of Education</td>
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<td>State-owned Assets Supervision and Administration Commission</td>
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<td>Ministry of Commerce</td>
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<td>Ministry of Science and Technology</td>
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