
Public hospitals in China: Privatisation, the demise of universal health care and the rise of patient-doctor violence

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Ensuring the safety of staff and patients has become a major problem for hospitals in China. This article examines whether one of the reasons for this violence may be the emerging injustice and inequality that have manifested in the Chinese health care system as a result of privatisation reforms since the early 1980s. It considers approaches to these issues that may assist the Chinese Government, and other nations contemplating similar policy changes, to create efficient but equity-based health care systems that minimise collateral trauma to patients and their families.

THE PRECONDITIONS: CHINA'S BOLD EXPERIMENT WITH HEALTH CARE PRIVATISATION

It is now well known that in the early 1980s the People's Republic of China (PRC) rapidly dismantled its socialised medical system. This had been based in a rural setting on commune health centres, free county hospitals and brigade health stations, staffed by briefly trained "barefoot doctors" and funded by local cooperatives.¹ Prior to the 1980s policy change, local health care was also closely linked to a state-funded population-based strategy of disease prevention and health promotion.² The four guiding principles of the PRC health system established in the early 1950s (with great symbolic significance for the ideals of the emerging society) were:

- to focus on serving workers, farmers and soldiers;
- to give priority to preventative medicine over curative medicine;
- to foster unity between traditional Chinese medicine and Western medicine; and
- to combine health work with mass movement.³

The phased-out universal health care system had been successful, in terms of population health outcomes. From 1952 to 1982 infant mortality fell from 200 per 1,000 live births to 34, and life expectancy increased from about 35 years to 68 years.⁴

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¹ Wong VCW and Chiu SWS, "Health-care Reforms in the People's Republic of China. Strategies and Social Implications" (1998) 12 (4/5) *Journal of Management in Medicine* 270.

² Chin SC, *The Development and Policy of Health Care in China* (China Medical and Pharmaceutical Technology Publications, Beijing, 1992).

³ Hen H and Zhu C, *Chinese Health Care: A Comprehensive Review of Health Services of the People's Republic of China* (MTP Press, London, 1984).

⁴ Hesketh T and Wei XZ, "Health in China: From Mao to the Market Reform" (1997) 314 *BMJ* 1543.

From 1978 to 1999, however, the central Chinese Government's fiscal contribution declined from 32% to 15% of total health care expenditure.⁵ Provincial and local authorities were required to fill the funding gap via local taxation, a move that immediately differentiated between wealthy urban provinces and poorer rural regions.⁶ Provincial authorities were given a fixed budget for the 400 or so (300-bed average) county hospitals (which declined in real terms as costs of services rose). The PRC Government imposed a cap on the out-of-pocket "user fees" that administrators could charge patients for basic health care; but this is renegotiated every two to three years by the Price Commission and has been steadily increasing.⁷ Most significantly, the central government permitted hospital administrators to profit-earn from new pharmaceuticals and medical technologies (after strong lobbying by the relevant multinational corporations), with salary bonuses for the staff involved.⁸ "Barefoot doctors", no longer adequately remunerated from the small village cooperative pool, took to selling (often counterfeit) pharmaceuticals.⁹ From 1990 to 2002, central government funding of non-hospital local public health initiatives also fell drastically, with local authorities being required to recoup the shortfall by charging for public health measures, such as sanitary inspections and compliance with environmental regulations.¹⁰

Currently, only approximately 30% of Chinese people (mostly comparatively wealthy urban dwellers) have private health insurance provided by private and public employers in the United States style. Another United States-style corporate innovation introduced to contemporary Chinese health care is medical savings accounts, in which employees are required to save a proportion of their regular income (like superannuation) to cover 10% of a worker's annual wages (with provision for higher "catastrophic" cover).¹¹ To ameliorate the plight of the rural poor, the central government has resorted to a state subsidy of private health insurance, which covers only inpatient care and not primary care or drugs.¹² Such initiatives have resulted in out-of-pocket expenses for patients' total health care spending in China increasing from 20% in 1978 to 58% in 2002.¹³

One adverse consequence of this extreme shift to privatised health care policies in China is that large numbers of sick rural dwellers are unable to afford hospital care (the cheapest hospital costs are US\$15 a day, approximately two weeks' earnings). Many patients in rural China increasingly self-medicate with whatever (often counterfeit or complementary) drugs they can find and afford (half of Chinese total health care spending is now on medicines).¹⁴ Once a person's illness becomes debilitating, their relatives contemplate trade-offs: if they pay to treat the illness, they will lack the money needed for marriage, education and, sometimes, food.¹⁵ Many rural Chinese are now delaying or avoiding going to hospital, until in the extreme grip of disease or suffering.¹⁶

When patients in rural China do go to hospitals, they find that not only are the fees for basic care too high for them to easily afford, but doctors frequently over-service for prescriptions and expensive tests (to achieve revenue-related bonuses). It has been reported, eg, that 30 to 40% of drug consumption in China now represents inappropriate utilisation.¹⁷ Most county hospitals in Shandong Province provide a 10 yuan bonus to the ordering doctor for every CT scan.¹⁸ Many physicians also

⁵ Liu Y, "China's Public Health-Care System: Facing the Challenges" (2004) 82 *Bulletin of the World Health Organisation* 532.

⁶ Blumenthal D and Hsiao W, "Privatisation and its Discontents – The Evolving Chinese Health Care System" (2005) 353 (11) *NEJM* 1165 at 1166.

⁷ Liu X, Liu Y and Chen N, "The Chinese Experience of Hospital Price Regulation" (2000) 15 (2) *Health Policy and Planning* 157.

⁸ Blumenthal and Hsiao, n 6.

⁹ Bloom G and Xingyuan G, "Health Sector Reform Lessons From China" (1997) 45 *Soc Sci Med* 351.

¹⁰ Liu, n 5.

¹¹ Blumenthal and Hsiao, n 6.

¹² Blumenthal and Hsiao, n 6.

¹³ Liu Y, Rao K and Hsiao WC, "Medical Spending and Rural Impoverishment in China" (2003) 21 *J Health Population Nutrition* 216.

¹⁴ Blumenthal and Hsiao, n 6.

¹⁵ French HW, "Wealth Grows, but Health Care Withers in China", *New York Times*, 14 January 2006.

¹⁶ "China Vows to Turn Around Poor Health Care", Channel News Asia, 9 January 2006: http://www.channelnewsasia.com/stories/afp_asiapacific/view/187338/1/html viewed 17 January 2006.

¹⁷ Liu et al, n 7 at 161.

¹⁸ Liu et al, n 7 at 161.

demand bribes for basic services. In 2005, Health Minister Gao admitted that more than 1,200 health workers were punished in China for corruption (no doubt a significant underestimate). "Hospitals are paying too much attention to making profit by selling medicines and ordering unnecessary tests", he stated, "instead of caring about the interests of patients."¹⁹ It is a reasonable hypothesis that those Chinese farmers with memories of the type of health care they enjoyed before corporate lobbying convinced their government to dismantle universal health care, are likely to become angry and even violent when denied basic care for themselves or their relatives, because they cannot pay for it.²⁰ This seems, however, a conclusion that some Chinese health care policy-makers, till recently, have appeared reluctant to reach, given the apparently thriving nature of the current Chinese economy.

HEALTH CARE VIOLENCE IN CHINA

No consensus has yet been reached on the exact definition of adequate safety for health care staff or patients. During a course of medical treatment, the physical and mental safety of staff and patients may be imperilled by the imperfection of medical treatment quality control systems, by mismanagement of medical treatment or by unforeseen third-party interventions. In nations such as Australia, patients presently (albeit tenuously, many would claim) enjoy the benefits of universal health care through a system of adequately funded public hospitals which enjoy prestige as teaching and research centres of excellence. In such a setting, health care violence, though underreported, appears to arise mostly commonly in relation to patient mental health, or drug and alcohol problems, or in stressful situations confronting ambulance officers, paramedics or emergency department staff.²¹

In China, health care violence is becoming an increasingly serious problem. A study of workplace physical or psychological violence in two large hospitals of Guangzhou, Guangdong Province, during October 2001 to October 2002, found that 678 of 1,043 hospital staff (65%) had such an experience during the previous year, mainly psychological violence. The violence was usually initiated by relatives (64.2% of total events). Main alleged causes, however, did not relate to patient or relative alcohol or illicit drug use or acute stress, but focused on dissatisfaction with the standard of care provided.²²

Complaints of violent or potentially violent disputes between doctors and patients notified to the China Consumers' Association have increased tenfold over the past three years as against the preceding period. Cases involving the murder of medical personnel, or hospital facilities being bombed, have been reported by various media in Beijing, Wuhan, Changsha, Chongqing and Zhuhai.²³ From 1991 to 2001 there were 568 violent attacks reported on hospitals and health care staff in Hubei Province. There was an average of 177 such violent attacks each year between 2000 and 2002 in Jiangsu Province. Even in Beijing, there were 502 reports of violent attacks on health care workers between 2000 and 2003.²⁴

Violent protests have recently erupted over the quarantining and treatment of SARS cases in rural areas of China, but these appear to have arisen mostly from fear of cross-infection amongst local peasants. Chinese state media were reported as being under orders not to report such events, suggesting that health care violence for other reasons is probably similarly underreported.²⁵

Great difficulties are associated with obtaining reliable statistical information about health care violence in any jurisdiction. Busy health care workers notoriously underreport such incidents, unless they involve serious injury. Hospitals will be loath to acquire and disseminate such information

¹⁹ Channel News Asia, n 16.

²⁰ Kahn J, "China's 'Haves' Stir the 'Have Nots' to Violence", *New York Times*, 31 December 2004.

²¹ Benveniste KA, Hibbert PD and Runciman WB, "Violence in Health Care: The Contribution of the Australian Patient Safety Foundation to Incident Monitoring and Analysis" (2005) 183 (7) *MJA* 348.

²² Chen ZH, Wang SY and Jing CX, "Prevalence of Workplace Violence in Staff of Two Hospitals in Guangzhou" (2003) 37 (5) *Chinese Journal of Preventative Medicine* 358 (article in Chinese).

²³ Hailan D, "Investigation in 326 Hospitals in China: Incidence Rate of Medical Disputes Reaches 98%", *Legal Daily*, 21 February 2002.

²⁴ Harris DM and Wu, Chien-Chang, "Medical Malpractice in the People's Republic of China: The 2002 Regulation on the Handling of Medical Accidents" (2005) 33 *J L Med & Ethics* 456.

²⁵ Ang A, "SARS Anger Hits China's Rural Hospitals", *The Age*, 7 May 2003: <http://www.theage.com.au/articles/2003/05/06/1051987701457.html> viewed 7 February 2006.

because of the damage to institutional reputation that may be involved. This will be compounded, of course, where the major revenue streams for hospitals have been shifted, as they have in China, to cost-recovery from patients. Given these constraints, the above information suggests a genuine problem has arisen with health care violence, particularly in rural China.

CONSEQUENCES OF HEALTH CARE VIOLENCE IN CHINA

One view, prevalent in regulatory discussions by government and hospital administrators in China, is that the problem of violence in health care is a serious one chiefly because of its negative economic consequences for health care staff and institutions. The economic costs of health care violence to a hospital, eg, in terms of damaged equipment and injured staff can be substantial. Such events are believed to tarnish the image and reputation of the hospital, affecting its capacity to earn necessary income by attracting wealthy patients from competitor institutions and requiring prudent managers to further raise out-of-pocket charges. Under such an apparently common regulatory model, a major search for a regulatory solution should focus on methods to incarcerate or financially punish “trouble-maker” patients.²⁶

Consequently, some investigators of the problem of violence in Chinese hospitals have proposed focusing on law reinforcement and education to maintain normal working order in public hospitals.²⁷ Others have claimed that the cause of such increasing violence in health care is due to the absence of an adequate dispute resolution, litigation and compensation system for medical error.²⁸

The hypothesis presented in this article, however, is that large-scale social anger such as this is more likely to be attributable both to dissatisfaction with the social injustice and lack of equity inherent in the model of privatised health care the PRC Government has introduced since the early 1980s and to the failure of central authorities to admit this fact. If this is so, then a regulatory approach to the problem of health care violence in China that focuses on shaming or punishing offenders is unlikely to be effective.²⁹ Restorative justice models emphasising repair, transformation and empowerment will fail when the impugned action is actually a process of civil disobedience attempting to change laws that are perceived to be creating injustices strongly contrary to conscience.

REFORM OPTIONS FOR CHINA’S HEALTH CARE SYSTEM

If the PRC Government begins to accept that mounting health care violence, particularly in rural China, is a genuine problem that needs a structural solution, then the next step is to search for policy options. Reform proposals involving government subsidisation of private health insurance, facilitation of superannuation-like medicines savings accounts, or the creation of a two-tier hospital system (where state-run hospitals become “low-cost” subsidised hospitals for uninsured farmers, laid-off workers and low-income citizens), would merely replicate the private industry-designed “solutions” that have failed (both in terms of restraining government expenditure and in health outcomes) in nations such as the United States.³⁰

The current Australian approach to universal health care provision, however, offers valuable lessons for China in light of the similarities in population distribution in the two countries. Both countries face the difficult task of providing a health care system that functions effectively in both dense urban conditions and sparsely populated, remote rural settings. Such a population distribution means that different regions have both different health care requirements and varying capacities to fund health care. A centralised funding system for basic or emergency health care (through fully government-financed public hospitals) would provide a better balance for private-insurance-based elective medical care and remove local distorted pricing structures and incentives to over-provide medicines and diagnostic tests. It would also permit the organisation and implementation of the health care system to be more rationally decentralised in order to allow the system to be tailored to each region’s needs. While chronic and degenerative diseases are the major cause of health problems and

²⁶ Personal experience of the Chinese regulatory situation in this area by Pingan Zheng.

²⁷ Chen et al, n 22.

²⁸ Harris and Wu, n 24.

²⁹ Braithwaite J “Setting Standards for Restorative Justice” (2002) 42 *British Journal of Criminology* 563.

³⁰ Reinhardt UE, “The Pricing of US Hospital Services: Chaos Behind a Veil of Secrecy” (2006) 25 *Health Aff* 57.

mortality in the wealthier urban provinces of China, its poorer urban centres and rural regions still face a high prevalence of infectious diseases.³¹ In Australia, management of the health care system takes place at a State level, while taxation revenue is collected by the federal government and distributed to the States according to population. This allows the States to be able to finance a public health system that offers basic medical services and emergency health care to the entire population and where public-funded hospitals in major centres become internationally respected centres of excellence for medical education and research. However, this decentralised management structure in Australia is itself a fragile public good. In what is perhaps a prelude to more thorough privatisation of the health care system in Australia, multinational health management corporations are increasing pressure on State governments to transfer their powers to manage public hospitals to the Federal Government.³²

Further, the PRC Government can learn from Australia's experience of the inequities for rural and regional communities created by the shift in government health spending towards private health insurance subsidies.³³ Regional Australia, with lower average income than urban areas and less access to fewer private health facilities, has a lower uptake of private health insurance than urban Australia. Government spending on private health insurance subsidies instead of on public health facilities results in substantially less federal government health funding for regional areas, compared with cities, than if these funds were allocated on a per capita basis. The evidence from Australia and from the United States is that encouraging private health insurance will not alleviate the problems of access to health care for the poor and rural populations of China.³⁴

Similarly, the option of user-pays medicines savings accounts also discriminates against the poorer and rural regions. The idea of medicines savings accounts has been offered by the pharmaceutical lobby organisation Medicines Australia as a long-term policy option for replacement of the Pharmaceutical Benefits Scheme (and its process of expert cost-effectiveness analysis and medicines price bargaining) in Australia.³⁵ However, such proposals ultimately result in the shifting of costs of health care from the government to the individual, a shift that has the effect of linking health care with income and further accentuates the problems for already disadvantaged groups within the population. This negative experience has been seen in Singapore where medicines savings accounts were introduced in the late 1990s, but have only increased out-of-pocket costs for patients.³⁶

The private industry-designed solutions currently being put forward as reform options for China (subsidised private insurance or medicines savings accounts) will not alleviate the severe structural problems arising in the Chinese health care system from an imbalanced emphasis on privatisation. The United States-style privatised health care system is now widely regarded as a fiscal and health-outcomes disaster by most experts in that country.³⁷ Since the mid-1990s the United Kingdom, The Netherlands and Sweden, for reasons of both equity and fiscal restraint, have reversed many of the policies that were attempting to privatise their national health programs.³⁸

Long-term financial growth for China will be critically dependent on maintaining high health levels in its population and this is more likely to be achieved with the type of balance between public and private funding of health care still present in the Australian health care system. Sorting out these models will be critical for China as it considers plans for the "liberalisation" of health care services (removal of barriers to foreign corporate ownership of health care institutions) under the World Trade

³¹ Hsiao W, "The Chinese Health Care System: Lessons for Other Nations" (1995) 41 (8) Soc Sci Med 1048.

³² Garnaut J, "Federalism Isn't Working: Abbott", *Sydney Morning Herald*, 25 January 2005: see <http://www.smh.com.au/news/National/Federalism-isnt-working-Abbott/2005/01/23/1106415457605.html> viewed 7 February 2006.

³³ Lokuge B, Denniss R and Faunce TA, "Private Health Insurance and Regional Australia" (2005) 182 (6) MJA 290.

³⁴ Starfield B, "Insurance and the US Health Care System" (2005) 353 NEJM 418.

³⁵ "PBS Reform for a Healthy Australia", Address by Will Delaat, Chairman, Medicines Australia, National Press Club, 3 August 2005: <http://www.medicinesaustralia.com.au/> viewed 14 February 2006.

³⁶ Barr MD, "Medical Savings Accounts in Singapore: A Critical Inquiry" (2001) 26 J Health Polit Policy Law 709.

³⁷ Sekhon JS, Reinhardt UE, Cheng T, Navarro V, Tuckson R, Woolhandler S, Campbell T, Himmelstein DU, Aaron HJ, "Costs of Health Care Administration in the United States and Canada" (2003) 349 NEJM 2461.

³⁸ Waitzkin H and Iriart C, "How the United States Exports Managed Care to Third World Countries" (2000) 52 (1) *Monthly Review* 1.

Organisation's *General Agreements on Trade in Services* (GATS).³⁹ Once China agrees to commit to liberalisation of services in the health sector, the options for reform will be immediately limited.

The PRC Government might also consider how its health care system could be further enhanced by a constitutional right to public-funded emergency health care, such as that instituted in South Africa. This right ensures that all citizens are granted a basic level of health care in emergencies without inhibiting the government's ability to allocate finite resources according to principles of distributive justice.⁴⁰ While in South Africa the constitutional protection was required to combat racial discrimination, in China the protection would prevent the geographical discrimination currently occurring. Chinese Health Minister Gao may have been earmarking such constitutional reform when he recently warned that Chinese hospitals refusing to provide emergency treatment for patients who cannot afford medical fees would face punishment. He admitted that China's health system was now failing to provide adequate health care to most of its citizens.⁴¹ A constitutional right to free emergency health care would also provide a great symbolic impetus and the necessary egalitarian ethos to make major Chinese public-funded hospitals centres of research and teaching excellence.

CONCLUSION

Widespread privatisation health policy changes in China since the 1980s have been to the detriment of most rural Chinese citizens. They have experienced increasing out-of-pocket expenses for health care, growing health care corruption and deliberate overservicing of expensive medicines and diagnostic tests, as well as a decrease in the overall health and wellbeing of citizens. This article has argued that it is in these negative consequences of structural changes in Chinese health care that the causes for the increase in incidents of violence against health care workers instigated by patients and their families reside. It is suggested that better policy options for necessary health care reform in China are likely to be found in the balance between public-funded universal health care epitomised by the Australian model rather than the excessively privatised approach that characterises the failing United States health care system.

³⁹ Fidler D, *Legal Review of the General Agreement on Trade in Services (GATS) From a Public Health Perspective* (World Health Organisation, Geneva, 2003).

⁴⁰ *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (CC).

⁴¹ Channel News Asia, n 16.