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China's 2009 health reform: What implications could be drawn for the NHS Foundation Trusts reform?

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Abstract
China's market-oriented health reforms since the early 1980s created a range of problems in its healthcare system. By mid-2000 healthcare costs had increased to a level which was too expensive even for average income families without any form of healthcare subsidy. On realising the severity of health related problems, China's central government launched its large-scale, expensive health reform in April 2009, intending to re-establish the universal healthcare system which would provide affordable basic health care to everyone in the country.
Using unformatted, in-depth interviews with multiple stakeholders of health care in China, this study aimed to provide the latest research-based evidence about access to health care for ordinary citizens in China two years into the April 2009 health reform. It aimed to find out what implications could be drawn for the English NHS (National Health Service) Foundation Trusts reform pursued by the UK Coalition Government from China's experience of health reforms.
The study provided evidence that, two years into the April 2009 health reform, there was a newly re-established, public health insurance based healthcare system in China. The new system was providing affordable basic health care to even the most remote and poorest of our participants who were among the most remote and poorest in China in July–August 2011. Given the geographical and population size of China, this is an enormous achievement.
The Chinese experience implies that if there is no effective and powerful regulatory system, the UK Coalition Government's policy to abolish the arbitrary private patient income cap on the amount of income NHS Foundation Trusts may earn from privately funded patients could have some negative impacts, for instance, on tackling health inequalities and ensuring good provider behaviour.

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Introduction

Maoist China (1949–1976) established what was essentially a universal free healthcare system providing basic health care to everyone in the country [1]. The state established public hospitals that played the key role in looking after the health of the nation. Under the Maoist regime, public hospitals were state-owned, government funded and government controlled. In the Chinese system, there is not a nationwide, non-hospital based, formally established primary care sector to date. Unlike hospitals in the UK or in other developed countries, public hospitals in China have provided both ***men zhen*** (non-hospitalised care – including primary care and any treatments that do not involve hospitalisation) and ***zhu yuan*** (hospitalised care) since the Maoist era.

In 1978 China launched its economic reform and this had a great impact on its healthcare system. In accordance with the economic reform, a series of health reforms began to take place in the early 1980s and this gradually phased out the Maoist universal healthcare system [2]. The central element of the health reforms in the 1980s and 1990s was the introduction and the reinforcement of the market mechanism into public hospitals, intending to make healthcare users share the financial burden with the government [3]. The government gradually reduced its budgets for public hospitals. In return, public hospitals were given almost unlimited freedom to raise funds [3–5]. A common practice of the hospitals was to maximise patients' medical bills, for instance, through over prescription of pharmaceuticals (drugs) and diagnostic tests [6].

The market-oriented health reforms created a problem of access to health care for ordinary citizens. Statistics from China's Ministry of Health revealed that by 2000 healthcare costs had increased to a level which was too expensive even for average income families without any form of healthcare subsidy [7]. Over 63% of the urban patients did not seek hospitalised care when needed and the major reason for this was the expensive medical charge [7]. Since 2000, healthcare expenses continued to increase sharply. Per capita total expenditure on health was US$44 in 2000, but this figure went up to US$169 in 2009 [8]. China's private expenditure on health as a percentage of total expenditure on health in 2009 was 49.9% whilst in the UK that was 16.4% in the same year [9]. A for-profit medical sector within China's public hospitals was established, providing Western-style medicine in beautiful new facilities to China's rich and urban elite [10].

On realising the severity of the problem, China's central government launched its large-scale health reform in April 2009, intending to re-establish the universal healthcare system which would provide affordable basic health care to everyone in the country [11,12]. To achieve this goal, the government would provide major funding through central and local budgets. The central government was committed to spend 850 billion ***yuan*** (£79.9 billion; in this article, the original monetary figures in Chinese ***yuan*** were converted into British Pound (£) using the November 2011 exchange rate: 1 ***yuan***≈£0.094) in the initial three-year implementation plan for 2009–2011 [12]. Two strategies were designed and proposed to achieve this goal. The first was to establish a public health insurance system so that everyone in the country was covered by a proper, suitable health insurance scheme [11,12]. The second was to reform public hospitals back to play the key role they had under the Maoist regime [4,5,13].

The English National Health Service (NHS) provides health care to anyone normally legally resident in England with almost all services "free at the point of use" [14]. The NHS is a single-payer health care system primarily funded through the general taxation system. The UK public sector net debt was £977.1 billion, equivalent to 62.8% of GDP, at the end of November 2011 [15]. The Coalition Government has repeatedly emphasised that the massive deficit means it has some difficult decisions to make. This means that the NHS is not immune from such fiscal challenges facing the government. In July 2010, the Coalition Government presented its White Paper ***Equity and Excellence: Liberating the NHS*** to Parliament, which set out its long-term plans for the English NHS [16]. Over the first four years of the Coalition Government, the health service is expected to save £20 billion as demand for health care continues to grow but big increases in funding come to an end [16].

One of the Coalition Government's proposals is to abolish the arbitrary private patient income cap (the PPI Cap) on the amount of income English NHS Foundation Trusts ("FTs") may earn from privately funded patients [16]. FTs were established as part of a wider NHS reform agenda, through the ***Health and Social Care*** (***Community Health and Standards***) ***Act 2003***, consolidated into the ***National Health Service Act 2006*** [17]. On 1 April 2004 the first 10 FTs came into being. FTs provide NHS services to NHS patients in accordance with the core principles of the NHS. Unlike existing NHS Trusts, FTs are independent legal entities—public benefit corporations; they are authorised and regulated by an independent regulator Monitor. Applying for the foundation trust status had been voluntary up to 2012, but access was dependent on the performance of Trusts: only the best performing Trusts were allowed to apply for the foundation trust status [18]. As at January 2013, there were 145 FTs, of which 41 were mental health trusts and four were ambulance trusts [19]. It is intended that all English NHS Trusts will become, or be part of, FTs by 2013/14 [16].

The private patient income cap ("the PPI Cap") was set out as part of the legislation to establish FTs [17]. The PPI Cap meant that an FT could not exceed the proportion of the total income that it derived from privately funded patients in what was referred to as the base year, which is 2002/03 (the year before the first FTs were authorised) [20]. The base year of 2002/03 applied to all English NHS Trusts that were applying for the FT status [21,22]. The PPI Cap was fixed at the base year as a proportion of an FT's overall income [21,22]. The PPI Cap varied between FTs, from zero percent up to around 30% [21,22]. There is uncertainty over the impact of lifting the PPI Cap due to lack of relevant evidence as this has never happened in the NHS to date. Concerns were raised in the press e.g. [23] and in the UK Parliament e.g. [24] that lifting the PPI Cap might result in a range of negative impacts.

This study aimed to provide the latest research-based evidence about access to health care for ordinary citizens in China two years into the April 2009 health reform, aiming to contribute to meeting the demand of the increasing academic interest in China's health system and health reforms [25]. It also aimed to find out what implications could be