

Editorial

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Access to healthcare is at the intersection of many challenges faced by China today. Aware of the stakes, the government has been engaged since the noughts in a series of reforms in which two philosophies co-exist: a highly regulated market, and competition in healthcare through the development of the private market. The year 2009⁽¹⁾ marked a turning point. Given the need to establish basic access for all, the State Council announced the introduction of universal and comprehensive health coverage by 2020. This objective was pursued during the 12th Five Year Plan (2012-2016) before the 13th Five Year plan (2016-2020) gave new directions.

Access to healthcare in China today poses a completely different challenge from 30 years ago, mainly because of the rapid ageing of the population, a result of the one-child policy, which led to a low birth rate, and an increase in life expectancy made possible by the organisation of the health system set up during the Maoist period, and then by the economic growth of the last three decades. In this new demographic context, the system of access to healthcare needs to be reorganised in order to treat patients in long-term care or in situations of dependence. The creation of reception structures is under discussion, and pilot experiments have been put in place. Although the third plenum of the 18th Party Congress in November 2013 decided to progressively relax the one-child policy, with the possibility of a second child in a defined number of cases,⁽²⁾ demographic inertia makes the impact of ageing inevitable.

Alongside these developments, the demand for healthcare has also undergone a transformation due to the drastic reduction of poverty. However, the distribution of the fruits of growth is far from homogeneous. Central and provincial government spending is much higher in rich and urban areas than in rural and poor areas.⁽³⁾ Thus, the Chinese health system is now confronted with a highly segmented population in terms of income and expectations.

Beyond the external shocks associated with demographic, economic, and social transition, China's healthcare system faces particular challenges due to the specific role played in it by the public hospitals. The quality of care now expected by a growing proportion of the population is only accessible in public hospitals, mainly those with a high level of care referred to as Tier 3 (*sanji* 三级), and which are therefore at the heart of the Chinese health system. Contrary to practice in the West where the patient consults a general practitioner in a healthcare practice for problems that are considered to be minor, China's public hospitals, especially those referred to as "excellent" (*sanji tedeng* 三级特等), deal with both outpatient consultations and hospital admissions on a massive scale, resulting in severe congestion.

This situation is the result of a three-stage evolution in provision.

From the 1950s to the economic reforms, the provision of healthcare was structured by local care and primary level hospitals (level 1). In rural areas, medicine was practiced by agricultural workers who had had rapid medical training (called barefoot doctors). Depending on the severity of the condition, the patient was then redirected to better-equipped facilities with more qualified staff. The higher the population density, the bigger the hospital in terms of number of beds and of medical staff: this was the intermediate level (level 2). Then, at the top of the pyramid, came high level healthcare

(so-called level 3). Administratively, the population had no other choice but to follow this funnel-shaped care pathway.

Beginning in the 1980s, the provision of healthcare was disorganised under the influence of several factors, leading to the disappearance and subsequent redefinition of this provision of local care. The cost of healthcare, hitherto virtually free, increased dramatically. The reason was the financial disengagement of the state and the possibility for hospitals to generate profits and use them as they saw fit. At the same time, the level of quality also improved. The result was a fragmentation of the population in its access to healthcare according to income, geographical area of residence, and residence permit (*hukou* 户口): rural or urban.

The third phase of the evolution of the health system corresponds to a greater openness, both geographical (with a more mobile population and improved transport) and administrative. At the same time, hospitals have acquired sophisticated equipment, greatly improving the quality of care, but with significant inequalities depending on the size of healthcare facilities and on geographical area. The effect of these developments is a greater incentive to attend hospitals offering a high level of quality of care, resulting in massive concentration in some areas and neglect of the provision of care elsewhere. Public healthcare is no longer defined solely by the financial accessibility of the populations, but also by the levels of quality offered by the health structures. Today some localities have empty public health facilities with low-grade equipment coexisting with high-tech public health facilities besieged by thousands of patients prepared to wait hours or even days for a medical consultation.

The aim of the central government is to regain control over the trajectory of patients by increasing the number of medical consultations, particularly high-quality medical consultations, and by putting in place family doctors or referring doctors. Because of these objectives, the health sector is booming. On the one hand, the number of medical and healthcare establishments continues to increase, with growth occurring in the city as well as in the countryside, and in the public as well as in the private sector, but with considerable heterogeneities.⁽⁴⁾ On the other hand, this sector employs an increasing number of people.⁽⁵⁾

1. For some observers, the turning point of the reforms towards a more social society was marked by the speech of Hu Jintao, Secretary General of the Party in 2006, when he introduced the notion of a "harmonious society." Joe C.B. Leung and Yuebin Xui, *China's Social Welfare*, Cambridge, UK, Malden, MA, Polity Press, 2015.
2. Deng Shouqiang, "'Dandu er tai' fang kai: Pinglun cheng houxu gonggong fuwu ying gen shang" (Relaxing the one-child policy: Comments say public services should follow up), *Zhongwenwang xinwen zhongxin*, 18 November 2013, http://news.china.com.cn/2013-11/18/content_30628501.htm (accessed on 18 November 2016).
3. Li Shi, Hiroshi Sato, and Terry Sicular (eds), *Rising Inequality in China: Challenges to a Harmonious Society*, Cambridge, Cambridge University Press, 2015.
4. In 2015, there were 982,443 such institutions. This figure includes 25,865 hospitals, 36,899 cantonal township health centres, 34,264 health centres at village or village agglomeration level, 646,044 clinics at village or village agglomeration level, 3,491 centres for the prevention of epidemic diseases, and health surveillance centres. Source: National Bureau of Statistics of China, "Statistical Communiqué of the People's Republic of China on the 2014 National Economic and Social Development," 26 February 2015, www.stats.gov.cn/english/PressRelease/201502/t20150228_687439.html# (accessed on 25 November 2016).
5. In 2015 there were 5.9 million beds, of which more than 5.5 million were for the care of the elderly. In total, 2.8 million seniors are residents of an institution. Source: National Bureau of Statistics of China, "Statistical Communiqué of the People's Republic of China on the 2014 National Economic and Social Development," *op. cit.*

A range of instruments has also been tested through public health insurance mechanisms: the establishment of a healthcare market through incentives for the creation of private institutions, the transformation of public institutions into private institutions, and the establishment of community health centres for medical consultations to act as a “gateway” to all care pathways. However, these measures are currently yielding mixed results.

In particular, these attempts at reform are hampered by the lack of professional mobility for medical staff. In order to maintain their status (which is equivalent to that of state officials with a number of additional benefits including broad social protection compared to the rest of the population, and low-cost access for their children to quality schools), medical personnel who meet the new standards of expectations (“trained, qualified, and effective”) are present only in large public institutions. Thus, while supply is becoming more diversified, demand remains concentrated in the high-quality public establishments, which does not resolve the congestion of these structures.

Faced with these difficulties, digital tools finally appear as a means of limiting the problems of congestion, if not of solving them. These solutions, grouped under the term “e-health,” are experiencing exponential growth, especially in recent years.

The contributors to this special issue highlight the evolution of the Chinese health system and the issues of access to care for the population. The health system is constantly changing to adapt to this new reality, torn between its opening to the market and strong administrative management. The first two articles analyse the two opposite sides of the central figure of the healthcare system, namely the doctor. The concentration of demand is based on the quality of healthcare provided by this healthcare professional. In her contribution, Jiong Tu analyses the role of barefoot doctors in the rural healthcare system. It presents their indisputable role in improving the health of the Chinese population during the period of the planned economy and documents their difficult place as caregivers in a society requiring a level of quality that no longer corresponds to their qualification. The article also helps our understanding of the ambiguous position of the Chinese authorities. Long considered the cornerstone of the health system and improving the health of the population, these healthcare providers have become an under-qualified medical workforce. According to the current criteria of the demand, they can no longer be recognised as fully-fledged doctors. However, lack of supply explains why they continue to provide an indispensable foundation of basic healthcare in certain areas of China. Thus, considered administratively as peasants and therefore without specific social protection or retirement, they continue to operate as health professionals on the ground.

Based on a field study at the other end of the spectrum of training and qualification, Longwen Fu and Cheris Shun-ching Chan focus on doctors in urban China. Their article analyses the influence of social relations between the patient and the doctor on the management of patients. Here, the analytical framework is a high-performing quality hospital located in an urban area. Physicians working in these health facilities are doctors whose training or qualification is comparable to what is called “doctor” in the West. The level of quality of care provided meets the current requirements of demand. In this case, doctors are faced with too much demand, resulting in overcrowding of hospital structures and an overload of work for the practitioner, who has to treat an average of 80 patients per day, resulting in a consultation time of less than five minutes per patient. In addition, these hospital structures are public in nature while maximising their profit. An abundant literature has revealed over-prescription and over-diagnosis.⁽⁶⁾ This contri-

but ion shows the importance of *guanxi*, the network of social relations, in the practices of physicians that can prevail, in some cases, over the doctors’ professional code.

Through a synthesis of empirical studies of hospital data carried out over the period 2000-2012, as well as interviews in hospitals and health authorities, Martine Audibert, Xiaoxian Huang, Xiezhe Huangfu, Jacky Mathonnat, Aurore Pelissier, and Laurène Petitfour study the effect of a series of reforms aimed at improving the quality of small hospitals and basic level (Tier 1) facilities in Weifang Prefecture of Shandong Province. Medical personnel in this type of hospital have a limited level of education in comparison with those working in excellent hospital facilities (Tier 3), where they would not be allowed to practice. The study focuses on two major reforms of the health system. On the one hand is the effect of the introduction of public health insurance from 2003 onwards in rural areas. There is a clear increase in the activity of these establishments, suggesting an increase in demand. However, despite the parallel increase in recruitment, there is no apparent increase in the effectiveness of these hospital structures. Another important part of the reform of the health care system covered in this article is the control of the price of medical drugs effected by drawing up a list of “essential” medicines with regulated prices. The article highlights the strategies put in place by institutions to escape this constraint by specialising in medical activities not affected by the imposition of price controls by the state.

Referring to administrative documents, press articles, and interviews conducted within hospitals and health authorities, Carine Milcent’s contribution provides a wider overview of the Chinese health system, its access, reforms, and current developments. It illuminates and analyses the changes in the Chinese health system from the Maoist period to the present day. There are details of the tensions between the pro-market and pro-welfare components of the reforms, but also the growing use of digital technology: mobile phone applications (whether online medical advice or payment methods for hospitals), Big Data containing patient medical information accompanied by socio-economic variables, and their virtual storage on remote servers, or clouds. A number of services offered by e-health are mentioned, such as the construction of databases on the history of patient care, telemedicine, teleconsultation, on-line sale of medicines, queue management, and payment methods via applications for mobile phones. Moreover, the use of WeChat for making appointments and managing one’s medical records, as well as the possibility of semi-private forums or discussion groups that make possible critical discussion spaces that give at least the appearance of being more discreet, contribute to transforming healthcare demand and thus the health system as a whole.

Mirroring the previous contributions, Veronika Schoeb’s article offers an alternative perspective on the current healthcare system in mainland China by focusing on the situation in Hong Kong. In this special administrative region, the issue of access to care does not arise in the same terms. The health system there has very few similarities with that of mainland China. The various implications include the spatial dimension of access to care. The development of a public social protection system has largely focused on health and access to care. However, at the same time, a private healthcare system offering high quality at a high cost has developed there. In order to ensure its solvency, a private insurance system covering expenses has been set up, in particular through companies subscribing to insurance “packages” for their employees. Hong Kong is now divided between a public health system

6. Karen Eggleston, Li Ling, Meng Qingyue, Magnus Lindelow, and Adam Wagstaff, “Health Service Delivery in China: A Literature Review,” *Health Economics*, Vol. 17, No. 2, 2008, pp. 149-165.

that is almost free but involves a high level of expenditure control, and a very expensive private health system involving, on the one hand, subscription to private health insurance, and on the other hand, induced demand behaviour by practitioners, who encourage patients to consume more care than their state of health requires in order to derive maximum profit from it. The goal is to achieve the maximum level of reimbursement allowed by commercial health insurance companies and thus maximise their profit. Hong Kong could have served as a health system model at a time when the Chinese mainland system is under construction, but current trends suggest that this will not be the case.

This special issue presents various aspects of the Chinese healthcare system and its access to care. While some factors are dealt with less than oth-

ers, particularly those related to the ageing of the population, this dossier offers a broad overview of access to healthcare in contemporary China. It makes it possible to account for the inefficiency of the current system: the division between pro-welfare state reforms and reforms favourable to the market, and the revolution effected by e-health. The impact of digital technology on access to healthcare affects not only China, but also the developed countries as a whole, requiring us to redefine health as a "good" in an economic perspective, both in its component requiring universal access for social stability, and in its component based more on private property criteria and market pricing, thus shaping a new health system.

■ Translated by Michael Black.