De-bureaucratisation: grand theme of reform?

De-bureaucratising is an emerging buzzword that some elevate to the status of a major reform theme. It means getting vestiges of the old planning system off your back. It addresses, in particular, a common affliction for service providers of all kinds: the more ‘legit’ you are, the more you are behind the eight ball.

Hospitals, the example in our accompanying text, are ‘bureaucratised’ through being subject to arbitrary rulings of external authorities—sometimes central, sometimes local. De-bureaucratising is no simple matter of cutting red tape, but goes to the reconstruction of the governance framework.

In developed economies, bureaucracy is seen as a force driving towards efficiency. While alienating, it connotes rationality and professionalism. In China not one, but many, agencies have fingers in the typical bureaucratic pie—creating layers of uncertainty and setting up minefields of competing jurisdiction. The Ministry of Health’s aim to reform health access is compromised before it begins by the vested interests of other empires with a stake in hospitals.

This situation has a deep institutional background, rooted in the planned economy era when virtually all social services were absorbed into the mono-organisational state structure. The ideal was for major enterprises to have their own schools, hospitals, housing, restaurants leisure facilities and so on. In the course of market reforms in the 1980s and 90s, in order to shift the burden of running them from the newly profit-oriented firms, these supporting ‘social enterprises’ (shiye danwei)—of which China has some 1.26 million—were placed on a market footing.

Subjecting parts of the economy to market discipline allowed many organisations to become profitable through relieving them of social welfare functions. Hospitals and other agencies hived off in this process are liable to abuse the system because the government prevents them from fixing suitable goals for themselves, while at the same time setting up regulatory hurdles that force them into questionable practices.

Social enterprises continue to be regarded as branches of government, to be included in staffing quotas (albeit off the books) and rankings of the administrative hierarchy. While presenting one face to the market, they inevitably present another to their ‘higher levels,’ with whose whims and wishes they are expected to comply.

Cadres gain political merit from hospital expansion, often creating idle assets. To service the resulting debt, hospitals focus on outpatient services, pharmaceuticals and such for cash flow, compromising the delivery of public medicine.

‘Performance’-based bonuses among social enterprises run from 30 to 60, sometimes up to 80 per cent of total wage bills. Here is the source of much of China’s controversial grey income; and in the case of hospitals, another reason for the weakening of their welfare function.

The burgeoning field of NGO regulation presents a similar case. Just as hospitals are driven to rapacious pricing policies by external administrative interference, recent loss of trust in the philanthropic sector has been traced back to ‘social organisations’ (the term for local NGOs) being by and large seen as remote arms of government agencies, with the same scope for rent-seeking and outright corruption.

Bureaucratisation in education is even more sensitive: nearly all families have children with futures to secure.

Rapacious charging by hospitals is a bad look for the government, and corruption of charities puts off donors. But bureaucratisation in education is even more sensitive: nearly all families have children with futures to secure.

Around the world, ancient wisdom established universities through independent charters, isolating their operations from political interference. Interference in China, not long ago broadly political, including prescription of course content and recruitment on the basis of political correctness, is now increasingly mercenary, tainted by family connections and wealth. 15 February 2012
The State Council promulgated the ‘new medical reform program’ in January 2009. Since then progress in the two areas of medical insurance reform and health care system reform has become seriously out of balance. Medical insurance reform is developing steadily; but reform of the health care system, especially public hospital reform, has been hesitant.

The purpose of medical insurance reform is firstly to diversify the risk of medical costs through medical insurance, and secondly to allow medical insurance providers to play a ‘group buying’ role, dampening increases in medical costs. However, many public health care institutions dominate and even monopolise the market for medical services. They are inefficient even where medical insurance reforms are in place. Medical insurance providers lack any right of choice, and many reforms curbing the rise of medical costs fail to be implemented. The lack of structural health care reform substantially offsets any relief from ‘expensive medical treatment’ that might be brought about by the medical insurance reform. Without success in public hospital reform, there can be no success in the ‘new medical reform.’

The ‘administrative market’ status quo

The organisational and institutional model of public hospitals in China today takes the form of a ‘bureaucratised market’ or ‘bureaucratised commerce.’

A very high proportion of public hospitals’ total revenue is derived from the services they provide; in contrast, government funding or subsidies have been insignificant. Public hospital operations, which are dependent on fees, seem to be becoming more market oriented. Many people even think this marketisation is responsible for ‘weakening the welfare role’ of public hospitals. This is really a misunderstanding. The so-called ‘marketisation’ in Chinese public hospitals is in fact ‘phony,’ severely constrained and distorted by the bureaucratic system.

One of the key features of this ‘phonyness’ in ‘bureaucratised marketisation’ is that amongst public health care institutions, the vast majority of prices for health care services are set by the government. Prices of the most commonly used drugs; maximum retail price; bid price and profit markup; are also determined by the government. Bureaucratised pricing always results in prices being distorted. Because medical services for common and frequently occurring illnesses have unusually low prices, it’s inevitable that for general medical services expenditure will exceed income. This forces public hospitals to resort to two ways to make up the shortfall in medical services: one is to sell more medication; and the second is to use more expensive supplies.

Seeking to curb the rapid increase in medical costs, the government resorted to administrative control measures. The result was total failure. Average outpatient and hospital costs in public hospitals grew very fast. One of the main reasons behind this rapid growth in costs is the emergence of large numbers of supplier-induced over-consumption (commonly known as ‘over-servicing’).

The idea of ‘re-bureaucratisation’

How exactly are public hospitals to be reformed? For this, the ‘new medical reform’ scenario provides two parallel suggestions. One is ‘re-bureaucratisation’; the second is ‘de-bureaucratisation.’

The idea of ‘re-bureaucratisation’ is to place the right to allocate hospital resources in the hands of health ministry departments. This would include:

• Implementing ‘income-expenditure management’ in public hospitals. Public hospitals would turn over all their income to health administration departments which would then manage the hospital’s entire budget
• Placing these departments in charge not only of management-level appointments, but all hospital staffing
• Approving infrastructure projects, equipment procurement and centralised purchase of medical supplies and drugs would rest with these departments
‘De-bureaucratisation’ has become one of the core principles of reform in China’s public institutions. The ‘new medical reform program’ reiterated the principles of separation of ‘government agencies and institutions’ and of ‘regulation and operation’, and also proposed to treat public hospitals as independent legal entities. But the theme of ‘de-bureaucratisation’ has never been explicitly promoted. In practice, ‘separation of regulation and operation’ is tougher to implement than separating agencies and institutions. In the main, discussion and practice of health care reform is limited to changing public hospital management responsibilities.

The key to ‘separating regulation and operation’ is in fact to push for ‘corporatisation’ of public hospitals. In a corporatised environment, all public hospitals sever administrative relations with health administration agencies. As completely independent legal entities, they independently assume all civil and criminal liabilities for their activities, including hiring personnel, service delivery, asset purchases, admissions and investments. Hospitals no longer need their existing administrative hierarchies. Hospitals will differ only in size, service area and service level.

On the surface, ‘de-bureaucratisation’ of public hospitals means changing organisational and institutional structures, but it comes down fundamentally to changing the relationship between the government and the hospitals. There are numerous government reforms related to hospital reform, but many experts, media and local authorities (especially the health professionals at the annual NPC and CPPCC meetings) have focused on ‘government financial compensation’ and chorused ‘implementation.’ In plain terms, they are demanding money from the public coffers, but care little about demarcating financial relations between government and hospital, or setting the rules of the game. This is clearly to misplace the focus of reform. If the government’s concepts, methods and institutions of governance do not change, its cavalier financial attitude will turn into a waste of taxpayer’s money.

For the most part, overall reform thinking at the highest level in the hospital system has failed to clearly expound the key elements of ‘de-bureaucratising.’ So far, pilot reforms fall basically between ‘re-’ and ‘de-bureaucratising,’ while continuing to preserve and even strengthen current administrative systems and mechanisms.
The key to structural reform the world over is recalibrating government power. In many cases, the root cause of delay or disruption is the negative attitude, even resistance, adopted by government towards any reform initiatives that may weaken its power. Government agencies everywhere by their very nature much prefer to expand, rather than relinquish, power.

Translated by China Policy

Source:
Gu Xin, ‘Gongli yiyuan ying quxingzhenghua’ [Public hospitals should de-bureaureatise], Xinshiji, 10 October 2011.