Commentary

Overcoming the legacy of marketisation: China’s response to COVID-19 and the fast-forward of healthcare reorganisation

Zhiyong Liu,1 Ian Kirkpatrick,2 Yaru Chen,3 Jixia Mei4

Having a healthcare system that’s a public strategic asset rather than a business run for profit allows for a degree of coordination and optimal use of resources.

This remark by David Fisman, an epidemiologist at the University of Toronto, reflects the views of many policy makers and clinical professionals globally about the relative merits of different organisational models of healthcare for managing the COVID-19 pandemic. COVID-19 emerged in China in November 2019 and was declared a pandemic by the WHO on 11 March. At the time of writing, on 27 July 2020, more than 16.11 million cases of the virus have been reported globally, resulting in more than 64 6641 deaths. Without doubt, responding to this crisis has placed an unprecedented demands on the expertise of public managers, notably those associated with healthcare. But as the opening quotation implies, it may be that these demands are far greater in systems where healthcare services are substantially commercialised and where the emphasis is on competition and fragmentation rather than integration. If this is the case, then how have policy makers and managers dealt with this organisational challenge and what can we learn from their initial responses?

The challenge of how to overcome fragmentation in health services and adopt a system-wide perspective has been one of the most significant wicked problems facing policy makers, managers and clinical leaders around the world. In any healthcare system, rising costs and resource constraints linked to more complex patient needs (associated with population ageing) demand effective collaboration between different parts of a healthcare value chain: public health, primary/community care and specialist hospital services. Ideally this would involve a ‘continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services’ (p10).2

But while this change is urgently needed (perhaps now more than ever), it is far from easy. Partly this is because of the historical imbalances in most healthcare systems, between well-resourced, high-status, hospital services and underfunded primary care. However, as David Fisman implies, it may be that the challenges associated with integration are even greater when healthcare is a ‘business run for profit’.1 When that applies, private hospitals (and other organisations) will understandably focus mainly (if not exclusively) on their own financial viability, survival and reputation. The need to compete may trump any desire to collaborate.

This problem, one might expect, will be greatest in health systems where clinical services are substantially privately owned and funded, such as in the USA. According to David Himmelstein, based at The City University of New York, the ‘fragmented system’ of healthcare in the USA has weakened the national response to COVID-19 because it ‘leaves public health separate and disconnected from medical care, and provides no mechanism to appropriately balance funding priorities’.1 However, the risks of marketisations and fragmentation also apply even to healthcare systems that are publicly owned. This is especially where governments have experimented with new public management (NPM) reforms.3 These reforms have encouraged the ‘disaggregation’ of public sector bureaucracies, using outsourcing and internal (or quasi) markets to stimulate competition and improve performance.

Returning to the main concern of this commentary, it is notable that China—the country where the COVID-19 pandemic originated—is a prime example of this market-led approach to healthcare. Contrary to its image as a centrally planned, command and control system, China has experimented over the years with many elements of NPM-style reform. This is notably in healthcare, where, since the late 1980s, publicly owned hospitals and other services have been expected to operate in some ways like private businesses.4 In what follows we consider how this legacy of marketisation influenced China’s initial response to the COVID-19 pandemic. Focusing on events in the city of Wuhan, we show how this legacy, by exacerbating service fragmentation, had serious consequences. However, this story also illustrates the benefits of a system where healthcare is a ‘public strategic asset’. In China’s case this made it possible for the city administration to adopt a system-wide perspective and to quickly reorganise services in a time of crisis. The result has been to fast-forward reforms aimed at healthcare integration, creating opportunities for managers and clinical leaders on the ground to develop integrated care pathways.

CHINA’S PUBLIC HEALTHCARE SYSTEM AND THE LEGACY OF MARKETISATION

In recent years China’s total health expenditure has grown significantly, from 5% of gross domestic product in 2009 to 6.4% in 2017.5 This growth has been associated with improvements in staffing levels, facilities and standards. It also went hand in hand with an extension of social health insurance, covering 95% of the population by 2011.6

1School of Medicine and Health, Huazhong University of Science and Technology, Wuhan, Hubei, China
2The York Management School, University of York, Sheffield, UK
3Cass Business School, City University of London, London, UK
4School of Public Administration, Zhongnan University of Economics and Law, Wuhan, Hubei, China

Correspondence to
Dr Jixia Mei, School of Public Administration, Zhongnan University of Economics and Law, Wuhan 430073, China; meijixia@zuel.edu.cn

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However, marked disparities in access to services still remain between urban and rural areas, with average out-of-pocket expenses (30% in 2016) being high by international standards. As noted earlier, a further challenge facing China’s health-care system has been poor integration and a significant gap in resources and capabilities between secondary (acute and tertiary hospitals) and primary and community services.

Although long-standing in China, this gap was greatly exaggerated by policies of ‘unbridled marketization’ from the mid-1980s. For the most part hospitals and primary care organisations such as community health centres (CHCs) in China are publicly owned and accountable to district, city, and regional tiers of government. Nevertheless, after China’s shift towards a market economy in 1984, these services were required to operate as semi-independent businesses (or state-owned enterprises), funding themselves partly through profits from the mark-up on drugs and diagnostic procedures. Consistent with China’s ‘results-oriented culture in the bureaucracy’ (p43), it was felt that some degree of competition was the best way of ensuring accountability and performance.

However, unsurprisingly, this market-based system generated perverse incentives for hospitals and CHCs to engage in over-prescription and the irrational use of services and technology. As mentioned, the policy of marketisation also contributed to fragmentation. Providers were strongly incentivised to focus on maximising their own turnover of patients to ensure continued financial viability. This weakened cooperation and helped to exaggerate disparities in funding and resources between parts of the system that were already substantial. Crucially, marketisation ensured that higher status (upper tier) tertiary hospitals, which were already better placed to attract patients, obtained the lion’s share of funding. This allowed them to improve their facilities, staffing levels and service quality at the expense of primary care. The lower ability of CHCs to compete in this ‘market’, in turn, made it harder for them to recruit and train staff or invest in alternative, community-based and preventative services, further undermining public confidence in the quality of their services and ultimately demand. The result, according to the WHO, is a system that is ‘hospital-centric, fragmented, and volume driven’ (p8). Even today public hospitals provide over 80% of health services and consume 60% of all health expenditures, and in 2016 the rate of hospital admission in China was 16.4%, higher than the average of the Organisation for Economic Co-operation and Development.

Responding to these challenges in 2009, the Chinese government published the Opinions on Deepening Health System Reform, highlighting their commitment to transform the funding and organisation of primary care. This led to a decision to replace the old funding system with a ‘zero-mark up’ policy and to invest heavily in primary care staff and facilities (p1805). The goal of integration was also supported by the establishment of medical alliances—close partnerships between tertiary hospitals and CHCs to manage admissions and rehabilitation discharge. However, while these reforms represented a ‘historic opportunity’ to build a ‘...well-coordinated and integrated health system’ by November 2019, on the eve of the COVID-19 outbreak, they were still incomplete. Crucially, uneven implementation of the reforms meant that perverse incentives for tertiary hospitals and CHCs to compete by trying to maximise their own income streams remained in place. Price mark-ups on drugs, for example, still accounted for 30% of public hospital income in 2018, while new fee-for-service payments, linked to performance (phased in after 2009), continued to generate incentives for them to maximise their patient throughput. Partly for these reasons, the legacy of marketisation in China’s health-care system was not eradicated, undermining the ability of CHCs to develop alternative services. Indeed, it is notable that between 2005 and 2015, the proportion of healthcare services provided by primary care in China actually decreased by 7%.

THE COVID-19 PANDEMIC: REACTING TO AND OVERCOMING SERVICE FRAGMENTATION

The initial shock

This failure to completely reverse the legacy of marketisation of China’s healthcare system had significant consequences for its initial response to COVID-19. In what follows we briefly explore two of these consequences, focusing on the experience of health practitioners and policy makers in the city of Wuhan between December 2019 and March 2020.

First, ongoing weaknesses in the primary healthcare system ensured that when the outbreak started, CHCs were unable to provide an early warning system. One of the objectives of the 2009 reforms was to establish a general practice (GP) profession in China, with a stronger focus on prevention and public health. However, according to Wu, many CHCs were only aware of COVID-19 outbreak around the time of the lockdown. Although there were increasing numbers of patients with fever in tertiary hospitals from end of December to mid-January, it was ‘business as usual’ for CHCs. This observation is also confirmed by unpublished research conducted by the authors in Wuhan based on interviews with GPs in four CHCs between December 2019 and early January 2020. In all cases we observed no increase in patient numbers or early intelligence relating to the pandemic.

Our second observation relates to how the hospital-centric nature of China’s healthcare system initially exaggerated the problems encountered in the first wave. Even before the outbreak, at the end of 2018, Wuhan’s health commission reported the occupancy rate of hospital beds was already at 94%. This situation reached breaking point soon after the first cases were detected. By mid-January, anxious and fearful patients did what they would normally do even when suffering mild cold symptoms: rush directly to tertiary hospitals. On 29 January, Aljazeera reported a ‘flood of patients in the initial days of the outbreak as people lined up in front of hospitals, hoping to get treatment’. In total, 75,221 patients rushed to tertiary hospitals between 22 January and 27 January in Wuhan, most with mild symptoms. While in January 2019, the fever clinics of Wuhan’s hospitals had received a peak of 3000 patients per day, this rose to 15,000 per day (at peak day) in January 2020. Similarly, the numbers entering Wuhan’s Fifth Hospital accident and emergency department increased from an average of 120 patients per day to over 500 patients on 22 January alone—the highest in its 97 years’ history.

This sudden influx of patients led, in the early stages, to a near meltdown at Wuhan’s tertiary hospitals, with dire consequences. Clinical professionals who witnessed this first hand talked about ‘utter chaos’ and how the system was ‘completely unready for a situation like this’. This meant that some people with virus symptoms were denied full-time admission because no beds were available. The rush to access tertiary hospitals and other facilities also led to widespread cross-infection and ultimately a hike in the number of fatalities, both among patients and busy hospital staff. In Wuhan’s Zhongnan Hospital, for example, between 1 and 28 January, it was estimated that 41% of cases were infected within the hospital, 29% of whom were healthcare workers. By 11 February, 1102 healthcare workers were infected and ultimately a hike in the number of fatalities, both among patients and busy hospital staff. In Wuhan’s Zhongnan Hospital, for example, between 1 and 28 January, it was estimated that 41% of cases were infected within the hospital, 29% of whom were healthcare workers. By 11 February, 1102 healthcare workers were infected...
workers were infected with COVID-19 in Wuhan City alone, partly because of cross-infection in the overcrowded tertiary hospital.19

The response
The story of how the Chinese healthcare system reacted to the initial surge in cases and ultimately brought the pandemic under control (at least at the time of writing) is well documented. One of the most significant developments was the speedy establishment of new facilities and redeployment of clinical professionals and managers. New Fangcang shelter hospitals were built from scratch and used to triage patients and treat patients with minor illnesses.16 However, in light of the previous discussion, what is noteworthy is how, under crisis conditions, the Wuhan government was also able to fast-forward reforms leading to the greater integration of local healthcare services. This involved the suspension of markets as a means of coordinating services and instead mobilising the authority of higher tiers of government to implement changes quickly.

Two early policy initiatives illustrate this approach. First was to establish, almost overnight, a formal gatekeeping and triage role for primary care services which, previously, had been largely bypassed by patients.17 Immediately after the lockdown, the Wuhan municipal government enrolled CHCs into the fight against COVID-19, formally allocating CHCs the tasks of triage and referral.16 Patients with symptoms of cough and fever were told to go directly to CHCs to receive initial diagnosis and then access tertiary hospital services only if referred.16 Of the 203 CHCs in Wuhan, 199 were designated for COVID-19 screening and triage, with 10 also able to treat patients with symptoms.20

As a result of this speedy intervention, ‘The Fangcang shelter hospitals in Wuhan were integrated into the overall health systems via simple pathways of referral and transfer’ (p1308).21 Subsequently the number of patients entering the fever clinics of tertiary hospitals fell by 50%, helping to reduce overcrowding and the risks of cross-infection.22

A second, related, intervention was to redeploy surplus clinical expertise (including GPs) from primary care to other parts of the system, notably the Fangcang shelter hospitals (see previous paragraph). This allowed GPs to get more involved in helping to manage and treat patients with minor symptoms, tasks which they were expected to perform previously but had been unable to do because of falling number of patients using CHC services.12 This also increased the role of GPs in the support of patients recovering from the virus, helping with psychological counselling and follow-up treatment.22 In support of this policy, the Wuhan City government promised to increase the salaries of CHC healthcare workers by as much as 86.3% per year.24

These interventions in Wuhan are all consistent with the intent of the 2009 reforms to integrate primary care (see previous paragraph)3 and in some respects have accelerated that process. According to Chang, ‘After the epidemic ebbs, the Chinese government will likely double-down on improving the quality and availability of CHCs’.20 In a speech delivered on 14 February, Xi Jinping stated that a key priority was ‘strengthening the construction of public health teams and capacity building of CHCs in prevention and control...so that problem can be solved in its cradle’.25 Similarly, Ma Xiaowei, Director of the National Health Committee, emphasised the need in the future for CHCs to act as sentinels for ‘early detection, early diagnosis, early isolation, and early treatment’ (p1200).23

CONCLUDING THOUGHTS
This story of how China’s healthcare system responded to the COVID-19 highlights two key messages. First is with regard to the risks of marketisation in public health services, specifically how it may interfere with ‘coordination and the optimal use of resources’.4 In China, over the past 20 years, the exposure of hospitals and CHCs to market forces generated perverse incentives leading to an unbalanced (hospital-centric) and poorly integrated healthcare system. These failings were thrown into sharp relief by the COVID-19 crisis.

Second, and more tentatively, this story illustrates how a healthcare system that operates in the public domain can quickly overcome many of the above challenges. Notably, it reveals how, in times of crisis, the apparatus of a state bureaucratic hierarchy might be effectively employed for the wider public good. In China’s case, this led to the immediate suspension of the (market-based) funding model and the rapid redeployment of staff and resources to deal with the COVID-19 threat. Interestingly this process also helped to fast-forward much needed reforms (originally set in motion in 2009) fostering, at least temporarily, a system-wide perspective. In this respect observations about the Chinese experience run somewhat against the grain of much contemporary thinking and wisdom in the public administration field.3 The latter emphasises the failings of bureaucracy and top-down planning, highlighting instead the need for competition to reinvigorate public services. But China’s recent experience suggests that marketisation comes with certain liabilities, and that in order to correct these it may be necessary to fall back on a command and control governance model, however unfashionable that may seem.

These conclusions mainly highlight the policy dimension of China’s response to COVID-19. However, macro-level policy decisions also had to be enacted by managers and clinical leaders within CHCs and Fangcang shelter hospitals, with implications for leadership practice more generally. Important in this regard are the project management and communication skills required to establish new training pathways for referral and transfer of patients with COVID-19 between formally separate organisations. There have also been significant challenges of ensuring effective teamwork between primary care professionals (GPs), redeployed to the shelter hospitals, and specialist doctors. The difficulty of managing this process was greatly exaggerated in China by clinical skill gaps in primary care and by the lower salaries of GPs, which may well have dented the enthusiasm of some professionals to engage.21 Although we have not explored these concerns in detail, the available evidence suggests that operational challenges of enacting policy were significant in Wuhan during the crisis. This evidence further highlights the critical role of managers in mediating this process and of front-line clinicians who stepped up into leadership roles.21 23

Of course, when making these observations, it is important to emphasise caveats and directions for future research. While we have emphasised the benefits of China’s command and control approach in times of crisis, it is open to question how well this would operate under normal conditions, nor is it clear that the reconfiguration of services that took place in Wuhan can be sustained. Without doubt ‘the role of CHCs has been shifted from an outsider to a strategic partner in the fight against COVID-19’ (p25),26 but will this important shift in practice be scaled up in future or even retained?

Lastly are bigger questions about the relevance of China’s experience in addressing the COVID-19 challenge to other health systems. On the one hand, our story is consistent with
the thrust of our opening quotation from David Fisman about the general benefits of healthcare systems that are “public strategic assets” rather than “businesses run for profit.”\(^1\) Yet this same conclusion might not necessarily be drawn about other publicly funded and managed healthcare systems, such as in Italy or the UK, which, to date at least, appear to have performed less well. In this regard, it is important to strike a note of caution. While command and control governance has arguably been a necessary condition for helping to manage the COVID-19 crisis, as the international experience shows so far, it may not be sufficient.

**REFERENCES**