

## GOVERNANCE CHALLENGES IN CHINA'S URBAN HEALTH CARE SYSTEM – THE ROLE OF STAKEHOLDERS

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With 3 figures

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**Summary:** The article at hand aims at contributing to a deeper understanding of problems in China's urban health system governance by comparing levels of influence and the roles of different stakeholder groups – government bodies, public, private and illegal health care providers, patients and their social networks, paying institutions, social organizations, and the civil society – in the production and reproduction of the layout of the health care system in the city of Guangzhou. Primary data was collected in several fieldwork studies in Guangzhou City between December 2006 and January 2009 and includes 27 in-depth interviews with administrative officials, health care providers and NGO representatives as well as 70 in-depth interviews and a quantitative survey with 450 rural-urban migrants. We use the actor-centred institutionalism approach by MAYNTZ and SCHARPF (1995) and SCHARPF (2000) which we combine with ARCHER's (1995) morphogenetic approach in order to develop an analysis tool. The findings show that although hierarchical steering by the municipal administrative units in Guangzhou is officially still in place, new corporate agents have emerged, such as influential hospital managers, social organizations and NGOs that, together with the multiple adaption and circumvention strategies of primary agents, patients and health care providers, are significantly reshaping the health system. Considering China's current debate on the general type of health system that should be put in place we argue that it is necessary to restructure the functions and influences of stakeholders in the health system if any such reforms should be successful in improving public health. The basis for this should be the establishment of an all-embracing health governance framework, which should include independent third-party supervision and monitoring and which requires overall reforms of the general state governance structures as well as a more profound integration of interests and collaboration of all stakeholders.

**Zusammenfassung:** Der Artikel fokussiert auf aktuelle Probleme im städtischen Gesundheitssystem Chinas. Die Rollen und Einflussnahmen von Akteuren bei der Mit- und Umgestaltung des Gesundheitssystems der Stadt Guangzhou werden verglichen: städtische Verwaltungen, öffentliche, private sowie illegale Anbieter von Gesundheitsdiensten, Patienten und ihre sozialen Netzwerke, zahlende Institutionen, soziale Organisationen sowie die Zivilgesellschaft. Die Primärdaten wurden von Dezember 2006 bis Januar 2009 erhoben. Sie umfassen 27 Tiefeninterviews mit Repräsentanten der Stadtverwaltung, Anbietern von Gesundheitsdiensten und Vertretern von NROs sowie 70 Tiefeninterviews und eine quantitative Befragung von 450 Land-Stadt-Wanderern. Als theoretischer Ansatz wird eine Kombination und Weiterentwicklung des akteurszentrierten Institutionalismus von MAYNTZ und SCHARPF (1995) sowie SCHARPF (2000) und des morphogenetischen Ansatzes von ARCHER (1995) appliziert. Die Datenanalyse belegt, dass trotz der Persistenz der hierarchischen Steuerung durch die lokale staatliche Verwaltung neue kooperative Agenten entstanden sind. Diese umfassen u. a. soziale Organisationen, NROs und einflussreiche Leiter von öffentlichen Krankenhäusern, die zusammen mit den mannigfaltigen Anpassungsstrategien von primären Agenten wie Patienten und anderen Anbietern von Gesundheitsdiensten das Gesundheitssystem bedeutend mit- und umgestalten. Angesichts aktueller Diskussionen über mögliche Reformen des grundsätzlichen Typus des Gesundheitssystems in China ist es notwendig, die aktuellen Rollen und Einflüsse von Akteuren im Gesundheitssystem zu berücksichtigen und ggf. zu verändern, damit solche Reformen Erfolg haben können. Die Reformierung des Gesundheitssystems sollte mit der Etablierung eines umfassenden institutionalisierten Steuerungsrahmens für das Gesundheitssystem einhergehen, der unabhängige Kontroll- und Monitoringinstitutionen einschließt. Zudem sind Reformen der allgemeinen staatlichen Steuerungsstrukturen sowie eine fundierte und nachhaltige Integration der Interessen von Akteuren im Gesundheitssystem sowie eine verstärkte Kooperation der Akteure erforderlich.

**Keywords:** Governance, health care system, transition, Guangzhou, China

### 1 Introduction

Since Deng Xiaoping's opening up policy China's health system has experienced deep changes and is still in an ongoing evolutionary process in which

it is constantly challenged by the growing influence of globalization, rapid national economic and social development, dispersal of market forces, and increasing autonomy of public health care providers as well as the flourishing private sector and private practice

(DONG and PHILLIPS 2008; MA et al. 2008; TAM 2010). These factors, combined with stepwise reforms of the health system, have led to the emergence of new and the transformation of old stakeholders as well as an overall shift in terms of the level of stakeholder influence and exertion of power within the governance network.

According to SIDDIQI et al. (2009), governance of the health system is currently the least well-understood aspect of health systems, and much more research is needed. This proves especially true in China, where rapid changes require a constant re-evaluation of past notions and open up new research questions and concerns. Only recently the number of publications dealing with governance issues in the health system has increased (e.g. CHAN et al. 2009; FANG 2008; GONG 2006; LI 2006; SUN 2006; XU 2004; XU and ZHANG 2006; YANG and SHI 2006). Hitherto, they have mainly focused either on the role of administration, planning and regulation, i.e. government, or on health care providers and their relationship to the government (e.g. BIAN et al. 2003; HOU and COYNE 2008; LIM et al. 2004; RAMESH and WU 2009; XU and ZHANG 2006; YANG and SHI 2006; ZHENG et al. 2006).

A comprehensive comparison of stakeholder influences and the relationships between all stakeholder groups in the health system is lacking so far. The article at hand aims at contributing to a deeper understanding of problems in China's health system governance by comparing levels of influence and the roles of different stakeholder groups – government bodies, public, private and illegal health care providers, patients and their social networks, paying institutions, social organizations, and civil society – in the production and reproduction of the layout of the health care system in the city of Guangzhou. In the article at hand we developed and applied an analysis tool based on a combination of the actor-centered institutionalism approach by MAYNTZ and SCHARPF (1995) and SCHARPF (2000) and ARCHER's (1995) morphogenetic approach. Currently debated lines of reform are discussed in the light of the here presented results.

Within the frame of this article results from fieldwork in Guangzhou serve as an example. The capital of the southeastern province Guangdong is located in the Pearl River Delta (PRD), which became an open economic region in 1985 and consequentially experienced booming economic development, industrialization, in-migration and rapid urbanization, making it one of the most dynamic and fastest growing regions in the world. These accelerated developments and the need to adapt to the constantly changing circumstances posed huge challenges for the urban adminis-

trations in the PRD. This required flexibility and adaptation strategies from the diverse urban population groups. At the same time, new stakeholders emerged that started to have a say in fields that have formerly been dominated by the central state.

## 2 Theoretical approach and methodology

Various meanings have been ascribed to the term governance (cf. for a discussion e.g. BENZ and DOSE 2010; RHODES 1996). According to BIERMANN (2007, 328) the term governance denotes “new forms of regulation that differ from traditional hierarchical state activity and implies some form of self-regulation by societal actors, private-public cooperation in the solving of societal problems”. In the field of health, these new forms of regulation are “adopted by a society to organize itself in the promotion and protection of the health of its population.” (SIDDIQI et al. 2009, 14). In order to meet the central objectives of this article – i.e. to point out the different levels of influence and the roles of different stakeholders in Guangzhou's urban health care system – a framework has to be applied that is able to operationalize these objects of investigation.

For this purpose, we chose the actor-centered institutionalism approach of MAYNTZ and SCHARPF (1995) and SCHARPF (2000) as a theoretical framework. They developed this approach as an analytical tool for investigating “governance and self-organization of complete societal subdomains” (MAYNTZ and SCHARPF 1995, 39, translated by the authors). They are based on the neo-institutional perspective, which has distanced itself from structuralist approaches – that emphasize the constraining nature of institutional mechanisms on organizational activities – since the late 1980s/early 1990s, turning to approaches that focus on the role of individuals and organizations in producing and reproducing the structures in which they act (cf. SCOTT 2008; WALGENBACH and MEYER 2008). We combine this approach with ARCHER's (1995) morphogenetic approach, which provides a method for conceptualizing the general interplay of structure and different types of actors over time and space. In the case of both approaches we selectively focus on the basic frame of explanation and utilize key terms and concepts.<sup>1)</sup>

<sup>1)</sup> Not all details of both approaches are transferrable or relevant to our topic. For example, ARCHER's (1995) third cycle of morphogenesis – culture – and her stratified model of the people are not considered as they go beyond the matter analyzed in this article. SCHARPF's (2000) game theory is

MAYNTZ and SCHARPF's basic theoretical approach is displayed in figure 1. They confine institutions to regulatory aspects that “relate especially to the distribution and exertion of power, the definition of responsibilities, the availability of resources as well to authority and dependency relationships” (MAYNTZ and SCHARPF 1995, 40, translated by the authors). The institutional framework structures the activities of actors (individuals and organizations)

(ARCHER 1995, 76). She therewith claims that structure, which is the result of past action, will impact on subsequent action.

The result is continuous cycles in which prior structures are either reproduced and hence maintained (morphostasis) or transformed (morphogenesis). It is important to note that structure does not determine action or vice versa: “it is precisely because such elaboration is co-determined by the con-

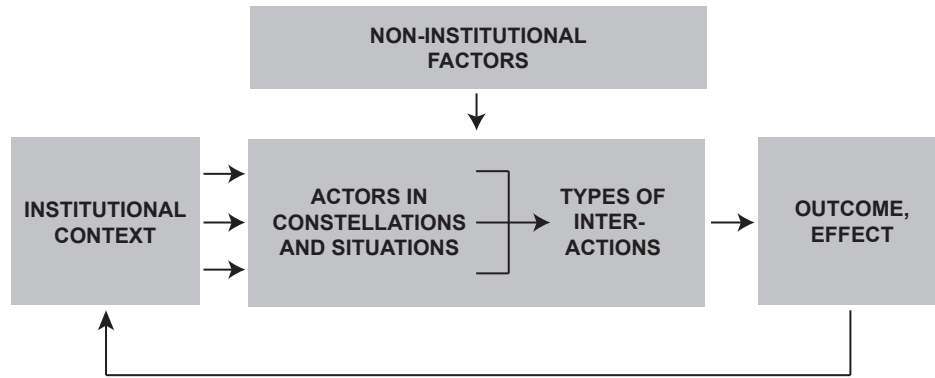


Fig. 1: Analytical model of the actor-centred institutionalism approach (source: MAYNTZ and SCHARPF 1995, 45 (changed))

through defining the rules of membership, of legitimate forms of action, of access to resources and of the aims and values of actors (MAYNTZ and SCHARPF 1995, 49). The actor constellation is an umbrella term for the description of the complex logic of situation, in which actors interact, and how this interaction is perceived by the actors. It can be pictured as a network that represents the actors and their stable and possibly even institutionalized relationships. The “types of interaction” concept is then introduced to systematically characterize the modes of social action coordination, which can be distinguished into one-sided or reciprocal adaptation, negotiation, coordination and hierarchical steering (MAYNTZ and SCHARPF 1995, 61; SCHARPF 2000, 88, 91).

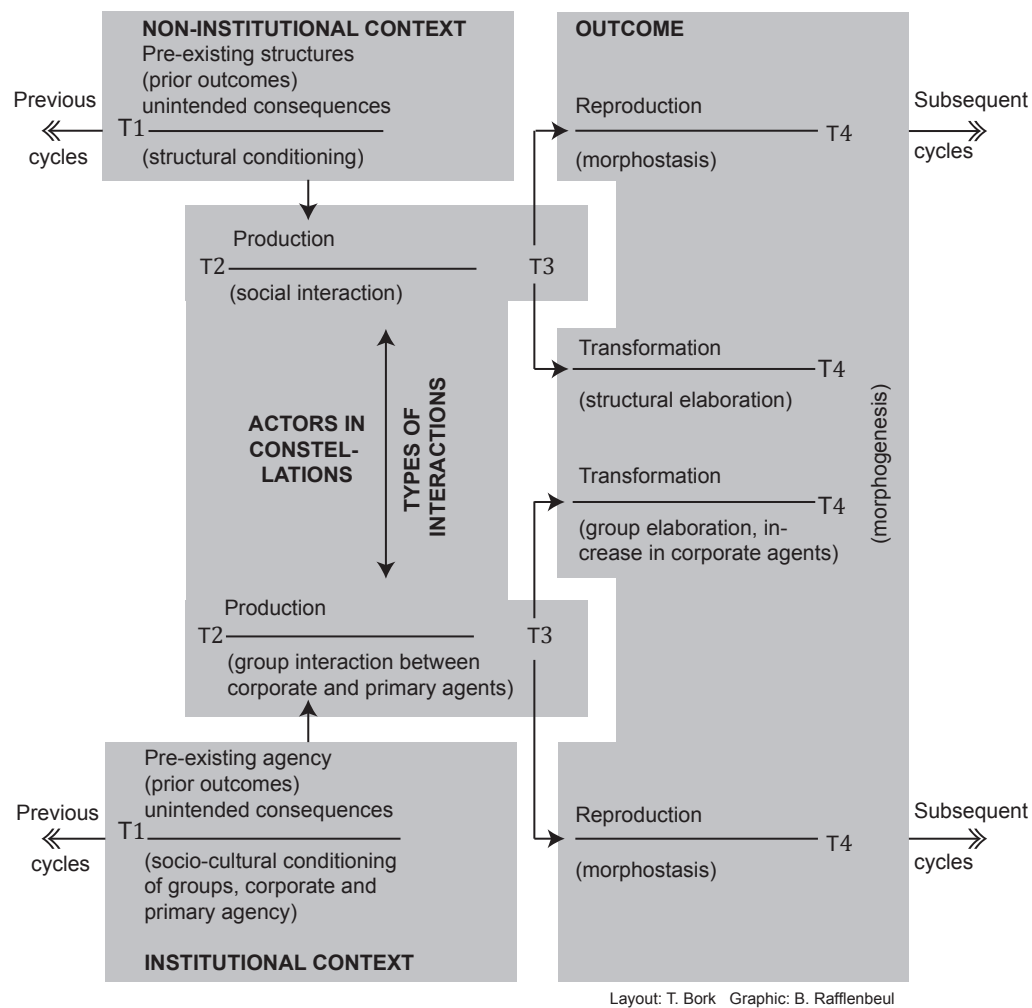
As a first enhancement (cf. Fig. 2 for the merged conceptualization), ARCHER's approach in more detail reflects on temporality, by underlining that the interplay of structure and the action of different actors operates sequentially, over different time periods: “that structure [defined here as the institutional and non-institutional frame] necessarily pre-dates the action(s) which transform it; and that structural elaboration [the outcome in MAYNTZ and SCHARPF's approach] necessarily postdates those actions”

ditional influence exerted by antecedent structures together with the autonomous causal powers of current agents, that society can develop in unpredictable ways” (ARCHER 1995, 75).

Central to the continuous cycles are interactions, which ARCHER defines with BUCKLEY as a “system of interlinked components that can only be defined in terms of the interrelations of each of them in an ongoing developmental process that generates emergent phenomena – including those we refer to as institutional structure” (BUCKLEY 1967 as cited in ARCHER 1982, 475). These interactions within the existing social structure cause the development of emergent properties, i.e. “relations between the results of interaction” (ARCHER 1982, 475), which possess causal powers of their own. Due to the emergence of such properties, groups or organizations as congregations of individuals can have their own powers, which are not possessed by the members independently of the group. Institutions as defined by MAYNTZ and SCHARPF (cf. above) are such emergent properties. They also govern the power levels of stakeholders. Notwithstanding, individuals have their own powers, i.e. their own emergent powers, which are not possessed by any group they might be part of (ARCHER 1982, 475; ARCHER 1995).

Another important addition taken from ARCHER is her notion of the “stratified nature of social reality” (ARCHER 1995, 9): She claims that it is not enough to

not applicable as not enough information is available on the self-conceptions of stakeholders, their understanding of the situation of action and their interaction orientation.



**Fig. 2:** Refinement of the actor-centred institutionalism approach by MAYNTZ and SCHARPF (1995) with the double morpho-genetic/static cycles of structure and agency by ARCHER (1995)

analyze individual actors (as is the case in GIDDENS' (1984) structuration theory that has lately often been used in neo-institutional approaches (cf. SCOTT 2008; WALGENBACH and MEYER 2008)), but that the role of congregations of actors has to be taken into account. She differentiates the latter into collectivities (unorganized groups of people, which are nevertheless a congregation through prior distributive structures), organised groups and populations; each of which possess different emergent properties<sup>2</sup>). When looking at the differential power of different stakeholders in shaping structure, ARCHER emanates from a dual distinction in which she distinguishes between organised groups (cooperate agents) which are the main power in actively reshaping structures in a co-

<sup>2</sup> SCHARPF (2000, 96) introduces a similar but less refined concept with the "complex actor".

ordinated way, and collectivities (primary agents) which are not actively involved in targeted remodeling of structures<sup>3</sup>) (ARCHER 1995, 190, 260–264).

In this context it is important to note that "Corporate Agency thus shapes the *context* for all actors (usually not in the way any particular agent wants but as the emergent consequence of corporate interaction). Primary Agency inhabits this context, but in responding to it also reconstitutes the *environ-*

<sup>3</sup> Contrary to ARCHER, SCHARPF (2000) postulates that there is a continuum of integration of actors from merely aggregated individuals without collective aims, to collective actors with collective aims, actions and resources. We agree that there is nothing such as a clear boundary delimitating both forms of agency. However, in terms of the here presented example, there are clearly identifiable corporate and primary agents in ARCHER's sense (cf. chapter 5), which serve as a simplified and useful distinction for evaluating their influence.

ment which Corporate Agency seeks to control [...] Corporate Agency thus has two tasks, the pursuit of its self-declared goals, as defined in a prior social context and their continued pursuit in an environment modified by the responses of Primary Agency to the context which *they* confront” (ARCHER 1995, 260, emphasized as in the original). MAYNTZ and SCHARPF (1995, 48) underline that who becomes a corporate agent is mostly defined by institutional regulation – usually established by the state. Furthermore, they clarify that within corporate agents there may be influential individual actors or smaller groups of actors that dominate the action of corporate agents.

ARCHER distinguishes different cycles – the morphogenesis of structure and the morphogenesis of agency – which are relatively independent from each other, but nevertheless interact with each other. Respectively there are different types of emergent properties. Structural emergent properties are distinguished through their “*primary dependence upon material resources*, both physical and human” (ARCHER 1995, 175, emphasized as in the original), therefore they constitute what MAYNTZ and SCHARPF refer to as the non-institutional context. Agential emergent properties develop from group interaction between corporate and primary agents, which is based on the various institutions in MAYNTZ and SCHARPF’s sense, and thus forms the institutional context in which interaction takes place.

The fieldwork incorporates results from a joint Sino-German interdisciplinary research project. As local problems were found to interfere profoundly with the layout of the national health system international academic literature from the fields of public health and health governance was integrated (chapter 3). **Primary data was collected in several fieldwork studies in Guangzhou City between December 2006 and January 2009.** In-depth interviews were conducted with different stakeholders in the health system of Guangzhou City, including 27 interviews with administrative personnel, public, private and unregistered health care providers (who practice illegally), and representatives of individually organized NGOs. The aim of these interviews was to understand the roles of these different stakeholders and the development of their stakes in the local health system as well as their requirements.

The perspective of patients is limited to the group of rural-urban-migrants. Although they by now make up for roughly one sixth of China’s total population and have been almost completely excluded from public urban health care planning and provision for a long time, scientific interest in this

heterogeneous group only has increased recently (e.g. HU et al. 2008b; MOU et al. 2009; TODRYS and AMON 2009; WONG and SONG 2008; XIANG 2004), making the group of rural-urban-migrants a good marker for the evaluation of the recent reform efforts. 70 in-depth interviews with rural-urban migrants and results from a quantitative face-to-face survey with 450 internal migrants in the city of Guangzhou were integrated. Participants of the quantitative survey were recruited from four villages-in-the-city<sup>4)</sup> in Guangzhou (Donglang, Kengkou, Shipai, Xinfenghuang). The majority of internal migrants in Guangzhou live in villages-in-the-city (TAUBMANN 2002).

The national developments and reforms as discussed in chapter 3 will serve as a framework in which the results as presented in the findings section for the Guangzhou health care system will be discussed.

### 3 Current status of research: economic development, marketization and health governance reforms in China

China’s economic and social development neglected an important stage of institutional development, of which the absence of a clearly defined health system governance framework is a by-product. The most profound struggles in the post-reform era are linked to the breakdown of previous social security and health insurance schemes following the economic reforms after 1978 and the resulting financing problems (c.f. DU 2009; GROSS 2006; HU et al. 2008a; LIU and MILLS 2002; RAMESH and WU 2009; YIP and HSIAO 2008). Since the government’s key priority during the first two decades following China’s opening up was “blind pursuit of economic growth at all costs” (PENG 2004, 149), reforms of the health care system, which were partial and uncoordinated, had the primary aim of alleviating financing problems and achieving cost recovery (BOGG et al. 1996).

One of these reforms was **far-reaching decentralization** of financing, organization and manage-

<sup>4)</sup> China’s villages-in-the-city are a special type of marginal settlement that have mushroomed in Chinese cities in the context of booming economic development, rapid in-migration and urban expansion processes since economic opening. They are former rural communities that are surrounded by urban land use or that are currently in the process of being engulfed by urban development due to massive urban sprawl.

ment of the health care system since the mid-1980s (cf. LIU et al. 2006). Decentralization was not accompanied by an institutionalization of the new central-local power relations for the most part, and has been applied very differently on the local level. As a consequence, informal institutions and informal unwritten regulation are important factors in the interaction between government bodies of different levels (ORBAN et al. 2003; ZHENG 2000).

Further, financing reforms entailed substantial cuts in public financing, due to which public health care facilities are facing increased pressure to acquire their own funds. As a result of these cuts and the introduction of the so-called double-track price system<sup>5)</sup> (cf. BIAN et al. 2003), over prescription of pharmaceuticals that are not subject to price regulation as well as the overuse of high-technology diagnosis methods have become a serious problem. YIP and MAHAL (2008, 928) estimate that about 90% of the providers' budgets by now have to be derived from revenue-generating activities, therefore they "are public in name only" (YANG 2006, 71). The provision of basic curative and preventive care, from which no profit can be made, has been neglected at the same time.

As a general problem in China's social system, while pushing towards marketization, the government focused on policy making, but neglected the objective circumstances and the supporting measures needed to implement and enforce policies (PENG 2004). Due to a lack of regulation and regular inspections the behavior of most health care providers, pharmaceutical producers and suppliers as well as civil servants has become purely profit-oriented and corruption has become abundant, disregarding the actual aim to improve public health (COHEN 2006; LI 2006; LIU and YI 2004; WANG 2003). This problem is aggravated by a lack of separation of regulation, planning and administrative functions which results in dysfunctional regulation and therefore a defective governance framework: Deficient monitoring in general and insufficient independent monitoring by external bodies or regulators in particular result in a lack of control of health care facilities and their fulfillment of regulatory requirements (PENG 2004; SUN 2006; XU and ZHANG 2006).

Considering the power relations within the health care system, the responsibility of developing public hospitals – which are dominant in terms of

patient numbers (LI 2006) – has to a large degree been passed on to the hospitals' managers. These use their information advantage, firstly to avoid government control in order to develop their hospitals in the increasingly competitive health care market, and secondly to influence aspects linked to regulation, e.g. the determination of prices for new pharmaceuticals and health services (LI 2006). The influence of public hospitals in the healthcare market was strengthened since managers and staff "have formed their own inner circles to protect the interest of their own small group" (YANG 2006, 71). Besides, imbalances in the health system are enhanced by the fact that key positions in the health care sector continue to be allocated on the basis of personal relations and political interests, and promotions are sold for cash (cf. YONG and RAN 2006).

Among the most profound negative effects on public health that followed economic and social reforms are the acceleration of socio-economic and regional disparities in access to health care and in health status, the (re)emergence of infectious diseases, and, compared to the accelerated economic development, a relatively modest record of health improvements – all of which have been discussed in numerous publications (e.g. FANG et al. 2010; GAO et al. 2002; GAO et al. 2001; LIU et al. 1999; LIU et al. 2008; REDDY 2008). Only in recent years has China's government admitted these negative developments and launched initiatives to counteract them (cf. CHEN 2009; LIU 2009; MA et al. 2008; WANG 2008). However, actual implementation of new reforms as well as the fulfillment of promulgated goals is by far deficient up-to-date (cf. GE et al. 2005; LIU and MILLS 2002; SUN 2006; WU 2008; YIP and MAHAL 2008).

Reacting to the breakdown of health insurance schemes of the Mao era, the basic urban medical insurance (BIS for employees) was introduced in 1998, and the new cooperative medical scheme (NCMS) for rural areas followed in 2003. In addition, new schemes for the unemployed and for population groups which are outside of the labor force (e.g. children) in urban areas (BIS for residents, introduced 2007) as well as insurance schemes for migrants are being experimented with locally. In 2008, 89.7% of rural residents were members of NCMS and 44.2% of urban residents members of BIS (MoH 2009). However, patients still pay 45.2% of their health spending out-of-pocket according to China's Health Survey (data for 2007, MoH 2009). One of the reasons is that each insurance policy covers different services and pharmaceuticals, and coverage is generally limited to certain services and

<sup>5)</sup> In accordance with the double-track price system basic medical services and pharmaceuticals have to be provided at regulated prices, while all other services and medical products are subject to market pricing.

drugs (cf. BATTACHARJYA and SAPRA 2008). This means that even insured patients are not financially resilient to all types of health risks.

## 4 Findings

### 4.1 Government bodies

Like in China's overall administrative system, the health care system in Guangzhou is currently highly fragmented with a variety of government departments responsible for different health system- and health care-related fields. In addition, regulation and administrative functions are all carried out by government bodies without independent supervision and monitoring (07/39/A, 07/41/A, 07/42/A, for a comprehensive overview on regulatory institutions in China and their effectiveness cf. FANG 2008). This greatly impedes effective health administration and regulation. Furthermore, vertical as well as horizontal cooperation between and within administrative units is low (07/41/A), which prevents data and information exchange. Likewise, cooperation and exchange between administration and government-owned health facilities or related institutions are far too limited and practically non-existent with private facilities (07/38/A, 07/41/A, 07/99/Su(f), 07/118/A).

According to an expert from the health administration, whilst facing new tasks due to decentralization, administrative and regulatory bodies in Guangzhou, are severely lacking financial and human capital (07/41/A<sup>6</sup>). Regulation and control of health care providers are hence rather aiming at enhancing cost recovery in the state-subsidized branches of the health care sector than at warranting the provision of appropriate health care to the population (07/41/A). As a consequence, private providers who do not receive state subsidies are even more inadequately monitored than their public counterparts (07/41/A).

The lack of executive personnel together with weak executive legislation results in powerlessness

towards illegal providers<sup>7</sup>: Possibilities to intervene are restricted to punishment through fines and confiscation of equipment, both of which do not prevent providers from continuing to operate their clinics or from reopening them elsewhere in order to obviate paying the fine (07/32/Su(in), 07/40/Su(in), 07/41/A). In addition, two unregistered health care providers (07/32/Su(in), 07/40/Su(in)) reported that the executive personnel either required or accepted bribes in order to overlook their existence or that of competing unregistered providers.

To prevent a further increase in the overprovision of health care services (triggered by marketization and booming economic development), in Guangzhou, licensing of new private providers was restricted (07/41/A). Yet, our interviews showed that weak regulation and control led to the informalization of providers in some cases, as they opened facilities and started practicing despite their failure to register (07/40/Su(in)).

### 4.2 Health care providers

Due to privatization, the Chinese health care system is becoming increasingly complex and pluralistic, as former and new government-owned health institutions are supplemented by an increasing number of private providers and also hybrid public-private partnership units. Despite diversification, public health care provision, and in this context especially public hospitals, are still dominant in urban areas (cf. chapter 3). Some of the reasons which migrants who were interviewed in both the qualitative and quantitative surveys gave are a lack of trust in the quality of services and skills of health professionals in private facilities and public facilities of lower hierarchy. This has often led the interviewees to seek care in hospitals independent of the severity of the medical problem faced, i.e. also in cases in which hospital care is not necessary, such as in the case of colds and other upper respiratory tract infections. Another likely reason applying to the general population in cities is the fact that many insurance schemes only reimburse costs incurred in public facilities (cf. Fig. 3).

In interviews with public, private and illegal practitioners in Guangzhou several interviewees, especially illegal providers, complained about financial

<sup>6</sup> Interviews which were conducted during our own fieldwork are indicated by code. The first two digits indicate the year. The following sequence of digits mirror the number in our interview list and the status of the interviewee: A = administration, Su = formal (f) or informal (in) health care provider, N = NGO or social organization. For example "08/105/A" means that this interview was conducted in 2008 with a representative of an administrative unit. Due to their large number, in case of the in-depth interviews with migrants, no single interview codes are listed.

<sup>7</sup> If a facility lacks one of three necessary licenses – a business license, a license for the medical unit and a license for the practicing physician – it has officially been regarded illegal since the year 1998.

hardships (07/32/Su(in), 07/35/Su(f), 07/40/Su(in), 07/114/Su(f)). As a result of the lack of public finances, the organization and financing of special health services for vulnerable groups are almost completely left to public health care providers, without support from the responsible local health administration (07/35/Su(f), 07/99/Su(f), 07/114/Su(f), 07/116/Su(f), 07/117/Su(f)). Only government-owned health facilities receive subsidies for these services; their operating ranges, however, can be determined by the facilities themselves and thus subsidies are often rather invested in developing the facility than in creating health care services for vulnerable parts of the population (07/35/Su(f), 07/41/A). The most common free service offered by health facilities are free check-ups (07/35/Su(f), 07/118/A). Several patients interviewed in in-depth interviews complained that after the free check-up it was recommended to them to undertake further procedures for which they had to pay and which they did not do, because they did not think that they were necessary.

Among the migrants surveyed in Guangzhou, almost one third assumed that doctors would treat them better if they paid under-the-table-fees, and of those patients who had visited a health facility in Guangzhou before, two thirds assumed that the health personnel had carried out more examinations or prescribed more medicine than necessary. In addition to financial hardship, lack of social responsibility among health care providers must be seen as an explanation for an increasingly commercial orientation and the choice of illegal strategies in order to improve revenues. Considering the interviews with the health care providers this applies especially to illegal providers, who virtually speculate with the health of their patients.

#### 4.3 Patients and their social networks

Problems linked to the affordability of health care and its consequences have been the most significant negative development of the post-reform era in the scientific literature (cf. chapter 3). Interestingly, survey results showed that among the migrant sample financial constraints were not the primary reason for not consulting medical advice or choosing self-treatment, but lack of responsiveness by the suppliers towards patients' needs: In the quantitative survey, time constraints (long or inconvenient waiting hours) were the most frequently, and feeling of discomfort with health professionals the second most frequently named reasons for not consulting medical advice. In addition,

interviewees complained about inscrutable bureaucratic procedures in health facilities (e.g. for registration or payment) in the in-depth interviews.

Uninsured and poor population groups, especially rural-urban migrants, are much more likely to use services offered by unregistered providers (07/35/Su(f), 07/40/Su(in), 07/102/N) and are more vulnerable to ill-treatment by these providers, which aggravates already existing disparities in health status between poor and affluent population groups.

Deficiencies in individual access to formal health care or support were partly counterbalanced through financial support or care by the interviewees' social networks, as well as through migrants' different strategies, according to both qualitative and quantitative data sources. Among the strategies were self-care, including buying medicine in drugstores based on the migrants' own knowledge or diagnosis by the pharmacists, making use of the less expensive services of illegal providers, returning to the place of origin in order to receive more affordable health care and to be cared for by the social network in the place of origin or in Guangzhou. Furthermore some of the interviewed migrants had health insurance coverage (NCMS, cf. chapter 3) in their place of origin which covers the costs of doctor's visits in their hometowns.

Further problems which were identified for the migrant sample were limited knowledge about health care options as well as lack of awareness concerning the existence of unregistered providers. Both problems were linked to deficient access to sources of information on available services or the use of questionable sources of information (e.g. TV commercials, advertisements) and low levels of education, but were also fostered by the increased supply diversity. In addition, consumer behaviour included some irrational features that call for an improved demand management, e.g. the propensity to want medication, the tendency to consult hospitals independent of actual need and frequent use of intravenous drips. These tendencies were also found in other segments of the population by GONG (2006).

Since patients are not organized (apart from social organizations, cf. section below) and lack legal representation they have no chance of realizing their interests and pressing for the recognition of their needs in terms of health care (07/102/N, 07/121/N).

#### 4.4 Paying institutions

Paying institutions in China are still dominantly government-owned providers, though coverage rate



with commercial insurances is growing at a fast pace due to many gaps left by NCMS and BIS schemes (cf. chapter 3) with regard to population groups and/or medical fields and pharmaceuticals not covered by government-initiated schemes. In general, most health insurance schemes are partial schemes. In Guangzhou, anti-poverty schemes and financial medical assistance (MFA) schemes have been established, but, according to an expert in the health administration of Guangzhou City, access barriers to the schemes are high (07/41/A).

As a further finding, in expert interviews with representatives of economic collectives in the villages-in-the-city, which succeeded the former rural village committees, it was discovered that some of these organizations established insurance schemes for their members (which does not include the migrant population in these settlements), independent of the official schemes (cf. chapter 2). The establishment of these schemes was an answer to the breakdown of the former cooperative health insurance systems, and they are persistent despite the development of other new schemes. In each village-in-the-city these schemes are organized differently (07/38/A, 08/103/A, 08/104/A, 08/105/A, 08/106/A, 08/107/A, 08/108/A, 08/109/A, 08/110/A).

In qualitative interviews, migrants complained about complex and inscrutable proceedings in applying for health insurance in general. Lack of knowledge on fields actually covered by insurance schemes was another problem identified in the quantitative survey. The diversity of schemes and the many fundamental changes of the schemes during the last years make it hard for patients to obtain sufficient information on options and their applicability, especially that of partial private insurance schemes is subject to fortuity.

In opposition to social insurance systems as e.g. in Germany, where paying institutions make contracts on services and prices with health care providers, and thereby take over a regulating role, Chinese insurance providers are not likewise involved in regulation and their influence in the network of stakeholders is therefore rather low.

#### 4.5 Civil society and state-organized social organizations

The activities of non-governmental organizations (NGOs) in China are still fairly limited. So-called NGOs are predominantly government-organized or quasi-official NGOs, while privately run NGOs, initiated from bottom-up, are rather small and less in-

fluent. In general, there is a wide continuum of organizations in terms of government influence, control mechanisms, and ownership (LEE and WANG 2005, 46, 49). Closest to the Western notion of NGOs are the bottom-up, individually-organized private non-enterprise organizations, as they are defined legally in China.

Two representatives of NGOs interviewed in Guangzhou (07/102/N, 07/121/N) complained that their status was uncertain and they faced a high risk of being banned at any time. Legalization requires registration, payment of a registration fee and subordination to an organization that offers guidance, which neither managed to obtain. The strategy of one was to register as an economic unit, while the other operates despite failure to register legally. Both complained that consequentially their operation range was very limited and obtaining funding is difficult. Both interviewees stated that they depended on foreign funding (including funding from Hong Kong, which plays a major role).

Local communities in Guangzhou have reservations towards the establishment of NGOs, as they fear that they might have a daunting effect on potential investors (07/42/A, 07/102/N). Among NGOs related to the field of health, those dealing with workers' rights, which often include support in case of occupational diseases, are most numerous, according to our interviewees (07/121/N, 07/102/N).

A special Chinese type of government-organized or quasi official NGOs are so-called social organizations of all types and at different levels. Their role in the reform process has been and continues to be gradually strengthened in the context of the administrative shift towards "small government and big society" (cf. LEE and WANG 2005, 49–50). One of the latest initiatives is the strategy of "community building", which intends to develop the two grassroots administrative units – Street Office and Residents' Committee (cf. BRAY 2006; WANG 2002). It aims at increasing self-management, self-education and self-service, i.e. managing and carrying out various tasks (e.g. security or sanitation) by relying mainly on own human as well as material resources, reducing the need for government investment and intervention.

Activities – all of which are usually restricted to members of the social organizations – of such organizations that were interviewed in the field of health include for example the organization of free medical services (e.g. check-ups), of health information campaigns, and of sports activities as well as hygiene and sanitation services, and direct care (e.g. for the elderly) (07/38/A, 08/104/A, 07/114/N, 07/115/A, 07/118/A,

07/39/A). However, they in fact are subsidiary units of government agencies whose role is to present the government's views to people, not vice versa. Furthermore they offer their services only to a certain part of the population in the city.

## 5 Discussion

Conflating general problems in the health care system with the findings and the theoretical framework leads to the following conclusions on the power network in Guangzhou's urban health system, which is displayed in figure 3. Corporate agency is still majorly embodied by the state institutions – as the state still has the major power in defining who can become a corporate agent, and hierarchical steering is the dominant type of interaction. However, hospital managers as influential individual actors within public hospitals, social organizations, and to a smaller degree NGOs are playing an increasing role in the layout of the health care system. The majority of health care providers as well as patients and their social networks are not organized and thus act as primary agents within the overall network of stakeholders. Through multiple individual strategies they reshape the system through aggregated effects.

Through stepwise reforms of the health system but also the overall economic and social spheres, the health system has been in a state of constant morphogenesis throughout the last 30 years. It is characterized by the following conditions and trends (cf. Fig. 3):

1. decreasing authority of state administration and a weak execution of regulation,
2. an unbalanced high and increasing influence of health care providers,
3. a powerless and unrepresented group of patients and their different social networks,
4. relatively powerless paying institutions,
5. a currently relatively low – though growing – influence of social organizations and the civil society.

According to CHUNG (2007), the decentralization of administration has not necessarily led to a loss of control of the government in China. In the case of the health care sector, however, we claim that government authority has been substantially weakened in the stakeholder network as a result of the following reasons: firstly, insufficient human and financial capital at lower levels and slow general development efforts and, secondly, the failure to provide explicit models and regulations in the

fields of organization, management and financing of health care provided by central authorities.

Fragmentation of responsible units, informal relations between units as well as corruption and financing problems result in a lack of control of health care providers, as could be shown in Guangzhou. As has been argued in chapter 3, a major problem which fosters the lack of control is the lack of separation of regulation, planning and administrative functions. Hence, some health care providers partly influence decision-making as corporate agents.

Furthermore, as primary agents, health care providers have multiple strategies of bypassing regulation aimed at controlling their behaviour. Hence they have increasingly shaped the layout of health care provision in an improper fashion. For example, in Guangzhou illegal providers continue to operate their clinics since punishment by executive personnel is not effective or they manage to survive through bribing the authorities. Formal providers urge patients to pay under-the-table fees and they generate artificial demand due to unnecessary treatments or by prescribing unnecessary medication, which is sold in their facilities.

Patients, as primary agents, influence the developments of the health care system through various individual strategies. For example, by using illegal health care providers as an alternative to the more expensive formal services, patients foster the development of these providers. By making use of their insurance in their places of origin, patients manage to circumvent the restrictions imposed by the Chinese household registration system.

However, due to the absence of political organization and representation, patients are subject to the arbitrariness of health care and insurance providers, which holds particularly true for less affluent patients. They have little capacity to judge the quality of services, while the government vacated its role in provider control and in safeguarding social justice. After the breakdown of the social security system that followed the opening reforms, social networks have taken over a greater supporting role, also in the health sector, thus strengthening the social networks and relations which traditionally have played an important role in Chinese society; they could be taken as a starting point for establishing increased patient organization and participation in the health system in the long term.

Patients' level of influence could also be increased by strengthening non-governmental and social organizations. Even if these organizations cur-

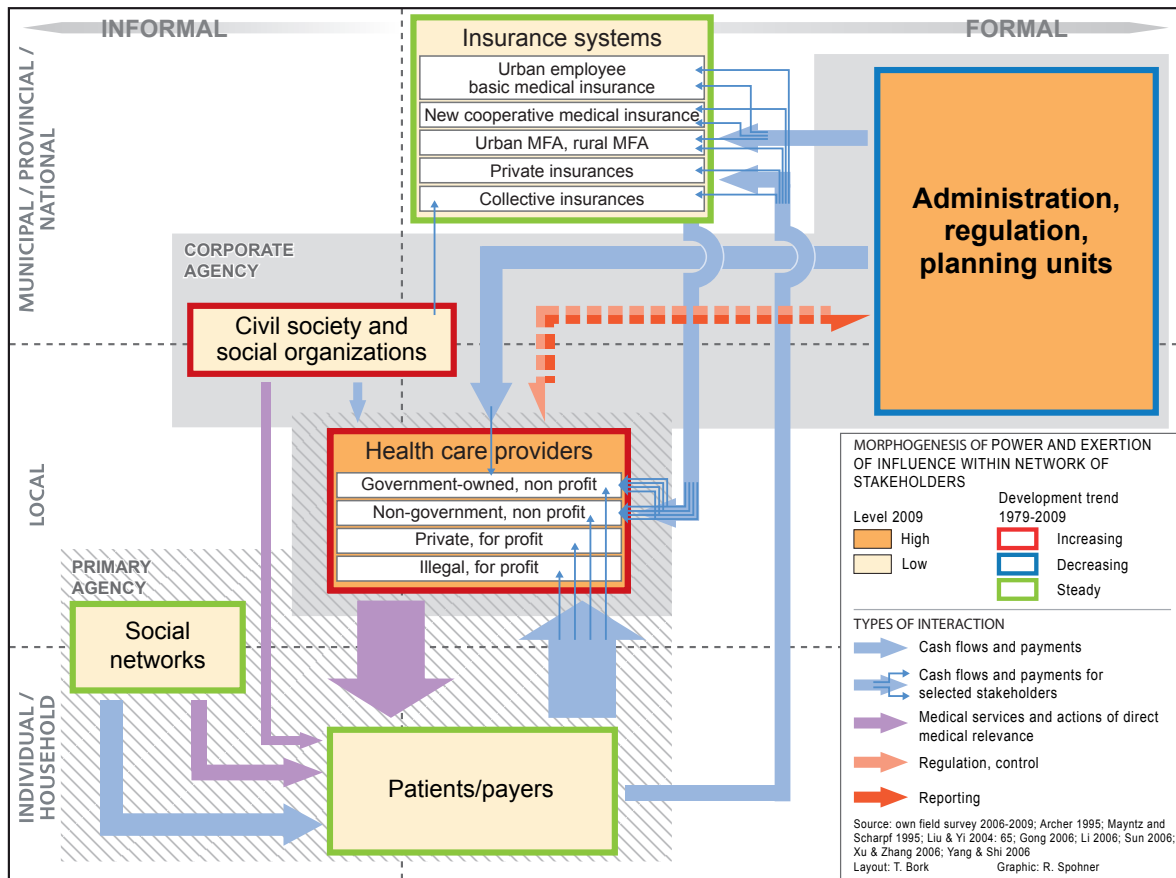


Fig. 3: Actor constellation, types of interaction and the morphogenesis of power and the exertion of influence within the network of stakeholder groups in Guangzhou's urban health care system between 1979 and 2009

rently still play a negligible role, they have entered a phase of rapid development since the 1980s (in urban areas since 1984 (cf. LEE and WANG 2005; SUN 2006)) and many of them are linked to the health sector. They could play an important role in the future in supplementing formal health services (e.g. in obtaining funds for facilities offering services for needy population groups, establishing networks of neighbourhood support or initiating health information campaigns). The establishment of self-organized insurance schemes offered by economic cooperatives of villages-in-the-city, which hence act as corporate agents, to their members, shows the high potential of the activities of such organizations and their flexible adaptation to gaps in the official health system. Nevertheless, while currently the operations of NGOs are very restricted, the activities of social organizations benefit only parts of the population. It must be warranted in the future that government-organized social organizations benefit all members of society.

Considering China's authoritarian regime strengthening civil society organizations might appear utopian. However, in the context of being faced with increasing protest activity and opposition in terms of deficiencies in intra-state relations, the Chinese Communist Party is debating political structural reforms which are supposed to establish accountability, transparency, reliability and trust among the population. The political leadership consents that rule of law, a higher degree of participation and sound supervision and balancing of institutions – is the goal of political reform (HEBERER and SCHUBERT 2006). These debates are often neither taken notice of adequately by Western nor by Chinese scholars. Nevertheless, all in all, China's 30-year-reform process shows that there have not been shortcomings in good intentions and promulgations, but rather in their realization, in their consistency with existing policies, regulations and guidelines and in their concrete formulation and configuration, which deviate from original targets.

## 6 Conclusions

The analysis of levels of influence of different stakeholders and governance problems in the Chinese health system suggests that, firstly, in the long term an all-embracing health governance framework needs to be established that includes third-party independent monitoring and supervision to ensure a balanced stakeholder network. The third party's interests must clearly differ from the providers' interests.

As a prerequisite, secondly, the organization of administration must be greatly improved. According to SIDDIQI et al. (2009), health system governance can perhaps be improved without addressing the overall governance of a country. In regard to China, however, this is not the case: Current major deficiencies of the health system are indirectly and directly related to economic reforms, general administrative structures, and informal aspects in governance and especially government. General steering problems, as e.g. corruption, are flourishing in all sectors and are not restricted to the health system. Separate solutions for the health care sector, therefore, would not have much success, which is also due to the high fragmentation of health-relevant administration into various ministries, departments and bureaus outside the health sector. Hence, an abrogation of administrative fragmentation, a clear assignment of responsibilities and possibly the subordination of most health- and medicine related fields to the Ministry of Health and respective health departments and bureaus seem to be prerequisites. In addition, as long as health governance is not given a higher priority in the overall governance framework, the impact of a health system reform will be rather limited.

Thirdly, a greater integration of interests of all stakeholders and higher collaboration must be achieved. The transfer of our theoretical frame that is derived from a conflation of MAYNTZ and SCHARPF (1995), SCHARPF (2000) and ARCHER (1995) shows that although hierarchical steering by the municipal administrative units in Guangzhou is still intended to be in place, new corporate agents – influential hospital managers, social organizations as well as NGOs – emerged that together with the multiple adaption or circumvention strategies by primary agents – patients and health care providers – are significantly reshaping the health system.

Currently, two possible reform lines are being discussed in China: the provision of basic health services for free or at substantially discounted prices which would be financed by increasing the budgets of public health facilities, and the expansion of

government-subsidized health insurance schemes (cf. RAMESH and WU 2009). On the one hand, the effectiveness of the former is limited due to the aggravation of already rocketing financing problems, meaning that neither an improvement of the quality of services nor the responsiveness and integrity of health care personnel can be warranted. On the other hand, as explicated above, the mere expansion of the social health insurance system with its partial schemes is also by no means sufficient. Independent of the overall financing reform that will be imposed, our analysis shows that a restructuring of functions and power of stakeholders in the health care system is needed in any case.

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