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Active stewardship in healthcare: Lessons from China's health policy reforms

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Abstract

Governments across the globe have made repeated attempts to reform their health systems in recent decades with the purpose of improving access while containing costs. What is the role of government in contemporary health policy in achieving these somewhat contradictory goals? This paper conceptualises this role as one of "active stewardship" wherein the government is a central actor steering and coordinating the sector through a portfolio of diverse policy tools. In this conceptualisation, the government is not a passive participant—in merely financing, delivering, or regulating the sector—but a steersman at the helm that sets policy objectives and actively pursues them. We argue that active stewardship is central to achieving contemporary health policy priorities of universal healthcare. We apply this conceptualisation to China's recent healthcare forms and show that the role of the government in governing the sector has changed substantially over time, particularly since 2009, and the changes are showing promising results. China's experience suggests that governments need to more actively guide and shape the behaviour of both public and private players in order to achieve the goals of universal health coverage. It also suggests that a high degree of policy capacity is essential if active stewardship is to be effective.

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KEYWORDS
China, governance, health policy, healthcare, reform, stewardship

1 | INTRODUCTION

Healthcare reform is prone to policy 'fads and fallacies' (Marmor et al., 2005), lurching from one grand design idea to another. The trend started in the 1980s with the rapid spread of market-centred reform ideas inspired by New Public Management (NPM). This was followed in the subsequent decade by ideas promoting collaborative governance and public-private partnerships under the banner of "governance" and its aspiration to expand "people's" role in policy matters. The one element that the two waves had in common was the motivation to substitute or at least offset the role of the government with larger role for market and/or partnership with business and civil society groups. The subsequent efforts to implement reforms based on this line of thinking, as it was realised later, did little to achieve the stated goal of reducing costs or making healthcare more accessible.

The disappointing results of market- and partnership-based reforms refocussed reformers' attention on the central role of the government in healthcare (Ramesh, 2008a). Many writings from this point of view relied on the concept of "stewardship" to underscore the need for central coordination by government in healthcare (Brinkerhoff et al., 2019; Greer, 2018). At the same time, the calls for larger role for community groups in health policy became louder, increasingly packaged in terms of "good governance" values such as transparency, participation, and accountability. International organisations such as the World Health Organisation (WHO) and World Bank produced numerous policy documents promoting "good governance" agenda in healthcare (Lewis & Pettersson, 2009).

Notwithstanding the deep differences in visions of healthcare, there is a broad acknowledgement of the need for coordination of the diverse and conflicting interests and ideas that characterise the sector. On one hand are those who view the government as a steward with clear responsibility for leading the sector (WHO Regional Office for Europe, 2005) while, on the other hand, are those who prefer community groups to have the decisive voice in health policy matters (Meessen, 2020). The former may be described as the "stewardship" perspective. In this view, the government, as the steward, has the primary responsibility for setting policy goals and directions and mobilising fiscal and other resources to achieve them (Barbazza & Tello, 2014; Ramesh et al., 2014). Writings from this perspective, however, ignore the centrifugal forces and entrenched self-interest, which impede the achievement of the steward's goals.

The objective of this paper is to contribute to understanding of the government's role in healthcare by proposing the concept of "active stewardship" and applying it to health policy in China. The notion of active stewardship goes beyond merely envisioning goals and mobilising resources by the government and includes undertaking a wider and deeper range of interventions to achieve the goals. Herein, the government has the ultimate responsibility for both policy and implementation design and is expected to take both direct measures to ensure that the design is implemented. Thus, for example, it may actively bargain with providers and suppliers to drive down prices rather than passively disburse funds (see for e.g. Tangcharoensathien et al., 2015). Similarly, it may establish and run its own hospitals and clinics to not only deliver services, but also use them to set standards for the sector (see for e.g. Bali & Ramesh, 2021). Regulations too may be structured in ways not only to encourage competition but also to promote desired behaviours across the sector. In this conception, the government is not merely a participant in the health system as a financier, manager, or regulator, as is the case in the WHO conception (World Health Organisation, 2000), but is a steersman at the helm that must also row when necessary. "Steering whilst rowing" (Storey, 2011) would be an apt metaphor for describing the role of government in healthcare.

In the wake of economic liberalisation that started in the 1980s, the Chinese government adopted reforms promoting private financing and market competition in healthcare. The reforms were an unqualified failure in terms of containing health expenditures or improving services, as the Chinese government itself later admitted (Research Development Center of State Council, 2005). The government sought to overcome the problems through regulation of prices and social insurance financing but to no avail (Lee, 2019). The situation began to improve only after the

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launch of comprehensive national reforms in 2009 (Yip et al., 2019), which targeted not only financing issues but also the entire range of critical conditions related to production and distribution of healthcare. The reforms have been underpinned by, as we will see in this paper, active stewardship that includes steering functions but also significant amount of rowing on its part. Although it is still early to draw firm conclusions, emerging evidence indicates that the recent reforms are producing better results than their predecessors (see Ta et al., 2020; Yip et al., 2019). If the promising results in China are sustained in the future, health policy reformers in other countries can look to "active stewardship" as an alternative to market- or community-centred reforms. In the following section, we anchor the concept of "active stewardship" in the recent health policy literature.

2 | HEALTH POLICY DEBATES: PROMISE AND PERILS

Health policy tends to be at the forefront of ideological debates and cross-boundary learning whereby policymakers selectively learn from each other's experiences (Leiber et al., 2015; Yip & Hsiao, 2015). In the 1980s and 1990s, NPM-inspired ideas around marketisation, competition, decentralisation, and deregulation and so on were rapidly adopted around the world as a way of dealing with the sector's diverse problems. However, as Marmor et al. (2005) point out, the diffusion of these ideas was associated with a great deal of unwarranted inferences, rhetorical distortion, and caricatures. While NPM-inspired reforms produced mixed outcomes in the developed world, their adoption in developing countries resulted in mostly negative outcomes as costs escalated while access to healthcare deteriorated (Blumenthal & Hsiao, 2005; Wu & Ramesh, 2009). In developing countries, NPM reforms suffered not only from the flaws intrinsic to the thinking but also from poor policy design as well as weak administrative capacity and lack of accountability (Wu & Ramesh, 2009). Many public hospitals were privatised or granted substantive autonomy without sufficient government oversight or accountability. This was not unique to developing countries, however, as unclear lines of accountability coupled with poor policy design stymied achievement of health policy goals even in developed countries.

The early 2000s saw the growing popularity of the idea of emphasising "governance" across diverse policy areas, which presented partnership among state and societal actors as a way to overcome the shortcomings of both the state and market (Barbazza & Tello, 2014; Brinkerhoff & Bossert, 2014; Ramesh et al., 2014). Much of the health governance literature focused on the preconditions for good governance – transparency, accountability, decentralisation (Greer, 2018; World Bank, 1997; World Health Organisation, 2000) – rather than how specifically to improve access or quality of healthcare or restrain costs. The reforms undertaken to put the ideas into practice did not fare well as the stakes were simply too high for the key governance partners in the sector as they are primarily driven by self-interest. The experience highlighted the need for a pivotal actor that inspired, cajoled, and coerced the actors in the sector in a desired direction (Ramesh et al., 2014).

Subsequently, the debate focussed on the "regulatory state" that is increasingly applied to the health sector. A regulatory state is one in which the government relies on regulation of markets instead of direct interventions such as public ownership or public expenditure (Levi-Faur, 2014). This concept is particularly salient in the health sector, which is well known for the multitude of market failures that require remedial interventions (Helderman et al., 2012). While this was a useful corrective to the 1990s discussions centred on sweeping generalisations about privatisation and marketisation and the subsequent discussions on superiority of collaborative governance, it overlooked many essential preconditions for effective health policy (Bali & Ramesh, 2015, 2017). Indeed, governments can use other policy tools that offer more regulation-like effects than regulations. These interventions aim to surrogate the effect of regulations through fiscal or organisation-based interventions that are typically associated in achieving a government's redistributive priorities (Levi-Faur, 2014). Thus, for example, governments are able to use their expenditures to shape providers' behaviour as a substitute for regulation. In healthcare, some of the best performing systems are those that employ a broad range of policy tools simultaneously, including ownership and expenditures, in addition to regulations (Bali & Ramesh, 2021). What matters most is not the individual policy tools used but how they are used in concert, highlighting the need for a clear central authority in orchestrating their use.

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Discussions on stewardship launched by the World Health Organisation (2000) did recognise the central role of governments in healthcare but the conversations soon got muddled with talks on good governance. More recently, scholars have refocussed attention on government stewardship in proactively designing and managing health governance relationships (Brinkerhoff et al., 2019; Greer, 2018). The notion of active stewardship conceived in recent formulations underlines the need for clear leadership in managing relationships among diverse interests and moving them in the desired direction through a cohesive ensemble of policy tools. It includes articulating strategic visions, devising strategy for achieving the vision, and aligning health system design with health policy goals (Barbazza & Tello, 2014; Brinkerhoff et al., 2019; Veillard et al., 2011). A capable steward not only sets goals and proactively establishes the conditions for their success but also intervenes directly in provision, financing, and payment when deemed necessary. The stewardship is driven by commitment to problem-solving rather than abstract goals.

Following Bali and Ramesh (2021), we argue that active stewardship involves a central policy actor—usually the national government—in assuming responsibility for achieving and sustaining universal healthcare. To acquit this responsibility, it is imperative that the government identifies critical health governance functions and allocates them appropriately among stakeholders. It is vital to ensure that the right agency and level of government is responsible for the functions for which it is most suited and that there exist mechanisms for holding them accountable. This involves design and execution of both vertical and horizontal coordination of governance of healthcare in the country.

Healthcare is a quintessentially a local function due to the diverse needs of population segments and it is for this reason that the responsibility for it is mostly vested in subnational governments. The decentralisation of responsibilities for healthcare poses challenges of its own, however, due to very different policy goals and financial and administrative capacities of the local governments, which undermine the achievement of national goals. It is therefore upon the national government to establish a cohesive national framework for ensuring minimum standards of access and care while allowing room for local initiatives and preferences.

In parallel with *vertical* stewardship, governments have a vital role in ensuring *horizontal* coordination across agencies (Peters, 2015). The critical need for policy coordination stems from two inter-related issues. First, contemporary health policy problems do not exist in isolation but are connected to other problems—such as social protection and economic development—in inextricable ways (Bali & Ramesh, 2021). This inter-connectedness among problems requires all related agencies to work in concert to deal with them effectively. Second, health systems are increasingly fragmented with growing divisions between key health services: primary and secondary care, diagnostic services, pathology and pharmaceuticals, and public health. These services are often delivered and financed by different agents at different levels of government, with limited policy coordination (He & Tang, 2021). Instead of working together to serve the population, they often actively undermine each other in pursuit of their self-interest, creating need for a steward to promote cooperation among them. One particularly widely used method for promoting horizontal coordination is the establishment of central agencies and super-ministries with the explicit mandate and authority to promote coordination among related policy functions.

Effectively addressing the twin coordination challenges across the sector is not an easy task: it requires deft use of a range of policy tools, as well as ensuring that policy actors develop sufficient policy capacity to use these tools to their potential. This includes analytical competencies to select the appropriate set of tools, operational skills to be able to implement and manage them, and political skills to manage diverse stakeholders with competing interests in the sector (Bali & Ramesh, 2021).

3 | HEALTHCARE REFORMS IN CHINA: 1980S–2000S

Healthcare reforms in China during the first two decades of economic restructuring offer instructive lessons in how misguided policy ideas undermine the achievement of government's objectives and compromise the population's welfare (Blumenthal & Hsiao, 2005; Lee, 2019). Prior to economic reforms in the 1980s, the socialist health system offered access to basic services to the entire population, a commendable achievement for a poor agrarian country.

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Fee schedule, medical supplies, and remuneration of health workers were all regulated by the state, allowing little incentive or scope for over-servicing or over-charging by providers. Wide insurance coverage coupled with controls on provider behaviours were the key to the Chinese health system's fine performance at low cost (Hsiao, 1995).

The basic tenets of the health system were undermined by the process of economic reforms that started in the 1980s. Health insurance programmes collapsed or withered following liberalisation of the command economy, leaving a large segment of the population uninsured (Gu & Tang, 1995; Liu, 2004). At the same time, the government drastically reduced subsidies for public hospitals, leaving them with no choice but to fill the gap by collecting fees directly from patients (Hsiao, 1995). The problem was compounded by fee-for-service (FFS) payment system that incentivised providers to increase prescription of drugs, diagnostic tests, and medical procedures with high profit margins (Lee, 2019). The result was skyrocketing total health expenditures as well as out-of-pocket (OOP) payment; both increased almost 20% a year (Eggleston et al., 2008; Hu et al., 2008). By 2000, two thirds of China's total expenditure on health was paid through OOP, making its health system one of the least equitable in the world (World Health Organisation, 2000). The hardships for household that these changes caused became a major source of social anxiety, which seriously threatened the government's performance legitimacy.

3.1 | Dysfunctional health governance

The main source of health governance failure in China was weak governance whose roots lay in lack of stewardship (Ramesh et al., 2014). Until the early 2000s, the government lacked a vision for healthcare and this was acutely reflected in its policies and actions. On the one hand, it wanted providers to show an entrepreneurial spirit and be self-reliant by earning their own income. It accordingly gave them broad operational autonomy to earn income as they deemed fit. At the same time, the government hoped that competition among providers would reduce prices while improving quality (Lee, 2019). It was not realised by policymakers that the two goals were mutually exclusive in healthcare as information asymmetries allow providers to use their autonomy to advance their interests at the expense of users. Not only did the government lack a coherent vision, it paid insufficient attention to the details of how to put its market-centred ideas into practice. Unlike most other products and services in which markets emerge naturally and function smoothly, healthcare markets require deep and targeted interventions to address systemic asymmetries in information across stakeholders and moral hazards innate to the sector (Bali & Ramesh, 2015). These focussed interventions were largely absent across health policy reforms during this period in China.

The lack of stewardship reflected as well as aggravated the various forms and levels of fragmentation that afflicted the Chinese health system (Ramesh et al., 2014). First, the health system is vertically fragmented. There are five levels of government in the country and each owns a certain number of public healthcare facilities. Provincial and sub-provincial authorities had neither incentive nor capacity to coordinate local health policymaking or service provision with their peers. Although central ministries formulate health policies, they had to rely on local departments for implementation, which unfortunately had few effective tools to rein in hospitals' perverse behaviours.

Second, the health system was also horizontally fragmented, even though the Ministry of Health (MOH) was responsible for overseeing the delivery of healthcare throughout the country. Its responsibilities included maintaining clinical and professional standards as well as managing the health insurance scheme for rural residents (the New Cooperative Medical Scheme, NCMS). However, the MOH had only a few policy tools available for intervention. It had regulatory tools for prescribing providers' and users' behaviours but did not have the requisite administrative capacity to enforce them across a vast and diverse country. Similarly, while it was responsible for allocating subsidies to public hospitals and clinics, the funds available for allocation were too small to give the government sufficient leverage, as subsidies formed barely 10% of hospitals' revenues (Ramesh et al., 2014). The MOH was also a weak agency with limited political capacity as it found it challenging to implement measures opposed by other agencies

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and stakeholders. Its authority was further tarnished by the perception that it was beholden to public hospitals, its key constituency, rather than users (Hsiao, 2007).

Crucially, MOH shared its healthcare responsibilities with the Ministry of Human Resources and Social Security (MHRSS), which was responsible for managing the Urban Employee Basic Health Insurance (UEBHI) and the Urban Resident Basic Health Insurance (URBHI) schemes. The MHRSS' responsibility for insurance financing made it focus more on budgetary issues, which was different from responsibility for managing public hospitals (Hsiao, 2007). The National Commission of Development and Reform (NCDR) also played a role in health policy as it regulated the price schedule for medical services and drugs until 2015 when gradual liberalisation of pricing began to be pursued (Hu & Mossialos, 2016). In addition to MHRSS and NCDR, the Ministry of Finance (MOF) and the Ministry of Civil Affairs (MCA) also had a vital say in health policy due to their responsibility for managing fiscal subsidies and operating the Medical Assistance Scheme (MAS), respectively. This administrative fragmentation at the national level extended to local levels. The cleavages within the fragmented health system not only stymied policy coordination but also provided ample room for providers to game the regulatory system, undermining the effect of health regulations (He & Qian, 2013; Qian et al., 2019).

Third, the healthcare delivery system in China also suffered from stark divisions between primary and secondary care. On paper, it was a tiered delivery system in which patients started at community outpatient clinics and moved up to higher level facilities only when given a referral letter. In reality, patients could visit any level they wished, with most choosing tertiary hospitals in the first instance (Eggleston et al., 2008). The problem was aggravated as profit-driven facilities saw others as competitors and sought to generate revenues for themselves. The fragmented governance system described above was reflected in all key components of healthcare in China: *financing*, *regulation*, and *provision*.

3.2 | Financing

China's health financing system was highly fragmented, with three main social health insurance (SHI) schemes: UEBHI, URBHI, and NCMS,[1] plus budget-funded schemes for retired public sector workers and the poor (the MAS). However, OOP payments accounted for a significant share of health expenditures until 2010. SHI schemes were steadily instituted, but once in place, the managers of the schemes were unable to use their purchasing power to shape the providers' behaviour (Hsiao, 2007). Moreover, the limited capacity of local health insurance agencies also impeded them from playing an active purchaser's role (Liu & He, 2018). While prospective payment methods such as capitation and global budget were widely discussed and gradually introduced through local pilots, FFS remained the dominant way of paying providers (Hu et al., 2008).

3.3 | Provision

Owned by the government and other public agencies, public hospitals and clinics are the dominant provider of health services in China. In principle, such significant ownership of hospitals across the country should make designing and implementing governance arrangements around the provision of care easier as the government can simply direct hospitals as required. However, in practice, this advantage was more than offset by the government's reluctance to use its ownership as a tool to pursue policy goals. Without clear direction, hospital managers and doctors pursued their self-interest. While wearing a "public hat", hospitals behaved as privatised entities in their concentration on earning revenues rather than on collective goals of sustaining universal healthcare at affordable costs (Allen et al., 2014). The only tools the MOH used to restrain profit-driven hospitals were limited to moral exhortation and ad-hoc administrative interventions that yielded temporary results (He & Qian, 2013).

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3.4 | Regulation

Regulations of providers in China clearly reflected the weakness of the broader fragmented system. Normally, regulations play a secondary role in health systems dominated by public providers as the government can achieve its goals through direct instructions as an owner (Ramesh, 2008b; Tangcharoensathien et al., 2015). This was not the case in China, however, as public providers enjoyed vast financial autonomy and operated more like profit-oriented private firms, making a robust regulatory framework essential for effective health service delivery (Allen et al., 2014). Unfortunately, the regulations that did exist were either weak, poorly targeted, or inadequately enforced. The most telling evidence was the ill-designed medical fee schedule the government had adopted for ensuring affordability in the 1990s. To make essential medical services affordable to the population, the government had set fees for designated basic services and drugs substantially lower than the market price. Hospitals got around the restrictions easily by prescribing drugs and procedures that were outside the list, thus undermining the regulation (Liu et al., 2000). Unsurprisingly, nearly half of China's total health expenditures for decades were on drugs (Sun et al., 2008).

Given the deep fragmentations in the Chinese healthcare system and their all-encompassing ill effects, shoring up governance through enhancing stewardship has been the focus of health policy reforms in China over the past decade, as we will see in the following discussion.

4 | HEALTHCARE REFORMS IN CHINA: 2009–PRESENT

A systematic evaluation of health policies in China in the mid-2000s led to the launch of comprehensive reforms in 2009. Concerned about rising social dissatisfaction and alarmed by the grave outbreak of the severe respiratory syndrome (SARS) in 2003, the Chinese government showed unprecedented political determination to reform its health system. Growing public coffers and increased administrative capacity, coupled with the new governance outlook of the Hu Jintao era also boosted the government's confidence in assuming a stronger role as steward. Often referred to as “the new healthcare reform”, the plan explicitly stated the government's commitment to achieving universal health coverage by 2020. It also accepted that the primary responsibility for ensuring access to healthcare rested with the government (Communist Party of China Central Committee & State Council of China, 2009). The then-President Hu Jintao underscored that healthcare was vital to not only socioeconomic development but also the future of the nation. His successor Xi Jinping further reiterated healthcare as a vital government responsibility. The reform programme that commenced in 2009 was clearly guided by the ethos of “bring the state back in”. Figure 1 exhibits the key milestones of the healthcare reform in the past two decades.

4.1 | New health governance order in formation

A new health governance order in China has emerged following a major organisational restructuring of central ministries. The National Health Commission (NHC) is now vested with the overall responsibility for managing the provision of healthcare in the country while the National Healthcare Security Administration (NHSA) is responsible for financing. Superseding the former National Commission of Health and Family Planning in 2018, the NHC was granted greater authority over matters related to production and delivery of healthcare services. Although NHC and its predecessor MOH share similar policy functions, the status of “commission” implies more comprehensive portfolios vis-à-vis “ministry” according to the Chinese administrative conventions. Indeed, the NHC was granted additional responsibilities related to ageing and elderly services, which have been expanding rapidly in China.

The establishment of the NHSA in 2018 marked a yet deeper shift in China's health policy as it indicated the recognition of purchasing as a powerful tool for shaping providers' behaviour. Partly inspired by local experiments, especially the Sanming Model (named after a prefecture in Southeastern China),[2] this reform consolidated all governance

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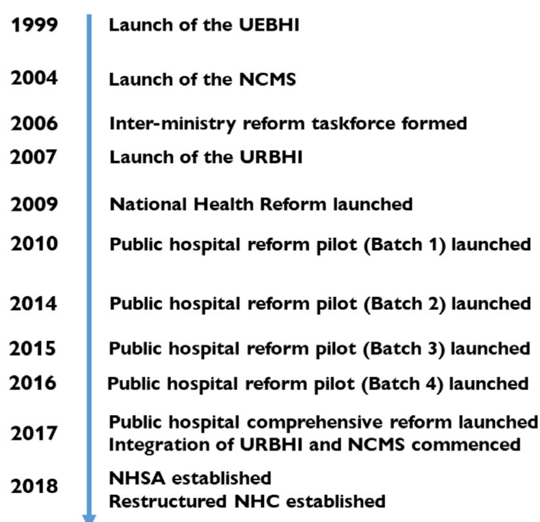

FIGURE 1 Key milestones of healthcare reforms in China. Source: Developed by the authors [Colour figure can be viewed at wileyonlinelibrary.com]

functions related to public financing and purchasing under the NHSA. As the custodian of all SHI programmes as well as the MAS, the NHSA became a "super master" of purchasers in the country with powerful financial levers. The regulatory authority for determining the price schedule and pharmaceutical procurement has also been transferred to the NHSA.

The consolidation of decision-making authority under NHC and NHSA has strengthened stewardship in the health sector. In the past, the NHC was responsible for managing the NCMS, the health insurance programme for rural residents. This role was criticised for generating contradictory incentives and weakening accountability because NHC was both the insurer and supervisor of public hospitals. With local healthcare security offices fully assuming the role of third-party payer, the NHC and its local arms are no longer involved in purchasing or payment decisions. This separation of roles is expected to accelerate NHC's transformation into a professional regulator of the health sector. The healthcare security administration, on the other hand, is envisioned to be a powerful prudent third-party purchaser representing the interest of users. Its privileged role as a single payer gives it tremendous levers over providers.

To map and better understand governance of healthcare in China under this dual steward structure, we collected and analysed all policy documents issued by the NHC and the NHSA from 2018 to March 2022. The corpus comprised of 261 official documents relevant to various aspects of healthcare reforms. Taking a text-as-data approach, we elicited key themes from the large corpus that is presented below.[3] Given the length constraint, the analysis focuses on central-level policy orientation only.

4.2 | Financing

The unprecedented political commitment to health reform by the Chinese government displayed since 2009 has been backed by vast fiscal commitment,[4] especially to subsidising the expansion of SHI coverage. As a result, the SHI and government expenditures' share of total health expenditures have grown exponentially while that of OOP has declined accordingly in recent years, as shown in Figure 2.

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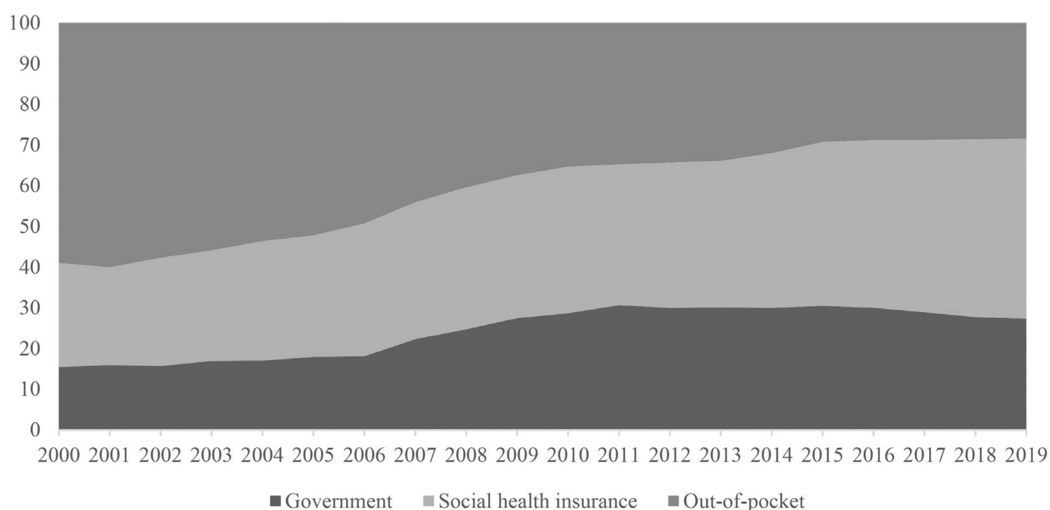

FIGURE 2 Source of health financing in China, 2000–2019. Source: 2020 China Health Statistical Yearbook, Beijing: National Health Commission

The subsequent expansion of SHI to cover almost the entire population was accompanied by an expansion of the role of NHSA, the agency responsible for financing matters. Given the near-universal coverage of SHI, the vast majority of both public and private providers are under the oversight of NHSA and its local offices. The enhanced role and responsibilities of NHSA are evident in its policy documents, which repeatedly underscore its role as the country's largest collective purchaser of health services (word cloud exhibited in Figure 3). Its documents frequently cite its responsibility for improving the performance of healthcare providers participating in SHI. As a part of its responsibility for regulating the management of SHI funds, the NHSA has set up a regulatory framework through the newly promulgated Provisional Healthcare Security Regulations on the Management of Designated Medical Institutions. The document summarises NHSA's responsibilities as following:

> *"The healthcare security administration is responsible for setting policies concerning the management of (SHI) designated medical institutions. The Administration shall regulate medical institutions in their application for designation, assessment of professional qualification, negotiation for service contract, as well as the design, execution, and termination of these contracts. SHI agencies determine the designation of medical institutions and sign service contracts with the designated institutions. They are responsible for the execution and evaluation of these contracts. Designated medical institutions shall comply with laws, regulations, decrees, and policies related to healthcare security, and provide medical services to SHI participants."*[5]

The NHSA's power as a steward stems not only from its authority as the master of purchaser but also from its enhanced policy capacity, especially analytical capacity. As shown in Figure 3, "internet" and "information system" are frequently mentioned in its documents. The NHSA has invested heavily in analysing data accumulated over two decades for the purpose of improving the sector's performance. In 2019, it initiated a nationwide smart surveillance demonstration project that leverages big data and upgraded digital infrastructure to monitor clinical and billing practices of service providers. The resulting advances in interconnectivity paved the way for universal portability of SHI as well as expansion of provider payment reforms. It has also launched extensive efforts to prevent health insurance fraud.

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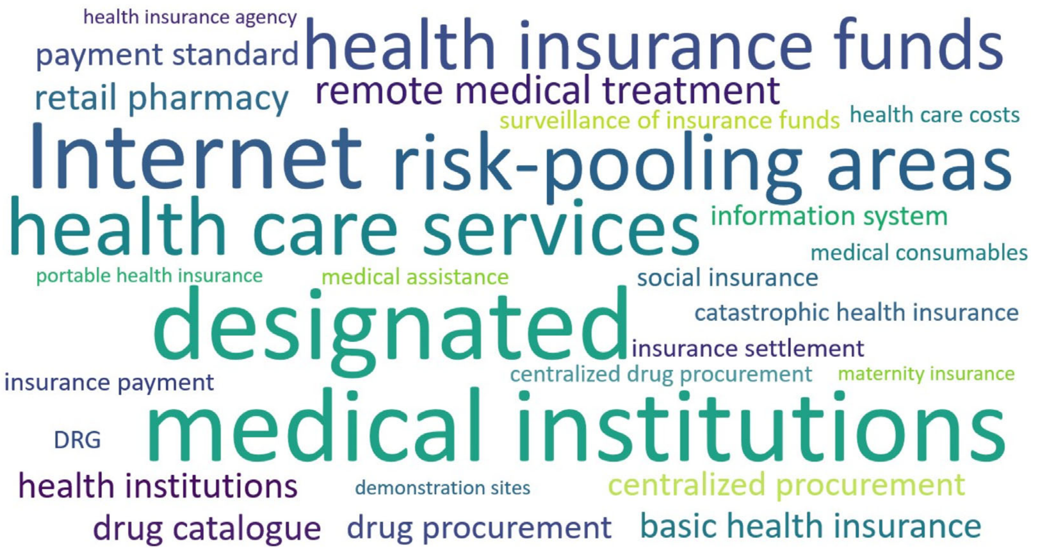

FIGURE 3 Word cloud of policy documents of the National Healthcare Security Administration. Note: The corpus consists of 87 policy documents issued between 2018 and March 2022. The Chinese version of this figure is provided in Figure A1. Source: the authors' analysis [Colour figure can be viewed at wileyonlinelibrary.com]

FIGURE 4 Word cloud of policy documents of the National Health Commission. Note: The corpus consists of 174 policy documents issued between 2018 and March 2022. The Chinese version of this figure is provided in Figure A2. Source: the authors' analysis [Colour figure can be viewed at wileyonlinelibrary.com]

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While the Chinese government has for nearly two decades recognised the perverse effects of FFS payments and a commitment to make changes, it lacked the analytical and administrative capacities to implement significant provider payment reforms (Hu et al., 2008). The initial payment reforms sought to curb cost escalation by altering providers' incentive were either too small in scale or too rudimentary in design to be effective (Chan & Zeng, 2018). The situation changed with the acquisition of massive data and capabilities to analyse it, which allowed the healthcare security administration to adopt sophisticated payment arrangements, especially case-based payment methods such as Diagnosis-related groups (DRGs).[6] Under DRGs, providers are paid a "bundled" fixed rate that makes them responsible for financial risk, which, in turn, imposes hard constraints to deliver cost-effective care. The NHSA has also introduced "diagnostic-intervention packet" (DIP) that relies on sophisticated analysis of historical healthcare and SHI data amassed at the local level. The DIP includes a price adjustment mechanism through which the actual reimbursement for each case is determined ex post, thus offering hospitals incentives to improve cost efficiency (Qian et al., 2021). The government expects the DRG/DIP payment system to cover all inpatient services by the end of 2025 and is currently rolling out policy pilots nationwide.[7]

The government's enhanced stewardship is also evident in regulating the procurement and prices of pharmaceuticals in the country. The NHSA has established mechanisms for screening the track record of pharmaceutical suppliers. More importantly, it now undertakes centralised strategic purchasing and actively uses its immense purchasing power to bargain with suppliers for best prices. It has launched a group-purchasing programme covering 70% of drugs consumed in 11 megacities on a pilot basis. The pilot is producing promising results, reducing the purchase prices of drugs by as much as 52% on average (Wang et al., 2021).

4.3 | Provision

Having addressed major demand-side issues by expanding insurance coverage, the government turned its attention to the supply-side, which had remained largely untouched in previous rounds of reforms. These reforms encompassed all major aspects of how healthcare was produced and distributed. Recognising the adverse effects of commercialising public hospitals, recent reform efforts have prioritised achieving health policy goals of serving the public rather than generating income. This in turn has required significant policy reforms across all aspects of provision. The government initiated a series of experimental hospital reforms over 7 years (2010–2016). The experiments generated a vast amount of practical information, which formed the foundation for nationwide launch of "public hospital comprehensive reform" in 2017. The intent of this "comprehensive reform" programme was to assert the central government's stewardship over the functioning of public hospitals.

The NHC has emerged as a manager and regulator since its establishment in a restructured form in 2018. As illustrated in the word cloud below (Figure 4), the NHC and its local arms are mainly responsible for the supply-side of healthcare, such as strengthening primary care, restructuring of the provision system, and promoting internet-medicine. As a part of improving management of hospitals, it has introduced a system of annual performance reviews at all public hospitals against 55 performance indicators, including medical quality, cost containment, institutional development, and patient satisfaction. The first round of review in 2018 evaluated all tertiary public hospitals while the second round included 3047 secondary hospitals throughout the country. During the first review, 141 out of 2413 tertiary public hospitals received an official warning for unsatisfactory performance (National Health Commission, 2020). This benchmarking exercise—a key aspect of the stewardship function—has been used to determine fiscal investment, hospital accreditation, and hospital managers' promotion prospects. Further, some local governments also linked hospitals' performance rating to the permissible sum of bonus payment of each year, thus creating a strong financial incentive for performance improvement.

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4.4 | Preliminary outcomes of reform

Emerging evidence suggest that the reforms show promising results (see Ta et al., 2020; Yip et al., 2019). Government spending on health grew rapidly from RMB 451 billion in 2009 to 2.20 trillion in 2020 and now accounts for about 2% of China's gross domestic product (GDP). Significantly, the share of OOP spending declined from 60% of total health expenditures in 2000 to 27.7% in 2020. As a result, financial accessibility to health services has improved which is evident in the decline of the proportion of households incurring catastrophic health expenditures from 14.4% in 2010 to 10.7% in 2016. During the same period, the incidence of catastrophic expenditures for the poorest segments of households dropped from 22.9% to 16.7% (Ta et al., 2020). In the meantime, life expectancy in China has increased from 74.83 in 2010 to 77.3 in 2020, and the differences in maternal mortality rate between low-, middle-, and high-income localities have decreased substantially. Disparities in infant mortality rate between urban and rural areas have also narrowed (Meng et al., 2019).

5 | CONCLUSION: ACTIVE STEWARDSHIP IN HEALTHCARE

The central argument developed in this paper is that achieving universal healthcare requires a more interventionist role on the part of governments than recognised by health policy researchers and policymakers. To govern the sector effectively, governments need to develop a clear vision and coherent goals, choose appropriate policy tools, and intervene directly and comprehensively to alter the key stakeholders' behaviour. We describe this form of health governance as "active stewardship". It involves not only selecting appropriate policy tools but also creating conditions for them to work effectively, and developing capacity to utilise the tools. We apply this conceptualisation to China's recent health policy reforms and show how the state is playing an increasingly active role in steering and coordinating the sector through governance and financing reforms.

The depth and scope of health policy reforms in China since 2009 has few parallels, involving comprehensive governance reforms with the purpose of strengthening the steering and coordination of the sector, in addition to large increase in public expenditures. The reforms have started to yield positive results in terms of increased risk-pooling and reduced OOP payments. The government has a clear vision of what it seeks and has created institutional foundations for achieving it. Yet, to achieve its vision of universal health coverage under government stewardship requires more efforts to address institutional challenges that afflict the sector. For instance, while DRGs help in realising cost efficiencies, they are challenging to implement in a fragmented health system because its effective functioning requires concomitant changes in reimbursement, pricing schedules, and so on. Similarly, provider payment reforms need to be continuously calibrated to ensure that they do not create incentives to deprioritise certain types of services or encourage other opportunistic behaviours. This, in turn, requires insurers and government agencies to develop capabilities to collect and interpret hospital utilisation data and adapt to local conditions.

China's experience in pursing active stewardship offers instructive lessons to other governments contemplating health policy reforms. First, it highlights the importance of actively learning from experience and recalibrating programs based on the lessons drawn. The speed and determination with which health policies are changed in China programs are remarkable. The changes are often driven by lessons learnt from multiple policy pilots experimenting with different arrangements to tackle specific problematic aspects of health care management with the objective of identifying solutions that work. The policy pilots not only feed into the design of programmes but gives agencies valuable experience in implementing them before they are rolled out nationally (Husain, 2017).

Second, the Chinese reform experience highlights the importance of developing systemic health policy capacities. Many countries around the word in recent years have introduced, for example, provider payment reforms but have struggled to implement them due to deficiencies in skills and competencies to monitor and hold healthcare

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providers accountable for their performance. In China, rapid build-up the analytical and operational capacities of the NHC and the NHSA have been critical to improved governance of the sector in recent years. Building similar capabilities is a necessary pre-requisite for navigating provider payment reforms.

Third, the Chinese reform experience underscores the importance of political will and commitment to sustain universal health coverage (Bali & Ramesh, 2021). Making changes to how healthcare is financed and delivered requires determined efforts to overcome entrenched interests and path dependencies that typically characterise the sector. The extent to which health policy is central to the policy agenda and prioritised by the national government is critical for the reforms to succeed.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

This study is associated with a large corpus of health policy documents issued by the central ministries of China. We are pleased to share the full dataset with peers.

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ENDNOTES

[1] The URBHI and NCMS have now been merged into the Urban–Rural Resident Basic Health Insurance Scheme as a major move towards defragmentation of social health insurance.

[2] To date, this is the most comprehensive local healthcare reform in China including health governance, management of social health insurance, service pricing, pharmaceutical procurement, staff remuneration, and provider payment. (For details, refer to Fu et al., 2017; He, 2018). The central authorities have described the Sanming Model as a 'remarkable success' and have been promoting its nation-wide emulation since 2017.

[3] The full list of policy documents is exhibited in Appendix.

[4] Budget allocation for healthcare increased by RMB 850 billion between 2009 and 2011 alone.

[5] Provisional Healthcare Security Regulations on the Management of Designated Medical Institutions, retrieved from http://www.gov.cn/zhengce/zhengceku/2021-01/12/content_5579285.htm (accessed on May 20 2021).

[6] Basic versions of DRGs started from local pilots since early 2000s. The typical practice was to assign a flat rate (commonly called "price cap") to simple diseases that usually do not cause complications, such as gallstone and caesarean section. Their rather limited scope of application did not yield substantive effect to the healthcare system as a whole in terms of cost containment.

[7] "National Healthcare Security Administration's Notice on Announcing the Three-Year Action Plan of DRG/DIP Payment Reform", November 19 2021, retrieved from http://www.gov.cn/zhengce/zhengceku/2021-11/28/content_5653858.htm.

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APPENDIX A

FIGURE A1 Word cloud of policy documents of the National Healthcare Security Administration (Chinese). [Colour figure can be viewed at wileyonlinelibrary.com]

FIGURE A2 Word cloud of policy documents of the National Health Commission (Chinese) [Colour figure can be viewed at wileyonlinelibrary.com]

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