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The Emerging Role of Private Health Care Provision in China: A Critical Analysis of the Current Health System

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Abstract

China continues to face great challenges in meeting the health needs of its large population. The challenges are not just lack of resources, but also how to use existing resources more efficiently, more effectively, and more equitably. Now a major unaddressed challenge facing China is how to reform an inefficient, poorly organized health care delivery system. The objective of this study is to analyze the role of private health care provision in China and discuss the implications of increasing private-sector development for improving health system performance.

This study is based on an extensive literature review, the purpose of which was to identify, summarize, and evaluate ideas and information on private health care provision in China. In addition, the study uses secondary data analysis and the results of previous study by the authors to highlight the current situation of private health care provision in one province of China.

This study found that government-owned hospitals form the backbone of the health care system and also account for most health care service provision. However, even though the public health care system is constantly trying to adapt to population needs and improve its performance, there are many problems in the system, such as limited access, low efficiency, poor quality, cost inflation, and low patient satisfaction. Currently, private hospitals are relatively rare, and private health care as an important component of the health care system in China has received little policy attention. It is argued that policymakers in China should recognize the role of private health care provision for health system performance, and then define and achieve an appropriate role for private health care provision in helping to respond to the many challenges facing the health system in present-day China.

Keywords Private health care, provision, role, health policy, China

Key messages

- There have been a limited number of studies on private health care provision in China, and this potentially important component of the health system has received little policy attention.
- With the current challenges in China, it is obvious that the increased demand cannot be met solely by public health care provision.
- Efforts in China should be focused on the development of policy and legislative frameworks that shape public-private partnerships.

Introduction

It has been recognized that it is difficult to define and achieve appropriate roles for the public and private sectors within health care systems (Eggleston, Wang, Rao 2008), and arrangements of these roles affect system performance relative to specific policy goals (Scott, 2001). In the past decades, many governments have introduced adjustment to the roles of, and interfaces between, the public and private sectors (Patouillard et al. 2007; Uplekar 2000; Zwi et al. 2001; Doyle and Bull 2000). Pressures for greater diversity and responsiveness in health care services have led to a reduced role for governments in providing services, and the provision of services on a more competitive basis (Harding 2003).

When the scope for increasing health expenditure is extremely limited, there is a need to search for ways of using existing budgets more efficiently and more effectively. A further concern has been the desire to ensure that access to health care for different populations is on an equitable basis. This has also been linked to a desire to improve patient choice and to make health care providers more responsive to patients. Therefore, some international organizations, such as the World Bank (WB) and International Monetary Fund (IMF), have promoted reforms designed to decrease the level of governmental health care and to encourage the private health sector (Commission on Social Determinants of Health 2007; World Bank 1993). Some of the recommendations by these organizations are based on the following assumptions: expenditure on health care is growing and government resources are limited; increasing private health care will free up limited government resources, which can be targeted to provide services for the poor; the private sector is free from administrative and political constraints and hence can deliver health care more efficiently; market forces such as competition will make improvements in health care quality possible (World Bank 1993; Uplekar 2000).

During the 1980s and 1990s, the world witnessed a rising willingness to make use of market approaches in the health sector (Uplekar 2000; World Bank 1997; Stiglitz 2000; Bennett 1997). This was true even in countries such as Australia, the United Kingdom, and Sweden, which have been regarded as historical bastions of the welfare state (Duckett 2007; Mason 2008; Doyle and Bull 2000). Private health care services are now also increasing in middle- and low-income countries, including China (Patouillard et al. 2007; Zwi et al. 2001; Smith et al. 2001; Nishtar 2004; De Costa and Diwan 2007; Chee 2008).

China, as both a developing country and a transitional economy, faces great challenges in meeting the health needs of its large and growing population. The challenges are not just a lack of resources, but also how to use existing resources more efficiently, more effectively, and more equitably. As China is gradually transforming itself from a planned to a market economy, private ownership and competitive forces are already dominating the economic sector (World Bank

2004). However, people in China still believe that health care is a part of the social welfare system and that health care provision is therefore the sole responsibility of the government (Chow 2006).

To date, there have been a limited number of studies on private health care provision in China, and this potential important component of the health care system has received little policy attention (Liu et al. 2005). Knowledge gaps still exist regarding the appropriate role of private health care provision for China and policies for engaging the private sector to contribute to health policy objectives. Therefore, research is needed to assess the role of private health care provision in China. The information will assist policymakers in developing strategies to meet the growing health care needs of Chinese people and in ultimately improving the performance of China's health system.

This paper describes the current health system in China, including health care provision and financing, and uses a case in one province to highlight the current situation of private health care provision. The paper then critically analyzes the current health care system in China in order to identify and discuss the contribution that private health care provision could make.

Methods

This study is based on an extensive literature review for the purpose of identifying, summarizing, and evaluating ideas and information on issues relating to private health care provision. Electronic databases such as PubMed, ScienceDirect, ProQuest, and CNKI Chinese Journal Database, as well as the Google Scholar search engine, were used to search for published literature. To comprehensively search the literature, the authors used key words (e.g., "private health care" or "nongovernmental health care"), and also limited the review to articles published after 1990, in English and Chinese. Using key words, the authors also searched the websites of the World Health Organization (WHO), WB, the Ministry of Health (MOH) of China, and the National Bureau of Statistics of China.

When all the searches were complete, the authors read articles and available documents and screened them according to two inclusion criteria. The first is a content criterion. For example, to ensure that clear categories of private health care provision are discussed, the authors excluded studies of private health care financing. The other is a quality criterion. To obtain authoritative information, the review for this paper focused mostly on peer-reviewed academic journal articles, government documents, and policy reports.

In addition, a review and analysis of secondary data can provide a cost-effective way of addressing issues, describing a current situation, and understanding country-specific conditions. Secondary data used for this paper was based mainly on statistics from government agencies (e.g., MOH of China).

It also uses the results of previous studies published in Chinese academic journals by the authors to illustrate the extent of the private health sector in China (Huang et al. 2005; Huang et al. 2006).

An Overview of China's Health Care System

Health care systems are commonly divided into different components, such as provision and financing (WHO, 2000). "Provision" means how health services are organised, managed and delivered. "Financing" means how services are paid for. The economic reforms that began in China in the late 1970s have contributed to great economic growth and social development. They have also affected China's health care system greatly.

Health Care Provision

During the Maoist era (1949–1978), China developed the largest public medical institutions network and the largest health care workforce in the world. This system became a model for many developing countries (Hou and Coyne 2008). The public health care system was intended to provide primary health care to all people at affordable prices (Dummer and Cook 2008).

In China, the hierarchical structure of health care in both urban and rural areas is based on a basic three-tiered organization for the delivery of health care. In the first tier, the doctors in village stations or street clinics provide preventive and primary health care. For more serious illnesses, they refer patients to the second tier: township health centers or district hospitals. The most seriously ill patients are referred to the third tier: county hospitals or municipal-level hospitals. Such a public system makes it possible to extend health care services rapidly to most localities (Chow 2006).

Table 1 shows that, in China in 2007, hospitals (including township health centers) account for most of the provision of health care services. There is no system of general practitioners (GPs), but each individual can go directly to health care providers. In urban areas, patients typically go directly to a hospital outpatient department, and that department performs the function of the GP. In rural areas patients may also go to clinics or hospitals. It is possible to be transferred within the system (both horizontally and vertically) according to the choice of the patient.

Table 1 Number of Outpatients and Inpatients in Various Medical Institutions in China in 2007

	Outpatients (100 million)	Inpatients (10, 000)
Total	28.42	9827
Hospital	16.38	6487
Township health center	7.87	2699
Community health center	2.26	107
Clinic	0.51	12
Maternal and child health care institution	1.21	458
Specialized disease prevention and treatment institution	0.18	26
Other	0.02	38

Source: MOH of China (2008)

In China, government-owned city hospitals form the backbone of health care provision. Although there is some evidence that private clinics are now playing a significant role in China's health system in rural areas (Lim et al. 2002), there is comparatively little development of private hospitals nationwide. Also, the development of private hospitals has received little policy attention. A noticeable indicator of this lack of attention is the shortage of basic data (Liu et al. 2005). There has been little analysis of how the impacts of the less-planned and less-regulated private health sector affect the national health system (Lim et al. 2004a). Even though the MOH of China publishes yearly statistics on physicians, nurses, hospitals, and beds for every province, there is limited data on the numbers and types of private hospitals. In 2004, the authors of this paper conducted a survey on the numbers and market share of private hospitals in Guangdong Province to seek more information about private hospitals in China (Huang et al. 2006; Huang et al. 2005). The following section provides the results of this study.

The Number and Market Share of Private Hospitals in Guangdong Province

Guangdong is the third-largest province of China in terms of its population (People's Government of Guangdong Province 2008). Since adopting the Reforms and Opening Policy in 1978, China has developed economically in truly remarkable ways. Leading China's drive toward modernization and industrialization has been Guangdong Province. The rapid economic growth is largely attributed to the development of the market economy.

The health care system in Guangdong Province is similar to that in the rest of China. In 2003, there were just 138 private hospitals in Guangdong Province, accounting for 5.7 percent of the total 2,410 hospitals of the province. The 138 private hospitals included 91 general hospitals, 38 specialized hospitals, and 9 traditional Chinese medicine (TCM) hospitals (Huang et al. 2005).

Furthermore, private hospitals in Guangdong Province are small-scale. There

were 10,617 beds in all private hospitals, accounting for 6.1 percent of the total 172,981 hospital beds of the province. Twenty-four private hospitals had more than 100 hospital beds, 43 private hospitals had 50 to 99 hospital beds, and 71 private hospitals had fewer than 50 hospital beds (Huang et al. 2005).

According to the survey, 6.93 million outpatients were in private hospitals in 2003, which accounted for 3.1 percent of the total 221 million outpatients in Guangdong Province (Table 2). There were 125,655 inpatients in private hospitals in 2003, which accounted for 2.9 percent of the total 4.24 million inpatients in Guangdong Province (Table 3). These tables indicate that the market share of private hospitals accounted for a mere 3 percent of the total market share of all hospitals in the province (Huang et al. 2005).

Table 2 Number of Outpatients in Private Hospitals and Percentage of Total Hospital Outpatients in Guangdong Province in 2003

	Outpatients in Private Hospitals	Outpatients in Total Hospitals	Percentage of Total in Private Hospitals
General hospital	6,147,175	188,158,212	3.3
Specialized hospital	593,536	7,517,382	7.9
TCM hospital	187,428	25,270,714	0.7
Total	6,928,139	220,946,308	3.1

Source: Huang et al. (2005)

Table 3 Number of Inpatients in Private Hospitals and Percentage of Total Hospital Inpatients in Guangdong Province in 2003

	Inpatients in Private Hospitals	Inpatients in Total Hospitals	Percentage of Total in Private Hospitals
General hospital	96,758	3,726,609	2.6
Specialized hospital	24,692	158,125	15.6
TCM hospital	4,205	356,297	1.2
Total	125,655	4 241,301	2.9

Source: Huang et al. (2005)

The distribution of private hospitals in Guangdong Province shows that most of them are located in the richer, more developed Pearl River Delta. Private hospitals in the cities of Guangzhou, Shenzhen, Zhuhai, Foshan, and Dongguan accounted for 68.8 percent of the total private hospitals of the province (which has 21 cities), contributing 81.6 percent of the total number of private hospital beds in Guangdong Province (Table 4) (Huang et al. 2005).

Table 4 Number of Private Hospitals and Beds in Five Cities and Percentage of Total Private Hospitals in Guangdong Province in 2003

	Number of Private Hospitals	Percentage	Beds of Private Hospitals	Percentage
Guangzhou	38	27.5	3,750	35.3
Shenzhen	23	16.7	1,842	17.3
Zhuhai	12	8.7	561	5.3
Foshan	12	8.7	1,211	11.4
Dongguan	10	7.2	1,303	12.3
Subtotal of five cities	95	68.8	8,667	81.6
Total of province	138	100.0	10,617	100.0

Source: Huang et al. (2005)

In summary, private hospitals in Guangdong Province were generally small-scale, accounting for a very limited market share. Also, private hospitals were relatively rare and were usually found only in the big cities.

Health Care Financing

In rural China, before economic reforms started in the 1980s, the communes provided health care through a three-tier system that was managed and financed locally (Chow 2006). The cooperative medical system (CMS) organized the “barefoot doctors” and provided other medical services to the rural population. (In China, barefoot doctors were farmers who received minimal basic medical and paramedical training and worked in rural areas where urban-trained doctors would not settle. They promoted basic hygiene, preventive health care, and family planning, and they treated common illnesses.) CMS was part of the commune system and was financed by the welfare funds of the communes (Liu 2004). After economic reforms, as the system of communes collapsed, so did the CMS. Only about 10 percent of the rural population in the 1990s was covered by some form of CMS, down from a peak of 85 percent in 1975 (Chow 2006). As a result, most rural Chinese people had to pay out-of-pocket directly for all health care services.

For the urban population, before economic reforms, health centers and hospitals associated with state-owned enterprises and other government institutions cared for employees and their family members. With urban economic reform in the 1990s, the Chinese government established a health insurance system to replace the previous system (Liu 2002). Under the new insurance system introduced in 1998, the employer contributes 6 percent of the employee’s wages, and the employee contributes 2 percent, in addition to a government contribution (Hougaard et al. 2008). A large number of private enterprises can also participate in this insurance system.

In connection with economic reforms, China’s health system went from an old-style system with the central government as owner, sponsor, and provider, to the current system, in which the central government’s role is much more limited

(Tang et al. 2008; Hougaard et al. 2008). The responsibility for financing the health care services was transferred almost entirely to the local government, and has resulted in substantial inequalities between rich urban areas and poor rural areas.

Over the past two decades, China's total spending on health has grown rapidly. According to the National Health Expenditure Study conducted by China National Health Economics Institute, China spent about 1,129 billion yuan on health in 2007 (China National Health Economics Institute 2008). However, the government spending contribution to the delivery of public health and basic health care services has been inadequate.

The total expenditure on the current health system, as well as the allocation between government, social, and personal health expenditure, are shown in Table 5. In 2007 the government covered only 20.4 percent of total health expenditure (local governments currently account for 90 percent of total government spending), while the people paid 45.2 percent directly out of their pockets and the health insurance share was 34.5 percent (MOH of China 2008). Reducing government financial support meant that the share of public financing was largely replaced by out-of-pocket spending. Also, the providers in the health sector were forced to earn profits, which resulted in a significant cost inflation and further inequality in access (Tang et al. 2008; Hu et al. 2008).

Table 5 Total Health Expenditure in China

	1980	1990	2000	2005	2007
Total health expenditure (100 million yuan)	143.2	747.4	4586.6	8659.9	11,289.5
Government health expenditure	51.9	187.3	709.5	1552.5	2297.1
Social health expenditure	61.0	293.1	1171.9	2586.4	3893.7
Personal health expenditure	30.3	267.0	2705.2	4521.0	5098.7
% of health expenditure	100.0	100.0	100.0	100.0	100.0
Government health expenditure	36.2	25.1	15.5	17.9	20.4
Social health expenditure	42.6	39.2	25.5	29.9	34.5
Personal health expenditure	21.2	35.7	59.0	52.2	45.2
% of GDP	3.15	4.00	4.62	4.73	4.52
Per-capita health expenditure (yuan)	14.5	65.4	361.9	662.3	854.4
Urban	...	158.8	813.7	1126.4	1480.1
Rural	...	38.8	214.7	315.8	348.5

Source: MOH of China (2008)

Moreover, health insurance coverage and financial protection of access to health care remains inadequate (Liu et al. 2005). Based on the two National Health Services Surveys conducted by the MOH of China in 1993 and 2003, the

percentage of the population with health insurance coverage varied from 53 percent in 1993 to 46 percent in 2003 in urban areas, and from 12 percent in 1993 to 21 percent in 2003 in rural areas (MOH of China 2004). Although there has been some increase in health insurance coverage under health security schemes, the extent of protection is often very limited. Reimbursement levels are low, and commonly needed outpatient services are often excluded from service benefit packages. This means that, despite being insured, patients still pay high medical costs from their own pockets (Hu et al. 2008; Liu and Mills 2002).

Problems in the Current Public Health Care System

It is clear that China's health care system faces many acute problems and serious future challenges. As providers focus on providing profitable, rather than cost-effective health services, overcharging, overdiagnosis, and the prescription of unnecessary medicines are common (Hu et al. 2008). As the purchasers of health care, patients are not in a strong position to judge the cost, efficiency, quality, and appropriateness of the care that they receive, because of their lack of knowledge and information (WHO 2008).

In 2000 the WHO ranked its 191-member nations on the overall performance of their health systems, and China was ranked 144 out of 191 countries (WHO 2000). Despite a relatively high ranking for levels of population health, China's system was deemed to be weak in the distribution of health and responsiveness, as well as in controlling the costs (Eggleston, Wang, Rao 2008). Cost inflation has been difficult to control, and as a result, the huge inequality in access seems to be even greater. Aside from these factors, the health system reform itself has made the people uncertain about their health rights. In addition, the lack of regulation exposes the system to more corruption, and hence has worsened the situation (Wang 2003). As a result, according to a recent report released by the Development Research Centre of the State Council, China's health system reform has been unsuccessful (Development Research Centre of the State Council of China and WHO 2005).

The Chinese central government is increasingly open in recognizing the problems posed by its health care system (*The Lancet* 2008; Wang 2005). However, even though the public system is constantly trying to adapt to population needs and improve its performance, there are many problems in public health care provision, such as limited access, low efficiency, poor quality, cost inflation, and low patient satisfaction. These problems are described in more detail in the following sections.

Limited access: China's current health system displays considerable inequities in utilization and outcomes between rural and urban areas, and across income groups. This system even excludes the poorest and most vulnerable groups, especially a large part of the rural population (Liu 2004; Tang et al. 2008). According to the third National Health Services Survey conducted by the MOH

of China in 2003, 36.4 percent of people who should have received medical care services in 1998 did not receive them; this figure rose to 48.9 percent in 2003. In particular for rural areas, this percentage was 63.7 percent in 1998 and rose to 75.4 percent in 2003 (MOH of China 2004). In reality, many people in need of health care services are left without the possibility of receiving help, even though they are covered by the public health system. This happens because considerable additional out-of-pocket expenses are required for receiving health care (Hu et al. 2008).

Low efficiency: In recent years, the number of providers has increased while their workload was fallen. Bed-occupancy rates are falling, especially in township hospitals where bed occupancy is very low (Eggleston, Li, Meng, et al. 2008; Wang 2003). Provider productivity is also falling in rural areas from a relatively low base. There is also evidence of waste in the use of high-tech equipment. Moreover, due to price regulation and lack of a well-functioning GP system, patients prefer to go to top-ranking hospitals. This preference produces long waiting lists at those hospitals, despite free capacity in lower-ranking hospitals. Furthermore, at all levels of government, investment seems to be focused on top-ranking hospitals, further exacerbating the problem (Hougaard et al. 2008).

Poor quality: The quality of health care services is also a matter of concern. It is widely accepted that the quality of public facilities in rural areas has deteriorated (Liu 2004; Blumenthal and Hsiao 2005). However, the quality of the large public city hospitals is more debatable. Many of these hospitals are now equipped with high-tech diagnostic and treatment medical devices, but improvements in overall patient services and hospital management have been very limited. Like many developing countries, China does not have a strong system for monitoring the quality of care. There is a great deal of evidence of unnecessary care being provided in China, especially with regard to the overprescription of drugs (Reynolds and McKee 2009).

Cost inflation: A further associated concern is the rapid cost increases in recent years. Health expenditure has risen much faster than people's income in China (Hu et al. 2008). Over the last ten years, these issues have made health care increasingly unaffordable for poor people. It is commonly known that there is a prevalent tendency for overtreating patients by using unnecessary drugs and high-technology tests (WHO 2008). Because of the lack of public funding, public hospitals are allowed to make a profit on certain high-tech treatments and drugs; hence, hospitals have incentives to shift activities into profit-yielding areas, creating substantial cost inflation. In addition, public hospitals operate under a regulated price. The prices for basic services are set below the average cost, with the initial intention to extend primary health care to all people. Yet the prices are set much higher than the average cost for high-tech treatments and some prescriptions (Hougaard et al. 2008). Such irrational pricing gives inappropriate incentives for public hospitals to overprescribe unnecessary and high-tech

procedures or high-priced prescriptions.

Low patient satisfaction: Today, people in China are typically distrustful of the health care system, and many patients have expressed their dissatisfaction about public hospitals' responsiveness to their expectations. Currently, most public hospitals are independent units in regard to financing, and the income of public hospitals basically comes from patient out-of-pocket expenses. That is, behaviorally, public hospitals are profit-driven rather than patient-driven. Also, it is well known that, to ensure good service, patients usually pay so-called red-bag money to doctors treating their case, and doctors furthermore obtain "rake-offs" from their prescriptions. Both red-bag money and rake-offs are examples of hospital management accepting the fact that doctors have the power to pursue their own interests (Hougaard et al. 2008). As a result, many people criticize public hospitals for operating as private for-profit hospitals despite the fact that they are still government-owned.

Hence, the low efficiency levels and incentive-driven approach of public hospitals push inflation and thereby aggravate the problem of limited access. It is somewhat ironic that price regulation ensuring cheap basic treatment, which was meant to promote access, seems to have had the opposite effect, due to anticipated provider incentives. In summary, the performance of the public health sector in China shows considerable room for improvement.

Discussion

As China is gradually transforming itself from a planned to a market economy, private ownership and competitive forces are already dominating the economic sector. However, health policies in China have mostly emphasized the development of government-owned health care services (Liu et al. 2005). People in China, whether in government or outside, still believe that health care is a part of the social welfare system and, therefore, that health care provision is the sole responsibility of the government.

However, with the current challenges in China, it is obvious that this increased demand cannot be met solely by public health care provision. At present, the health care system in China faces a dilemma: on the one hand, government resources are apparently insufficient and most public hospitals are in urgent need of investment; on the other hand, according to the current government policy, opportunities for private hospitals are limited (Hougaard et al. 2008; Huang et al. 2006). Now a major unaddressed challenge facing China is how to reform an inefficient, poorly organized health care delivery system (Blumenthal and Hsiao 2005). One proposed aspect of reform is the increase in the private-sector provision of health care services.

As previous sections have described, public hospitals provide most health care services in China. However, the current health care system is associated with

great inequities in utilization and outcomes between rural and urban areas, and across different income groups (Tang et al. 2008). This current system generally excludes the poorest and most vulnerable groups. In addition, there is a widespread phenomenon of overtreating patients and using too many unnecessary medicines and high-tech examinations (Eggleston, Li, Meng, et al. 2008; WHO 2008).

Returning to the question of whether to use private-sector provision, it is apparent that some international agencies (e.g., IMF and WB) promote reforms designed to decrease the level of government health care provision and at the same time to encourage the private sector. They suggest that public provision is inherently less efficient than provision through the private sector. In an economic sense, health care is not a pure public good, though most aspects of public health and environmental health are (Preker and Harding 2000). Theoretically, a market providing health care services and private provision would bring the advantages of competitive efficiency and consumer responsiveness. In addition, increasing private health care provision will free up limited government resources, which can be targeted to provide services for the poor.

However, the arguments for government involvement are based on the consideration that private health care provision would create various forms of market failure. But this does not necessarily mean that all health care services must be directly provided by the government. There is wide evidence of government failure to provide efficient and responsive public services. As Preker and Harding (2000) described, public monopolies demonstrate many negative characteristics: monopoly providers often decrease output and quality, while raising prices. Furthermore, monopoly providers have strong incentives to lower expenditures through decreased output when staff members benefit from the financial residuals.

Policymakers in China should recognize and examine the appropriate role of private health care provision, and especially private hospitals. The relationship between the public and private sectors need not be adversarial. Many countries, such as Australia, the United Kingdom, and Sweden, have successfully demonstrated that the public sector can treat the private sector as a partner in the health systems, with whom they cooperate to improve the access, efficiency, and quality of health care (Australian Private Hospitals Association 2008; Mason 2008; Doyle and Bull 2000). In reality, China does not need to privatize all public hospitals, but only to allow a certain proportion of private hospitals to exist. These private hospitals can then compete with one another and with public hospitals (Chow 2006).

Additionally, policymakers should include the private health sector in regional health planning. It might be necessary for the government to scale down or withdraw the public health sector from some areas, such as urban hospitals, that can be well served by the private sector. Then the freed-up resources could be redistributed to reach the poor and underserved rural areas. Of course, due to

the great difference among the regions in China, the pace of development of the private health sector should consider the prevailing local conditions, particular health needs, and readiness for change (Lim et al. 2002).

It is important to note that the suggestions outlined here do not imply a privatization of China's health system. This system, at least in rural areas, is already highly privatized (Blumenthal and Hsiao 2005). The collapse of the public sector has led to the emergence of a disorganized and unregulated private sector in rural areas. When examined in detail, it is evident that the quality of care offered by many private providers is poor. Furthermore, poor people more often use less qualified or totally untrained private providers than do the rich (Lim et al. 2004b). What may be required in rural areas is not necessarily more private health care provision, but better-quality health care provision overall. Regulation is perhaps the most important job among the government's responsibilities for ensuring quality.

Conclusion

It is clear that in China, the increased demands placed on the health system cannot be met solely by the public health sector. Collaboration between the public and private health sectors is likely to provide a better health care service or to better meet the health care needs. Therefore, it is timely for the Chinese government to develop policy and legislative frameworks that shape public-private partnerships.

A better understanding of the role of private health care provision would have important implications for developing policies that could help the private providers achieve quality, equity, and efficiency goals in the health sector, while avoiding the potential pitfalls of market failures. Policymakers should consider the health system as a whole and increase their efforts to work with the private health sector as an integral means of achieving health sector goals, such as improved access and efficiency for the unquestionably large and growing population.

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