

**Using Ethical and Legal Analysis
to Better Shape China's Healthcare System Reform**

De inzet van ethische en juridische analyses
om de hervorming van het Chinese zorgstelsel beter gestalte te kunnen geven

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Chapter 1

General introduction



1.1 PROBLEM STATEMENT

1.1.1 The starting point of thought: the ‘trolley dilemma’

The famous ‘trolley dilemma’ was first introduced by Philippa Foot (1967) and then extended by Judith Thomson (1976, 1985) as follows:

A trolley is running on the railway. Ahead of the trolley, there are merely two directions (or tracks): five skilled workers are working on one direction while one skilled worker is working on the other direction. The trolley by schedule should be headed down the track where five men are, but if someone pulls the lever, the trolley will be headed down the track where the one man is. Supposing that the trolley could not stop and you were next to that lever, what would you do and what is the right action?

The choice you made, either pulling the lever or not, could be justified by fairly persuasive arguments from two classic ethical theories: Consequentialism and Deontology (e.g. Kantianism¹). The debate between these two distinct schools of thoughts is long and historical, which has greatly affected the kind of public policies that governments enact (Table 1.1).

Table 1.1 Two paths to right action and implications for public policy

Two paths	Trolley dilemma	Basic points	Implications for public policy
Consequentialism	Pull the lever to generate a greater positive effect on society	Value the consequences of acts Pursue ‘the greatest good for the greatest number’ (Mill, 1863)	A policy can be justified if, all things considered, it promotes the overall goal of maximising the utility In some cases, the interests of the minority may be given less weight
Kantianism	Not pull the lever regardless of how appealing the results might be	Some acts are intuitively right while some are intuitively wrong People are ends-in-themselves and should not be treated as merely means to ends	Respecting and protecting human rights should be the basis grounding all kinds of public policy The interests, goals and values of every individual human being deserve to be equally respected

Consequentialism values the consequences of acts and treats intentions as irrelevant. The paradigm case of consequentialism is utilitarianism. In the eye of utilitarian, pulling the lever is the right thing to do because it is a way of maximising the utility, that is, saving five lives rather than merely one life is likely to generate a greater positive effect on society. Reflected in public policies, if implementing certain policies could benefit the majority of the society,

1 Deontology is an ethical theory that focuses on assessing the rightness or wrongness of choices themselves, rather than the consequences of choices. Immanuel Kant’s moral philosophy is considered a deontological theory. For detailed introduction of deontology, please refer to Stanford Encyclopedia of Philosophy via <https://plato.stanford.edu/entries/ethics-deontological/#DeoTheKan> (last accessed 24 March 2019).

it is morally permissible to ignore or even sacrifice the welfare of the minority. From this perspective, public policies should be designed and implemented with the aim of producing ‘the greatest good for the greatest number’ (Mill, 1863).

Kantianism criticises consequentialism by stating that the welfare of the minority is equally important because people are ends-in-themselves and should not be treated as merely means to ends. To treat people as ends-in-themselves means to recognise the humanity of them, that is, to realise that every individual human being has his or her own goals, values and interests that deserve to be equally respected. Furthermore, according to Kant, telling the rightness from the wrongness of an action is to assess whether this action conforms to the universal moral law (i.e. a *categorical imperative*²). Kant (1785, p. 37) argued that “act only in accordance with that maxim through which you can at the same time will that it should become a universal law.” Accordingly, Kant would be highly unlikely to pull the lever regardless of how appealing the result might be because he would not wish ‘pull the lever’ to be a *categorical imperative* followed by people when they have to make this trade-off. Reflected in public policies, respecting the autonomy and rationality of human beings should always be the fundamental principle of policymaking no matter what the policy is about.

Seemingly, there is no single right answer to the trolley dilemma because the arguments given above have their own merits with different priority settings for public policy: either pursuing ‘the greatest good for the greatest number’ (Mill, 1863) or prioritising the autonomy and rationality of each individual human being. Actually, these priorities are at the two extremes of the spectrum of desirable policy goals, neither of which can be regarded as a policy panacea because of the changing conditions influenced by diverse socio-economic and cultural factors. Yet, it is this uncertainty that leaves us with an interesting question to be considered:

In a given context, how do we achieve an optimal balance between protecting individual rights and benefiting the overall population in the long run, when hard choices are inescapable?

1.1.2 The trolley dilemma in healthcare

Healthcare is an important public policy issue in which tough questions are often raised in a close relationship with the trolley dilemma and its modifications. For instance, Leonard Fleck (2009, p. 72) once referred to the trolley dilemma when he argued about the inescapability of healthcare rationing:

“This case (i.e. the ‘trolley dilemma’) does present well at least one dimension of health-care rationing – namely, the inescapability of the need to make rationing decisions with life and death consequences for different individuals or different groups of individuals.”

2 “The categorical imperative would be that one which represented an action as objectively necessary for itself, without any reference to another end.” Kant I. (1785). p. 31.

Interpreting Fleck's argument, it is impossible to satisfy the healthcare needs of every individual patient, especially when it relates to some limited healthcare resources such as ICU beds and artificial hearts. Put differently, there exists an inevitable conflict between protecting individual rights (e.g. satisfying the unlimited patient needs) and sustaining healthcare resources when taking the scarcity of healthcare resources into account. Thus, the interesting question raised in the above section can be modified as follows:

Given that healthcare resources are often limited, how do you achieve an optimal balance between protecting individual rights (e.g. satisfying patient needs) and sustaining healthcare resources?

Or

Given that healthcare resources are often limited, how should the conflict between the protection of individual rights (e.g. satisfying patient needs) and the sustainability of healthcare resources be mitigated?

This is precisely the fundamental problem at stake that underlies this thesis.

1.2 TWO PROBLEM-SOLVING PERSPECTIVES: PERSONAL RESPONSIBILITY AND STATE ACCOUNTABILITY

From all relevant studies on dealing with the problem raised above, scholarly literature largely builds arguments on addressing state accountability in protecting and promoting individual right to health – namely, securing the ‘accessibility, acceptability, availability and quality (AAAQ)’³ of healthcare resources for patients. The rationale underlying this argument is the pricelessness of human life. Needless to say, limiting a patient's access to certain medical services is counterintuitive when it relates to a concrete single case. However, such behaviour may become acceptable if we take a systematic point of view because sustainability, as another key consideration, will come into play.

In the field of health and healthcare where individuals have great control over their own health,⁴ encouraging every individual human being to play a more active role in taking care of their own health – namely, to be more responsible for one's own health – is likely to be a plausible way to respond to the sustainability concern. In this regard, not only can

3 For more information about AAAQ, please refer to <https://www.who.int/gender-equity-rights/knowledge/AAAQ.pdf?ua=1> (last accessed 24 March, 2019)

4 Scholarly literature has proved that there exists a causal relationship between disfavoured habits (e.g. excessive smoking, eating disorders and alcoholism) and several chronic diseases (e.g. cardiovascular diseases, lung cancer, and overweight). For detailed discussion, please refer to Watson and Conte (1954); Rehm et al. (2009); Brownell and Walsh (2017).

the health condition of every individual human being benefit from responsible individual behaviour but also, it will in turn contribute to the sustainability of healthcare resources. Thus, addressing personal responsibility in protecting and promoting one's own health has been raised as another problem-solving perspective.

Hitherto, two problem-solving perspectives that are often used to mitigate the conflict between protecting individual rights and sustaining healthcare resources have been mentioned. In order to provide a deeper understanding, relevant studies concerning personal responsibility and state accountability are discussed separately below.

1.2.1 Personal responsibility

By and large, personal responsibility means letting people be responsible for their own choices. In health and healthcare, it can be identified in many ways and it is important to acknowledge that different ways of identifying personal responsibility will result in different, or even conflicting, reform strategies for promoting the healthcare system. That is, if one considered personal responsibility in health and healthcare as an excuse to blame or punish patients, then reform strategies would turn to limiting, rather than increasing, the accessibility of healthcare. On the contrary, if one identified the core value of personal responsibility in health and healthcare as taking good care of one's own health, such as developing a healthy lifestyle and being active in preventive healthcare, then reform strategies would be more likely to reflect the common conceptual basis of a decent society that we owe to each other in matters of healthcare distribution.

Thus, throughout this thesis, personal responsibility in health and healthcare is identified as follows: *people should play a positive role in managing their own health*. In the Chapter 3 of this thesis, a specific interpretation on what constitutes 'a positive role' is provided.⁵

In practice, reform strategies addressing personal responsibility for health have already been taken by some countries; for instance, the bonus policy in the German healthcare system (Schmidt, 2008), and the West Virginia Medicaid State Plan in the United States (Steinbrook, 2006). Behind these reform measures, there are several philosophical foundations, including liberal egalitarianism, luck egalitarianism and communitarianism.⁶ How to justify the role of personal responsibility in healthcare distribution is a key question attracting attention from these philosophical traditions.

From the perspective of liberal egalitarianism, people should be held accountable for their health-related choices, but not necessarily the consequences of their choices (Cappelen & Norheim, 2005, p. 478). According to liberal egalitarianisms, health policy should take two principles into account: holding people accountable for their own choices (i.e. 'the principle

⁵ Please refer to page 67 of this thesis.

⁶ Chapter 2 of this thesis includes a detailed introduction of each theory of justice and their potential implementations for reform policies. Please refer to page 55 of this thesis.

of responsibility') and people who make the same choices should be treated equally regardless of the resulting consequences (i.e. 'the principle of equalisation') (Cappelen & Norheim, 2005, p. 478). The reason why liberal egalitarianism separates choices from consequences is that they believe the same choices may not lead to the same consequences. For instance, the chance of developing lung cancer may be increased by excessive smoking. If A and B are both highly addicted to cigarettes but only B develops lung cancer and needs healthcare badly, liberal egalitarianism would argue that a just healthcare system should hold A and B accountable for their excessive smoking behaviour but not for the consequences (i.e. A is healthy but B has lung cancer). With regard to policy implications, liberal egalitarianism is in favour of using the tax mechanism to hold people accountable for their health-related choices (Cappelen & Norheim, 2005, p. 479). Reflected in the case above, imposing progressive taxation on cigarettes is a recommended way to hold A and B to be responsible for their choice to smoke.

Whether choices are free or not is the core value of luck egalitarianism. Applied in health and healthcare, its basic standpoint implies that a just healthcare system cannot let people be responsible for inequalities caused by factors that are out of their control (Segall, 2009). That is, limiting people's access to healthcare can be justified if people's unhealthy condition resulted from their 'option luck'⁷ (e.g. lifestyle choices). For those people, luck egalitarianism argues that health insurance is a way to protect themselves from bad consequences (Dworkin, 1978).

Different from the above two theories of justice, communitarianism values the common good of the society (Ezioni, 2010). People need to contribute to foster common good by taking responsibility for their own health (Callahan, 2003, p. 496). Communitarianism does not care about the diversity of healthcare needs (Houtepen & Ter Meulen, 2000, p. 360). Accordingly, weighting public health over healthcare for rare diseases is justified in the eye of communitarianism.

Overall, personal responsibility in health and healthcare, if suitably interpreted, should be adopted as a key consideration in balancing individual interests (or rights) and the sustainability of healthcare resources.

1.2.2 State accountability

Drawn from literature, addressing state accountability is another perspective that is employed fairly often in discussions concerning how to achieve an optimal balance between protecting individual rights and sustaining healthcare resources. Roughly, there are two prominent aspects guiding the majority of discussions.

⁷ Ronald Dworkin distinguished 'brute luck' and 'option luck'. For a detailed introduction, please refer to Chapter 2 of this thesis on pp. 53-54. Also, please refer to Dworkin (2000), p. 73.

Social determinants of health

Given that in certain situations where individual patient's access to healthcare is impeded by factors that are out of their control (Figure 1.1), it is reasonable to assign responsibility to the state for the sake of empowering people to claim their denied medical needs and other dissatisfactions.

Apparently, not all determinants demonstrated by Figure 1.1 can be controlled by the state, for instance, the individual lifestyle factors. Nevertheless, the state is still assigned with a major responsibility to correct the injustice of some structural determinants, such as 'poor social policies and programmes, unfair economic arrangements, and bad politics' (Commission on Social Determinants of Health 2008, p. 26).

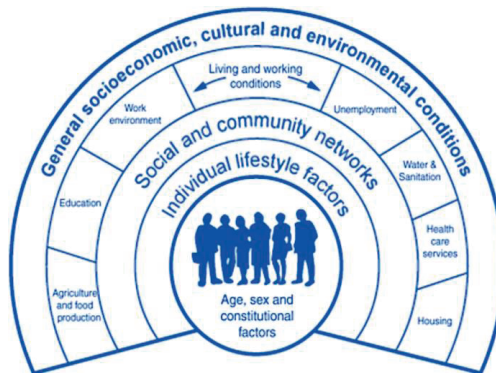


Figure 1.1 The main determinants of health
Source: Dahlgren & Whitehead (1991), p. 11.

The social determinants of health (SDH) are often argued as key factors causing health inequalities (Sage, 2017, p. 10). Defined by the World Health Organization (WHO, 2008), SDH are the conditions 'in which people are born, grow up, live, work and age, and the systems put in place to deal with illness.'⁸ In real-life situations, SDH are not always the same but de facto shaped differently within and between countries due to a wide range of forces (Box 1.1) and the interactions between those forces.

Box 1.1 The solid facts (driving forces underlie SDH)

In the booklet, *Social Determinants of Health: The Solid Facts* (Richard Wilkinson and Michael Marmot eds., 2nd ed., 2003), ten solid facts that greatly impact SDH have been summarised: (1) the social gradient; (2) stress; (3) early life; (4) social exclusion; (5) work; (6) unemployment; (7) social support; (8) addiction; (9) food; (10) transport.

8 Retrieved from https://www.who.int/social_determinants/thecommission/finalreport/en/ (last accessed 24 March 2019). For more information on the social determinants of health, please refer to http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/ (last accessed 24 March 2019)

Uncovering these solid facts helps to develop a richer understanding of SDH and thereby suggests clear directions for addressing state accountability in healthcare (Marmot, 2005).

Health and human rights

Addressing state accountability plays a central role in the widely employed human rights-based approach to health (Potts & Hunt, 2008, p. 7; Yamin, 2008). According to this human rights-based approach, all health policies must integrate – or at least answer to – the principles of human rights (i.e. ‘universal and inalienable’, ‘interdependent and indivisible’, ‘equal and non-discriminatory’, and ‘both rights and obligations’).⁹ The close relationship between health policies and human rights principles can be best justified by the treaties and instruments of international human rights law. Among these documents, Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR, Box 1.2) and its General Comment No. 14 clearly stipulate that ‘States Parties to the present Covenant’ should be assigned with prime duties in protecting and promoting the health of its citizens – namely, to respect, protect and fulfil the right to health in line with the AAAQ standards for its citizens.

In most cases, states have committed to achieving AAAQ standards through implementing policies on expanding accessibility (e.g. achieving the goal of universal health coverage) and improving the quality of healthcare (e.g. the goal of ‘building high-quality and value-based service delivery’¹⁰). Some countries, such as Costa Rica, even adopt health rights litigation and let the Supreme Court play a key role in assuring more fairness in access to healthcare for people (Norheim & Wilson, 2014).

Box 1.2 Article 12 of ICESCR: The Right to Health

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

9 Retrieved from <https://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx> (Last accessed 24 March 2019)

10 ‘Building high-quality and value-based service delivery’ is the goal of deepening healthcare system reform in China. For detailed information, please refer to Healthy China: deepening health reform in China. Retrieved from <http://www.wpro.who.int/china/publications/2016-health-reform-in-china/en/> (last accessed 24 March 2019).

Overall, studies either addressing personal responsibility or in favour of state accountability all seem to be plausible and have convincing arguments. However, I agree with what Martha Nussbaum once put, ‘a good analysis will attend both to personal and to structural factors’ (Nussbaum, 2011, p. xii). Thus, for the question concerned, the state should be assigned ‘a certain degree of responsibility’ (Schmidt, 2008, p. 200; Schmidt, 2016, p. 219) in securing the health of its citizens while citizens, in return, should also take personal responsibility seriously. Holding a similar standpoint, this thesis is designed to give equal weight to personal responsibility and state accountability in exploring the problem at stake.

1.3 SETTING THE CONTEXT: HEALTHCARE IN CHINA AT A GLANCE

1.3.1 General background

China is a populous nation with 1.379 billion people living in mainland China in 2016.¹¹ The average life expectancy at birth was 76.09 years in 2015, which showed a tremendous increase compared with 1949 (i.e. average 35 years).¹² As a rapid ageing nation, nearly 10% of the general population was older than 65 years in 2016 which is expected to increase to 18.2% by the year 2030.¹³ Furthermore, the ratio of urban/rural residents changed from 1: 2.3 in 1993 to 1: 1.43 in 2016 along with urbanisation and industrialisation.¹⁴

The above factors and their interactions together contribute to a significant change of the disease spectrum in China: from communicable diseases to non-communicable diseases (NCDs). Data for 2012 demonstrate that cardiovascular diseases, diabetes, cancer, chronic respiratory diseases and other kinds of NCDs accounted for approximately 85% of all deaths and 70% of the total disease burden.¹⁵ As a consequence, the Chinese healthcare system, especially the scope and content of health services and the method of delivery, needs to be reformed in order to meet the changing health needs.

1.3.2 The Chinese healthcare system

Generally, there are three essential dimensions of the Chinese healthcare system: delivery, financing and supervision (Meng et al., 2015, p. 14). In this section, these three dimensions will be briefly introduced through discussions on healthcare delivery system, health insurance schemes, and health governance and legislation.

11 Data source from the World Bank, please refer to https://data.worldbank.org/indicator/sp.pop.totl?end=2016&name_desc=false&start=1960 (last accessed 24 March 2019).

12 Data source from the World Bank, please refer to <https://data.worldbank.org/indicator/sp.dyn.le00.in?end=2015&start=1960> (last accessed 24 March 2019).

13 Please refer to <http://www.sic.gov.cn/News/455/5900.htm> (in Chinese, last accessed 24 March 2019).

14 Please refer to http://www.stats.gov.cn/tjsj/sjjd/201702/t20170228_1467357.html (in Chinese, last accessed 24 March 2019).

15 Ministry of Health, *China National Plan for NCD Prevention and Treatment (2012-2015)*, retrieved from http://www.chinacdc.cn/en/ne/201207/t20120725_64430.html (last accessed 24 March 2019).

Healthcare delivery system

In China, the healthcare delivery system has been established with a three-tier structure (Figure 1.2). Patients are allowed to choose from those medical institutions for healthcare (i.e. both outpatient and inpatient services) freely which means there is no mandatory gatekeeping in healthcare in China. Although lower level medical institutions are designed to undertake primary medical services (e.g. ‘health education, prevention, rehabilitation, family planning, and treatments for common diseases’¹⁶) for people, they do not play a gatekeeping role in healthcare delivery in China (Meng et al., 2015, p. 203).

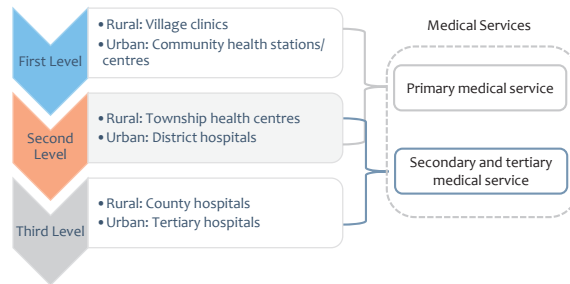


Figure 1.2 Three-tier structure and medical services on three levels

Source: Meng Q., Yang H., Chen W., Sun Q., & Liu X. (2015). People’s Republic of China: health system review. *Health Systems in Transition*, 5(7): 1-246. p. 133.

With regard to patient pathways, they are likely to choose medical institutions on lower levels as their first contact for diseases even though they are aware that the higher the level of the medical institution, the better facilities it will have. Furthermore, data show that there has been no big change in this preference from 2008 to 2013 (Figure 1.3).

However, medical institutions on the lower level, especially village clinics and community health stations, generally fall short of advanced medical facilities and qualified healthcare professionals. Such deficiency results in an awkward situation where healthcare services are indeed easy to access but the quality of services cannot be guaranteed. In some cases, patients have to go to higher level medical institutions for their unhealed diseases. Due to a poor referral system, patients often need to take certain medical tests for a second time in order to provide reliable information for doctors’ new diagnosis. During that period, not only will patients suffer more from extra medical tests and aggravated diseases but also, they will have to pay a higher medical bill with out-of-pocket money. The weak primary medical services and the poor referral system generate far-reaching consequences for healthcare in China

16 Examples of primary medical services are summarized by Meng et al., 2015, p. 20. Retrieved from https://iris.wpro.who.int/bitstream/handle/10665.1/11408/9789290617280_?jsessionid=6F183D3886BA2F4E81B8A9996E64F036?sequence=1 (last accessed 24 March 2019)

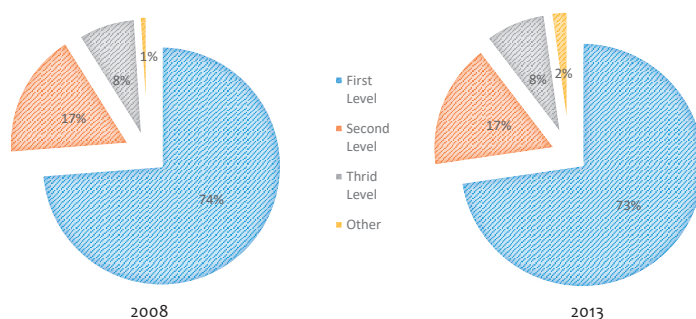


Figure 1.3 First contact medical service (2008 vs. 2013)

Source: Developed by the author with data from the 5th National Health Service Survey in 2013 (Centre for Health Statistics and Information, 2013 p. 39)

which are well expressed by a short phrase: ‘看病难，看病贵’ (to see a doctor is difficult, to see a doctor is expensive).

Another issue that cannot be overlooked is the rapidly growing private sector in healthcare in China. By the end of 2016, the number of private medical institutions (PMIs) was increased to 16,432 which accounted for 56.39% of all medical institutions. Although the average size of PMIs is relatively small in China, they still took care of approximately 12.8% of total patient visits in 2016 (Meng et al., 2015, p. 112). The increasing involvement of the private sector in healthcare in China not only will make the healthcare delivery system more efficient, but it will also contribute to diversifying health services and thereby expanding the accessibility of medical services and protecting patient rights. Nevertheless, negative effects will also be generated if countries lack related advanced technical and administrative capacity (Roberts et al., 2008, p. 254).

Health insurance schemes

In China, health insurance schemes are roughly divided into social insurance schemes and private insurance schemes. Social insurance schemes include three basic types: Urban Employee Basic Medical Insurance (UEBMI), Urban Resident Basic Medical Insurance (URBMI), and New Rural Cooperative Medical Scheme (NRCMS). Easily observed from their names, enrolling in which insurance scheme is mainly based on the registered residence of people and their status of employment. Furthermore, UEBMI requires mandatory enrolment. URBMI, NRCMS and private insurance are voluntary insurance schemes. Contributions to social insurance schemes are designed differently in China. For example, UEBMI is relying on the employee and the employer; the contribution to URBMI is mainly made by individuals with limited government subsidies; NRCMS is financed by individuals, collectives and government (Meng et al., 2015, p. 86).

By the end of 2015, over 95% of the general population had been protected by one of these three social insurance schemes in China.¹⁷ Staying over 95% coverage contributes greatly to protecting and promoting the right to health, especially in terms of expanding the accessibility of healthcare by making services affordable for patients in China.¹⁸

Nevertheless, difficult issues still exist, such as the reimbursement problem of seeking healthcare in places other than the patients' place of residence. For example, taking migrant workers,¹⁹ they are rural residents but working in the urban areas of China. Due to their registered place of residence, they can only enrol in NRCMS which may limit their access to healthcare in their working places for two reasons: (1) NRCMS has a relatively lower benefit coverage than URBMI and UEBMI; (2) migrant workers have to go back to their place of residence to get reimbursement (Yu, 2015, p. 1149). Such reimbursement problems do not merely block migrate workers' access to healthcare; people who want to seek better healthcare in a place other than their place of residence will also have to face this difficult issue. In most cases they have no choice but to bear unaffordable, out-of-pocket medical costs, which ultimately bankrupts many families in China.

Health governance and legislation

In China, healthcare is governed by a complex set of policies, government agencies (central and local) and legislation.

On the state level, healthcare issues are mainly administrated by the National Health and Family Planning Commission (NHFPC) and the State Administration of Traditional Chinese Medicine (SATCM). On the provincial level, city level, and county/district level, these two governance bodies have their own affiliations to assume and fulfil their responsibilities (Meng et al., 2015, p. 21). Other departments of government, such as the Food and Drug Administration (FDA), the Ministry of Education (MOE), the Ministry of Finance (MOF), the Ministry of Human Resource and Social Security (MOHRSS), and the National Development and Reform Commission (NDRC), are assigned with their own responsibility in relation to healthcare (Meng et al., 2015, p. 21).

17 Please refer to http://www.mohrss.gov.cn/SYrlzyhshbzb/dongtaixinwen/bunciyaowen/201612/t20161214_261978.html (in Chinese, last accessed 24 March 2019)

18 World Bank Group, World Health Organization, Ministry of Finance, National Health and Family Planning Commission, Ministry of Human Resources and Social Security. (2016). *Deepening Health Reform in China: Building High-Quality and Value-Based Service Delivery*. p. xxvi. Please refer to <https://openknowledge.worldbank.org/bitstream/handle/10986/24720/HealthReformInChina.pdf> (Last accessed 24 March 2019)

19 In 2016, China had over 281 million migrant workers (National Bureau of Statistics, 2016). Data is available online, please refer to http://www.stats.gov.cn/tjsj/zxfb/201704/t20170428_1489334.html (in Chinese, last accessed 24 March 2019).

Table 1.2 Special health laws in China

Laws	Date of Issued and Effective	Concerns
Frontier Health and Quarantine Law (2009 Amendment)	Issued and Effective: 27/08/2009	Public Health
Law on Maternal and Infant Health Care	Issued: 27/10/1994; Effective: 27/08/2009	Women and Children
Law on Population and Family Planning (2015 Amendment)	Issued and Effective: 27/12/2015	Public Health and Reproductive Rights
Law on Prevention and Treatment of Infectious Diseases (2013 Amendment)	Issued and Effective: 29/06/2013	Public Health
Law on the Prevention and Control of Occupational Diseases (2011 Amendment)	Issued and Effective: 31/12/2011	Public Health and Occupational Health
Law on Traditional Chinese Medicine	Issued: 25/12/2016; Effective: 01/07/2017	TCM
Law on Practicing Doctors of the PRC (2009 Revision)	Issued and Effective: 6/26/1998	Medical Professionals
Law on Blood Donation	Issued: 29/12/1997; Effective: 01/10/1998	Public Health
Law on the Red Cross Society (2009 Amendment)	Issued and Effective: 27/08/2009	Humanitarian and Public Health
Mental Health Law	Issued: 26/12/2012; Effective: 01/05/2013	Mental Health
Pharmaceutical Administration Law (2015 Amendment)	Issued and Effective: 24/04/2015	Drug

Source: Developed by the author with data from pkulaw, please refer to <http://en.pkulaw.cn/>

Similar to many other countries, China has not yet enacted an ‘umbrella’ health law (Meng et al., 2015, p. 18). Nevertheless, there were eleven special health laws in China by 2017 (Table 1.2). Besides these special health laws, other health-related legislations are stipulated in legal fields such as administrative law, contract law or even criminal law, which implies a characteristic of fragmentation of effective health-related legal rules. Lawmakers in China are now drafting an ‘umbrella health law’²⁰ to connect the Constitution; eleven special health laws, and health-related legislations in other legal fields.

1.3.3 Other considerations

Other considerations, especially cultural and political contexts, have a particular relevance to healthcare because they demonstrate the uniqueness of healthcare in certain countries. Therefore, those cultural and political considerations cannot be downplayed or overlooked when studying the Chinese healthcare system.

20 The ‘umbrella health law’ is named as ‘Basic Healthcare and Health Promotion Law of People’s Republic of China’. It is still in its ‘drafting, discussing, and revising’ process. The first draft was discussed on December 2017 and the second draft was discussed on August 2018. For more information, please refer to http://www.npc.gov.cn/npc/lftz/rlyw/node_33534.htm (in Chinese, last accessed 24 March 2019)

Confucian tradition and Chinese bioethics

Confucian ethical tradition attaches great importance to the virtue of ‘仁’ (benevolence) and ‘孝’ (filial piety).²¹ From a Confucian viewpoint, the individual human being is incomplete without belonging to a family (Chen & Fan, 2010, p. 577). Confucian societies (e.g. Singapore and China) therefore value close family ties and attach great importance to the role of the family when drafting social policies (Wong et al., 2009, p. 53). To a large extent, this viewpoint decides the family-based character of the healthcare system in these societies, such as emphasising the role of the family in healthcare decision-making.

Decentralised reform on administrative system

Due to three waves of decentralisation reform in China (1958, 1970 and 1978), the administrative powers of central government have been gradually transferred to local governments and specific government agencies for the sake of maximising overall social welfare and satisfying the diverse sets of preferences of local people (Feng, 2016, pp. 13–14). As a consequence, health policies formed by central government are often enforced unevenly across local communities, which inevitably raises several concerns such as the vulnerability of local governments (e.g. local interest groups and private capital investment may greatly influence the autonomy of local governments in fully enforcing health policies) and the enhanced inequity in healthcare (Collins & Green, 1994, p. 465).

Household registration system

The household registration system (户口, *hukou*) has been in operation since 1949 for the administration of China’s residents. People born legally in China acquire a personal registration card (*hukou* page) to be added to a household registration record (*hukou* booklet). The household registration record is issued per family; it thus certifies not only the legal residence of a citizen, but, more importantly, the relationships between family members. At the very beginning, the household registration record was designed to identify an individual as a permanent resident of a specific place, either rural (agricultural household registration record) or urban (non-agricultural household registration record). Therefore, it exerts a significant influence on access to social benefits, such as education and healthcare (Qiu, 2014, p. 113). However, the impacts of urban-rural differences regarding registered residence has been partially eliminated since the implementation of the Guiding Opinion of the State Council on Deepening the Reform of the Household Registration System in 2014.²² Following the Guiding Opinion, the reform focused on the innovation of population management by abolishing classification of the agricultural and non-agricultural household registration records. The ongoing reform of the household registration system is believed to bring more fairness to the Chinese healthcare system.

21 For the English translation of those basic virtues of Confucianism, please refer to Runes (1983), p. 338.

22 The State Council (2014). Guiding Opinion of State Council on Deepening the Reform of the Household Registration System, para. 9. Please refer to http://www.gov.cn/zhengce/content/2014-07/30/content_8944.htm (in Chinese, last accessed 24 March 2019).

1.4 RESEARCH QUESTION AND SUBQUESTIONS

The general aim of this thesis is to develop proper strategies for balancing the protection of individual rights (e.g. satisfying patient needs) and the sustainability of healthcare resources in the context of Chinese healthcare system reforms. Special attention is given to drawing a fair ‘cut’ between personal responsibility and state accountability in order to make the reforms of the Chinese healthcare system more effective. Therefore, the central question of this thesis is designed as follows:

In the context of Chinese healthcare system reforms, how should the conflict between the protection of individual rights (e.g. satisfying patient needs) and the sustainability of healthcare resources from ethical and legal perspectives be mitigated?

In order to address and answer this central question, I formulate five subquestions that can be mainly categorised into two major dimensions (i.e. personal responsibility and structural injustice) and three concrete topics (i.e. patient empowerment, healthcare delivery model and a supportive environment). These five subquestions will be explored and answered respectively by five independent but interrelated papers which are also in Chapters 2–6 of this thesis. The first two subquestions are mainly framed from the perspective of addressing personal responsibility in healthcare in China, while questions 3 to 5 are framed with a special concern given to the role of the state in correcting structural injustice in healthcare in China.

Given that healthcare systems worldwide are currently experiencing more pressure posed by the ageing population and the increasing burden of non-communicable diseases (e.g. chronic diseases),²³ reform strategies (e.g. the WHO framework on integrated people-centred health services²⁴) tend to suggest that policymakers should pay more attention to the role of personal responsibility in healthcare. Yet, what is personal responsibility in healthcare? How do we address personal responsibility properly to make healthcare reforms more effective in a given context? In order to address these concerns, the first two subquestions have been framed as follows:

Q 1. To what extent should personal responsibility be addressed in advancing the reform of the Chinese healthcare system?

23 World Bank Group, World Health Organization, China’s Ministry of Finance, National Health and Family Planning Commission, and Ministry of Human Resources and Social Security. Healthy China: deepening health reform in China, at xv–xvi. Please refer to <http://www.wpro.who.int/china/publications/2016-health-reform-in-china/en/> (last accessed 24 March 2019).

24 For more information about integrated people-centered health services, please refer to <http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/> (last accessed 24 March 2019).

Q 2. How do we place patient personal responsibility fairly in healthcare in China to make the reform measures (i.e. measures derived from the people-centred integrated care (PCIC) model) more effective?

Before governments embark on any restructure of healthcare systems, especially implementing market-oriented reform measures, questions such as whether those new health measures would actually benefit people's health and whether they are formulated in line with existing priorities (e.g. the principle of solidarity and the goal of universal health coverage) need to be carefully addressed (Rosenblatt, 1981, p. 1067). In China, introducing GP services to strengthen primary healthcare is one of those measures. Therefore, the following question has been framed:

Q 3. Will the implementation of general practitioner (GP) services strengthen China's primary healthcare delivery and how do we structure regulatory interventions to secure the successful nationwide implementation of GP services?

For the sake of driving more efficiency in delivering healthcare and preventing the inherent coercion of certain public policies, market-oriented measures are gradually introduced to healthcare systems worldwide (Enthoven, 2002). Even countries with robust public healthcare systems (e.g. the Canadian healthcare system) tend to encourage more private sector involvement in healthcare. In China, despite the fact that the public sector (i.e. public hospitals) accounts for roughly 90% of health services, the private sector (i.e. both for-profit and not-for-profit medical institutions) have increased rapidly since 2009 along with achieving the goal of universal health coverage (Yip et al., 2012, p. 379). Nevertheless, promoting private sector involvement in healthcare shall not endanger other existing values, such as solidarity and universal health coverage (Cortez, 2011, p. 360). Therefore, the following question has been framed:

Q 4. To what extent does privatisation impact healthcare in China and how does the state fulfil its role in measuring the rapid growth of private medical institutions (especially using legal/regulatory measures) from a human rights perspective?

Preconditions for an effective nationwide implementation of new health policies should at least include a sound legal/regulatory framework (Sage, 2017, p. 19). Furthermore, adhering to the 'rule of law' requires using legislation to ensure the consistency and coherence of guidance on implementing policy priorities. In China, the 13th five-year plan for healthcare sets the integration of healthcare delivery and the consolidation of three health insurance schemes as reform priorities (Li & Fu, 2017). However, health law in China has a characteristic of fragmentation, which is not likely to conform with these integrated-oriented reform priorities and may ultimately create obstacles reducing the effectiveness of reform policies. From this concern, the following question has been framed:

Q 5. To what extent is the performance of the Chinese healthcare system tied to China's health law and how do we form a coherent health law that will best meet China's new health reform initiatives?

1.5 METHODOLOGY

This methodology section briefly outlines research materials and methods used by this thesis for exploring the central question and subquestions raised above.

1.5.1 Research materials

Research materials used by this thesis can be roughly categorised into three main kinds: legal texts, statistical data, and monographs and scientific literature.

Legal texts refer not merely to laws and regulations on local, national and international levels that are relevant to health and healthcare, but also include certain case law. A vast array of laws and regulations on the domestic level was searched for via pkulaw (北大法宝)²⁵ which is a database of Chinese law. With regard to the international level, relevant sources are, to a large extent, directly available online to the public (e.g. International Covenant on Economic, Cultural, and Social Rights (ICESCR), International Covenant on Civil and Political Rights (ICCPR)). A systematic but brief review of these legal texts was performed to ground the basis of one essential segment of this thesis (Chapter 6). For the sake of simplifying arguments, case law is also employed in certain parts of this thesis. Relevant materials are collected from searching the HUDOC database²⁶ which is published by the European Court of Human Rights and the case law of the European Court of Justice.

Materials such as statistical data are mainly second-hand data collected either by government bureaus (e.g. National Bureaus of Statistics of China, National Health and Family Planning Commission of the PRC) or by relevant intergovernmental organisations (e.g. the World Health Organization, the World Bank Group); that is, data published in government documents, white papers or other authorised project reports is included.

Reviewing classic monographs and relevant literature aims at formulating a theoretical framework to ground this research, to link the five independent studies and thereby support the consistency and coherence of this thesis. Relevant literature also includes grey literature, which refers to documents and guidelines launched by governments, reports produced by non-governmental organisations, conference proceedings, theses and news released by websites sponsored by professional institutions.

25 The pkulaw website is an online database, please refer to <http://pkulaw.cn/>

26 HUDOC database. Please refer to <https://hudoc.echr.coe.int/eng#> and the case-law of the European Court of Justice. Please refer to <http://curia.europa.eu/juris/>.

1.5.2 Research methods

Given that the research question at the heart of this thesis is essentially a question that is at the interface of disciplinary boundaries, research methods applied therefore have an interdisciplinary character. Specifically, the methods applied in this thesis mainly include theoretical analysis, historical analysis and classic legal analysis. In certain parts of this thesis, case study is also applied for the sake of simplifying specific arguments.

Employing theoretical analysis aims to address two fundamental issues that are not only relevant to the whole research but also essential to each individual study included: (1) to clarify terminologies and thereby define the scope of this research; (2) to explain the reasoning behind the research question and subquestions.

Historical analysis is conducted for this research. It is a method of discovering and examining past evidence and thereby helps to understand why things happened (Thorpe & Holt, 2008). Institutions like healthcare systems have their unique developing history, which could profoundly influence the subsequent performance of these institutions. Thus, examining historical evidence is of great importance, especially in terms of helping to develop a better understanding of the system design. Taking China's healthcare system for example, employing historical analysis will help to explain why its delivery system now has a three-tier structure. Furthermore, historical analysis can provide evidence and justification for explaining why certain old institutions prove to be incompatible with reality and need to be revised or even abolished, such as China's three basic healthcare insurance schemes. In addition, historical analysis is a meaningful method to evaluate past experience and thereby provide lessons for new developments.

In order to answer the final subquestion regarding the interactions between the performance of the Chinese healthcare system and China's health-related legislation, classic legal analysis is used to evaluate laws and regulations on both national and international levels that are effective in governing health and healthcare in China. The analysing process follows the IRAC framework, which consists of four sections: issue, rule, application and conclusion; that is, identifying the *issue* in concern, exploring the applicable legal *rules*, *applying* relevant legal rules to the facts of the issue, and drawing a *conclusion* (Miller & Charles, 2009, p. 193). The section of *application* also requires an explanation of the reason why certain legal rules are applicable or not applicable to the issue concerned. Furthermore, case study is also employed in answering this subquestion, because typical cases are useful to identify the *issue* concerned.

1.6 STRUCTURE OF THE THESIS

This thesis consists of seven chapters. Besides the introduction (Chapter 1) and the conclusion (Chapter 7), Chapters 2 to 6 are independent but interrelated papers, which are designed around the central research question (Figure 1.4). These five papers can be arranged into two

major perspectives (personal responsibility and structural injustice) and three specific themes (patient empowerment, healthcare delivery model and a supportive legal environment).

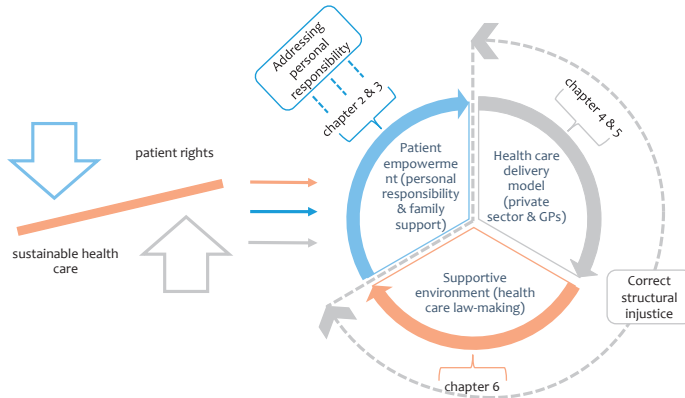


Figure 1.4 Structure of thesis

In the part of patient empowerment, I claim that personal responsibility is a plausible criterion in achieving distributive justice in healthcare (Chapter 2). Meanwhile, I argue that it is of great importance to involve family as a supplementary consideration to assist the implementation of the principle of personal responsibility in healthcare when taking the Chinese context (e.g. the Confucian tradition and the Chinese bioethics) into account (Chapter 3). Nevertheless, designing a healthcare delivery model is de facto setting the scope of ‘choice architects’²⁷ for patients. Therefore, in the part considering the healthcare delivery model, I argue that the hospital-based healthcare delivery system needs to be reoriented. In this regard, I focus my attention on two evolving parties: the general practitioner (Chapter 4), and the private medical institutions (Chapter 5). The conditions under which patients are empowered to claim their denied but reasonable medical needs and the healthcare delivery system is structured and operated are of great importance. Therefore, a supportive environment, especially a sound legal framework, is in great need. To respond to this concern, I briefly review all health-related laws and regulations on both national and international levels, draw lessons from representative theoretical debate on the coherence of health law, and thereby make corresponding recommendations (Chapter 6).

27 ‘Choice architects’ is a concept formulated by Richard Thaler and Cass Sunstein. It refers to an organised context in which people are able to make better choices. For detailed explanations, please refer to Thaler & Sunstein, (2003, 2008); Sunstein & Thaler, (2003).

1.7 REFERENCES

- Brownell, K. D., & Walsh, B. T. (Eds.). (2017). *Eating disorders and obesity: A comprehensive handbook* (3rd ed.). New York, NY: The Guilford Press.
- Callahan, D. (2003). Individual good and common good: A communitarian approach to bioethics. *Perspectives in Biology and Medicine*, 46(4), 496-507.
- Cappelen, A. W., & Norheim O. F. (2005). Responsibility in health care: A liberal egalitarian approach. *Journal of Medical Ethics*, 31, 476-480.
- Chen, X., & Fan, R. (2010). The family and harmonious medical decision making: Cherishing an appropriate Confucian moral balance. *Journal of Medicine and Philosophy*, 35, 573-586.
- Collins, C., & Green A. (1994). Decentralization and primary health care: Some negative implications in developing countries. *International Journal of Health Services*, 24(3), 459-475.
- Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*, p. 26. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=4807D18C4B37FEBE403D16763727C5B8?sequence=1 (last accessed 24 March 2019).
- Cortez, N. (2011). The elusive ideal of market competition in United States' health care. In J. W. van de Gronden et al. (Eds.) *Health care and EU Law: Legal issues of services of general interest*, p. 359-386. The Hague: Asser Press.
- Dahlgren, G., & Whitehead, M. (1991). *Policies and strategies to promote social equity in health*. Background document to WHO – Strategy paper for Europe, No. 2007, 14. Arbetsrapport: Institute for Future Studies.
- Dworkin, R. (1978). *Taking rights seriously*. Cambridge, MA: Harvard University Press.
- Dworkin, R. (2000). *Sovereign virtue*. Cambridge, MA: Harvard University Press.
- Enthoven, A. C. (2002). *Health plan: The practical solution to the soaring cost of medical care*, pp. 37-54; pp. 89-92; pp. 112-113. Washington DC: Beard Books.
- Etzioni, A. (2010). Communitarianism. In H. K. Anheier & S. Teopler S. (Eds.) *International Encyclopedia of Civil Society*, p. 521-524. New York, NY: Springer..
- Feng, Y. (2016). *Legislative decentralization in China in the reform era – Progress and limitations*. Erasmus University Rotterdam pp. 13-14. (Doctoral thesis). Retrieved from <https://hdl.handle.net/1765/94595>
- Fleck, L. (2009). *Just caring: Health care rationing and democratic deliberation*, p. 72. New York, NY: Oxford University Press.
- Foot, P. (1967). The problem of abortion and the doctrine of the double effect. *Oxford Review* 5, 5-15.
- Hayek, F. (1945). The use of knowledge in society. *American Economic Review*, 35, 519-530.
- Houtepen, R. & Ter Meulen, R. (2000). The expectations of solidarity: Matters of justice, responsibility and identity in the reconstruction of the health care system. *Health Care Analysis*, 8, 355-376.
- Kant, I. (1785). *Groundwork for the metaphysics of morals*, A. W. Wood (Ed. and Trans). New Haven, CT: Yale University Press.
- Li, L., & Fu, H. (2017). China's health care system reform: Progress and prospects. *The International Journal of Health Planning and Management*, 32, 240-253.
- Marmot, M. (2005). Social determinants of health inequalities. *Lancet*, 365, 1099-1104.
- Meng, Q., Yang H., Chen W., Sun Q., & Liu, X. (2015). People's Republic of China: Health system review. *Health Systems in Transition*, 5(7), 1-246.
- Mill, J. S. (1863). *Utilitarianism*. London: Parker, Son & Bourn, West Strand.

- Miller, N. P., & Charles B. J. (2009). Meeting the Carnegie Report's challenge to make legal analysis explicit – subsidiary skills to the IRAC framework. *Journal of Legal Education*, 59(2), 192-220.
- Norheim, O. F., & Wilson, B. M. (2014). Health rights litigation and access to medicines: Priority classification of successful cases from Costa Rica's Constitutional Chamber of the Supreme Court. *Health and Human Rights*, 16(2), 47-61.
- Nussbaum, M. (2011). Foreword. In I. M. Young, *Responsibility for justice*. New York, NY: Oxford University Press.
- Potts, H., & Hunt, P. (2008). *Accountability and the right to highest attainable standard of health*, p. 7. Retrieved from: <http://repository.essex.ac.uk/9717/1/accountability-right-highest-attainable-standard-health.pdf> (Last accessed 24 March, 2019).
- Qiu, S. (2014). Equality and the right to health: A preliminary assessment of China. In B. Toebes (Ed.), *The right to health*, pp. 97-120. Dordrecht: Springer.
- Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., Teerawattananon, Y., & Patra, J. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet*, 373(9682), 2223-2233.
- Roberts, M., Hsiao, W., Berman, P., Reich, M. (Eds.). (2008). *Getting health reform right: A guide to improve performance and equity*. New York, NY: Oxford University Press.
- Rosenblatt R. E. (1981). Health care, market, and democratic values. *Vanderbilt Law Review*, 34, 1067-1115.
- Runes, D. D. (1983). *Dictionary of Philosophy*. New York, NY: Philosophical Library.
- Sage, W. M. (2017). Relating health law to health policy: A frictional account. In I. G. Cohen, A. K. Hoffman, & W. M. Sage (Eds.), *The Oxford Handbook of U.S. Health Law*, p. 10. New York, NY: Oxford University Press.
- Schmidt, H. (2008). Bonuses as incentives and rewards for health responsibility: A good thing? *Journal of Medicine and Philosophy*, 33(3), 198-220.
- Schmidt, H. (2016). Personal responsibility as a criterion for prioritization in resource allocation. In E. Nagel, & M. Lauerer (Eds.), *Prioritization in medicine: An international dialogue*. Heidelberg: Springer. doi: 10.1007/978-3-319-21112-1_16.
- Segall, S. (2009). *Health, luck, and justice*. Princeton, CT: Princeton University Press.
- Steinbrook, R. (2006). Imposing personal responsibility for health. *The New England Journal of Medicine*, 355, 753-756.
- Sunstein, C., & Thaler, R. (2003). Libertarian paternalism is not an oxymoron. *The University of Chicago Law Review*, 70(4), 1159-1202.
- Thaler, R., & Sunstein, C. (2003). Libertarian paternalism. *The American Economic Review*, 93(2), 175-179.
- Thaler, R., & Sunstein, C. (2008). *Nudge: Improving decisions about health, wealth, and happiness*. New Haven, CT: Yale University Press.
- Thomas, J. J. (1976). Killing, letting die, and the trolley problem. *The Monist*, 59(2), 204-217.
- Thomas, J. J. (1985). The trolley problem. *Yale Law Journal*, 94(6), 1395-1415.
- Thorpe, R., & Holt, R. (2008). *The SAGE dictionary of qualitative management research*. London: Sage. Retrieved from <http://methods.sagepub.com.eur.idm.oclc.org/Reference/the-sage-dictionary-of-qualitative-management-research/n50.xml> (Last accessed 24 March 2019).
- Tiebout, C. M. (1956). A pure theory of local expenditure. *The Journal of Political Economy*, 64, 418-419.
- Watson, W. L., & Conte, A. J. (1954). Smoking and lung cancer. *Cancer*, 7(2), 245-249.

- Wong, C. K., Wang, K., & Kaun, P. Y. (2009). Social citizenship rights and the welfare circle dilemma: Attitudinal findings of two Chinese societies. *Asian Social Work and Policy Review*, 3, 51-62.
- Yamin, A. E. (2008). Beyond compassion: The central role of accountability in applying a human rights framework to health. *Health and Human Rights* 10(2), 1-20.
- Yip, WC-M, Hsiao, W. C., Chen, W., Hu, S., Ma, J. & Maynard, A. (2012). Early appraisal of China's huge and complex health-care reforms. *Lancet*, 3,379(9818), 833-42. doi: [http://dx.doi.org/10.1016/S0140-6736\(11\)61880-1](http://dx.doi.org/10.1016/S0140-6736(11)61880-1) PMID: 22386036.
- Yu, H. (2015). Universal health insurance coverage for 1.3 billion people: What accounts for China's success? *Health Policy* 119(9), 1145-1152.



PART I

Balancing Patient Rights and
the Sustainability of the Chinese Healthcare System
from an Ethical Perspective:
The Individual Focus



Chapter 2

Reaffirming personal responsibility in healthcare in China: Theoretical reflections and practical implications*

* This chapter is based on a published paper.
Alternations have been made for the sake of integrality.

Liu, Z., & Buijsen, M. (2017).
International Journal of Social Science and Studies, 5(4), 14-23.



ABSTRACT

Aim: This chapter aims to answer the question: *To what extent should personal responsibility be addressed in advancing the reform of the Chinese healthcare system?*

Background: Great achievements have been made by China's healthcare system since it started its first round of reform in 1978. However, a number of problems such as 'to see a doctor is difficult, to see a doctor is expensive' are remaining, which indicates that reform efforts are still insufficient and future steps may need to be taken in an innovative way.

Methods: Theoretical analysis is employed to clarify certain conceptions and to explore the reasoning behind certain reform measures. Historical analysis is also adopted to track the development of China's healthcare system and thereby form the contextual basis for future innovative healthcare reform.

Findings: Addressing state accountability in health and healthcare is widely accepted and discussed in literature while personal responsibility receives relatively less attention. A back-and-forth feature of reform has been identified after a historical analysis of China's healthcare system development. Given that new challenges occur along with the ageing population and the increasing burden of non-communicable diseases, it is unlikely to succeed if reform efforts continued to merely focus on addressing the responsibility of the state. Reform attention needs to be switched to encourage people to be responsible for their own health, namely to play an active role in taking care of their own health. All in all, addressing personal responsibility in health and healthcare should be an integral part of China's healthcare system.

Keywords: China's healthcare system, reform, state accountability, personal responsibility

2.1 INTRODUCTION

In literature, discussions mainly focus on addressing state accountability in protecting and promoting the right to health (Chapman, 1994, 2010; Chapman et al., 2015; Toebes, 1999a, 1999b, 2006, 2015; Daniels, 2001, 2008, 2011; Fisher et al., 2010; Schrecker et al., 2010). Yet, under the influence of inefficient utilisation and the free-rider problem²⁸, protecting and promoting the right to health through emphasising the state accountability corresponds poorly with reality. Situations are likely to be even worse after healthcare systems encounter new problems caused by the ageing population and the increasing burden of non-communicable diseases. Thus, it is time to bring other stakeholders into account. Given that individuals are believed to have a great control over their own health whereas the active role that individuals can play in healthcare system reforms has long been simply overlooked, this chapter aims at addressing this gap and then provides recommendations on how and where personal responsibility should be addressed in health policies in China. Furthermore, considering the diversified conditions of healthcare systems, this chapter mainly embeds discussions in the context of the Chinese healthcare system. Although recommendations for policy options are largely context-based, other nations can still draw meaningful lessons from this study.

2.2 A CASE STUDY OF THE CHINESE HEALTHCARE SYSTEM

2.2.1 Basic structure

From a macro perspective, the Chinese healthcare system has a multilevel structure, including a public health service system, a medical care system and a medical security system. It is also a hybrid of public and private elements, allocating healthcare resources via state intervention and market transactions (Ho, 2014). Specifically, the public health service system with a nationwide function accounts for ‘disease prevention and control, health education, maternity and child care, mental health, health emergency response, blood collection and supply, health supervision, and family planning as well.’²⁹ Unlike the public health service system, the medical care system is constructed differently in rural and urban China. In rural areas, medical care is mainly delivered by three institutions: the county hospitals, the township hospitals and the village clinics. In urban China, however, medical care is delivered by the general hospitals and the specialised hospitals. Besides the above regular medical institutions, several community clinics have emerged to take care of the preliminary diagnosis and treatment of

28 The free-rider problem often occurs when people benefit from certain kinds of goods but do not pay for them, which brings about an underprovision of these goods or public services. For detailed discussion, please refer to William (1965).

29 Information Office of the State Council. (2012). White Paper on Medical and Health Services in China. Please refer to http://xinhuanet.com/politics/2012-12/27/c_124156559.htm (last accessed 24 March 2019).

certain ordinary illnesses, such as colds and fever. With regard to the medical security system, it is a multilevel insurance scheme that comprises three basic health insurance schemes: the urban resident basic medical insurance scheme (URBMI), the urban employee basic medical insurance scheme (UEBMI) and the new rural cooperative medical system (NRCMS). In 2012, nearly 95% of Chinese people were under the protection of these three basic health insurance schemes. Despite the high rate of health insurance coverage, the Chinese healthcare system still faces with great challenges posed by both old problems, such as ‘to see a doctor is difficult, to see a doctor is expensive’ (看病难, 看病贵), and new problems such as the ageing population and the increasing burden of non-communicable diseases.³⁰

From a micro perspective, the Chinese healthcare system is special in terms of its financial support and administrative structure, as well as legal regulations. These special aspects in turn aggravate the existing formidable problems over time. First, the financial budget is mainly guaranteed by local governments rather than by central government. As a consequence, health policies launched by central government are carried out unevenly from province to province, which results in an increasing geographical disparity in healthcare delivery and becomes a crucial impediment to equal access to healthcare. Second, the Chinese healthcare system is administrated uniquely. Nearly all of the general hospitals in China are state-owned institutions (公共事业单位), which refers to organisations that are established by the government with state-owned facilities. Furthermore, the employees of these organisations enjoy the same welfare conditions as civil servants (Ho, 2014). Third, the legislative and judicial supports for the Chinese healthcare system are far from adequate. The Chinese healthcare system performs poorly when it relates to judicial remedy because China’s judicial system has often been criticised for lacking independence from the government (Liu, 2015, p. 440). According to an authoritative statistic, most health-related cases are solved without resorting to judicial process but through petition (上访). Compared to going through the judicial process, the petition (上访) is believed to be a more accessible and friendly alternative. It depends on an administrative system called ‘letters and visits’ (信访) which allows citizens to solve their conflicts by means of writing a letter of complaint or visiting certain departments of the government directly for redress (Ho, 2014, p. 273). Yet, patients often feel reluctant to use the petition (上访) as well, due to the fact that the government actually plays not only as an executant but also as a supervisor of the Chinese healthcare system. As a consequence, conflicts between doctors and patients cannot be released properly, which eventually results in threats or violence against doctors and other medical staff (Hesketh, 2012). All these tough issues mentioned above are de facto incentives triggering the progressive reforms of the Chinese healthcare system.

30 The World Bank Group, World Health Organization, China’s Ministry of Finance, National Health and Family Planning Commission, and Ministry of Human Resources and Social Security. Healthy China: deepening health reform in China, at xv–xvi. Please refer to <http://www.wpro.who.int/china/publications/2016-health-reform-in-china/en/> (last accessed 24 March 2019).

2.2.2 Progressive reforms and the back-and-forth feature

The principle of solidarity has a long history of being valued by Chinese society. Influenced by this principle, it is the government that plays a leading role in nearly all kinds of social services in China (Yip & Hsiao, 2015). Almost every aspect of social life is controlled by state-owned enterprises, which are de facto established, managed and monitored by the government. In healthcare, the financial budget was adequate because priority was given to a nationwide coverage rather than the quality of service. The annual reports show a great decrease in mortality and a steady increase in life expectancy.³¹ Apparently, the healthcare system functioned well at the very beginning without any noticeable problems concerning availability and affordability (financial accessibility). However, developments are accompanied by some hidden troubles. The first trouble relates to the ‘barefoot doctor’ (赤脚医生). It represents a group of people who have not received formal education but are in charge of providing healthcare for people living in the rural areas of China. Along with the establishment of a cooperative healthcare scheme (合作医疗) and a three-tier preventive healthcare net (三层保障), the mechanism of healthcare in rural China was recommended by the WHO as a model at that time. Yet, as time goes on, the legitimacy of the barefoot doctors’ medical practices has become questionable, which has turned out to be an impediment threatening the whole healthcare system of rural China. The second trouble relates to the financial budget. The national coverage of healthcare was achieved on a rather low level. Every small increase in the quality of healthcare demands a large additional financial support. These increasing demands might put the realisation of other social goods on hold. The third trouble relates to inefficient utilisation. Inefficient utilisation is not a special issue that merely happens in the sphere of healthcare, but the entire Chinese society suffers from it in different ways. The lack of competition threw the state-run centrally planned strategy into a tight corner, which unexpectedly simulates free market thinking.

The first round of healthcare system reform was initiated in 1978. At that time, the Chinese government liberalised its economic system from a central-planning economy to a socialistic market economy, with a premise that the free market should be more productive by virtue of efficient distributive mechanisms. It is certainly an innovative strategy, trying to find a third way to balance the government’s central planning and the free market mechanism in the context of China. Furthermore, the Chinese government became increasingly active in the international arena at that time, signing a series of international documents³² and mak-

31 According to the analysis conducted by Yip & Hsiao (2015) pp. 54–55, infant mortality has decreased ‘from 200 to 57 per 1,000 while the life expectancy has extended from 45 to 68 years.’ Data is available online, please refer to <http://esa.un.org/wpp/> (last accessed 24 March 2019).

32 Those international documents are issued from diverse perspectives. The following list of documents with signifying/ratifying time in brackets is only concerning the field of healthcare. The International Convention on the Elimination of All Forms of Racial Discrimination (only ratifying in 1981); The International Covenant on Civil and Political Rights (only signifying in 1998); International Covenant on Economic, Social and Cultural

ing great efforts to cooperate with the international community. With such a background, the first round of healthcare system reform was launched. Consistent efforts were devoted to various aspects, including slowing down the increasing financial budget and modifying the salary structure of physicians. During that time, public hospitals were changed from ‘public good-oriented’ institutions into ‘for-profit’ entities. Undeniably, achievements were made. For instance, the life expectancy grew to 71.8 years in 2001, higher than the average of the whole world (65 years) (Wang, 2004). Nevertheless, deficiencies were obvious. First of all, efficiency might be improved at the expense of fairness in distributing healthcare. Although the market mechanism in China had a due consideration to fairness, it still gave priority to efficiency.³³ Addressing the market mechanism intensifies the tendency to treat healthcare as a kind of exchangeable commodity, which implied that the ability to pay decides the allocation of healthcare resources. Yet, healthcare is special. Humane caring cannot be abandoned when distributing healthcare. As a response, a mechanism of price control was put forward by central government with the aim of protecting vulnerable groups from the potential side effects of the market mechanism. However, the price controlling mechanism unexpectedly contributed to the practice of compensating for low health services charges with high drug prices (以药补医). Compensating for low health services charges with high drug prices (以药补医) allowed the public hospitals to make extra profits through prescriptions, which unexpectedly strengthened the interest in relations between physicians, hospitals and pharmaceutical companies. It deviated public hospitals from their original goals (i.e. curing and caring) and drove them crazy to make as much money as possible. The increased medical expenses, which often could not be reimbursed by the three basic insurance schemes, became the financial burden that was ultimately placed on the patients.³⁴ If a family member unfortunately suffers from an incurable disease, such as cancer, it would be equal to bankrupting their family due to the catastrophically expensive healthcare. Even worse, due to a lack of effective regulations, the market mechanism opened the door to corruption in healthcare, such as the so-called red envelope (红包) custom. The red envelope (红包) custom created an extra financial burden for patients and their families. The potential heavy financial burden made people, especially the worse off, hesitant to access healthcare. Furthermore, it caused healthcare disparities to be more pronounced, not only geographically but also in terms of

Rights (1997/2001); Convention on the Elimination of All Forms of Discrimination against Women (1980/1980); Convention on the Rights of the Child (1990/1992); Convention on the Rights of Persons with Disabilities (2007/2008).

33 ‘Give priority to efficiency with due consideration to fairness’ was first put forwarded by the 14th National Congress of the Communist Party of China as a solitary principle and then reaffirmed by the 15th National Congress of the Communist Party of China. For detailed explanation, please refer to Zhang & Chang, (2016) p. 47.

34 According to the National Bureau of Statistics of China, patients paid 20% of total health expenditure out-of-pocket in 1978 while they shouldered 60% in 2001. For more information, please refer to National Bureau of Statistics of China. (2011).

wealthy and poverty. These problems were aggravated after the epidemic of SARS in 2003. Some scholars argued that it was the market-oriented reform that deteriorated the situation (Liu, 2004; Wang, 2004; Li et al., 2012). Seemingly, this round of reform led the Chinese healthcare system to the other extreme where too much emphasis was given to marketability and therefore inevitably resulted in overriding the right to health of patients.

To deal with these parameters that emerged in the first round of reform, the Chinese government planned to reshape the whole healthcare system with an aim to provide safe, efficient and affordable basic healthcare for all Chinese residents by 2020. It was a starting point of the second round of reform, launched in 2009. Besides the regular budget, an extra amount of 850 billion Chinese yuan has been committed to support the coming round of reform (Meng & Tang, 2013, p. 331). Going over all the efforts, the second round of reform moved backwards to emphasise the state accountability in distributing healthcare. Influenced by the *Primary Health Care*³⁵ project of the World Health Organization, the fundamental goal of the Chinese healthcare system was readjusted to guarantee a decent minimum of care. To achieve this goal, the Chinese government reaffirmed its obligation and increased its financial budget for healthcare. According to authority reports, the total amount of healthcare expenses in China was on the rise, occupying 5.57% of GDP in 2013. Among these healthcare expenses, the expenditure of the Chinese government accounted for 30.1%, which is 2.6% higher than in 2009 (Fang, 2015, p. 38). Guaranteed by virtue of the government, nearly all of the Chinese people could get access to the basic healthcare. Nevertheless, the quality of healthcare still needs to be improved according to the AAAQ standards. One possible reason is that 'a decent minimum' has a drawback that it might limit the scope and the content of the state-supported healthcare. The majority of costly diseases are actually not on the list of diseases that can be reimbursed. As a consequence, many patients still suffer from catastrophically expensive medical services. In addition, there are two contradictions. One is that the majority of healthcare demands are converged to large hospitals where medical facilities are believed to be the most advanced, while very few medical functions are used by hospitals and clinics in the countryside. The other contradiction is that the number of physicians is decreasing while the number of patients is increasing. As mentioned before, the 'barefoot doctors' (赤脚医生) used to be the major force in providing healthcare for people living in rural China. However, they are no longer allowed by law to practice healthcare these days, which results in a lack of health personnel in rural China. Meanwhile, urban China also confronts the same problem but for different reasons. It is partially because of the decreasing number of medical graduates; the high risk but unstable income makes people reluctant to choose the medical profession as a lifelong career.

Reacting to this, the Chinese government planned to take extra steps to deepen the healthcare system reform in 2014. Among newly issued reform measures, major steps in-

35 Please refer to <http://www.who.int/whr/2008/en/> (last accessed 24 March 2019)

clude formulating a system of tiered diagnosis and treatment (分级诊疗), reorganising the institutional structure of public hospitals, and abolishing the practice of compensating for low health service charges with high drug prices (以药补医). Yet, none of them is easy to achieve. Taking the practice of compensating for low health service charges with high drug prices (以药补医) as a simple illustration, it is tough to abolish a system as such. This is not only because of the existing solid interest in relations but also due to the fact that the practice of compensating for low health services charges with high drug prices' (以药补医) accounts for one part of physician's income. Unfortunately, there is no alternative way except increasing the financial budget to make up that part. However, healthcare is not the only good that needs financial support from the government. The increased financial budget on healthcare might negatively influence the realisation of other social goods. This is the problem that the Chinese healthcare system had met before the first round of reform.

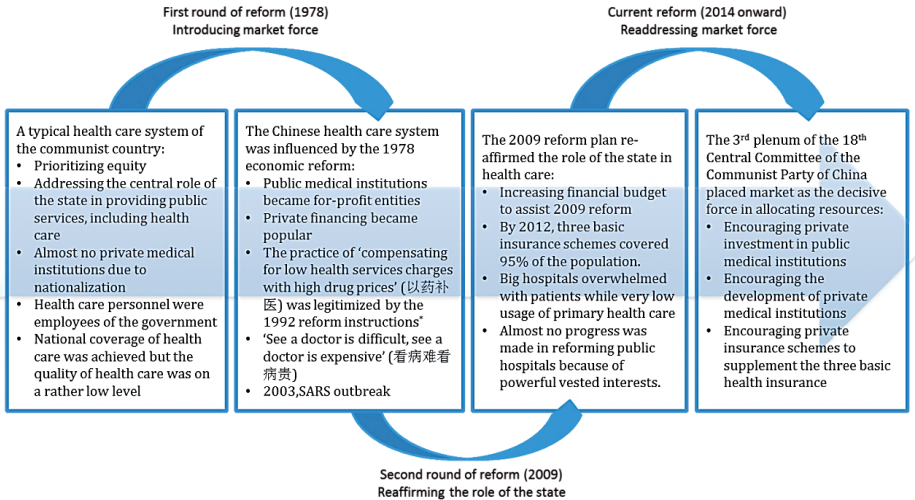


Figure 2.1 Progressive Chinese healthcare system reforms

* In 1992, the State Council launched *Opinions on further reforming healthcare systems*. This government document stimulated the profit-seeking behaviours of public medical institutions. For more information, please refer to <http://www.reformdata.org/content/19920923/25367.html> (in Chinese, last accessed 24 March 2019)

Source: Yip & Hsiao (2015).

Drawing from the progressive Chinese healthcare system reforms, it is easy to observe that reforms hitherto present a back-and-forth feature (Figure 2.1): from addressing the role of the state (1949–1978) to introducing market forces (1978), then to reaffirming the role of the state (2009), then to readdressing the decisive role of market in allocating resources (2014).

The rationale behind the back-and-forth feature is essentially a trade-off between two driving forces – the state and the market – for Chinese healthcare system reforms. Owing to

such a trade-off relationship, big achievements have been made over the past few decades. Yet, old problems, such as ‘to see a doctor is difficult, to see doctor is expensive’ (看病难, 看病贵), remain largely unsolved and, therefore, raise a question for consideration: besides the state and the market, are there any powerful forces that actually play an essential role in Chinese healthcare system reforms but have long been overlooked?

2.3 ADDRESSING PERSONAL RESPONSIBILITY IN HEALTHCARE

Scholarly literature has proved that there exists a causal relationship between disfavoured habits (e.g. excessive smoking, eating disorders and alcoholism) and certain kinds of chronic diseases (e.g. lung cancer, cardiovascular diseases and obesity).³⁶ In this regard, it is safe to claim that people do have a great control over their health status. Yet, the active role that individuals can play in healthcare system reforms has long been simply overlooked because addressing the responsibility of the state (often known as ‘state accountability’) to protect and promote the healthcare interests of individuals is regarded as the mainstream. Thus, discussions in this section mainly focus on addressing personal responsibility in healthcare with special attention given to both theoretical and applied aspects.

In a general sense, addressing personal responsibility in healthcare means to hold individuals accountable for their own health. However, this general definition leaves some ambiguity, such as when it is just to address personal responsibility in healthcare and how to address personal responsibility in ways that are just. Before embarking on the applied aspect (i.e. developing policy recommendations), it is important to have some theoretical reflections on what the personal responsibility is in the sphere of healthcare and the necessity of addressing personal responsibility in promoting healthcare delivery.

2.3.1 Theoretical reflections on personal responsibility in healthcare

In theory, how to place personal responsibility fairly in health policies and practices has long been the key question for many prominent philosophical traditions, including liberal egalitarianism (Cappelen & Norheim, 2005, 2006), luck egalitarianism (Dworkin, 2000; Cohen, 2008; Roemer, 1993; Arneson, 1989; Knight, 2009; Knight & Stemplowska, 2011; Segall, 2007, 2009) and communitarianism (Callahan, 2003).

36 For detailed discussion, please refer to Watson & Conte, (1954); Rehm et al., (2009); Brownell & Walsh, (2017).

Liberal egalitarianism

Liberal egalitarianism is a theoretical approach that mainly focuses on assessing the direct relationship between health disadvantages and individual choices. According to liberal egalitarianism, people should be responsible for their health-related choices, but not necessarily for the consequences of these choices (Cappelen & Norheim 2005, p. 478). To a larger extent, society should concentrate on eliminating the inequalities in health that arise from individual choices but not from factors that are out of individual control, namely, circumstances (Cappelen & Norheim 2006, p. 313). By taking this standpoint, liberal egalitarianism sets itself apart from typical liberal arguments and thereby largely escapes the critique that risky behaviours are hardly recognised as the direct and sole factor to negative health outcomes. With regard to how to place personal responsibility fairly in related policies and practices, Cappelen & Norheim (2005, p. 479) who are active proponents of liberal egalitarianism, are in favour of using a tax mechanism to hold people accountable for their health-related choices. That is, it is legitimate for the government to tax people's unhealthy choices beforehand while guaranteeing equal access to treatment for all people.

Nevertheless, criticisms such as 'bottomless pit' (Buyx, 2008, p. 872), 'coherence, non-monetary shortage and ignoring social determinants' (Albertsen, 2016, pp. 563–565), increasingly appear in scholarly literature which suggest the need for further perfection.

Luck egalitarianism

Luck egalitarianism is a theoretical framework that assigns personal responsibility a central role to play in assuring the distributive justice of healthcare. Despite a variety of ideals,³⁷ luck egalitarians have reached a consensus on one basic claim: it is morally unacceptable that people suffer from inequalities in care caused by factors that are beyond their control (Segall, 2009). Being sensitive to individual choices can be traced back to a special distinction between 'brute luck' and 'option luck' developed by Ronald Dworkin.³⁸ According to Dworkin, a just society should be sensitive to people's voluntary choices ('option luck') while remaining insensitive to their 'brute luck' when distributing resources.³⁹ Taking tobacco use as an example, according to the data collected by the WHO more than 1.1 billion people smoked tobacco worldwide in 2015 and up to half of tobacco users died from smoking.⁴⁰ If an individual chooses to smoke

37 There are diverse views of luck egalitarianism. They are different from one another primarily on the way of advocating equality. For instance, Ronald Dworkin's *equality of resources*; Richard Arneson's *equality of welfare*; G. A. Cohen's *equality of access to advantages*; Eric Rakowski's *equality of fortune*; John Roemer's *equality of opportunity*.

38 According to Dworkin, 'option luck is a matter of how deliberate and calculated gambles turn out ... Brute luck is a matter of how risks turn out which are not in that sense deliberate gambles.' Please refer to Dworkin (2000), p. 73.

39 Dworkin, (2000). *Sovereign virtue*, p. 334. Cambridge, MA: Harvard University Press.

40 For more information about the prevalence of tobacco and tobacco control, please refer to <http://www.who.int/gho/tobacco/use/en/> (last accessed 24 March 2019) and <http://www.who.int/mediacentre/factsheets/fs339/en/> (last accessed 24 March 2019).

tobacco with full awareness of possible health disadvantages, then this option is like taking a gamble on their health. If they lose the gamble (i.e. health problems happen), that person should be held accountable for the loss, not the healthcare system or even the community.

Yet, this argument generates some difficulties. One major difficulty relates to the causal relationship between individual choices and health problems because health problems are often caused by complex factors. Factors other than individual choices (e.g. gene structure) may be the key driving force for diseases. Furthermore, criticised by Buyx (2008, p. 872), merely relying on the criterion of 'free choice' not only makes luck egalitarianism a one-sided theory, but also would make it easily fall into a situation where one can either 'choose freely' or 'not choose at all'. Another strong critique is raised by Elizabeth Anderson. She argues against luck egalitarianism by expressing her special concern for 'negligent victims' and the Good Samaritan (Anderson, 1999). According to her analysis, using the principle of free choice to distribute healthcare would increase the risk of abandoning people who freely choose to sacrifice themselves for the sake of other people's interests (or rights).

Communitarianism

Communitarianism addresses the social characteristics of individual human beings and the importance of fostering shared values in designing policies and practices (Etzioni, 2010; Callahan, 2003, p. 496). Since health is endorsed as one such shared value, the state, in the eyes of communitarians, is justified to require individual human beings to make their best contribution to fostering health – namely, to be responsible for their health-related behaviours and choices (Buyx, 2008, p. 871). In this regard, personal responsibility features in the communitarianism's view of health policies and practices.

However, criticisms are strongly persuaded, which are mainly against some built-in problems such as 'the inability of communitarianism to deal with the diversity of healthcare needs and preferences' (Houtepen & Ter Meulen, 2000, p. 360) and the problem of 'being a paternalistic approach' (Buyx, 2008, p. 872).

Overall, despite all limitations discussed above, these three philosophical traditions do have distinct meaningful policy implications for the government regarding how to improve healthcare delivery through the lens of addressing personal responsibility (Table 2.1).

2.3.2 Practical advice on addressing personal responsibility in healthcare in China

Policy implications from the above philosophical traditions are of equally great value to healthcare systems with different models of governance. In this section, discussions mainly focus on assessing these policy implications in the context of the Chinese healthcare system with a specific aim of developing practical advice for policymakers in China on how to address personal responsibility properly when designing and implementing health policies.

Table 2.1 Three philosophical traditions on addressing personal responsibility

Three Philosophical Traditions on Addressing Personal Responsibility in Health Care		
Liberal Egalitarianism	Basic Arguments	Two supreme principles: responsibility and equalization Focus on assessing health disadvantages that reflect individual choices Holding people accountable for their health-related choices but not for the consequences of these choices
	Policy Implication	Tax people's unhealthy choices beforehand while guarantee equal access to treatment for all people
Luck Egalitarianism	Basic Arguments	It is morally unacceptable that people suffer from inequalities in health care caused by factors that are beyond their control. A just society should be sensitive to people's free choices ('option luck') while remains insensitive to people's 'brute luck' when distributing health care resources.
	Policy Implication	A hypothetical insurance market for health care (Dworkin, 2000) Health incentive schemes (Schmidt, 2009) From an <i>ex-ante</i> perspective, empowering patients (e.g. cultivating health literacy, strengthening self-management skills, encouraging shared decision-making, etc.)
Communitarianism	Basic Arguments	Common good overweighs individual preference Individuals should contribute to the common good by choosing responsible health behaviors
	Policy Implication	Health policies should be designed and implemented with the goal of fostering the shared values of the community.

Addressing personal responsibility by taxing unhealthy choices beforehand

The central argument of liberal egalitarianism is to tax unhealthy choices with the goal of providing equal access to treatment for all people, even for those who choose unhealthy behaviours. To put it simply, liberal egalitarianism holds people accountable for their health-related choices by taxing unhealthy choices beforehand.

Many choices can be classified as being unhealthy, among which smoking tobacco and consuming unhealthy food and drinks are the two leading risk factors accounting for a large proportion of avoidable illness in China. According to the World Health Organization (2015), the tax rate on tobacco in China (approximately 44.43% of retail prices in 2015) needs to be raised up to 75% of retail prices.⁴¹ This suggestion addresses the significant role that the tax mechanism plays in averting illness and deaths that would otherwise be caused by smoking tobacco. With regard to controlling unhealthy food and drinks, several countries have already started to tax unhealthy food and drinks, such as 'fat tax' in Denmark⁴² and

41 World Health Organization. (2015). WHO report on the global tobacco epidemic: raising taxes on tobacco. Please refer to http://apps.who.int/iris/bitstream/10665/178574/1/9789240694606_eng.pdf?ua=1&ua=1 (last accessed 24 March 2019)

42 In 2012, the Danish Parliament repealed the 'fat tax' due to the threat of job losses. This kind of taxation lasted only one year in Denmark. For detailed analysis, please refer to Stafford (2012).

‘junk food tax’ in Hungary⁴³ and Mexico⁴⁴. In China, however, improving health by taxing unhealthy food and drinks is merely a recent interest among researchers and policymakers. Given that the Chinese healthcare system is currently faced with a great challenge posed by the increasing burden of non-communicable diseases (NCDs), using a tax mechanism may serve as a good strategy for not only protecting people from the harm of NCDs but also helping to sustain the Chinese healthcare system. Yet, due to lack of general guidelines, introducing a tax mechanism may also bring about negative effects on society. For instance, taxing unhealthy food and drinks is likely to put an extra burden on low-income families, which may ultimately widen the existing disparities between the rich and the poor in China. Thus, empirical evidence needs to be collected and analysed critically before introducing a tax mechanism.

Addressing personal responsibility from an ex ante perspective: developing health incentive schemes and empowering people in their own health

Addressing personal responsibility from either an ex ante perspective or an ex post perspective makes a difference, especially in terms of understanding the policy implications of luck egalitarianism. The ex ante aspect concerns prevention while the ex post aspect is often related to the attribution of blame, and punishment. Addressing personal responsibility in healthcare from an ex post perspective brings counterintuitive feelings because it is most likely to use personal responsibility as an excuse to punish people for avoidable losses. Conversely, addressing personal responsibility in healthcare from an ex ante perspective cultivates an attitude of risk prevention because it provides people with opportunities to prevent or, at least alleviate, the negative influence of avoidable suffering.

A typical example of addressing personal responsibility in healthcare from an ex ante perspective is the health incentive schemes of the German healthcare system. According to Schmidt’s (2007) study, Germany’s statutory sickness fund has been offering diverse kinds of bonuses for people who actively participate in preventive care, since 2004. Among all kinds of bonuses, awarding healthy behaviours with reward points is a normal measure. People can gain reward points for their healthy behaviours and thereby use these points to redeem against sports equipment, health books, iPods, and gift cards for music download (Schmidt, 2007, p. 243). In this regard, policymakers in China should learn from Germany’s experience to develop context-based incentive schemes to encourage people to be active in taking care of their own health.

43 The ‘junk food tax’ is put on a wide range of prepackaged foods which contain high salt and sugar. For detailed analysis, please refer to Holt (2011).

44 In 2014, the Mexico government introduced an 8% tax on unhealthy food and drinks. According to the policy, the ‘unhealthy food and drinks’ refers to ‘non-essential foods with energy density ≥ 275 kcal/100g and sugar-sweetened beverages (SSBs).’ For more analysis on the effects of this tax, please refer to Batis et al. (2016).

Another example relates to engaging people in their own health and healthcare. It mainly refers to encouraging people to play a more active role in taking care of their own health, such as leading a healthy lifestyle, strengthening self-management skills and improving shared decision-making.⁴⁵ Some countries have already enacted special laws to improve people's engagement in their own health and healthcare. Referring to a study by Schmidt (2007, pp. 242–243), the citizens of German are required by law (i.e. Article 1 of Book V of Germany's Social Security Code) to take a kind of 'co-responsibility' for their health, which essentially means that the citizens of German should 'lead a health-conscious lifestyle, take part in appropriately timed preventive measures and play an active role in treatment and rehabilitation, avoid sickness and disability, and overcome the respective consequences.' However, China has not yet enacted a similar law addressing the importance of engaging in their own health, which may point out a meaningful direction for future lawmaking efforts in China.

Addressing personal responsibility with a special concern to foster the shared values of the Chinese community

Drawing from the policy implication of communitarianism, designing and implementing health policies should aim at fostering the shared values of the community. In China, the majority of the shared values lie in the Confucian ethical tradition. Confucian ethical tradition attaches great importance to the virtue of *ren* (benevolence) and *xiao* (filial piety).⁴⁶ From a Confucian viewpoint, the individual human being is incomplete without belonging to a family (Chen & Fan, 2010, p. 577). Confucian societies (e.g. Singapore and China) therefore value close family ties and attach great importance to the role of the family when drafting social policies (Wong et al., 2009, p. 53). To a large extent, this viewpoint decides the family-based character of the healthcare system in China, such as emphasising the role of the family in healthcare decision-making. Thus, personal responsibility in healthcare should be addressed so it is compatible with the aim of fostering the shared value of the Chinese community, such as its long tradition of valuing family ties.

⁴⁵ These measures are recommended by the World Health Organization for the sake of achieving integrated, people-centered care. Chapter 3 of this thesis provides a more detailed analysis on how to implement these measures in the Chinese context. Here, for more information about the policy options for this framework, please refer to <http://www.who.int/servicedeliverysafety/areas/people-centred-care/strategicapproach.pdf?ua=1> (last accessed on 24 March 2019)

⁴⁶ The English translation of those basic virtues of Confucianism, Please refer to Runes (1983), p. 338.

2.4 CONCLUDING REMARKS

Given that the reforms of the Chinese healthcare system hitherto have a back-and-forth characteristic and the system encounters an increasingly heavy burden posed by the ageing population and non-communicable diseases, it is time to bring other stakeholders into consideration for the sake of the success of future reforms. Thus, this paper focuses on addressing personal responsibility in healthcare by stating that every individual needs to play a more active role in taking care of their own health. In order to develop practical advice for policymakers in China, supportive evidence from three typical theoretical frameworks and their policy implications are collected and analysed. Practical advice is largely context-specific recommendations, yet other nations can still derive meaningful lessons from the above analysis when similar problems occur.

Although the main focus of this paper is to raise the concern of how and where personal responsibility should be addressed in healthcare, it by no means denies the primary role of the state in protecting and promoting people's health, but rather to remind policymakers the importance of including every stakeholder and drawing a clear boundary between their responsibilities.

2.5 REFERENCES

- Albertsen, A. (2016). Taxing unhealthy choices: The complex idea of liberal egalitarianism in health. *Health Policy*, 120(5), 561-566.
- Anderson, E. (1999). What is the point of equality? *Ethics*, 109, 287-337.
- Arneson, R. (1989). Equality and equal opportunity for welfare. *Philosophical Studies*, 56, 77-93.
- Batis, C., Rivera, J. A., Popkin, B. M., & Taillie, L. S. (2016). First-year evaluation of Mexico's tax on nonessential energy-dense foods: An observational study. *PLOS Medicine*, 13(7), e1002057.
- Buyx, A. (2008). Personal responsibility for health as a rationing criterion: Why we don't like it and why maybe we should. *Journal of Medical Ethics*, 34(12), 871-874.
- Callahan, D. (2003). Individual good and common good: A communitarian approach to bioethics. *Perspectives in Biology and Medicine*, 46(4), 496-507.
- Cappelen, A. W., & Norheim, O. F. (2005). Responsibility in health care: A liberal egalitarian approach. *Journal of Medical Ethics*, 31(8), 476-480.
- Cappelen, A. W., & Norheim, O. F. (2006). Responsibility, fairness and rationing in health care. *Health Policy*, 76(3), 312-319.
- Chapman, A. R. (1994). *Health care reform: A human rights approach*. Washington, DC: Georgetown University Press.
- Chapman, A. R. (2010). The social determinants of health, health equity, and human rights. *Health and Human Rights*, 12(2), 17-30.
- Chapman, A. R., Forman, L., & Lamprea, E. (2015). Evaluating essential health packages from a human rights perspective. *Journal of Human Rights*. doi: 10.1080/1475835.2015.1107828.
- Chen, X., & Fan, R. (2010). The family and harmonious medical decision making: Cherishing an appropriate Confucian moral balance. *Journal of Medicine and Philosophy*, 35, 573-586.
- Cohen, G. A. (2008). *Rescuing justice and equality*. Cambridge MA: Harvard University Press.
- Daniels, N. (2001). Justice, health, and health care. *The American Journal of Bioethics*, 1(2), 2-16.
- Daniels, N. (2008). *Just health: Meeting health needs fairly*. New York, NY: Cambridge University Press.
- Daniels, N. (2011). Individual and social responsibility for health, In C. Knight & Z. Stemplowska (Eds.), *Responsibility and distributive justice*, Oxford: Oxford University Press.
- Dworkin, R. (2000). *Sovereign virtue*. Cambridge, MA: Harvard University Press.
- Etzioni, A. (2010). Communitarianism. In H. K. Anheier & S. Teopler (Eds.), *International encyclopedia of civil society*, pp. 521-524. New York, NY: Springer.
- Fang, P. (2015). *Green book of health reform and development*. Beijing: Renmin Press.
- Fisher, K. R., Shang, X., & Blaxland, M. (2010). Review article: Human rights based social policies – Challenges for China. *Social Policy and Society*, 10(1), 71-77.
- Hesketh, T., Wu, D., Mao, L., & Ma, N. (2012). Violence against doctors in China. *BMJ*, 345, e5730.
- Ho, C. S. (2014). Health rights at the juncture between state and market: The People's Republic of China, In C. M. Flood & A. Gross (Eds.), *The right to health at the public/private divide: A global comparative study*, New York, NY: Cambridge University Press.
- Holt, E. D. (2011). Hungary to introduce broad range of fat taxes. *Lancet*, 378(9793), 755.
- Houtepen, R. & Ter Meulen, R. (2000). The expectations of solidarity: Matters of justice, responsibility and identity in the reconstruction of the health care system. *Health Care Analysis*, 8, 355-376.
- Knight, C. (2009). *Luck egalitarianism: Equality, responsibility, and justice*. Edinburgh: Edinburgh University Press.
- Knight, C. & Stemplowska C. (Eds.). (2011). *Responsibility and distributive justice*. Oxford: Oxford University Press.

- Li, L., Chen, Q., & Powers, D. (2012). Chinese health care reform: A shift toward social development. *Modern China*, 38(6), 630-645.
- Liu, S. (2015). The shape of Chinese law. *Peking University Law Journal*, 1(2), 415-444.
- Liu, Y. (2004). China's public health care system: Facing the challenges. *Bulletin of the World Health Organization* 2004, 82(7), 532-538.
- Meng, Q., & Tang, S. (2013). Universal coverage of health care in China: Challenges and opportunities. *Procedia-Social and Behavioral Sciences*, 77, 330-340.
- National Bureau of Statistics of China. (2011). *China statistical yearbook*. Beijing: China Statistical Press.
- Roemer, J. E. (1993). A pragmatic theory of responsibility for the egalitarian planner. *Philosophy & Public Affairs*, 22(2), 146-166.
- Runes, D. D. (1983). *Dictionary of Philosophy*. New York, NY: Philosophical Library.
- Schmidt, H. (2007). Personal responsibility for health – development under the German healthcare reform 2007. *European Journal of Health Law*, 14(3), 241-250.
- Schrecker, T., Chapman, A. R., Labonté, R., & De Vogli, R. (2010). Advancing health equity in the global marketplace: How human rights can help. *Social Science & Medicine*, 71(8), 1520-1526.
- Segall, S. (2007). In solidarity with the imprudent: A defense of luck egalitarianism. *Social Theory and Practice*, 33(2), 177-198.
- Segall, S. (2009). *Health, luck, and justice*. Princeton, NJ: Princeton University Press.
- Stafford, N. (2012). Denmark cancels 'fat tax' and shelves 'sugar tax' because of threat of job losses. *BMJ: British Medical Journal (Online)*, 345, e7889.
- Toebes, B. (1999). *The right to health as a human right in international law*. Antwerp: Intersentia.
- Toebes, B. (1999). Towards an improved understanding of the International Human Rights to Health. *Human Rights Quarterly*, 21, 661-679.
- Toebes, B. (2006). The right to health and the privatization of health care services: A case study of the Netherlands. *Health and Human Rights*, 9(1), 102-127.
- Toebes, B. (2015). Human rights and Public Health: Towards A Balanced Relationship. *International Journal of Human Rights*, 19(4): 188-504.
- Wang, S. (2004). China's Health System: From Crisis to Opportunity. *Yale-China Health Journal*, 3, 5-49.
- William, B. (1965). *Welfare economics and the theory of the state*. Cambridge: Harvard University Press.
- Wong, C. K., Wang, K., & Kaun P. Y. (2009). Social citizenship rights and the welfare circle dilemma: Attitudinal findings of two Chinese Societies. *Asian Social Work and Policy Review*, 3, 51-62.
- Yip, W., & Hsiao, W. (2015). What drove the cycles of Chinese health system reforms? *Health Systems & Reform*, 1(1), 52-61.
- Zhang, X., & Chang, X. (2016). *The logic of economic reform in China*. China Social Sciences Press and Springer.

Chapter 3

Patient engagement at the household level: A feasible way to improve the Chinese healthcare delivery system towards people-centred* integrated care*

* This chapter is based on a published paper. Alternations have been made for the sake of integrality.

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ABSTRACT

Aim: The general aim of this chapter is to assess the recent reform proposal for China's healthcare system (i.e. Healthy China 2030) and to figure out the question: *How do we place patient personal responsibility fairly in healthcare in China to make the reform measures (i.e. measures derived from the people-centred integrated care (PCIC) model) more effective?*

Background: Influenced by the PCIC model, Healthy China 2030 was drafted recently with a special concern given to patient engagement. Although there are three levels of engagement (i.e. individual, household and community), engaging patients at the household level appears to have been overlooked so far.

Methods: This chapter performs a theoretical analysis on personal responsibility and luck egalitarianism. Furthermore, context-based study is also adopted.

Findings: Discussion in this chapter identifies an attribution of Chinese bioethics; that is, family-centred. Furthermore, it collects some practical evidence in supportive of addressing personal responsibility in health and healthcare. Supported by ethical values and practical evidence, it is safe to conclude that engaging patients at the household level is a feasible approach to shape the Chinese healthcare system with the PCIC model orientation. Accordingly, four strategies are recommended for empowering and activating patients at the household level in the Chinese context.

Keywords: patient engagement, personal responsibility, family, Chinese bioethics, China

3.1 INTRODUCTION

'Healthy China 2030' (WB et al., 2016, p. 52) was drafted recently to deal with the emerging challenges of China's rapidly ageing population and its increasing burden of non-communicable diseases. Supported by the World Health Organization (WHO), the World Bank Group (WB) and correlative governmental agencies, Healthy China 2030 aims to restructure the Chinese healthcare delivery system by using the people-centred integrated care (PCIC) model. Under this model, the Chinese healthcare delivery system should be reorganised around satisfying the healthcare needs of individual patients and families through the use of five strategies: (1) empowering and engaging people; (2) reorienting the model of care; (3) coordinating services within and across sectors; (4) strengthening governance and accountability; and (5) creating and enabling the environment.⁴⁷ Accordingly, how to improve patient engagement is the top concern of Healthy China 2030.

Patient engagement has been recognised widely as a fundamental component in constructing a high-quality and value-based healthcare delivery system. Questions on patient engagement have been discussed intensively in academia, addressing the conceptualisation of patient engagement, the importance of engaging patients and the feasible measures for improving the engagement of patients, e.g. cultivating health literacy, strengthening self-management skills, improving shared decision-making and creating a supportive environment. (See Barlow et al., 2002; Forbat et al., 2009; McCarley, 2009; Gruman et al., 2010; Barelllo et al., 2012; Ishikawa & Yano, 2011; Berkman et al., 2011; Carman et al., 2012; Hibbard & Greene, 2013; Castro et al., 2016). Likewise, the measures proposed above de facto implicate the core action areas of empowering and engaging patients that are recommended by Healthy China 2030. Although there are three levels of engagement (i.e. individual, household and community) (WB et al., 2016, p. 51), patients are more likely to be empowered through an individualistic approach, because contemporary bioethics has a remarkable ability to address patient autonomy (Wang, 2014). Considerable research concentrates on how to protect and promote patient autonomy from different perspectives, including discussion of the protection of patient rights, the liability of healthcare providers and the accountability of the state. There is also growing research advocating patients' personal responsibility associated with the increasing burden of lifestyle-related chronic diseases (Denier et al., 2013). As one crucial party in healthcare, the patient's family appears to have been overlooked thus far.

Engaging patients at the household level refers mainly to empowering and activating patients with the assistance of the family in building health literacy, strengthening self-management skills, improving shared decision-making and creating a supportive environment.

47 For a detailed introduction, please refer to <http://www.who.int/servicedeliverysafety/areas/people-centred-care/strategies/en/> (last accessed 24 March 2019).

One matter needs to be clarified in terms of what we mean by ‘family’. To avoid any ambiguity, family (or ‘household’) is conceptualised within a narrow scope, to include ‘two or more individuals who are related by birth, by marriage or by adoption.’⁴⁸ In this context, family refers to the ‘nuclear family’ that merely includes mother, father and children. Therefore, it excludes all other kinships, such as grandparents and siblings. Admittedly, addressing the essential function of involving family in assisting patient engagement is highly contextual and culture-based. Chinese values and traditions show a high level of coherence in this respect. Engaging patients at the household level is thus the key element that should not be missing when discussing how to construct an effective Chinese healthcare delivery system oriented towards the PCIC model targets.

Accordingly, this chapter attempts to address the importance of engaging patients at the household level in shaping the Chinese healthcare system with a PCIC model orientation, and thus provides several recommendations on how to engage patients at the household level in the Chinese context. We begin with a philosophical reflection on defining what is meant by engaging patients at the household level. By invoking the notion of personal responsibility, and by briefly introducing luck egalitarianism, which is a responsibility-sensitive theoretical framework of healthcare justice, we believe that using personal responsibility as a distributive criterion, while adopting family support as a complementary consideration, should be plausible for achieving distributive justice in healthcare in China. To certify the feasibility of engaging patients at the household level from a practical perspective, we explore four dimensions of the Chinese context (i.e. Confucian tradition, the household registration system, health insurance schemes and correlative legislation). Based on the analysis above, we intend to approach the core action areas of patient engagement, as recommended by Healthy China 2030, by placing more emphasis on the role of the family to develop proper strategies for engaging patients at the household level in China. Specifically, we recommend the following four strategies: (1) cultivating health literacy as a family asset; (2) advocating family monitoring and family support to assist the improvement of patients’ self-management skills; (3) adopting family-based informed consent in the shared decision-making process; and (4) using the development of healthy families as a parallel pathway for creating a supportive environment for patient engagement.

48 US Census Bureau, *Census 2000 Profiles of General Demographic Characteristics*; please refer to <https://www.census.gov/prod/cen2000/doc/ProfilesTD.pdf> (last accessed 24 March 2019)

3.2 ENGAGING PATIENTS AT THE HOUSEHOLD LEVEL: PERSONAL RESPONSIBILITY PLUS FAMILY SUPPORT

As already summarised, engaging patients at the household level refers mainly to empowering and activating patients with the assistance of the family. Compared with the individual and community levels, empowering and activating patients at the household level can easily be overlooked, especially when considering the individualistic feature of medical ethics. This subsection will therefore illustrate the importance of engaging patients at the household level from a philosophical perspective.

The underlying philosophical foundation for patient engagement is that people can take care of their own health if they are adequately empowered, which invokes the notion of personal responsibility. By and large, personal responsibility means holding individuals accountable for their own choices. This can be identified in a number of ways in healthcare, but in broad terms it means that people should manage their own health through building health literacy, improving self-management skills and being active in shared decision-making (Vincent, 2009). Emphasising personal responsibility in distributing healthcare resources is preferable, especially when there is a great need to secure the sustainability of a healthcare system.

Luck egalitarianism is a theoretical framework that assigns personal responsibility a central role to play in assuring the distributive justice of healthcare. Despite varied ideals,⁴⁹ luck egalitarians have reached an overlapping consensus on one basic claim: it is morally unacceptable that people suffer from inequalities in care caused by factors beyond their control (Segall, 2015). In concrete terms, if two people are equally well-off at the very beginning, and one of them opts to reduce their wealth in some way voluntarily, then the eventual inequality between their wealth statuses is justified (Huseby, 2016). This basic standpoint can be traced back to a special distinction between ‘brute luck’ and ‘option luck’ from Ronald Dworkin.⁵⁰ Accordingly, a just society should be sensitive to people’s voluntary choices (‘option luck’) while remaining insensitive to their ‘brute luck’ in distributing resources (Dworkin, 1981, p. 293; Dworkin, 2002, p. 287; Brown, 2005, p. 25). In order to distinguish ‘option luck’ from ‘brute luck’, luck egalitarianism adopts personal responsibility as its basic criterion. In health and healthcare, this means that individuals may get no reimbursement for their disadvantages if those disadvantages are the result of their own imprudent behaviour. Be-

49 There are diverse views of luck egalitarianism. They are different from one another primarily in the way of advocating equality. For instance, see Ronald Dworkin’s *equality of resources*; Richard Arneson’s *equality of welfare*; G. A. Cohen’s *equality of access to advantages*; Eric Rakowski’s *equality of fortune*; John Roemer’s *equality of opportunity*.

50 According to Dworkin, ‘option luck is a matter of how deliberate and calculated gambles turn out ... Brute luck is a matter of how risks turn out which are not in that sense deliberate gambles.’ Please refer to Dworkin, (1981), p. 293.

cause of this viewpoint, luck egalitarianism has long been criticised for abandoning negligent victims (Anderson, 1999). To defend luck egalitarianism, meaningful countermeasures have been raised from different perspectives, such as Ronald Dworkin's (2013, p. 299) mandatory health insurance scheme, Shlomi Segall's (2007) adoption of the principle of solidarity and Nicholas Berry's (2006) strategy of multiple principles.

Among these plausible proposals, adopting the principle of solidarity to complement luck egalitarianism is likely to be more feasible in the Chinese healthcare system, because China is a Confucian society prioritising the value of solidarity. In other words, the Chinese people attach great importance to the welfare of society above individual gains. But this is not to say that the Chinese people are absolutely willing to share their fate with strangers without calculating gains and losses. Yet sacrificing individual gains for family members is common behaviour within the Chinese families, because family relationships (e.g. through birth, marriage or adoption), as a solid source of family support, bind family members together.⁵¹ The way we propose adopting the principle of solidarity thus differs slightly from that of Shlomi Segall. Alongside personal and social responsibility, we assert that a position should also be accorded to family support and care in light of Chinese values and traditions. In other words, family members should accept the obligation to support each other when 'the abandonment of negligent victims' (Anderson, 1999, p. 296) occurs. To offer a simple example: luck egalitarianism holds that a just healthcare system should not compensate individuals when they choose reckless behaviour voluntarily. In this case, individual patients are 'abandoned' by the healthcare system, but they could still ask for financial support from their family members in order to obtain healthcare, because their family members are obliged to offer support. Understanding the principle of solidarity by preserving a place for the family thus makes sense, in terms of defending the implementation of luck egalitarianism in shaping the Chinese healthcare delivery system towards balancing people-centred care and sustainability.

The preliminary idea behind engaging patients at the household level is to emphasise the patient's personal responsibility in managing their own health, while adopting family support as a supplementary consideration to prevent the individual patient from being abandoned by the healthcare system. Admittedly, laying stress on the mutual support and care between family members implies that the feasibility of engaging patients at the household level is

51 Marriage Law of the People's Republic of China (2001 Amendment): Article 21 (related by birth), Article 26 (related by adoption), and Article 20 and 27 (related by marriage). The English translation of these Articles is available online, please refer to <http://en.pkulaw.cn/display.aspx?id=1793&lib=law&SearchKeyword=&SearchCKeyword=%bb%e9%d2%f6> (last accessed 24 March 2019). Law of the People's Republic of China on the Protection of the Rights and Interests of the Elderly (2015 Amendment): Article 15. The English translation of this Article is available online, please refer to <http://en.pkulaw.cn/display.aspx?id=19790&lib=law&SearchKeyword=&SearchCKeyword=%c0%cf%c4%ea%c8%cb> (last accessed 24 March 2019). Also, please refer to Moskowitz (2001), p. 711.

highly contextual and culture-based. We therefore provide a detailed explanation concerning four dimensions of the basic Chinese context (i.e. Confucian tradition and bioethics, the household registration system, health insurance schemes and correlative legislation), in order to find more practical evidence for justifying the feasibility of engaging patients at the household level in China.

3.3 PRACTICAL EVIDENCE FOR THE FEASIBILITY OF ENGAGING PATIENTS AT THE HOUSEHOLD LEVEL IN CHINA

3.3.1 Confucian society and Chinese bioethics

Confucian ethical tradition attaches great importance to the virtue of *ren* (benevolence) and *xiao* (filial piety).⁵² From a Confucian viewpoint, the individual human being is incomplete without belonging to a family (Chen & Fan, 2010, p. 577). Confucian societies (e.g. Singapore and China) therefore value close family ties and attach great importance to the role of the family when drafting social policies (Wong et al., 2009, p. 53). To a large extent, this viewpoint decides the family-based character of the healthcare system in these societies, such as emphasising the role of the family in healthcare decision-making.

As a Confucian society, China preserves the tradition that family plays a crucial role in healthcare decision-making (Fan & Li, 2004; Chen & Fan, 2010, p. 579). As Ruiping Fan (2004, p. 179) states,

‘China medical ethics ... remains committed to hiding the truth as well as to lying when necessary to achieve the family’s view of the best interests of patients.’

In most cases, physicians would comply with the opinions of family members even when the patient is competent (2002). This indicates that Chinese bioethics assigns the family a privileged position in the essential dimensions of healthcare (e.g. informed consent and decision-making), thus differing from Western bioethics which prioritises patient autonomy. But laying stress on the importance of family in healthcare does not equate to Chinese bioethics taking patient autonomy for granted. On the contrary, it attaches great importance to protecting patient autonomy, because family members are the people who are supposed to know the patient best, and who are able to provide the best interpretation of patient expectations and preferences, and who can therefore take the most appropriate healthcare decisions in the best interests of the patient (Lee, 2014). Furthermore, with family support, patients are believed to be better prepared in both psychological and physical aspects (Yung, 2014). Contrary to the traditional relationship between one doctor and one patient, Chinese

52 For the English translation of those basic virtues of Confucianism, please refer to Runes (1983), p. 338.

bioethics tends to cultivate the doctor-patient relationship with a strong involvement of family members. Studies show that in Confucian societies, patients, especially older ones, are likely to give up life-sustaining treatments for the sake of reducing the financial burden on their family members (Choi, 2004, p. 86). Involving family members in healthcare is therefore a way of preventing such self-sacrificing behaviour. Family support is also of great importance for patients who need long-term care (e.g. the elderly with disabilities) or suffering from life-threatening illnesses (e.g. a severe heart attack or cancer). Studies indicate that family support is a primary factor influencing the survival rate of such patients (Ell, 1996).

The Confucian ethical tradition thus underpins Chinese bioethics in terms of involving family in healthcare, thereby providing a cultural and ethical foundation for engaging patients at the household level in China.

3.3.2 Household registration system

The household registration system (*hukou*) has been in operation since 1949 for the administration of China's residents. People born legally in China acquire a personal registration card (*hukou* page) to be added to a household registration record (*hukou* booklet). The household registration record is issued per family; it thus certifies not only the legal residence of a citizen, but, more importantly, the relationships between family members.

The household registration system exerts a significant influence on access to social benefits, such as education and healthcare (Qiu, 2014, p. 113). At the very beginning, the household registration record was designed to identify an individual as a permanent resident of a specific place, either rural (agricultural household registration record) or urban (non-agricultural household registration record). Studies show it is this categorisation that has generated the inequality in social benefits in China so fundamentally, in particular the access to healthcare (Qiu, 2014, p. 113). This argument may be partially true, but the negative effects resulting from this classification should be eliminated with the implementation of the Guiding Opinion of the State Council on Deepening the Reform of the Household Registration System in 2014.⁵³ Following the Guiding Opinion, the reform focused on the innovation of population management by abolishing the classification of the agricultural and non-agricultural household registration records.

This ongoing household registration system reform is therefore believed to provide administrative support for corresponding policies regarding patients' household engagement, such as contracting each family as a unit with general practitioners (GPs), and creating a household-based medical file system.

53 State Council. (2014). Guiding Opinion of State Council on Deepening the Reform of the Household Registration System, para 9. Please refer to http://www.gov.cn/zhengce/content/2014-07/30/content_8944.htm (in Chinese, last accessed 24 March 2019).

3.3.3 Integrated health insurance

Influenced by the rural-urban household registration system, China's health insurance system also features a similar classification (with three basic types of health insurance schemes): people born in the rural areas participate in a health insurance scheme called the New Rural Cooperative Medical Scheme (NRCMS); people born and employed in urban China should participate in the Urban Employees' Basic Medical Insurance (UEBMI); and people born in urban China but without employment should participate in the Urban Residents' Basic Medical Insurance (URBMI). These three schemes differ slightly in terms of their reimbursement rates and benefit package. Some scholars argue that the different reimbursement rates may aggravate unequal accessibility to healthcare in China (Wang et al., 2012, p. 80). But de facto, the casual relation is very weak which can be demonstrated by the example of UEBMI and URBMI.

For quite a long time, sharing social medical insurance with family members has been customary among urban residents. In other words, if the patient has been insured by the URBMI, but their father is insured by the UEBMI and the reimbursement rate of the URBMI is slightly lower than that of the UEBMI, it would not be a surprise that the father is willing to use his health insurance to help the patient to get medication and treatment not included in the URBMI. Actually, it was seen as dishonest behaviour in the past and, therefore, prohibited at that time. Nowadays, due to the strong incentives of the mass population to share their social medical insurance, more and more local governments have selected pilot cities to implement a household-based 'sharing insurance' in the urban areas of China, which is de facto the integration of URBMI and UEBMI.⁵⁴ Furthermore, scholars advocate integrating the URBMI and the UEBMI, or even integrating all three health insurance schemes into one household-based rural-urban basic health insurance scheme (Zhou, 2010; Xia & Yin, 2010; Zheng, 2012; Yuan et al., 2015).

Although the integration of these health insurance schemes is still under discussion, the direction of these discussions has already indicated the potential feasibility of engaging patients at the household level in China. More importantly, it is believed that integrated health insurance schemes would contribute to the effectiveness of household-based engagement in terms of providing financial support.

3.3.4 Legislation in relation to family and healthcare

Although China, like many other countries, does not have a unified health law legislation relating to family and healthcare comprises many regulations. These include Article 15 of the Law on Protection of the Rights and Interests of the Elderly (2015 Amendment) which

⁵⁴ In 2012, Guangzhou province initiated the experiment of family-based 'sharing insurance'. Thereafter, Chengdu and Shenzhen became the pilot areas of family-based sharing insurance in 2015. In 2017, the local government of Zhejiang province issued a series of supportive policies to encourage the development of family-based sharing insurance.

stipulates filial responsibility; Article 11 of the Law on the Protection of Minors (2012 Amendment) which regulates parental responsibility; Article 15 of the Law on Blood Donation; Article 21 of the Mental Health Law; four regulations (Article 20, Article 21, Article 26 and Article 27) of the Marriage Law relating to reciprocal responsibility between family members; and Article 26 of the Law on Practising Doctors (2009 Amendment), which stipulates the involvement of family in informed consent.⁵⁵

Take elderly care and filial responsibility, for example. In the Confucian ethical tradition, the virtue of respecting and caring for older generations in a family is named *xiao* (filial piety). *Xiao* is not only a moral virtue that is valued and advocated by Chinese society, but it is also a mandatory responsibility affirmed by China's legislation, such as Article 15 of the Law on Protection of the Rights and Interests of the Elderly (2015 Amendment):

'The supporters shall ensure that the elderly suffering from illness receive timely treatment and care, and shall pay medical expenses for the elderly in financial hardship. For the elderly who cannot take care of themselves, their supporters shall bear the responsibility of taking care of them; and if they cannot take care of the elderly in person, they may, according to the will of the elderly, delegate the responsibility of caring to other individuals or institutions.'⁵⁶

As stated in the second paragraph of Article 14 of the Law on Protection of the Rights and Interests of the Elderly, 'supporters' in this law refers mainly to the children of the elderly. Accordingly, it is stipulated in law that children owe their parents a duty of medical care. The value of family involvement is therefore clearly affirmed. Yet some scholars express their concern at the effectiveness of enforcing this Article, because parents may be reluctant to bring a lawsuit against their children (Moskowitz, 2001, p. 709; Edelstone, 2002; Ting & Woo, 2008).

Another typical example of family involvement relates to informed consent. In Western bioethics, informed consent should be given by the patient except in certain circumstances, such as emergency cases or situations where patients exercise their right not to know. However, Article 26 of the Law on Practising Doctors (2009 Amendment) affirms the involvement of the patient's family when informed consent is required:

'Doctors shall tell the patients or their family members the patient's condition truthfully. However, care shall be taken to avoid any adverse impact on the patients.

55 The English version of the legislation is available at the pkulaw database. Please refer to <http://en.pkulaw.cn/> (last accessed 24 March 2019).

56 The English translation of this Article is available online, please refer to <http://en.pkulaw.cn/display.aspx?id=19790&lib=law&SearchKeyword=&SearchCKeyword=%c0%cf%c4%ea%c8%cb> (last accessed 24 March 2019).

Doctors shall get approval from the hospital and the consent of the patient or family members before conducting clinical treatment on an experimental basis.⁵⁷

This Article carries two layers of meaning: doctors must tell the patient's condition to the family members truthfully and without delay, but doctors must also take the patient's family's expectations and preferences into consideration, along with the patient's psychological condition, before letting the patient know their health condition. It also indicates that, with such a provision, patients cannot exercise any self-sacrificing behaviour for the sake of their family, and doctors are able to comply with their truth-telling obligation.

These regulations all legitimise the involvement of family in healthcare, and thus explain the legal reason why engaging patients at the household level is feasible in China.

3.4 RECOMMENDATIONS FOR ENGAGING PATIENTS AT THE HOUSEHOLD LEVEL

'Healthy China 2030 lists four core action areas of patient engagement, and correspondingly provides detailed guidance on how to approach these areas' (WB et al., 2016, pp. 52–64). Contrary to what is recommended in Healthy China 2030, we try to approach these areas by laying more emphasis on the role of the family in order to develop feasible strategies for engaging patients at the household level in China.

3.4.1 Building health literacy: health literacy as a family asset

As Healthy China 2030 summarised, health literacy is the ability to read and understand health-related information so that people are able to take care of their health (WB, 2016, p. 52). As Don Nutbaum (2008) summarised, health literacy can be interpreted from both negative and positive perspectives. The negative perspective interprets health literacy as a risk factor focusing on dealing with the impacts of low health literacy on health outcomes, while the positive perspective regards health literacy as an asset, which implies that a high level of knowledge and skills can be beneficial to personal health. Engaging patients at the household level mainly interprets health literacy from the positive perspective, meaning cultivating health literacy as a family asset.

Building health literacy is not merely an individual task, but a family issue. According to Healthy China 2030, accessible and understandable health information is fundamental to patient engagement. But health information is merely one prerequisite in assisting patient engagement. Patients with a low level of health literacy are still likely to experience more

57 The English translation of this Article is available online, please refer to <http://en.pkulaw.cn/display.aspx?id=22771&lib=law&SearchKeyword=&SearchCKeyword=%D6%B4%D2%B5%D2%BD%CA%A6> (last accessed 24 March 2019).

mistakes in understanding and adhering to a doctor's prescribed treatments (Coulter & Ellins, 2007, p. 24). So involving a patient's family members in assisting patients to read, understand and adhere to a doctor's diagnosis and treatment is favourable and important, especially when considered alongside the evolving telecare services.

Younger generations of the family are generally considered to be more open to accepting and using new technologies such as e-health. So regarding health literacy as a family asset requires the provision of more opportunities to educate the younger generation in the use of e-health, expecting them to help the family's older generations. This is not, however, to say that the older generation can shirk their responsibilities in cultivating health literacy. As a family asset, the earlier high health literacy has been built, the more beneficial it will be for the family members, especially for the family's younger generations. Children under a certain age are highly influenced by their parents in terms of forming their eating style, undertaking physical activities and cultivating their personal characters (Troost et al., 2003). The level of the older generation's health literacy is a decisive factor in controlling the risks of certain illnesses, such as childhood obesity and autism. Here, taking health literacy as a family asset lays more emphasis on the responsibility of the older generation in terms of cultivating a healthy lifestyle.

3.4.2 Strengthening self-management skills: Family monitoring and family support

In accordance with Healthy China 2030, self-management education, self-monitoring, self-administered treatment and telecare are the essential dimensions of a patient's self-management skills (WB et al., 2016, p. 52). These dimensions indicate that the individual patient may face the situation where they are forced to perform certain duties (e.g. recording blood sugar, adhering to prescribed medication and performing the rehabilitation practice at home) or to give up bad habits (e.g. being addicted to drink, cigarettes or even drugs). But none of them are easy to achieve, so extra assistance is required such as support from peers, family and friends (Greca et al., 1995; Toljamo & Hentinen, 2001). Here, Healthy China 2030 suggests that patients should participate in self-help groups in order to acquire peer support (WB et al., 2016, p. 52). Nevertheless, studies show the effectiveness of peer support to have mixed results (positive effects for certain illnesses, but no obvious influence for some others) (Van Uden-Kraan et al., 2009; Van Uden-Kraan et al., 2011; McGowan, 2012; Chan et al., 2014; Markowitz, 2015; Zhong et al., 2015). Concerns are also raised in terms of a patient's willingness to seek peer support, and the potential negative influence arising from patients' experience-sharing.

Compared to peer support, family support seems to be more emotional and functional in helping patients overcome their illnesses. The relationships (e.g. birth, marriage or adoption) between family members are acknowledged as a solid source of family support, motivating family members to share their fate with one another voluntarily. But some studies observe that there is a link between family support and certain negative outcomes in healthcare. For

instance, patients may feel self-blaming or even take self-sacrificing actions for the sake of their families (Carter-Edwards et al., 2004; Miller & Dimatteo, 2013; Choi, 2014, p. 86). Yet these negative outcomes could be prevented by involving family members at the earliest stage of diagnosis and treatment, such as emphasising the involvement of the family in the shared decision-making healthcare process.

3.4.3 Shared decision-making: Family-based informed consent

Being respectful and responsive to a patient's expectations and preferences in healthcare stimulates the adoption of a shared decision-making process (WB et al., 2016, p. 58). The shared decision-making process, as the essential element of the PCIC delivery model, is believed to be beneficial to a doctor's diagnosis and treatment, not only in terms of improving the correction and effectiveness of healthcare services, but also in restoring trust in the doctor-patient relationship.

It is noteworthy that a difference exists between Western and Chinese bioethics in how to interpret 'shared'. In many Western countries, 'shared' means that patients and their doctors are working together to discuss treatment plans and to set treatment goals. For this kind of 'shared', respecting and protecting patient autonomy is the 'golden rule' guiding the healthcare decision-making process. For example, patients in the Netherlands are entitled to a 'right not to know'⁵⁸. In effect, this leaves it up to the patient rather than the family to decide whether they will be told certain healthcare information. Even in the most extreme case where telling the truth may impose a heavy psychological burden on the patient, doctors still need to inform the patient rather than the family when the patient's health condition allows.⁵⁹

As already discussed, Chinese bioethics attaches great importance to the role of family in healthcare. Accordingly, 'shared' in the Chinese context should mean joint efforts not only by patients and their doctor, but also by patients' family members. There are several evidence-based studies demonstrating that treatment plans are usually finalised on the basis of the opinions of patient's family members in China (Li et al., 2016, p. 237). Therefore, besides professional knowledge and patient preferences, doctors should also take the expectations of the patient's family members into consideration, or even assign priority to the opinions of the patient's family members, when drawing up the treatment plan. Involving family in the shared decision-making process has already been put into practice by some local governments in China. For instance, Shanghai has implemented a family doctor system that encourages patients and families to exercise joint efforts in setting treatment plans and goals (WB et al., 2016, pp. 59–60).

58 Dutch Civil Code, Article 7, 449.

59 Dutch Civil Code, Article 7, 448, para. 3.

3.4.4 Creating a supportive environment: healthy families as a parallel pathway

Healthy China 2030 concentrates on creating a supportive environment by developing healthy cities and using environmental ‘nudges’⁶⁰ to complement regulations. To date, ten cities have joined the healthy cities movement as pilot cities in China (WB et al., 2016, p. 62). Although people’s health is affected de facto by the interactions of environmental and social factors, developing healthy families is likely to bring benefits to the individual patient more directly than promoting healthy cities. But the intention is not to replace the healthy cities movement with healthy families; it is rather to adopt the promotion of healthy families as a parallel pathway for engaging the patient. Developing healthy families will also contribute to the development of healthy cities, because the family is always regarded as the basic societal unit.

Developing healthy families should be approached with corresponding institutional support. Here the Chinese government has responded actively. Taking the field of primary care as an example, the Chinese government has initiated nationwide implementation of GP services aimed at establishing and strengthening the primary care gatekeeping.⁶¹ The system’s design mandates that GP services are administered on the basis of Chinese households. In other words, it is each household, rather than the individual patient, which is encouraged to contract a GP who practises medicine in the neighbourhood. Meanwhile, the household registration system and the integrated reform of the health insurance schemes are paving the way for contracting GP services that are household based.

Another example of providing institutional support for healthy families is to create one united medical file for each household, along with the nationwide implementation of the GP services. The household-based medical file will be particularly helpful for detecting and diagnosing illnesses, especially hereditary diseases, at the earliest stage. As the responsible party, GPs are the most appropriate candidates to keep their clients’ medical files confidential. They may only release an individual patient’s health information if required by law or by a patient’s family members. Although this statement appears to conflict with Western bioethics which prioritises respect for, and the protection of, patient autonomy, it is not prohibited by Chinese bioethics.

60 ‘Nudges’ is a new concept developed by Richard Thaler and Cass Sustein. It refers to an organised context (‘choice architects’) in which people are able to make better choices. A given example is that doctors have to provide alternative treatments for their patients. The activity of providing alternative treatments is exactly making a ‘choice architect’. For detailed analysis, please refer to Thaler & Sustein, (2003, 2008); Sustein & Thaler, (2003).

61 National Health and Family Planning Commission of the P. R. China 2016: Guiding opinions on advancing the contracts with general practitioners. Please refer to <http://www.nhfpc.gov.cn/tigs/s3577/201606/e3e7d-2670a8b4163b1fe8e409c7887af.shtml> (last accessed 24 March 2019).

3.5 CONCLUDING REMARKS

Overall, engaging patients at the household level is believed to be more feasible in shaping the Chinese healthcare system towards the PCIC model.

The Confucian tradition and Chinese bioethics provide a solid cultural foundation for engaging patients at the household level. The household registration system and the integrating health insurance reform also provide the institutional basis for engaging patients at the household level. Family-related laws and regulations also explain the legal reasons why engaging patients at the household level is feasible in China. In light of the Chinese traditions and values, it is safe to conclude that involving the family should be beneficial in protecting patient rights. Future efforts need to be devoted, at least partially, to cultivating health literacy as a family asset, to emphasising family support in promoting a patient's self-management skills, to involving families in shared decision-making, and to developing healthy families as a parallel pathway for creating the supportive environment for patient engagement.

Although the feasibility of engaging patients at the household level is highly contextual and culture-based, emphasising the essential role of the family in healthcare is a valuable experience from Chinese bioethics that could also be beneficial for Western bioethics.

3.6 REFERENCES

- Anderson, E. S. (1999). What is the point of equality? *Ethics*, 109(2), 287-337.
- Barello, S., Graffigna, G., & Vegni, E. (2012). Patient engagement as an emerging challenge for healthcare services: Mapping the literature. *Nursing Research and Practice*, 905-934. doi: 10.1155/2012/905934.
- Barlow, J., Wright, C., Sheasby, J., Turner, A., & Hainsworth, J. (2002). Self-management approaches for people with chronic conditions: A review. *Patient Education Counseling*, 48(2), 177-187.
- Barry, N. (2006). Defending luck egalitarianism. *Journal of Applied Philosophy*, 23(1), 89-107.
- Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, & D. J., Crotty, K. (2011). Low health literacy and health outcomes: An update systematic review. *Annals of Internal Medicine*, 155(2), 97-107.
- Brown, A. (2005). If we value individual responsibility, which policies should we favor? *Journal of Applied Philosophy*, 22(1), 23-44.
- Carman, K. L., Dardess, P., Manurer, M., Sofaer, S., Adams, K., Bechtel, C., & Sweeney, J. (2012). Patient and family engagement: A framework for understanding the elements and developing interventions and policies. *Health Affairs*, 32(2), 223-231.
- Carter-Edwards, L., Skelly, A. H., Cagle, C. S., & Appel, S. J. (2004). They care but don't understand: Family support of African American women with type 2 diabetes. *The Diabetes Educator*, 30(3), 493-501.
- Castro, E. M., Regenmortel, T. V., Vanhaecht, K., Sermeus, W., & Hecke, A. V. (2016). Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review. *Patient Education Counseling*, 99(12), 1923-1939.
- Chan, J., Sui, Y., Oldenburg, B., Zhang, Y., Chung, H. H., Goggins, W., ... Fisher, E. (2014). Effects of telephone-based peer support in patients with type 2 diabetes mellitus receiving integrated care: A randomized clinical trial. *JAMA Internal Medicine*, 174(6), 972-981.
- Chen, X., & Fan, R. (2010). The family and harmonious medical decision making: Cherishing an appropriate Confucian moral balance. *Journal of Medicine and Philosophy*, 35, 573-586.
- Choi, K. (2004). The ideal of autonomy and its misuse. In R. Fan (Ed.), *Family-oriented informed consent: East Asian & American perspectives*, pp. 83-92. Dordrecht: Springer.
- Coulter, A., & Ellins, J. (2007). Effectiveness of strategies for informing, educating, and involving patients. *BMJ*, 335, 24.
- Denier, Y., Gastmans, C., and Vandeveld, A. (2013). *Justice, luck & responsibility in health care: Philosophical background and ethical implications for end-of-life care*. Dordrecht: Springer.
- Dworkin, R. (1981). What is equality? Part 2: Equality of resources. *Philosophy & Public Affairs*, 10(4), 283-345.
- Dworkin, R. (2002). *Sovereign virtue: The theory and practice of equality*. Cambridge, MA: Harvard University Press.
- Dworkin, R. (2013). *Taking rights seriously*. London: Bloomsbury Academic, 299.
- Edelstone, S. F. (2002). Filial responsibility: Can the legal duty to support our parents be effectively enforced? *Family Law Quarterly*, 36(3), 501-514.
- Ell, K. (1996). Social networks, social support and coping with serious illness: The family connection. *Social Science & Medicine*, 42(2), 173-183.
- Fan, R. (2002). Reconsidering surrogate decision making: Aristotelianism and Confucianism on ideal human relations. *Philosophy East and West*, 52(3), 346-372.

- Forbat, L., Cayless, S., Knighting, K., Cornwell, J. and Kearney, N. (2009). Engaging patients in health care: An empirical study of the role of engagement on attitudes and action. *Patient Education Counseling*, 74(1), 84–90.
- Greca, A., Auslander, W., Greco, P., Spetter, D., Fisher, E. Jr., & Santiago, J. (1995). I get by with a little help from my family and friends: Adolescents' support for diabetes care. *Journal of Pediatric Psychology*, 20(4), 449–476.
- Gruman, J., Rovner, M. H., French, M. E., Jeffress, D., Spfaer, S., Shaller, D., & Prager, D. J. (2010). From patient education to patient engagement: Implications for the field of patient education. *Patient Education Counseling*, 78(3), 350–356.
- Hibbard, J. H., & Greene, J. (2013). What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. *Health Affairs*, 32(2), 207–214.
- Huseby, R. (2016). Can luck egalitarianism justify the fact that some are worse off than others? *Journal of Applied Philosophy*, 33(3), 259–269.
- Ishikawa, H. & Yano, E. (2011). The relationship of patient participation and diabetes outcomes for patients with high vs. low health literacy. *Patient Education Counseling*, 84(3), 393–397.
- Lee, S. C. (2014). Family consent in medical decision-making in Taiwan: The implication of the new revisions of the Hospice Palliative Care Act. In R. Fan (Ed.), *Family-oriented informed consent: East Asian & American perspectives*, 125–136. Dordrecht: Springer.
- Li, X., Xing, Y., Lin Q., Wei, L., Dong, M., Ma, X., ... Wu, X. (2016). Female cancer patients' awareness and role in family-based medical decision making mode in Confucian area. *Journal of Clinical Oncology*, 34(26), 237.
- Markowitz, F. E. (2015). Involvement in mental health self-help groups and recovery. *Health Sociology Review*, 24(2), 199–212.
- McCarley, P. (2009). Patient empowerment and motivational interviewing: Engaging patients to self-manage their own care. *Nephrology Nursing Journal*, 36(4), 409–413.
- McGowan, P. T. (2012). Self-management education and support in chronic disease management. *Primary Care: Clinics in Office Practice*, 39(2), 307–325.
- Miller, T. A., & DiMatteo, M. R. (2013) Importance of family/social support and impact on adherence to diabetic therapy. *Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy*, 6, 421–426.
- Moskowitz, S. (2001). Filial responsibility statutes: Legal and policy considerations. *Journal of Law & Policy*, 9, 709–736.
- Nutbaum, D. (2008). The evolving concept of health literacy. *Social Science & Medicine*, 67(12), 2072–2078.
- Qiu, S. (2014). Equality and the right to health: A preliminary assessment of China. In B. Toebes, (Ed.), *The Right to Health*, 97–120. Dordrecht: Springer.
- Runes, D. D. (1983). *Dictionary of Philosophy*. New York, NY: Philosophical Library.
- Segall, S. (2007). In solidarity with imprudent: A defense of luck egalitarianism. *Social Theory and Practice*, 33(2), 177–198.
- Segall, S. (2015). What's so egalitarian about luck egalitarianism? *Ratio*, 28(3), 349–368.
- Sustein, C. and Thaler, R. (2003). Libertarian paternalism is not an oxymoron. *The University of Chicago Law Review*, 70(4), 1159–1202.
- Thaler, R. and Sustein, C. (2008). *Nudge: Improving Decisions about Health, Wealth, and Happiness*. New Haven, CT: Yale University Press.
- Thaler, R., Sustein C. (2003). Libertarian paternalism. *The American Economic Review*, 93(2), 175–179.

- Ting, G. H. Y., & Woo, J. (2008). Elder care: Is legislation of family responsibility the solution? *Asian Journal of Gerontology & Geriatrics*, 4, 72-75.
- Toljamo, M., & Hentinen, M. (2001). Adherence to self-care and social support. *Journal of Clinical Nursing*, 10(5), 618-627.
- Trost, S. G., Sallis, J. F., Pate, R. R., Freedson, P. S., Taylor, W. C., & Dowda, M. (2003). Evaluating a model of parental influence on youth physical activity. *American Journal of Preventive Medicine*, 25(4), 277-282.
- Van Uden-Kraan, C. F., Drossaert, C. H., Taal, E., Seydel, E. & Laar, M. A. (2009). Participation in online patient support groups endorses patients' empowerment. *Patient Education and Counseling*, 74(1), 61-69.
- Van Uden-Kraan, C. F., Drossaert, C. H., Taal, E., Smit, W. M., Bernelot Moens, H. J., & Van de Laar, M. A. (2011). Determinants of engagement in face-to-face and online patient support groups. *Journal of Medical Internet Research*, 13(4), e106.
- Vincent, N. A. (2009). What do you mean I should take responsibility for my own ill health? *Journal of Applied Ethics and Philosophy*, 1, 39-51.
- Wang, H., Liu, Z., Zhang, Y., & Luo, Z. (2012). Integration of current identity-based district-varied health insurance schemes in China: Implications and challenges. *Frontiers of Medicine*, 6(1), 79-84.
- Wang, J. (2014). Family and autonomy: Towards share medical decision-making in light of Confucianism. In R. Fan (Ed.), *Family-oriented informed consent: East Asian & American perspectives*, 63-84. Dordrecht: Springer.
- Wong, C. K., Wang, K., & Kaun, P. Y. (2009). Social citizenship rights and the welfare circle dilemma: Attitudinal findings of two Chinese Societies. *Asian Social Work and Policy Review*, 3, 51-62.
- World Bank Group, World Health Organization, China's Ministry of Finance, National Health and Family Planning Commission, and Ministry of Human Resources and Social Security. (2016). Healthy China: deepening health reform in China. Retrieved from <http://www.wpro.who.int/china/publications/2016-health-reform-in-china/en/> (last accessed 24 March 2019).
- Xia, Q. & Yin A. (2010). Analysis on the universal coverage medical insurance system with urban-rural integration in China. *Chinese Journal of Health Policy*, 3(1), 49-53 (in Chinese).
- Yuan, B., Xu, J. & Meng, Q. (2015). Analysis on integrating medical insurance schemes in China: Lessons from international experiences. *Health Development Outlook*, 23 (in Chinese). Retrieved from: <file://campus.eur.nl/users/home/56835zli/Desktop/Health+Development+Outlook-23.pdf> (last accessed 24 March 2019).
- Yung, L. (2014). The East Asian family-oriented principle and the concept of autonomy. In R. Fan, (Ed), *Family-oriented informed consent: East Asian & American perspectives*, 109-124. Dordrecht: Springer.
- Zheng, X. (2012). Review on integration of urban-rural basic medical insurance research. *Chinese Journal of Health Policy*, 5(9), 58-61 (in Chinese).
- Zhong, X., Wang, Z., Fisher, E. B. & Tanasugarn, C. (2015). Peer support for diabetes management in primary care and community settings in Anhui province, China. *Annual Family Medicine*, 13, S50-S58.
- Zhou, S. (2010). The condition, problems and recommendations on realizing the equalization of essential healthcare services. *Chinese Journal of Health Policy*, 3(7), 52-56 (in Chinese).



PART II

Balancing Patient Rights and the Sustainability of the Chinese Healthcare System from a Legal Perspective

The Systematic Focus



Chapter 4

Legal reflections on the evolving role of general practitioners in China's primary care: An assessment of regulatory interventions*

* This chapter is based on a published paper. Alternations have been made for the sake of integrality.

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ABSTRACT

Aim: To assess the regulation of the Chinese healthcare system in assisting a nationwide implementation of general practitioner (GP) services.

Background: Along with the perennial problems of unaffordable and inequitable healthcare, a rapidly ageing population and the increasing burden of non-communicable diseases pose challenges to the Chinese healthcare system. Recognising these challenges and to satisfy people's demands for more and better healthcare, China has initiated a plan, named Healthy China 2030, based on the findings from a two-year joint study by the World Health Organization (WHO) and the World Bank Group (WB) in collaboration with Chinese agencies. The Chinese healthcare plan, officially approved in 2016, is an attempt to use the people-centred, integrated care (PCIC) model recommended by the WHO and the WB to shape the Chinese healthcare system. In accordance with PCIC, China began the implementation of gatekeeping primary care by introducing GP services to local communities.

Methods: A comparative analysis was employed to point out the importance of introducing GP services. A systematic assessment was carried out to evaluate the regulatory sector of the Chinese healthcare system, including a critical review of related legal norms and a theoretical exploration of external impediments (e.g. cultural attitudes, government capacity and interest groups).

Findings: Results demonstrate that the current regulatory sector of the Chinese healthcare system needs to be improved in order to assist the nationwide implementation of GP services and to strengthen its gatekeeping role. Major deficiencies include the problematic relationship between legal norms and health policies, the lack of coherent laws, the low rate of social acceptance of GP services and the lack of continuing support for GP services from both formal and informal interest groups. To address those challenges, this paper recommends that preliminary efforts be devoted, in part, to two changes in the legal structure: enacting a specific law, and creating an independent regulatory oversight body.

Keywords: Chinese healthcare system reform, GP services, gatekeeping primary care, legislation, regulatory strategies

4.1 INTRODUCTION

Along with the perennial problems of unaffordable and less equitable healthcare, a rapidly ageing population and the increasing burden of non-communicable diseases pose challenges to the Chinese healthcare system (Anonymous, 2011; Huang, 2011; Tang et al., 2013; Xiao et al., 2014). Recognising these challenges, China initiated a healthcare reform plan in 2016 named Healthy China 2030 (WB et al., 2016). The plan was developed in response to a joint study by the World Health Organization (WHO) and the World Bank Group (WB) in collaboration with government agencies in China. Healthy China is oriented towards satisfying people's demands for more and better healthcare. It is an attempt to reform Chinese healthcare services by adopting the people-centred, integrated care (PCIC)⁶² model.

In general, the PCIC model requires health planners to divert attention from treatment to preventive care, and from merely curing diseases to satisfying people's healthcare needs and expectations (WHO, 2015; Wiley, 2016). The backbone of a successful PCIC model is a strong primary care system (Starfield et al., 2005). Accordingly, Healthy China prioritises the rebuilding of the healthcare delivery system at the level of the local community with an attempt to strengthen the gatekeeping role of its primary care. To ensure the accessibility and quality of primary care gatekeeping, general practitioner (GP) services (or family doctor services) have been introduced to replace the traditional hospital-based delivery system. Major reform efforts are devoted towards providing a GP for every household in China and establishing electronic personal health records for each Chinese citizen before 2020.⁶³

Although much of the existing literature is centred on evaluating and promoting the performance of GPs in high-income countries, it is still a new concept for low and middle-income countries like China. Therefore, many questions need to be answered. What services will the GP provide? Why does the Chinese healthcare system need the GP system? Will the primary care gatekeeping in China be strengthened by introducing GP services? What is the proper role of the GP in the Chinese healthcare system? Will the adoption of the GP system expand access to healthcare? Will the adoption of the GP system reduce medical expenses, or slow the rate of escalation, while increasing the efficiency of the Chinese healthcare system? Will the GP strategy relieve the tension and restore the trust between doctors and patients? What is the most effective and feasible way to adapt the GP system to the Chinese healthcare system? Finally, the most important question: is the Chinese healthcare system, or even China's entire society, prepared to embrace the GP system?

62 World Health Organization, (2016). Framework on integrated, people-centered health services. Please refer to <http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>. (last accessed 24 March 2019)

63 National Health and Family Planning Commission of the P. R. China. (2015). Guiding opinions on advancing the management and the quality of community health care. Please refer to <http://www.nhfpc.gov.cn/jws/s3581r/201511/1742007746a64005a16e32de00cc5fc5.shtml> (In Chinese, last accessed 24 March 2019)

Our study attempts to respond to these questions. First and foremost, the chapter affirms that the core and unique function of the GP is to provide front-line and preventive healthcare. By comparing community-based healthcare services designed earlier with the new concept of GP services, the chapter acknowledges the necessity of introducing GP services to establish and strengthen the primary care gatekeeping in China, but cautions that the regulatory sector of the Chinese healthcare system may need to be improved prior to the nationwide transition to GP services. To support this position, the paper appraises the regulatory sector of the Chinese healthcare system, in terms of not only relevant legal norms, but also external factors. Results show that major deficiencies in the regulatory sector include the problematic relationship between legal norms and health policies, the lack of effective and coherent laws, the low rate of social acceptance of GP services, and the lack of support for GPs from both formal and informal interest groups. Recognising these challenges, the chapter recommends that future efforts be devoted, in part, to the following two legal changes: enacting a specific law, and creating an independent regulatory supervisory body.

4.2 GP SERVICES: ESTABLISHING AND STRENGTHENING THE PRIMARY CARE GATEKEEPING

Mariner once said that ‘the change from medical terminology to market terminology both reflects and encourages conceptualising healthcare [as] a market commodity’ (Mariner, 1998, p. 3). Likewise, identifying the GP’s role is clearly of great importance, not only for policy-making, but also for further improvement. The GP (or family doctor) has been recognised as someone skilled in a medical discipline, who is as important as, or complementary to, a doctor practising a medical specialty (Olesen et al., 2000). Despite the fact that no consensus has been reached on the definition so far, all interpretations should at least reflect the core and unique function of GP services, which is to practise at the front line of healthcare (Franks et al., 1992; Yip & Hsiao, 2009a).

4.2.1 Primary care in China before the implementation of GP services

The current Chinese healthcare system is a hospital-based delivery one where public hospitals, as ‘one-stop shops’, take care of the majority of healthcare demands. At the local level, primary care is supposed to be guaranteed by community health centres (CHCs) and community health stations (CHSs) in urban China, and by township health centres (THCs) and village health stations (VHSs) in rural areas (Bhattacharyya et al., 2011). These medical institutions should, in principle, serve as the gatekeepers to hospitals and specialised medical care, but in reality, they fail to play this role.

This failure is partially because patients in China can access walk-in services in public hospitals without a referral letter. Even worse, two factors aggravate the problem. One is

the current Chinese health insurance scheme, which has covered over 95% of the Chinese population since 2012 (Meng et al., 2015, p. 78). It consists of multiple schemes: the Urban Employee Basic Health Insurance (1998), the New Rural Cooperative Medical Scheme (2003), the Urban Resident Basic Health Insurance (2007), and the Medical Financial Assistance System (2012). In general, these schemes prioritise the reimbursement of inpatient care over outpatient care (Xiao et al., 2014); furthermore, the reimbursement rates of these schemes differ. The priority of reimbursement and the different reimbursement rates drive patients to seek inpatient care provided by public hospitals without considering whether it is necessary or not, which, in turn, results in a comparatively low rate of outpatient care provided by the community-based medical institutions. Although the community-based medical institutions also provide limited inpatient care, their major function still focuses on expanding the accessibility of outpatient care. The other impediment to discouraging hospital use concerns the quality of medical services. Compared with the community-based medical institutions, public hospitals are believed to have advanced facilities and better-educated medical professionals. Naturally patients demand high-quality medical services. The lower level of trust in the quality of medical services provided by medical institutions, such as CHCs, causes patients to hesitate to access community resources as their 'first contact care' (Bhattacharyya et al., 2011, p. 179).

The combination of easy access to public hospitals and distrust in the quality of community care results in a tricky dilemma: public hospitals are overwhelmed with patients, while community-based medical institutions receive and treat fewer patients. To tackle the imbalance, public hospitals used to cut the number of beds, rather than cooperate with the community-based medical institutions. Unsurprisingly, cutting beds worsened the situation by causing inaccessibility of medical services, particularly tertiary care, and escalating medical expenses.

The public hospital dilemma was exacerbated by drug mark-ups (WB et al., 2016), which refers to the system by which 'hospitals receive kickbacks from drug companies for prescribing their products' (Yip & Hsiao, 2008, p. 463). This system gives health professionals financial incentives to overprescribe drugs with high profit margins. Even worse, the problem of overprescription results in some patients' resistance to certain drugs and increases tensions in the doctor-patient relationship (Yip & Hsiao, 2009a, 2009b; Ling et al., 2011).

The traditional hospital-based delivery system needs to be changed, with special attention devoted to improving preventive care. In this regard, the primary care gatekeeping is of vital importance and should be addressed as the top concern. Either as a supplement or an alternative to the current system of community-based healthcare services, GP services represent a step forward, and should be introduced in China in line with the PCIC model.

4.2.2 A brief overview of the GP system

Under current conditions in China, the GP system refers to a small group of medical professionals who provide basic medical care, public health and any contractual health management services.⁶⁴ Regardless of whether the GP is considered a supplement or an alternative to community-based medical institutions, how will the GP system be characterised?

Table 4.1 outlines GP services and compares them with community-based healthcare services. As shown in Table 4.1, GP services should include, but not be limited to, ‘common diseases management; immunisation and primary community health prevention; rehabilitation and family planning’ (Kong & Yang, 2015). Furthermore, the qualified GP should, in principle, be fully educated and trained to provide these services, but the system currently permits practising specialists and medical professionals with a background in Chinese medicine to be GPs, in order to address the shortage (Bhattacharyya et al., 2011). Moreover, medical expenses should be covered by health insurance mechanisms, the public health budget and patient co-payments. In addition, the regulatory strategy should adopt incentive schemes to encourage patients to use the GP as the first contact for healthcare, and should rely on the power of the local communities to monitor and assess the performance of these doctors. Leadership should also be clarified and strengthened by smoothing communication and fostering collaboration among different government agencies, with an appropriate division of labour. Last but not least, an information-sharing system and an effective referral network are required to improve the performance of GPs.

In 2015, the Chinese government introduced the GP concept to limited areas, such as Shanghai (Jing et al., 2015), Chongqing (Chen et al., 2015), and Guangdong (Kuang et al., 2015), to study the impact. A great deal of positive evidence has been reported, especially enhanced and timely medical services and a growing satisfaction with the medical experience. These promising outcomes accelerate the progress of nationwide implementation. Nevertheless, the selected experimental areas are mainly well-developed cities where people enjoy a higher level of social welfare, including education and medical care, than the average person in China.

Situations will be different, or even more complicated, when GP services are extended to the whole nation. Admittedly, it is necessary to introduce the GP to establish and strengthen the primary care gatekeeping in China, but it might turn out to be a problem if the Chinese healthcare system or even the entire society is unprepared. Thus, it is important for central government to secure a sound legal environment for GP services before nationwide implementation.

64 National Health and Family Planning Commission of the P. R. China, (2016). Guiding opinions on advancing the contracts with general practitioners. Please refer to <http://www.nhfpc.gov.cn/tigs/s3577/201606/e3e7d-2670a8b4163b1fe8e409c7887af.shtml> (in Chinese, last accessed 24 March 2019).

Table 4.1 Comparative analysis of the current community-based healthcare system and the general practitioner (GP) services under the PCIC model

	Current community-based healthcare system	GP services under the PCIC model
Medical Providers	CHCs, CHSs, THC, VHSs	GP Group
Accountable Sector(s)	CHCs, CHSs, THC, VHSs	GP
Major Services	CHC example: Disease Prevention and Control; Healthcare Survey and Education; Common Diseases Management; Rehabilitation and Family Planning.	Common Diseases Management; Immunisation and Community Health Prevention; Rehabilitation and Family Planning; Any Contractual Services of Health Management
First Contact Care or Not	Flexible Choice of Patients	Strict
Referral Method	Allow Patient Self-Refer to Higher-Level Medical Institutions	Encourage a Strict Referral Method: '1+1+1' Contract Model[1]
Relationship with Secondary and Tertiary Hospitals	Weak Communication, Loose Collaboration, Ambiguous Division of Labour[2]	More Integrated Collaboration; A Clear Division of Labour
Reimbursement	Less Rate of Reimbursement	Health Insurance Schemes; Public Health Budget; Co-Pay of Patients
Regulation (legal)	Government as Provider Doctor-patient relationship is mainly regulated by legal norms in public law area.	Government as Regulator Doctor-patient relationship should be regulated by legal norms in private law area.

CHC = community health centres; CHS = community health stations; THC = township health centres; VHS = village health stations.

Notes:

[1] National Health and Family Planning Commission of the P. R. China. (2016). Guiding Opinions on Advancing the Contracts with General Practitioners. Please refer to <http://www.nhfpc.gov.cn/tigs/s3577/201606/e3e7d2670a8b4163b1fe8e409c7887af.shtml> (in Chinese, last accessed 24 March 2019).

2] There are roughly three models of collaboration between hospitals and community-based medical institutions: loose collaboration model, medical consortium model and direct management model. The above three traits are generated from the loose collaboration model since it is employed more often than the other two models. For detailed analysis, please refer to Xu et al., (2016) p. 8.

4.3 PREPARED OR NOT: ASSESSMENT OF THE REGULATORY SECTOR FOR GP SERVICES

Roberts and colleagues proposed a 'five-control knob' (Roberts et al., 2004) framework to measure the achievement of healthcare system reform goals. The control knobs are financing, payment, organisation, regulation and behaviour. By using the regulation knob, we have appraised the current Chinese healthcare system in terms of whether it is prepared for the national rollout of GP services. The appraisal consists of assessing the internal structure and

external factors. The internal structure assessment mainly focuses on analysing relevant legal norms, while external factors are explored by answering three questions: (1) What are the general and specific cultural attitudes towards regulation of the Chinese healthcare system? (2) Do the relevant government agencies have adequate capacity to assure the enforcement of regulations? (3) Does the regulatory sector have enough support from relevant interest groups to promote the GP system?

4.3.1 Assessing internal structure: current effective laws and regulations

Theoretical studies involving legal norms and GPs mainly concentrate on altering individual behaviours in the healthcare sector, such as from the perspective of controlling the overprescription of drugs and medical malpractice, or from the perspective of dealing with violence against GPs.⁶⁵

Specifically, Chinese lawmakers have enacted the Tort Law (2009) to control medical malpractice, the Law on Practising Doctors (Revision, 2009) to deter and punish physician misbehaviours, and Amendment (IX, 2015) to the criminal law to punish perpetrators of physical violence against medical professionals.

Table 4.2 outlines provisions contained in a select group of relevant laws and regulations covering the important areas of medical practice. It is easy to see that the majority of current legal norms have been effective since 2009. This is partially because a deep reform of the Chinese healthcare system was initiated in that year. In truth, legal norms have served mostly as tools for achieving certain political goals, rather than as a means of an independent supervisory function to monitor and assess the performance of government agencies. This practice has placed the authority of legal norms at risk. Thus, the proper role of legal norms in improving the Chinese healthcare system needs to be reaffirmed deliberately.

The fragmented legal norms may also be incompatible with the concept of GP services, since they were issued to deal with the problems generated by the hospital-based delivery system. Put differently, the current version of Chinese healthcare was designed with less attention to support integrated care, and there was hardly any attempt to consolidate the fragmented legal norms. Thus, the fragmentation of legal norms needs to be taken seriously before any substantial steps are taken to implement GP services nationwide.

The current legislative method also has a deficiency. Regulations are more likely to be issued in the domain where bad behaviour causes the worst consequences (Roberts, 2004). Consequently, certain domains are overwhelmed by overlapping legal norms, while some domains are regulated either implicitly or far from adequately. For instance, informed consent, which is the essential element of patient rights, is merely protected by Article 26 of the Law on Practising Doctors, which stipulates: 'Doctors shall tell the patients or their

65 In literature, related discussions include: Sage et al., (1994); Allen, (2000); Hoffmann & Tarzian, (2003); Durand et al., (2015); Xiao et al., (2014); Hesketh et al., (2012).

Table 4.2 Effective legal norms concerning important areas of medical practice ^[1]

	Medical Malpractice	Confidentiality	Informed Consent	Physical Violence
Issuing Authority: Standing Committee of the National People's Congress^[2]				
Law on Practising Doctors (Revision, 2009)	Article 29 Article 37-38 Article 42	Article 37 (9)	Article 26	Article 40
Tort Law (2009)	Article 54-64			
Amendment (VII, 2009) to the Criminal Law		Article 253 (A)		
Amendment (IX, 2015) to the Criminal Law				Amend Article 290
Public Security Administration Punishments Law (Amendment, 2012)	Article 72			Article 23 (1)
Law on Prevention and Treatment of Infectious Diseases (Amendment, 2013)		Article 12 Article 68 (5)		
Issuing Authority: State Council				
Regulation on the Handling of Medical Accidents (2002)		Article 10		
Regulation on the Prevention and Treatment of HIV/AIDS (2006)		Article 39 Article 56		
Issuing Authority: Department Regulatory Documents				
Notice of the Ministry of Health on Issuing the Basic Norms for Electronic Medical Records (for Trial Implementation, 2010)		√		
Regulations on Medical Institutions for Medical Records Management (2013)		√		

Notes:

[1] English translation of laws and regulations is from pkulaw.cn <http://en.pkulaw.cn/> (last accessed 24 March 2019).

[2] The 2013 National People's Congress announced the establishment of the National Health and Family Planning agency to replace the former Ministry of Health and National Population and Family Planning Commission.

family members the patients' condition truthfully. However, care shall be taken to avoid an adverse impact on the patient. Doctors shall get the approval from the hospital and the consent of the patient or family members before conducting clinical treatment on an experimental basis' (Article 26, Law on Practising Doctors, 2009 Revision). Thus, doctors have a 'notification responsibility' (Meng et al., 2015) to honestly provide medical information (e.g. illness conditions, risks and treatment options) to patients and their families, but there is no explicit regulation on the extent and scope of discourse. Since no consensus has been reached regarding whether informed consent is a legal mandate or merely an ethical require-

ment, this implicit way of regulation seems to be fine for the current Chinese healthcare system. Nevertheless, it would no longer be sufficient after transition to the GP system, since the good performance of GPs relies on a higher level of mutual trust and a closer, contractual doctor-patient relationship. In the new context, informed consent should be affirmed as a mandatory duty, and should be regulated strictly in terms of both extent and scope. Therefore, optimisation of the legislative method to cover all related domains needs to be addressed in order to regulate GP services effectively.

In summary, the regulatory sector of the Chinese healthcare system is unprepared in terms of its internal legal structure. Before the nationwide implementation of GP services, relevant government agencies need to make a joint effort to alter the problematic role of legal norms, to consolidate fragmented legal norms and to optimise the legislative method.

4.3.2 Exploring external factors: cultural attitudes, government capacity and interest groups

Which external factors are impediments to the regulatory changes required for reform of the Chinese healthcare system? According to the ‘five-control knob’ (Roberts et al., 2004) framework, there are three external factors influencing reform efforts in the regulatory sector: cultural attitudes, government capacity and political support. In our analysis, we have replaced the third benchmark with ‘interest groups’. Although Roberts and colleagues (2004) have briefly discussed the organised interest groups and their potential influence on the reform efforts, their major concern is not to identify those interest groups, but to use them as a juncture to address the importance of strengthening political support (i.e. political skills, regulatory process and effective implementation) in regulation design. However, the aim of this section is to identify the external factors that actually impede the reform of China’s primary care. Thus, we use ‘interest groups’ instead of ‘political support’ with a conviction that the solid alliance that has been formulated between pharmaceutical companies and major hospitals deserves equal attention.

External factors will be explored by answering questions. What is the cultural attitude, generally and specifically, about using regulations to drive the performance of the Chinese healthcare system? Do the relevant government agencies have adequate capacity to assure the enforcement of regulations? Does the regulatory sector have enough support to ensure the effectiveness of the GP system?

Cultural attitudes

Roberts and colleagues concluded that the majority of Chinese citizens are likely to find ways of avoiding regulations instead of complying with them, since they are more vulnerable and are more likely to suffer from rule violations when compared to people living in countries like Denmark (Roberts et al., 2004). Besides, *yansu* (antipathy to litigation) solidly underpins traditional Chinese culture, which assigns a low priority to resorting to court to

resolve disputes (Meng et al., 2015, p. 63). This general cultural attitude may impede the substantive function of legal norms in advancing the performance of GP services.

With regard to the cultural attitude specific to healthcare, Mathers and Huang point out that 'the Chinese people tend to seek high-level care even for minor, self-limiting conditions' (Mathers & Huang, 2014, p. 270). To change this attitude, should legal norms take up the responsibility of educating patients to use healthcare resources more reasonably? What about the personal preferences of GPs regarding where to practise healthcare? Should legal norms be issued to influence GPs to serve rural areas? Some countries, such as India, have forced medical graduates to serve resource-scarce areas for a certain period of time (Bhattacharyya, 2014). As for China, however, medical graduates are encouraged, rather than forced, to serve rural areas by some incentive schemes, including a high salary and more opportunities to receive advanced training. Further investigation is needed as to whether the interference of law is appropriate in these personal aspects. After all, both general and specific cultural attitudes are of great importance for the effectiveness of regulations in advancing the performance of the new GP system. Thus, regulators should be fully aware of these attitudes.

Government capacity

According to the analysis of Roberts and colleagues (2004), countries with a high-quality civil service, well-functioning police and court systems and effective tax-reporting are more likely to achieve success in constructing an effective regulatory agency for their healthcare systems. Using these criteria as benchmarks, China seems to fall short of capacity.

Table 4.2 shows relevant legal norms concerning practising doctors launched by different levels of authority in China. The Standing Committee of the National People's Congress has the highest authority in enacting laws and regulations, followed by the State Council and the National Health and Family Planning Commission. Although China is governed by a single party, these central government agencies have a clear division of labour in line with a strict legal order. By the same token, a clear division of labour does not equally imply effective checks and balances. The deficiency of government capacity becomes aggravated in the implementation process, since there is substantial discretion by local governments.⁶⁶ Regulations issued by central government are presumed to be subject to uneven reactions at the local level, either because of different socio-economic conditions, or due to the uneven organisational capacity of different regions. Therefore, the substantial discretion of local governments should be taken into account by regulators before issuing any regulation of GP services.

66 Roberts, M., Hsiao, W. C., and Berman, P. (2004). *Getting health reform tight: A guide to improve performance and equity*. New York, NY: Oxford University Press.

Interest groups

The reform efforts will confront resistance from formal and informal organised interest groups for various reasons. In the healthcare sector, pharmaceutical companies and major medical institutions – in particular public hospitals – have formed a solid alliance since pharmaceutical incentives, known as drug mark-ups, have become a popular source of hospital revenue in the Chinese healthcare system. Although this activity has now been recognised as illegitimate and forbidden (WB et al., 2016), the solid alliance is not that easy to destroy. Any reform that may pose a threat to vested interests will certainly face great opposition.

A nationwide shift to GP services is believed to be one of those efforts that will engender stiff opposition, since the intention is to change the traditional hospital-based delivery system fundamentally. Likewise, any new regulation proposed in support of GP services will be influenced by these powerful players in the Chinese healthcare system. Regulators should therefore be clear about their expectations regarding those vital players, including their roles, attitudes and potential for compromise. Only by recognising sources of support and opposition realistically can legal norms be issued effectively, with the full engagement of every relevant player.

In summary, the regulatory sector of the Chinese healthcare system is unprepared to address the influence of external factors, such as cultural attitudes, government capacity and organised interest groups. Cultural attitudes, both general and specific, show a rather low acceptance of regulatory engagement with the GP system. Moreover, the substantial discretion of local governments results in self-interested enforcement of regulations. The uneven regional implementation will impede the effectiveness of regulations in protecting and improving the GP system. In addition, players such as public hospitals and pharmaceutical companies lack incentives to engage in reform. How to obtain adequate support from them is of great importance for a well-established GP system.

4.4 RECOMMENDATION: ENACT A SPECIFIC LAW AND CREATE AN INDEPENDENT REGULATORY SUPERVISORY BODY

Recognising that the regulatory sector is unprepared for the challenge posed by the nationwide implementation of GP services, we propose two ways to improve internal structure and address external factors, respectively. We recommend that, prior to the nationwide implementation of GP services, efforts should be devoted to, but not limited to, the following two directions: enacting a specific law, and creating an independent regulatory supervisory body.

4.4.1 Internal reform: enactment of a specific law

Legal norms should be issued and organised to shield people from the potential adverse effects of the GP system. Apparently, the current effective legal norms concerning practising

doctors are incompatible with the proposed GP services. A review of the laws and regulations, as listed in Table 4.2, indicates a great need to eliminate fragmentation to prevent conflict between overlapping legal norms.

In the future, steps can be taken to revise the Law on Practising Doctors by amending and inserting articles in line with the requirements for the administration of GP services. Take licensing and accreditation as simple examples. Medical institutions in China, whether focusing on medical treatment or disease prevention, have an affirmative responsibility to measure the performance of all doctors who have registered in their institutions, not only in terms of reporting malpractice and medical accidents (Article 16), but also in terms of providing training and continued education (Article 35). With regard to the proposed GP services, who should take up those responsibilities? In accordance with the Guiding Opinions on Advancing the Contracts with General Practitioners (2016), the GP is an identifiable person with primary responsibility for their medical group (Jing et al., 2015). Put differently, the GP has to self-report malpractice and medical accidents, which seems difficult or even impossible to do. Such regulations should therefore be revised with a thorough consideration of feasibility.

Furthermore, the GP system adopts a '1+1+1' contract model, which means that patients are encouraged to sign the contract with one GP group plus one secondary hospital plus one tertiary hospital. This contractual character of the doctor-patient relationship under the GP system deserves special attention. It implies that people living in China need to be empowered and activated in order to choose the best contract. Once again, regulators have to be cautious when adopting new concepts. If GP services are governed by contractual considerations, then regulations have to deal with the unequal positions of GPs and their patients. In this respect, regulations should be formulated with special attention devoted to creating a supportive legal environment, such as securing patients' rights to information, providing an effective complaint process and other empowering measures (e.g. 'building health literacy, improving self-management skills, cultivating shared decision-making and creating a supportive environment' (WB et al., 2016)).

Moreover, does the GP have the right to choose patients when the contractual relationship implies an exclusive relationship? According to Article 24 of the Law on Practising Doctors, doctors have an affirmative responsibility to take care of patients under emergency situations. Certainly, any emergency case should be excluded from contractual conditions due to humanitarian values. How about other cases? If the GP is entitled to select patients, is there any difference between commercial insurance companies and the GP? Will the rights of doctors or insurance companies limit the accessibility of healthcare for patients who suffer from severe chronic diseases? Since the law will affect everyone, Chinese lawmakers need to consider this issue carefully.

Last but not least, considering the fact that there exists a wide disparity between urban and rural areas in primary care in China (Shi, 1993; Liu et al., 1999; Zhang et al., 2016),

future legislation should pay special attention to assisting the implementation of GP services in the rural areas of China where people are more likely to suffer from lack of medication and qualified personnel in healthcare. However, this raises many other questions, such as: should legislation interfere in the career choices of medical graduates for the sake of dealing with the shortage of healthcare personnel in rural China? Questions like this are crucial for future legislation and thus need to be considered fully during legislative design.

4.4.2 External reform: creation of an independent regulatory supervisory body

In general, Chinese healthcare reform has been managed in a multileadership style. The government agencies in charge are the National Health and Family Planning Commission, the Ministry of Finance, the National Development and Reform Commission, and the Ministry of Human Resources and Social Security. Each government agency represents its own political constituency, which results in weak interagency communication and collaboration. Reform plans developed in this multileadership style are highly likely to fall short in accountability provisions for each sector, and contain contradictory arrangements. Although a typical example of multisector cooperation exists in China – the ‘Patriotic Health Campaign’ (Meng et al., 2015, p. 15) – this cross-sector coordination mainly focuses on protecting and promoting public health services instead of the entire primary care sector. Given these drawbacks, together with the substantial discretion of local governments and the physicians’ self-reporting dilemma, the enforcement process performs poorly in practice. Successful implementation of the GP system calls for greater attention to the regulatory body. Creation of an independent regulatory supervisory body may be a feasible strategy to pave the way for nationwide implementation.

There are two essential elements of the proposed independent regulatory supervisory body. One refers to the involvement of professionals with multidisciplinary backgrounds. Since healthcare reforms depend on consistent systematic efforts, the proposed body should recruit physicians who are able to provide clinical insight due to their front-line role in the healthcare system, economists who can provide input on sustainability and effectiveness, legal professionals who can draft laws and regulations to prevent misbehaviour and shield people from the adverse effects of reform, ethicists who can provide guidance on humanitarian performance, and professionals from social media who can cultivate cultural attitudes by educating people to be responsible and rational beneficiaries of the reform.

Procedural justice is another concern. Formulating an independent regulatory supervisory body should not be regarded as an attempt to replace any effective government agency. On the contrary, it should function independently as a bridge to mitigate the conflicts resulting from the multileadership style. In addition, the supervisory body should not only serve as a surveillance tool, but should also provide an open process for mediating medical disputes.

4.5 CONCLUDING REMARKS

As the cornerstone of the people-centred, integrated care framework, the evolving GP system has been introduced to establish and strengthen the primary care gatekeeping in China. Compared with the previous system of community-based medical services, GP services are believed to perform better in serving the gatekeeper role. The new GP system is promising, not only in terms of restoring trust between doctors and patients, but also with regard to the enhanced referral mechanism, which will contribute to improvements in communication and collaboration among different levels of medical institutions. However, these promising aspects could also produce unexpected adverse effects if the healthcare system, or even the entire society, is unprepared. In this regard, we have considered the current Chinese healthcare system, with special attention paid to the regulatory sector. Results show that major deficiencies in the regulatory sector include the problematic relationship between legal norms and health policies, the lack of effective and consistent new legislation, the low rate of social acceptance of GP services, and the lack of support for GPs from government agencies. Therefore, neither the internal structure nor the external environment of the regulatory sector is prepared. Recognising that a well-developed regulatory sector is of vital importance for the effective nationwide implementation of the GP system, future efforts should be directed, at least in part, towards enacting a specific law and establishing an independent regulatory supervisory body. Only after these requirements are met can GP services be implemented effectively on a nationwide scale.

4.6 REFERENCES

- Allen, P. (2000). Accountability for clinical governance: Developing collective responsibility for quality in primary care. *BMJ*, 32, 608-611.
- Anonymous. (2011). China's major health challenge: control of chronic diseases. *Lancet*, 378, 475.
- Bhattacharyya, O., Delu, Y., Wong, S. T., & Bowen, C. (2011). Evolution of primary care in China 1997–2009. *Health Policy*, 100, 174-180.
- Bhattacharyya, S. (2014). Compulsory rural service for medical graduates in India. *Student BMJ*, 22, g1681.
- Chen, F., Xu, X., Yang, Z., Tan, H., & Zhang, L. (2015). The willingness-to-pay for general practitioners in contractual service and influencing factors among empty nesters in Chongqing, China. *International Journal of Environmental Research and Public Health*, 12, 9330-9341.
- Durand, M. A., Moulton, B., Cockle, E., Mann, M., & Elwyn, G. (2015). Can shared decision-making reduce medical malpractice litigation? A systematic review. *BMC Health Services Research*, 15, 167.
- Franks, P., Clancy, C. M., & Nutting, P. A. (1992). Gatekeeping revisited: Protecting patients from over-treatment. *New England Journal of Medicine*, 327, 424-429.
- Hesketh, T., Wu, D., Mao, L., & Ma, N. (2012). Violence against doctors in China. *BMJ*, 345, e5730.
- Hoffmann, D. E., & Tarzian A. J. (2003). Achieving the right balance in oversight of physician opioid prescribing for pain: The role of state medical boards. *Journal of Law, Medicine, and Ethics*, 31, 21-40.
- Huang, Y. (2011). The sick man of Asia: China's health crisis. *Foreign Affairs*, 90, 119-136.
- Jing, L., Shu, Z., Sun, X., Chiu, J. F., Lou, J., & Xie, C. (2015). Factors influencing patients' contract choice with general practitioners in Shanghai: A preliminary study. *Asia Pacific Journal of Public Health*, 27, 77S-85S.
- Kong, X., & Yang, Y. (2015). The current status and challenges of community general practitioner system building in China. *QJM*, 108, 89-91.
- Kuang, L., Liang, Y., Zhao, J., Wang, Y., Liang, H., & Shi, L. (2015). Family practice and the quality of primary care: A study of Chinese patients in Guangdong province. *Family Practice*, 32, 557-563.
- Ling, R., Liu, F., Lu, X., & Wang, W. (2011). Emerging issues in public health: A perspective on China's healthcare system. *Public Health*, 125, 9-14.
- Liu, Y., Hsiao, W. C., & Eggleston, K. (1999). Equity in health and health care: The Chinese experience. *Social Science & Medicine*, 49, 1349-56.
- Mariner, W. K. (1998). Standards of care and standard form contracts: Distinguishing patient rights and consumer rights in managed care. *Journal of Contemporary Health Law & Policy*, 15, 1-56.
- Mathers, N., & Huang Y. C. (2014). The future of general practice in China: From 'barefoot doctors' to GPs? *British Journal of General Practice*, 64, 270-217.
- Meng, Q., Yang, H., Chen, W., Sun Q., & Liu X. (2015). People's Republic of China: Health system review. *Health Systems in Transition* 5. Retrieved from http://www.wpro.who.int/asia_pacific_observatory/hits/series/chn/en/ (last accessed 24 March 2019).
- Olesen F., Dickinson J., & Hjortdahl, P. (2000). General practice: Time for a new definition. *BMJ*, 320, 354.
- Roberts, M., Hsiao, W. C., & Berman, P. (2004). *Getting health reform tight: A guide to improve performance and equity*. New York, NY: Oxford University Press.

- Sage, W. M., Hastings K. E., & Berenson R. A. (1994). Enterprise liability for medical malpractice and health care quality improvement. *American Journal of Law and Medicine*, 20, 1–28.
- Shi, L. (1993). Health care in China: A rural-urban comparison after the socioeconomic reforms. *Bulletin of the World Health Organization*, 71, 723–736.
- Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. *The Milbank Quarterly*, 83, 475–502.
- Tang, S., Ehiri, J., & Long, Q. (2013). China's biggest, most neglected health challenge: non-communicable diseases. *Infectious Diseases of Poverty*, 2, 1.
- Wiley, L. F. (2016). From patient rights to health justice: Securing the public's interest in affordable, quality health care. *Cardozo Law Review*, 37, 883–9.
- World Bank Group (WB), World Health Organization, China's Ministry of Finance, National Health and Family Planning Commission, and Ministry of Human Resources and Social Security. (2016). *Healthy China: Deepening health reform in China*. Retrieved from <http://www.wpro.who.int/china/publications/2016-health-reform-in-china/en/>. (last accessed 24 March 2019)
- World Health Organization. (2015). WHO global strategy on people-centered and integrated health services. Retrieved from http://apps.who.int/iris/bitstream/10665/155002/1/WHO_HIS_SDS_2015.6_eng.pdf?ua=1&ua=1. (last accessed 24 March 2019).
- Xiao, N., Long, Q., Tang, X., & Tang, S. (2014). A community-based approach to non-communicable chronic disease management within a context of advancing universal health coverage in China: Progress and challenges. *BMC Public Health*, 14, S2.
- Xu, J., Pan, R., Pong, R., Miao, Y., & Qian, D. (2016). Different models of hospital-community health center collaboration in selected cities in China: A cross-sectional comparative study. *International Journal of Integrated Care*, 16(1), 8.
- Yip W. & Hsiao, W. C. (2008). The Chinese health system at a crossroads. *Health Affairs*, 27, 460–468.
- Yip W., & Hsiao, W. C. (2009a). China's health care reform: a tentative assessment. *China Economic Review*, 20, 613–619.
- Yip W., & Hsiao, W. C. (2009b). Non-evidence-based policy: how effective is China's new cooperative medical scheme in reducing medical impoverishment? *Social Science & Medicine*, 68, 201–209.
- Zhang L., Bossert T., Mahal A., Hu G., Guo Q., & Liu Y. (2016). Attitudes towards primary care career in community health centers among medical students in China. *BMC Family Practice*, 17, 75.

Chapter 5

Regulating private medical institutions: A case study of China*

*Liu, Z. *Health Economics, Policy and Law*, in press.



ABSTRACT

Aim and Background: The expansion of privatisation in healthcare has been discussed extensively in most European countries and remains a hot topic nowadays. In China, privatisation has resulted in considerable changes in its healthcare system, especially accelerating the ever-growing private medical institutions (PMIs). The rapid growth of PMIs raises the question of regulation for the Chinese government. Given the fact that few studies are available on the regulation of PMIs in China, I attempted to fill that gap by discussing the development of PMIs with a special focus on legal regulatory strategies.

Methods: Adhering to the guidelines of PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses), literature has been selected through electronic databases, including PubMed and Google Scholar, by using keywords: ‘Privatisation’, ‘Private medical institutions’, ‘Health care’, ‘Regulation’ and ‘China’. With regard to searching legislations, I use a law database: pkulaw. The benchmarks of the diagnostic process (Figure 6.1) are mainly originated by the ‘control knob’ framework in Roberts et al.’s book: *Getting Health Reform Right: A Guide to Improve Performance and Equity*. Key findings have been summarised in Figure 6.2 and two tables.

Findings: After assessing current legal/regulatory strategies concerning PMIs, the paper identifies three major concerns regarding effective legal rules (i.e. weak coherence, inconsistency, and legislative vacancy) and three difficult issues regarding government capacity (i.e. the negative effects of decentralised political structure, the low professionalism of bureaucrats, and lack of reliability) that impede the well-functioning of regulatory agencies in China. As a plausible response, the paper recommends enacting an ‘umbrella health law’ in which a separate chapter should be assigned to regulating PMIs and also establishing an independent regulatory body to manage the issues of PMIs in China. Detailed recommendations are the practical implications of ICESCR General Comment No. 14. The increasingly involvement of private sector in healthcare is not identified as purely a ‘good’ or ‘bad’ tendency in itself. In most cases, how the state plays its role in regulating and governing the rapidly developing private sector is the key issue and of crucial importance.

Keywords: Private medical institutions, privatisation, international human rights law, regulation, China

5.1 BACKGROUND

The increasing involvement of the private sector in healthcare has been discussed extensively in most European countries and remains a hot topic nowadays (Mackintosh et al., 2016; Morgan et al., 2016; Montagu & Goodman, 2016; McPake & Hanson, 2016). As a result of privatisation, the rapidly growing involvement of the private sector in healthcare is gradually challenging the role of the state, implying an urgent need to rebalance public and private sectors in delivering health services (Marshall & Bindman, 2016). Scholarly literature has not presented a single attitude towards private sector involvement in services like healthcare (Barlow et al., 2013; Roehrich et al., 2014; Torchia et al., 2015; Mills, 2014; Andre & Bati-foulrier, 2016). Similarly, this paper will not explore whether gradually relying on the private sector is an effective approach for expanding the accessibility of better quality healthcare or not. It aims rather to address special concerns about how to measure the private sector properly (especially using legal measures) in order to secure an efficient and sustainable way of delivering health services and, more importantly, enabling people to optimally benefit from the increasing involvement of the private sector in healthcare.

In general, existing literature tends to be context-specific.⁶⁷ Thus this paper takes the Chinese healthcare system as its basic context, taking into account that the private sector has been offered a great opportunity to grow in China and is having a significant impact on the Chinese healthcare system. Although a great deal of literature is available on private sector involvement in healthcare in China (Yu, 2007, pp. 223–224; Ramesh & Wu, 2009; Liu & Darimont, 2013; Tu et al., 2015; Blumenthal & Hsiao, 2005, 2015; Yip & Hsiao, 2014), discussions rarely include a human rights perspective. This chapter therefore attempts to fill this gap by approaching the question from a human rights perspective. In order to develop a better understanding of private sector involvement in healthcare in China, the chapter takes private medical institutions (PMIs) as an example. By studying the case of PMIs, the chapter attempts to find the answer to the following question: given the great influence of privatisation on the Chinese healthcare system, how will the Chinese government fulfil its role in measuring the rapid growth of private medical institutions from a human rights perspective?

5.1.1 Context: Private medical institutions (PMIs) in China

The very first PMI was set up in 1984, encouraged by Chinese economic innovation (Liu et al., 1994, p. 167), the decentralised reforms of China's administrative system and the 1982 edition of the Chinese Constitution. Thereafter, the State Council and its General Office released a series of administrative regulations and interpretations to support and promote the development of PMIs. Nevertheless, the development of PMIs was slower than expected

67 Researches concerning privatisation and healthcare are often embedded with special social contexts, such as Blumenthal and Hsiao (2005, 2015), Yip and Hsiao (2014), Maarse (2006), Toebes (2006), and Larsen (2015).

due to the lack of explicit internal classification at that time. Recognising this impediment, in 2000 the State Council and the Ministry of Health issued guiding opinions and detailed implementations on differentiating for-profit PMIs from not-for-profit ones. Since then, for-profit and not-for-profit PMIs have both had many opportunities to improve. Besides these supportive policies, public medical institutions tend to ease their financial burden, resulting from reduced governmental subsidies, by contracting out certain parts of their healthcare services to PMIs. Contracting out activities effectively contributed to the rapid development of PMIs in China. In the 2009 healthcare reform, the Chinese government affirmed the supplementary role of PMIs in its healthcare system. From then onwards, the Chinese government released a series of provisions to support and encourage the development of PMIs, such as the recently released Guiding Principle on the Establishment of Medical Institutions in China (2016–2020).

The rapidly growing PMIs do expand healthcare accessibility and improve the quality of health services (Mills et al., 2002; Albrecht, 2009). However, they also inevitably result in certain risks, such as the violation of human rights and the deterioration of public health delivery (Horton & Clark, 2016; Bloche, 2005; Toebes, 2006). However, as Bloche (2005) argued, these risks can be minimised if the healthcare system is facilitated with effective regulatory strategies, especially legal regulatory measures.

5.1.2 Structure: Map the discussion

The chapter is structured as follows: it describes the background of this study by a selective literature review and a brief narrative on the context. In order to avoid any ambiguity, the chapter includes a conceptual clarification of various key terms, such as *privatisation*, in the section Conceptual Clarification and Theoretical Background. Thereafter, it briefly explores the reasons and risks (advantages and disadvantages) of involving the private sector in healthcare and emphasises the importance of how the state fulfils its role in measuring the gradually evolving private sector. The chapter then describes in detail the relevant international human rights law, thereby observing that the state is required to assume an active regulatory role rather than play a ‘provider’ role in controlling and supporting the development of the private sector in healthcare. Thus, the major concern of the following discussion shifts to address the regulatory role of the state in dealing with the rapidly growing private sector in healthcare. In ‘Method’, the searching criteria and assessing tools (Figure 5.1: The diagnostic process) are introduced. These originated from the PRISMA guidelines and the ‘control knob’ framework developed by Roberts and his colleagues. The Results and Discussion section evaluates current legal regulatory strategies (including effective legal rules and related regulatory bodies) concerning PMIs in China and provides corresponding recommendations for improving these strategies. Finally, the chapter reaffirms the need to strengthen and improve the regulatory role of the state in order to guide and support the rapidly growing private sector in healthcare in China.

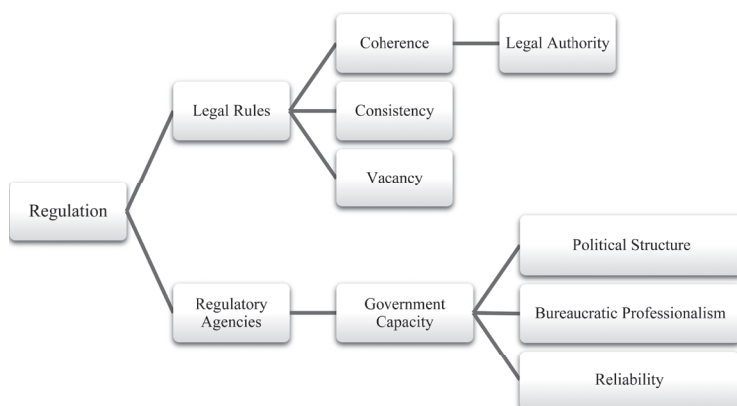


Figure 5.1 Diagnostic process

Source: Adapted from the ‘regulation control knob’ of the ‘control knob framework’ in Roberts et al., (2004), pp. 248–280.

5.2 CONCEPTUAL CLARIFICATION AND THEORETICAL BACKGROUND

5.2.1 Privatisation in healthcare

According to the World Health Organization definition, privatisation involves the change of ‘ownership and government functions from public to private bodies.’⁶⁸ Potential benefits of privatisation in healthcare include increasing efficiency (Kozinski & Bentz, 2013–2014; Bloche, 2005), promoting patient rights (e.g. diversifying health services, expanding individual choices and improving the quality of healthcare) (Albrecht, 2009), and covering remote areas which are beyond the attention of the public sector (Mills et al., 2002). Inevitably, there are also certain concerns, such as the risk of human rights violation and deteriorating public health delivery due to the profit-seeking behaviour of private actors (Horton & Clarks, 2016; Bloche, 2005; Toebes, 2006).

In general, there are two prominent types of privatisation: full privatisation (i.e. the transfer of ownership from public sector to private sector), and contracting out (or outsourcing) (Feyter & Isa, 2005; Toebes, 2006). In contrast to full privatisation, contracting out (outsourcing) in healthcare refers to the situation whereby the public sector merely delegates responsibility for providing healthcare and the corresponding risk management to the private sector on the basis of contracts but retains ownership (Graham, 2005). These two types of privatisation cover a wide range of models regarding public-private partner-

68 Health Systems Strengthening Glossary. Please refer to http://www.who.int/healthsystems/hss_glossary/en/index3.html (last accessed 24 March 2019).

ships in healthcare (Barlow et al., 2013, p. 147). Research shows that cultivating a healthy public-private partnership is a plausible way to manage the gradually evolving private sector in healthcare and will be better able to secure the accessibility of good quality health services (Roehrich, 2013; 2014, p. 110). In this regard, the question is how to optimally balance public and private sectors in healthcare from a human rights perspective. I intend to explore the answer to this question with a special focus on the role of the state.

5.2.2 International human rights law and state accountability

International human rights law requires state members to take state accountability to protect and promote the right to health. However, the gradually increasing reliance on the private sector is easily misunderstood as a process of reducing state accountability in healthcare. Although increasing privatisation in healthcare accelerates the transfer of ‘ownership and government functions’ from public medical institutions to the private sector, thus promoting the development of private sector, the state is still responsible for ensuring that healthcare delivery remains the answer to the basic principles of human rights.

General Comment No. 3 of Article 2 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) broadly stipulates that the state should have a minimum core obligation in ensuring the satisfaction of the rights recognised by ICESCR, which includes guaranteeing primary healthcare services. Specifically, Article 12 of ICESCR recognises ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ and state accountability in protecting and promoting this right. This highly abstracted stipulation is very difficult to enforce. In response, the UN Commission on Economic, Social and Cultural Rights issued General Comment No. 14 to provide a further interpretation. General Comment No. 14 requires the state members of ICESCR to protect and promote the right to health according to the standards of ‘availability, accessibility (non-discrimination, physical accessibility, affordability and information accessibility), acceptability and quality (AAAQ).’ Furthermore, in line with General Comment No. 3 and General Comment No. 14, the scope and extent of implementation may differ and be achieved progressively in accordance with the diverse conditions of the member states, but actions towards AAAQ must be taken ‘within a reasonably short time after the Covenant’s entry into force for the States concerned.’

There are other international human rights treaties and provisions which generate an indirect but profound influence on state accountability in regulating the private sector in healthcare services. For instance, General Comment No. 31 of Article 2 of the International Covenant on Civil and Political Rights (ICCPR) specifies the general legal obligations of states in regulating private entities. General Comment No. 15 of Article 11 and Article 12 of ICESCR and General Comment No. 22 of Article 12 of ICESCR delineate state accountability in monitoring and controlling the behaviour of the private sector in protecting and promoting the right to water. General Comment No. 16 of Article 17 of ICCPR

stipulates the importance of the private sector such as databanks in protecting the right to privacy. With regard to vulnerable groups, such as women and children, there are articles (e.g. General Comment No. 15 and General Comment No. 24) which stipulate that state accountability in protecting and promoting the right to health of women and children cannot be absolved by delegating medical services to the private sector.

5.2.3 ICESCR General Comment No. 14 and the regulatory role of the state

Specifically, regulating the private sector mainly relies on ICESCR General Comment No. 14. According to General Comment No. 14, states should take their obligation to protect the right to health from third party infringements. In other words, it requires states to adopt their regulatory role to ensure the fulfilment of the following guidelines before allowing the expansion of privatisation in their healthcare systems:

(1) Ensuring that the privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; (2) ensuring that harmful social or traditional practices do not interfere with access to prenatal and postnatal care and family planning; (3) ensuring that third parties do not limit people's access to health-related information and services; (4) to ensure equal access to health care and health-related services provided by third parties; (5) to control the marketing of medical equipment and medicines by third parties; (6) to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct; (7) to prevent third parties from coercing women to undergo traditional practices; (8) to protect all vulnerable or marginalised groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence.

(ICESCR General Comment No. 14, para. 35)

Overall, the increasing involvement of the private sector does not change 'the role of the state as the ultimate guarantor of the realisation of health rights obligations' (Minow 2003, p. 1257). In contrast, the state should assume an active regulatory role in controlling, supporting and encouraging the private sector towards achieving national health goals (Mills et al. 2002).

5.3 METHODS

This section explains strategies and criteria in searching and selecting existing literature and related legislation in China. Furthermore, tools for assessing legal regulatory strategies are also briefly introduced.

5.3.1 Selection strategy and search criteria

This research follows the PRISMA guidelines.⁶⁹ To capture peer-reviewed literature, I searched for information through electronic databases, including PubMed and Google Scholar, using the timeline between 1 January 1990 and 1 January 2017. Besides peer-reviewed literature, classic monographs were also included for the sake of analysis, such as *Getting Health Reform Right: A Guide to Improve Performance and Equity* which was edited by Roberts and colleagues, *The Privatization of Health Care Reform: Legal and Regulatory Perspectives*, which was edited by Bloche, and *Privatization and Human Rights: In the Age of Globalization* which was edited by Feyter and Isa.

Details of the literature search are given below with an example from PubMed: I used five key terms ('private medical institutions', 'privatisation', 'health care', 'China' and 'regulation') to search for the information through the PubMed advanced search builder. The search details are:

Key term 1: ("private"[All Fields]) AND "medical" [All Fields] AND ("Institutions"[Journal] OR "institutions"[All Fields])

OR

Key term 2: ("privatisation"[MeSH Terms] OR "privatisation"[All Fields])

AND

Key term 3: ("delivery of health care"[MeSH Terms] OR ("delivery"[All Fields] AND "health"[All Fields] AND "care"[All Fields]) OR "delivery of health care"[All Fields] OR "health care"[All Fields])

AND

Key term 4: ("China"[MeSH Terms] OR "China"[All Fields])

AND

Key term 5: ("social control, formal"[MeSH Terms] OR ("social"[All Fields] AND "control"[All Fields] AND "formal"[All Fields]) OR "formal social control"[All Fields] OR "regulation"[All Fields])

The results showed that there were only 24 studies in PubMed that met the selection criteria. The same strategy was used to search for studies in Google Scholar. The results were fairly similar to those in PubMed. Given the fact that few studies are available on the regulation

69 PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) [Online]. Please refer to <http://www.prisma-statement.org/> (last accessed 24 March 2019).

of PMIs in China, I attempted to fill that gap by discussing the development of PMIs with a special focus on legal regulatory strategies.

With regard to the legislation search, I used a law database, pkulaw, to collect China's laws and regulations relating to PMIs. Presented in Figure 5.2, many legal rules, including laws, administrative regulations, the interpretations of administrative regulations, the regulatory documents of the State Council and department rules concerning PMIs have been released since 2000.

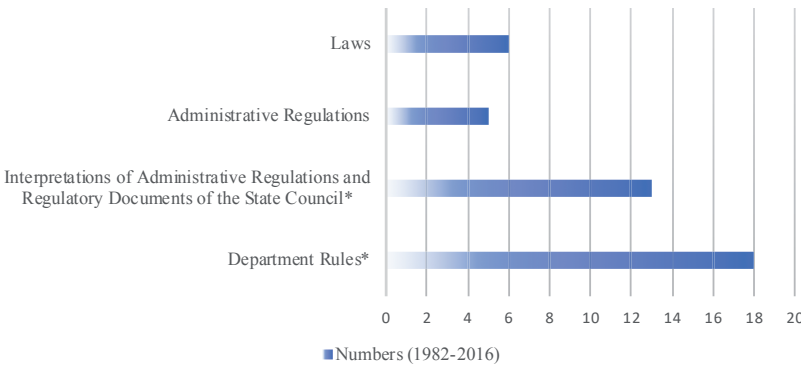


Figure 5.2 Legal rules concerning PMIs at the state level

* Notes:

The Interpretations of Administrative Regulations and the Regulatory Documents of the State Council are separated from the Administrative Regulations because the Legislation Law of the People's Republic of China (2015 Amendment) does not have an explicit stipulation on the authority of these legal rules. Source: pkulaw, please refer to <http://en.pkulaw.cn/> (last accessed 24 March 2019)

In terms of the assessment strategy, I used the 'regulation control knob' as the basis for my diagnostic process (Figure 5.1) to assess current legal regulatory strategies (including legal rules and regulatory agencies) of PMIs in China. The benchmarks used for the assessment were originated by the control knob framework in Roberts et al.'s (2004) book: *Getting Health Reform Right: A Guide to Improve Performance and Equity*. Specifically, in terms of assessing legal rules, I focused more on assessing the consistency and coherence of legal rules because they are also the key to the rule of law (Fuller, 1969, p. 39). Regarding the assessment of regulatory agencies, the benchmark is government capacity (i.e. political structure, professionalism of bureaucrats and reliability). Through the diagnostic process, I intended to answer the question: does China have effective legal regulatory strategies to control and support the development of PMIs?

5.3.2 Bias

The bias of the literature search was minimised by including the analysis of classic monographs. Some search results from Google Scholar were excluded due to not being published in English or in the form of books.

With regard to the selection of legislation, I merely focused on assessing legal rules which had been enacted by the National People's Congress or the Standing Committee of the National People's Congress (Table 5.1). These legal rules have higher legal authority in China's legal system, but there was actually a lack of such legal rules regulating PMIs.

In terms of my diagnostic process, however, the control knob framework was formulated to provide guidelines for improving healthcare reform. These guidelines may also be helpful for diagnosing the performance of healthcare systems and adjusting the direction of government actions (Roberts et al., 2004, p. 128).

5.4 RESULTS AND DISCUSSION

5.4.1 Deficiencies in legal regulatory strategies concerning PMIs in China

Effective legal rules: weak coherence, inconsistency and legislative vacancy

Like many other countries, China has not yet enacted an umbrella health law. Protecting and promoting the right to health in China is therefore mainly achieved by enforcing legal rules in other legal fields, such as administrative law, contract/tort law or even criminal law. As a consequence, legal rules regarding healthcare tend to be fragmented, as are the legal rules related to PMIs. Figure 5.2 presents a macro view of effective legal rules concerning PMIs in China. The majority of effective legal rules relating to PMIs seem to have lower legal authority in the Chinese legal system, making it very difficult to enforce them. According to the Legislation Law of the People's Republic of China (2015 Amendment), Constitution in China has the highest legal authority. Below this are laws, administrative regulations, department rules and local regulatory documents. Compared to laws and administrative regulations, department rules and local regulatory documents have lower legal authority in the Chinese legal system. These are likely to be less stable, easily clash with each other and endanger substantive discretion during enforcement. PMIs are mainly regulated through department rules and local regulatory documents in China. For instance, a department regulatory document issued by the State Administration for Industry and Commerce deals with the question of whether the drug mark-ups of not-for-profit PMIs should be regulated by the Anti-unfair Competition Law or not. Although some legal rules with higher legal authority (i.e. laws and administrative regulations) do exist for regulating PMIs in China (Table 5.1), they are few and not specifically designed for regulating PMIs. Due to the lack of legal rules with high legal authority at central government level, PMIs are regulated

unevenly across local governments. As a consequence, the coherence of legal rules relating to PMIs in China is relatively weak.

Furthermore, legal rules concerning PMIs also encounter the problem of inconsistency. The strictest part of regulation is always centralised at the registration stage, while less effort is devoted to regulating the behaviour of PMIs after they obtain a certificate from the relevant registration agencies. As Chapman (2014) said, it is crucial to take measures in advance (e.g. registration and licensing strategies) to control the upcoming behaviour of the private sector in line with human rights principles. Nevertheless, it is equally important to monitor and control the behaviour of PMIs after they obtain the certificate. Therefore, this deserves more attention at the current stage because regulating PMIs after registration is more likely to be overlooked.

Besides inconsistency and weak coherence, a marked disagreement regarding the legal attribute of PMIs, especially for-profit ones, may present an extra challenge for enforcement because of a legislative vacancy. In literature, the question of whether for-profit PMIs should be treated as social institutions or as market entities has been discussed intensively (Bloom, 2001; Nichols et al., 2004). Scholars, especially human rights professionals, lean in favour of regarding for-profit PMIs as social institutions, considering the special nature of healthcare in terms of morality and ethics. Conversely, for-profit PMIs themselves are willing to be identified as free market competitors, even though they run a 'business' that influences people's lives. This controversial issue is made worse by some health policies in China. The Chinese government tends to force for-profit PMIs to increasingly assume social responsibility while requiring them to deliver healthcare services as efficient and productive as other free competitors in the market. As illustrated in Table 5.1, for-profit PMIs are temporarily treated as business entities in China. However, the 'business' run by for-profit PMIs is a health service which is in a morally special position and which cannot therefore be totally handed over to the market (Daniels, 1996, p. 179; 2001, p. 2). Thus, the legislative vacancy leaves patients at the mercy of a *laissez-faire* policy in healthcare in China (Roberts et al., 2004, p. 253).

Relative regulatory agencies: the negative effects of decentralised political structure, the low professionalism of bureaucrats and lack of reliability

Government capacity is an essential determinant of regulatory success, especially in terms of promulgating and enforcing regulations (Roberts et al., 2004). As argued by Roberts et al. (2004, p. 254), government capacity has an interactive relationship with the level of economic development and cultural attitude. Thus low and middle-income countries have relatively lower administrative capacity and less support from citizens. This section therefore aims at verifying this assumption by assessing relative regulatory agencies concerning PMIs in China with three benchmarks: political structure, bureaucratic professionalism and reliability.

Table 5.1 Laws and administrative regulations concerning PMIs in China

Name	Issuing Authority	Level of Authority	Date of Issue and Effective	Revision	Summary
Constitution of the People's Republic of China (1982)	National People's Congress	Laws	Issue: 4 Oct 1982	Yes 1988/1993/1999/ 2004 Amendments	Article 21 affirms the evolving social capital in establishing medical institutions.
Law on Practising Doctors of the People's Republic of China	Standing Committee of the National People's Congress	Laws	Issue: 26 Jun 1998; Effective: 1 May 1999	Yes Date: 27 Aug 2009 Revised Article 40	Doctors who are practising medicine in PMIs should also pass the examination for a doctor's qualification and apply for registration with the relevant health administration department of, or above, the county level.
Law of the People's Republic of China on Traditional Chinese Medicine	Standing Committee of the National People's Congress	Laws	Issue: 25 Dec 2016; Effective: 1 Jul 2017	No	Article 13 affirms that the state supports social forces in their launching of traditional Chinese medicine medical institutions, and those PMIs should enjoy equal rights with medical institutions launched by government.
Tort Law of the People's Republic of China	Standing Committee of the National People's Congress	Laws	Issue: 26 Dec 2009; Effective: 1 Jul 2010	No	Chapter VII regulates the liability of medical malpractice, including the compensatory liability of medical institutions.
Enterprise Income Tax Law of the People's Republic of China	National People's Congress	Laws	Issue: 16 Mar 2007; Effective: 1 Jan 2008	No	The for-profit PMIs shall pay the enterprise income taxes. However, there is a Notice of the Ministry of Finance and the State Administration of Taxation (2000) providing a three-year exemption of taxation for for-profit PMIs.
Anti-unfair Competition Law of the People's Republic of China	Standing Committee of the National People's Congress	Laws	Issue: 2 Sept 1993; Effective: 1 Dec 1993	No	In 2001, the State Administration for Industry & Commerce issued a reply (No. 248) to affirm that all PMIs which have taken a rebate from prescribing medications shall be the subject to regulation by the Anti-unfair Competition Law.

Table 5.1 Laws and administrative regulations concerning PMIs in China (continued)

Name	Issuing Authority	Level of Authority	Date of Issue and Effective	Revision	Summary
Regulation on the Handling of Medical Accidents	State Council	Administrative Regulations	Issue: 4 Apr 2002; Effective: 1 Sept 2002	No	Article 7 affirms that all medical institutions should set up relevant departments to control the quality of medical treatments.
Administrative Regulations on Medical Institution	State Council	Administrative Regulations	Issue: 26 Feb 1994; Effective: 6 Feb 2016 1 Sept 1994	Yes Date: 6 Feb 2016 Revised Article 9	The central-local separation of powers in terms of controlling and managing the development of medical institutions, including for-profit PMIs.
Nurses Regulation	State Council	Administrative Regulations	Issue: 31 Jan 2008; Effective: 12 May 2008	No	All practising nurses should pass the practising nurse qualification examination organised by the health administrative department of the State Council and apply for registration.
Interim Regulation of the People's Republic of China on Business Tax	State Council	Administrative Regulations	Issue: 13 Dec 1993; Effective: 1 Jan 1994	Yes Date: 1 Jan 2009	The 2009 revision affirms that the business tax of for-profit PMIs shall be exempted.
Regulations on the Management of Medical Waste	State Council	Administrative Regulations	Effective: 16 Jun 2003	Yes Date: 8 Jan 2011	It aims at strengthening the safe management of medical waste for all kinds of medical institutions.

Source: pkulaw, please refer to <http://en.pkulaw.cn/> (last accessed 24 March 2019).

Following three waves (1958, 1970 and 1978) of decentralisation reform in China, the administrative power of central government has gradually been transferred to local governments and specific government agencies, in order to maximise overall social welfare and satisfy the diverse sets of preferences of local people (Feng, 2016, pp. 13–14). Reflected in healthcare, regulating PMIs involves a number of government agencies in China (Table 5.2). Some regulatory agencies control and manage many different PMIs but focus on different aspects. For example, the China Food and Drug Administration or CFDA oversees the use of drugs and medical devices,⁷⁰ the General Administration of Quality Supervision, Inspection and Quarantine or AQSIQ is responsible for controlling the quality and safety of medical products,⁷¹ while the Ministry of Ecology and Environmental or MEE is responsible for medical waste.⁷² Various other government agencies are assigned to manage the differences between for-profit PMIs and not-for-profit PMIs (e.g. administrative processes and taxation). In terms of administrative processes, for-profit PMIs need to apply for registration and obtain a certificate from the State Administration for Industry and Commerce because they are temporarily regarded as business entities. The registration process for not-for-profit PMIs, on the other hand, is under the control of the Ministry of Civil Affairs and is comparatively simple. With regard to taxation, for-profit PMIs are required to pay corporate tax to the State Administration of Taxation, while not-for-profit PMIs are not. Although for-profit PMIs have a three-year exemption from taxation, very few for-profit PMIs benefit from that policy because the registration and other administrative processes normally take longer than three years. Such a self-contradictory policy endangers the reliability of relative regulatory agencies. Furthermore, due to the gap between the policy design and the real-life situation, more and more for-profit PMIs decide to become not-for-profit ones. Such a change would make it difficult to manage PMIs and thus challenges the capacity of relative regulatory agencies.

As illustrated in Table 5.2, all involved government agencies have been assigned responsibility for regulating PMIs. As such, the political structure seems to function well. However, there are certain overlapping areas where the professionalism and reliability of the involved government agencies encounter challenges. In order to ensure professionalism and reliability, the good performance of regulation expects these government agencies to work together to address the overlapping areas (Roberts, 2004, p. 253). In China however, due to the lack of a legislative authorised division of power among these involved government agencies, regulating overlapping areas usually results in disagreements, inaction and corruption rather than

70 For more information about the main responsibilities of CFDA, please refer to https://en.wikipedia.org/wiki/China_Food_and_Drug_Administration#Main_responsibilities (last accessed 24 March 2019)

71 For more information about the main responsibilities of AQSIQ, please refer to <http://english.aqsic.gov.cn/AboutAQSIQ/Mission/> (last accessed 24 March 2019)

72 For more information about the main responsibilities of MEE, please refer to <http://english.mee.gov.cn/> (last accessed 24 March 2019)

Table 5.2 Main sector on the state level in regulating PMIs in China

Actor	Tasks	Subject
State Administration for Industry and Commerce (SAIC)	It is responsible for issuing business licences and the registration of for-profit PMIs. It is responsible for supervising the advertisement of for-profit PMIs.	For-profit PMIs
State Administration of Taxation (SAT)	It is responsible for taxing for-profit PMIs.	For-profit PMIs
Ministry of Human Resources and Social Security (MOHRSS)	It is responsible for listing or delisting medical institutions for getting reimbursements from health insurance schemes.	For-profit PMIs
Ministry of Civil Affairs (MCA)	It is responsible for the registration of not-for-profit PMIs.	Not-for-profit PMIs
National Development and Reform Commission (NDRC)	It is responsible for developing PMIs. It is responsible for controlling, monitoring and regulating drug prices.	PMIs
China Food and Drug Administration (CFDA) & General Administration of Quality Supervision, Inspection and Quarantine (AQSIQ)	They are responsible for administrating and supervising the production, distribution and utilisation of drugs and medical devices. They work in cooperation to inspect and oversee the quality and safety of medical products.	PMIs
Ministry of Environmental Protection (MEP)	It is responsible for regulating medical waste.	PMIs
National Health and Family Planning Commission (NHFPC)	It is responsible for making laws and regulations. It is responsible for planning and distributing healthcare resources. It is responsible for the health quality management. It is responsible for developing drug policies.	PMIs
State Administration of Traditional Chinese Medicine (SATCM)	It is responsible for developing and supervising plans and policies concerning traditional Chinese medicine.	PMIs
Ministry of Education (MOE)	It is responsible for organising medical education, delivering continuous medical training and managing medical personnel development.	PMIs

Source: Meng et al., (2015).

checks and balances. Take drug policy for example, where the government agencies involved are CFDA, the National Development and Reform Commission, and the National Health and Family Planning Commission (Table 5.2). They all have some power to manage and supervise the distribution and utilisation of drugs in PMIs, but very few can be identified as the liable party in the event of a trade-off. This raises a question regarding the capacity of the Chinese government and the need to establish an independent regulatory body.

Overall, the issues raised (i.e. the inconsistency and weak coherence of legal rules and the lack of adequate government capacity) not only demonstrate that China does little to govern

and regulate the gradually increasing number of PMIs in healthcare, but more importantly highlights the need to address the regulatory role of the state in guiding the private sector towards achieving national health goals.

5.4.2 Applying ICESCR General Comment No. 14 to improve legal regulatory strategies concerning PMIs in China and recommendations

Considering the fact that China has signed and ratified all the relevant international treaties regarding the protection and promotion of people's health, provisions of those treaties should be applicable in guiding related health policies and law in China. In accordance with ICESCR General Comment No. 14, regulating PMIs must take the following aspects into consideration: identifying attribute, securing equity, ensuring quality and facilitating transparency (Albreht, 2009). First and foremost, enacting an umbrella health law is vitally important for strengthening the weak coherence of effective legal rules. The umbrella health law should include a separate section for regulating PMIs. In the Chinese legal system, the umbrella health law should be given a higher legal authority (the level of laws and administrative regulations) in order to link the fragmented legal rules in other legal fields.

Second, the PMIs section of the umbrella health law should include legal rules to clarify the attribute of PMIs, especially for-profit PMIs. If for-profit PMIs continue to be treated as business entities, then new legal rules should focus on how to control and guide the profit-seeking behaviour of for-profit PMIs for achieving national health goals. If for-profit PMIs are regarded as social institutions, then new legal rules should establish the distinction between for-profit PMIs and not-for-profit PMIs regarding the extent of their social responsibility.

Third, the PMIs section of the umbrella health law should include legal rules to ensure equal access to healthcare and other health-related services provided by PMIs. Due to profit-seeking incentives, for-profit PMIs may limit access to healthcare services for certain groups of people or charge higher fees on the basis of age or gender. Legal rules on eliminating discrimination as such should be included in the PMIs chapter of the umbrella health law.

Fourth, ensuring the quality of healthcare provided by PMIs should be an essential task of the umbrella health law. New legal rules should be enacted to control and regulate the marketing of PMIs, especially their profit-seeking activities after registration. Furthermore, requirements on the quality of healthcare services should be the same for both public and private medical institutions. Responsibility for monitoring the enforcement of related legal rules should be assigned to an independent regulatory body. 'Independent' means that the regulatory body should be independent of all regulatory agencies of central government and under the direct control of the State Council. In each local area (i.e. city or town level), the independent regulatory body should have its own branches for daily control. These branches should also be independent from local governments and other government agencies.

Last but not least, the PMIs chapter of the umbrella health law and the independent regulatory body should aim at facilitating the transparency of the healthcare market. In the market of health services, information asymmetry impedes patients' access to good quality healthcare. In the real-life situation, for instance, doctors tend to recommend conservative treatments to their patients to avoid the risk of medical accidents and disputes if there are no relative regulatory rules (Havighurst, 2003, p. 14). Even worse, doctors working for for-profit PMIs are 'forced' to prescribe treatments whose effects are relatively low but which generate high profits because they need to make a profit for their PMIs in order to keep their jobs. In this regard, new legal rules and the independent regulatory body need to be established to ensure that the involvement of PMIs does not limit people's access to health-related information and services. Future efforts can be devoted to making the price of health services transparent to patients, empowering patients to defend their medical rights and express other dissatisfactions, and to ensure that health professionals comply with the ethical codes of health services (Mills, 2002, p. 327).

5.5 CONCLUDING REMARKS

The chapter begins by conceptualising privatisation and identifying potential benefits and risks it may entail. Once privatisation is recognised as an inevitable tendency in healthcare, what truly matters is how to guide the gradually increasing private sector to contribute to achieving desired public policy goals. In China, the rapidly growing PMIs demonstrate the huge impact of privatisation on healthcare and the tension between the rapid expansion of privatisation and the less effective legal regulatory strategies (i.e. effective legal rules and relative regulatory agencies). Thus, the overall aim of this chapter is to find out how the Chinese government fulfils its role in measuring the rapid growth of private medical institutions from a human rights perspective.

Through the case of PMIs, the chapter observes that gradually relying on the private sector in healthcare not only makes the Chinese healthcare system more efficient, but it also diversifies health services and thus expands the accessibility of healthcare and protects patient rights in China. Nevertheless, there are also related concerns about involving the private sector in healthcare in China, such as the risks of violating human rights and deteriorating public health delivery, which raise a range of regulatory issues. In assessing current legal regulatory strategies concerning PMIs in China, the chapter identifies three major concerns regarding effective legal rules (weak coherence, inconsistency and legislative vacancy) and three difficult issues regarding government capacity (the negative effects of decentralised political structure, the low professionalism of bureaucrats and lack of reliability) that impede the proper functioning of regulatory agencies in China. As a plausible response, the chapter recommends enacting an umbrella health law in which a separate section should be assigned

to regulating PMIs and also establishing an independent regulatory body to manage the issues of PMIs in China. Detailed recommendations are the practical implications of ICESCR General Comment No. 14.

The increasing involvement of the private sector in healthcare is not identified as purely a 'good' or a 'bad' tendency in itself. In most cases, how the state plays its role in regulating and governing the rapidly developing private sector is the key issue and of crucial importance.

5.6 REFERENCES

- Albrecht, T. (2009). Privatization processes in health care in Europe – a move in the right direction, a ‘trendy’ option, or a step back? *European Journal of Public Health*, 19(5), 448-450.
- Andre, C., & Batifoulier, P. (2016). Health care privatization in Europe: Theoretical justifications and empirical classification. *International Journal of Social Security Review*, 69(1), 3-23.
- Barlow, J., Roehrich, J., & Wright, S. (2013). Europe sees mixed results from public-private partnerships for building and managing health care facilities and services. *Health Affairs*, 32(1), 146-154.
- Bloche, M. G. (2005). Is privatization of health care a human rights problem? In K. D. Feyter & F. G. Isa (Eds.), *Privatisation and human rights: In the age of globalization* (pp. 207-228). Antwerp: Intersentia.
- Bloom, G. (2001). Equity in health in unequal societies: meeting health needs in contexts of social change. *Health Policy*, 57(3), 205-224.
- Blumenthal, D., & Hsiao, W. (2005). Privatization and its discontents – The evolving Chinese health care system. *New England Journal of Medicine*, 353, 1165-1170.
- Blumenthal, D., & Hsiao, W. (2015). Lessons from the East – China’s rapidly evolving health care system. *New England Journal of Medicine*, 372, 1281-1285.
- Chapman, A. (2014). The impact of reliance on private sector health services on the right to health. *Health and Human Rights*, 16(1), 122-133.
- Daniels, N. (1996). *Just and justification: Reflective equilibrium in theory and practice*. Cambridge: Cambridge University Press.
- Daniels, N. (2001). Justice, health and healthcare. *American Journal of Bioethics*, 1, 20-14.
- Feng, Y. (2016, December 15). Legislative decentralization in China in the reform era – Progress and limitations. Erasmus University Rotterdam. Retrieved from <https://hdl.handle.net/1765/94595>. pp. 13-14.
- Feyter, K. D., & Isa, F. G. (2005). Privatization and human rights: an overview. In K. D. Feyter & F. G. Isa (Eds.), *Privatization and human rights: In the age of globalization* (pp. 1-8). Antwerp: Intersentia.
- Fuller, L. L. (1969). *The morality of law (revised ed.)*. New Haven, CT: Yale University Press.
- raham, C. (2005). Human rights and the privatization of public utilities and essential services. In K. D. Feyter & F. G. Isa (Eds.), *Privatization and human rights: In the age of globalization* (pp. 33-56). Antwerp: Intersentia.
- Havighurst, C. C. (2003). American health care and the law. In M. G. Bloche (Ed.), *The privatization of health care reform: Legal and regulatory perspectives*. New York, NY: Oxford University Press.
- Hayek, F. (1945). The use of knowledge in society. *American Economic Review*, 35, 519-530.
- Horton, R., & Clark, S. (2016). The perils and possibilities of the private health sector. *Lancet*, 388(10044), 540-541.
- Kozinski, A., & Bentz, A. (2013–2014). Privatization and its discontents. *Emory Law Journal*, 63, 263-282.
- Larsen, L. T. (2015). Governing health care through free choice: Neoliberal reforms in Denmark and the United States. *Journal of Health Politics, Policy and Law*, 40(5), 941-970.
- Liu, D., & Darimont, B. (2013). The health care system of the People’s Republic of China: Between privatization and public health care. *International Journal of Social Security Review*, 66(1), 97-116.
- Liu, G., Liu, X., Meng, Q. (1994). Privatization of the medical market in socialist China: a historical approach. *Healthy Policy*, 27(2), 157-74. p. 167.

- Maarse, H. (2006). The privatization of health care in Europe: An eight-country analysis. *Journal of Health Politics, Policy and Law*, 31(5), 981-1014.
- Mackintosh, M., Channon, A., Karan, A., Selvaraj, S., Cavagnero, E., & Zhao, H. (2016). What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. *Lancet*, 388(10044), 596-605.
- Marshall, M., & Bindman, A. B. (2016). The role of government in health care reform in the United States and England. *JAMA International Medicine*, 176(1), 9-10.
- McPake, B., & Hanson, K. (2016). Managing the public-private mix to achieve universal health coverage. *Lancet*, 388(10044), 622-630.
- Meng, Q., Yang, H., Chen, W., Sun, Q., & Liu, X. 2015. People's Republic of China: Health system review. *Health Systems in Transition*, 5(7), 29-32.
- Mills, A. (2014). Health care systems in low- and middle-income countries. *New England Journal of Medicine*, 370, 552-557.
- Mills, A., Brugha, R., Hanson, K., & McPake, B. (2002). What can be done about the private health sector in low-income countries? *Bulletin of the World Health Organization*, 80(4), 325-330.
- Minow, M. (2003). Public and private partnerships: accounting for the new religion. *Harvard Law Review*, 116, 1229-1270.
- Montagu, D., & Goodman, C. (2016). Prohibit, constrain, encourage, or purchase: How should we engage with the private health-care sector? *Lancet*, 388(10044), 613-621.
- Morgan, R., Ensor, T., & Waters, H. (2016). Performance of private sector health care: Implications for universal health coverage. *Lancet*, 388(10044), 606-612.
- Nichols, L. M., Ginsburg, P. B., Berenson, R. A., Christianson, J., & Hurley, R. E. (2004). Are market forces strong enough to deliver efficient health care systems? Confidence is waning. *Health Affairs (Millwood)*, 23(2): 8-21.
- Ramesh, M., & Wu, X. (2009). Health policy reform in China: Lessons from Asia. *Social Science & Medicine*, 68, 2256-2262.
- Roberts, M. J., Hsiao, W., Berman, P., & Reich, M. (2008). From diagnosis to health-sector reform. In M. Roberts, W. Hsiao, P. Berman, & M. Reich (Eds.), *Getting health reform right: A guide to improve performance and equity*. New York: Oxford University Press.
- Roehrich, J., Barlow, J., & White, S. (2013). Delivering European healthcare infrastructure through public-private partnerships: The theory and practice of contracting and bundling. In T. K. Das (Ed.), *Managing Public-private Strategic Alliances* (series: Research in strategic alliances). Charlotte, NC: Information Age Publishing.
- Roehrich, J., Lewis, M., & George, G. (2014). Are public-private partnerships a healthy option? A systematic literature review. *Social Science & Medicine*, 113, 110-119.
- Tiebout, C. M. (1956). A pure theory of local expenditure. *Journal of Political Economy*, 64, 418-419.
- Toebe, B. (2006). The right to health and the privatization of national health systems: A case study of the Netherlands. *Health and Human Rights*, 9(1), 102-127.
- Torchia, M., Calabro, A., & Morner, M. (2015). Public-private partnerships in the health care sector: A systematic review of the literature. *Public Management Review*. 17(2), 236-261.
- Tu, J., Wang, C., & Wu, S. (2015). The Internet hospital: An emerging innovation in China. *Lancet*, 3(8), e445-6.
- Yip, W., & Hsiao, W. (2014). Harnessing the privatization of China's fragmented health-care delivery. *Lancet*, 384(9945), 805-818.
- Yu, W. (2007). Hospitals ownership: What can China learn from the US experience? In S. Lin, & S. Song (Eds.), *The revival of private enterprise in China*. Aldershot: Ashgate.

Chapter 6

Cohering health law in China: Lessons from an American debate*

* This chapter is based on a published paper. Alternations have been made for the sake of integrality.

Liu, Z. (2017). *Medicine and Philosophy* (in Chinese), 38(8A), 62–66.

Liu, Z. (2018). *Medicine and Law*, 37(3), 449–476.



ABSTRACT

Aim: This chapter mainly focuses on assessing current effective legal norms and their role in governing China's healthcare system and system reform. Thus, the question is framed as follows: *to what extent is the performance of the Chinese healthcare system tied to China's health law and how do we form a coherent health law that will best meet China's new health reform initiatives?*

Background: The Healthy China 2030 Blueprint points out that the Chinese healthcare system reform should be approached following the people-centred integrated care model. As a consequence, current fragmented legal norms in the sphere of health in China cannot face the challenge posed by this new reform initiative, which in turn is a practical requirement calling for a unified law-making model.

Methods: Classic legal analysis is used to evaluate laws and regulations on both national and international levels that are effective in governing health and healthcare in China. Furthermore, this chapter also adopts theoretical analysis on a heated debate over the coherence of health law.

Findings: In health and healthcare, fragmentation is an attribution of legal norms. In China, the fragmented health law is likely to aggravate the inefficiency of reform efforts. New reform measures, such as the nationwide implementation of general practitioner services and encouraging the involvement of private actors in healthcare, need to be assessed and supported by a sufficiently coherent legal framework. All meaningful points raised by the debate over the coherence of health law deserve to be taken into account by lawmakers in China.

Keywords: Health law, fragmentation, coherence of health law, recommendations

6.1 INTRODUCTION

Along with the ageing population and the increasing burden of non-communicable diseases, the traditional hospital-based model of healthcare delivery in China encounters great challenges. Prominent problems include: (1) the current division of labour is not clear causing an awkward situation in which large tertiary hospitals are overwhelmed with patients while many primary medical institutions are underutilised (Li & Xie, 2013); (2) a substantial geographic disparity exists in health facilities and health personnel; (3) the performance of the referral system is relatively poor; (4) people have limited access to claim their health benefits because the responsibility of each involved government agent is not clearly defined; (5) the dual problem of overprescription of certain drugs (e.g. antibiotics) and the defensive behaviour of doctors (or, defensive medicine). In order to solve these problems and increase the accessibility of high-quality healthcare, Healthy China 2030 (WB et al., 2015) was issued by the Chinese government under the guidance of the World Health Organization and the World Bank Group.

Healthy China 2030 points out that the Chinese healthcare system reform should be approached following the people-centred integrated care model, that is, reform efforts should be taken to integrate the current fragmented healthcare delivery. The integration direction of healthcare delivery calls for a coherent health law to secure the consistency of concrete policy measures. Given that there is no specific section of Healthy China 2030 devoted to analysing health law in China, this paper intends to fill the gap by discussing the necessity of cohering health law in China and how to consolidate the fragmented laws and regulations. Useful lessons will be drawn from an American debate on the coherence of health law.

6.2 HEALTH LAW IN CHINA

6.2.1 International health law that applies to China

China plays an active role in the international community, not only as a co-founder of many international governmental organisations (IGOs) but also as a state member of numerous multilateral international treaties and conventions. China has signed and ratified nearly all international treaties and conventions that protect people's health benefits (Table 6.1).

Among all international health regulations, the first section of Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) affirms the general accountability of the state in protecting and promoting the right to health while the second section lists four steps towards protecting the right to health (Box 6.1).

Box 6.1 The second section of the Article 12 of ICESCR: The Right to Health

The steps to be taken by the State Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

From the list above, it is easy to see that the state accountability is mainly addressed in the following spheres: protecting maternal and infant health, preventing and curing special diseases, and creating supportive conditions. In these regards, China, as a signatory country of ICESCR, endeavours to meet the state accountability by enacting special laws and regulations, such as the Law of Maternal and Infant Health Care (2009), the Law of the PRC on Prevention and Treatment of Infectious Diseases (2013 Amendment), and the Law of the PRC on the Prevention and Control of Occupational Diseases (2016 Amendment).

Considering that Article 12 of ICESCR is a very general stipulation, the Committee on Economic, Social and Cultural Rights issued General Comment No. 14 to provide state members with a more detailed explanation on the right to health. Although state members are not legally obligated to comply with international documents like General Comments, they still provide authoritative guidance on how state members should fulfil their accountability.⁷³ According to General Comment No. 14, state members should ‘respect, protect and fulfil’ the right to health of their citizens. Given that state members have different levels of development, General Comment No. 14 allows its state member to take steps towards achieving the ‘availability, acceptability, accessibility, and quality’ (AAAQ) of healthcare.

Besides ICSECR, many other international conventions and treaties that are signed and ratified by China have stipulations regarding health and healthcare (Table 6.1). For instance, Article 5 of the International Convention on the Elimination of all Forms of Racial Discrimination (1969), Article 6, Article 7, Article 9 and Article 10 of the International Covenant on Civil and Political Rights (1976), Article 1, Article 12 and Article 16 of the Convention on the Elimination of All Forms of Discrimination against Women (1981), Article 24 of the Convention on the Rights of the Child (1990), Article 25 of the Convention on the Rights of Persons with Disabilities (2008), and the Framework Convention on

73 FXB Center for Health and Human Rights, *Health and Human Rights: Resource Guide*. (2013). p. 5. Retrieved from <https://cdn2.sph.harvard.edu/wp-content/uploads/sites/5/2013/09/HHRRG-master.pdf> (last accessed 24 March 2019).

Tobacco Control. Furthermore, there are many international organisations (e.g. the United Nations, the United Nations Educational, Scientific and Cultural Organizations, and the World Health Organization) that have their own standards regarding health and healthcare; China needs to comply with these standards to which it is a state party (Table 6.1). For instance, as a permanent member of the United Nations, China needs to comply with Article 3, Article 5 and Article 25 of The Universal Declaration of Human Rights; as a state party of the United Nations Educational, Scientific and Cultural Organizations, China needs to follow Article 14 of the Universal Declaration on Bioethics; as a state member of the World Health Organization, China needs to obey the international health regulations.

In principle, these international documents are legally binding for state members once they have ratified them. However, there is no explicit provision on how to implement them domestically and to what extent these international provisions impact the existing domestic legal systems. The domestic implementation of these international treaties is a rather complicated issue and they differ from one another due to diverse economic-political-legal contexts (Tamanaha, 2004).⁷⁴ In China, ratifying international treaties should follow a special legal procedure regulated by the Law of the People's Republic of China (PRC) on the Procedure of the Conclusion of Treaties (1990) (Xue & Jin, 2009). Based on the procedure, the international treaties, except the Articles with reservations⁷⁵ have – in principle – had a binding force in domestic China. However, there is no explicit provision affirmed by the Legislative Law of the PRC (2015 Amendment) on the substantive enforcement. As a consequence, the substantive enforcement of these international treaties is likely to be more intricate. Furthermore, implementing international treaties concerning protecting health as a human right may encounter an extra obstacle, because the human rights discourse is easily misunderstood as an imposition of Western ideology, which Eastern countries hesitate to adopt domestically (Cerna, 1994).

6.2.2 Domestic health-related laws and regulations

The Legislation Law of the PRC (2015 Amendment) affirms that the Chinese legal system has a multi-tier structure. There are mainly three official sources of law in China: statutory law (e.g. laws, administrative regulations, local regulations, administrative rules, and military regulations), judicial interpretations, and treaties (Zhang, 2011). Influenced by the decentralisation reform of the administrative system, the central government, its State Council department and local governments have the power to issue legally binding rules and regulations (Yang, 2003).

⁷⁴ Tamanaha, B. Z. (2004). *On the rule of law: History, politics, theory*. Cambridge University Press.

⁷⁵ A reservation in international law refers to 'a unilateral statement, however phrased or named, made by a State, when signing, ratifying, accepting, approving, or acceding to a treaty, whereby it purports to exclude or to modify the legal effect of certain provisions of the treaty in application to that State.' For more analysis, please refer to Hylton (1994).

Table 6.1 The international health-related documents joined by China

Documents	Related Articles	Date in Force	China
Binding Documents			
Convention on the Rights of the Child	Article 24	02/09/1990	Effective: 01/04/1992
Convention on the Elimination of All Forms of Discrimination against Women	Preamble, Article 1, Article 12, Article 16	03/09/1981	Signed: 17/07/1980 Ratified: 04/11/1980
Convention on the Rights of Persons with Disabilities	Article 25	Signed: 30/03/2007; Effective: 03/05/2008	Signed: 30/05/2007 Ratified: 01/08/2008
Framework Convention on Tobacco Control		Adopted: 21/05/2003	Signed: 11/2003 Ratified: 01/2005
International Convention on the Elimination of all Forms of Racial Discrimination	Article 5	04/01/1969	Accession: 29/12/1981 Effective: 28/02/1982
International Covenant on Civil and Political Rights	Article 6, Article 7, Article 9, Article 10	23/05/1976	Signed: 05/10/1998
International Health Regulations		Adopted: 2005 Entered into Force: 15/06/2007	State Member of WHO
International Covenant on Economic, Social and Cultural Rights	Article 12	03/01/1976	Signed: 27/10/1997 Ratified: 27/05/2001
Non-Binding Documents			
General Comment No. 20 (1992) replaces General Comment 7 concerning prohibition of torture and cruel treatment or punishment (Article 7)			
General Comment No. 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child, Committee on the Rights of the Child			
General Recommendation No. 24 (20th session, 1999) (Article 12: Women and Health)			
General Comment No. 3 (2003) HIV/AIDS and the rights of the child, Committee on the Rights of the Child			
Recommendation No. R (1998) 71 of the Committee of Ministers to Member States concerning the ethical and organisational aspects of health care in prison			
The Right to the Highest Attainable Standard of Health: General Comment No. 14 (2000) on Health; 11/08/2000. E/C 12/2000/4.			
Declaration on the Rights of Mentally Retarded Persons		Proclaimed: 20/12/1971	State Member of UN
International Declaration on Human Genetic Data		Proclaimed: 16/10/2003	State Member of UN
Madrid Declaration on Ethical Standards for Psychiatric Practice (Declaration of Madrid)		Approved: 25/08/1996 Last Enhanced: 21/09/2011	State Member of World Psychiatric Association (WPA)

Table 6.1 The international health-related documents joined by China (continued)

Documents	Related Articles	Date in Force	China
Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care		Adopted: 17/12/1991	State Member of UN
Standard Minimum Rules for the Treatment of Prisoners	Rules 22–26, Rules 82–83	First Adopted: 30/08/1955 Most Recently Adopted: 17/12/2015	State Member of UN
The Universal Declaration of Human Rights	Article 3, Article 5, Article 25	Adopted and Ratified: 10/12/1948	State Member of UN
Universal Declaration Bioethics UNESCO	Article 14	Adopted: 19/10/2005	State Member of UNESCO
United Nations Rules for the Protection of Juveniles Deprived of their Liberty	Chapter H - Medical Care (Rule 49–55)	Adopted: 14/12/1990	State Member of UN

Source: Please refer to Den Exter (2011), Wan (2007). Originally from the International Human Rights Instruments, please refer to

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CoreInstruments.aspx> last accessed 24 March 2019). Human Rights Library, University of Minnesota, please refer to <https://www1.umn.edu/humanrts/research/ratification-china.html> (last accessed 24 March 2019).

In health and healthcare, numerous laws and regulations from different levels of authority have been enacted in China. Due to the vast spectrum of laws and regulations that govern healthcare in China, Table 6.2 merely lists the laws that were enacted by the National People's Congress and its standing committee. As shown in Table 6.2, the National People's Congress has enacted several special statutes for governing particular health spheres, including the Law of the PRC on Blood Donation (1998), the Law on Practising Doctors of the PRC (2009 Amendment), the Law of Maternal and Infant Health Care (2009), the Law of the PRC on the Red Cross Society (2009 Amendment), Frontier Health and Quarantine Law of the PRC (2009 Amendment), the Mental Health Law of the PRC (2013), the Law of the PRC on Prevention and Treatment of Infectious Diseases (2013 Amendment), the Pharmaceutical Administration Law of the PRC (2015 Amendment), the Law of the PRC on Population and Family Planning (2015 Amendment), the Law of the PRC on the Prevention and Control of Occupational Diseases (2016 Amendment), and the Law of the PRC on Traditional Chinese Medicine (2017).⁷⁶ The eleven special statutes listed draw greater

⁷⁶ Before the enactment of the Law of the PRC on the Traditional Chinese Medicine (2017), scholars largely agree that there are eleven special health laws governing healthcare in China. According to this view, the Food Safety Law of the PRC (2015 Amendment) should be regarded also as one special health law. However, the author disagrees with this category by arguing that only certain Articles of the Food Safety Law of the PRC (2015 Amendment) are correlated to health and healthcare.

Table 6.2 The domestic health-related legal regulations in China

Laws (People's Republic of China – PRC)	Related Articles	Date Issued/ Effective	Health-related Aspect
Administrative Litigation Law of the PRC (2014 Amendment)	Article 57 (advance enforcement on the social insurance for medical treatments) Article 21, Article 36, Article 45, Article 111, Article 119	Issued: 01/11/2014; Effective: 10/05/2015	Judicial Remedy
Anti-domestic Violence Law of the PRC	Article 7 (medical records), Article 9, Article 14/ Article 35 (medical institutions' responsibility to report and liability)	Issued: 27/12/2015; Effective: 01/03/2016	Domestic Violence
Atmospheric Pollution Prevention and Control Law of the PRC (2015 Amendment)	Article 8, Article 78, Article 95	Issued: 29/08/2015; Effective: 01/01/2016	The Right to Health and Living Surroundings
Animal Epidemic Prevention Law of the PRC (2015 Amendment)	Article 13, Article 67	Issued and Effective: 24/04/2015	Public Health and the Right to Health of Employees
Agricultural Law of the PRC (2012 Amendment)	Article 83–84	Issued and Effective: 28/12/2012	Health Protection in Rural China
Advertising Law of the PRC	Article 10/ Article 40 (minors and disabled persons), Article 15–16/Article 18–19 (forbidden content in health-related advertising), Article 46, Article 55–59, Article 62, Article 68–69	Issued: 24/04/2015; Effective: 01/09/2015	Health-related Advertising, Minors and Disabled Persons
Constitution of the PRC (2004 Amendment)	Article 21, Article 36, Article 45, Article 111, Article 119	Issued: 14/03/2004 Issued: 01/11/2014; Effective: 10/05/2015	General Regulation
Criminal Procedure Law of the PRC (2012 Amendment)	Part Five (Chapter IV: Procedures for Involuntary Medical Treatment of Mental Patients Legally Exempted for Criminal Liability)	Issued and Effective: 14/03/2012	Mental Patients
Criminal Law of the PRC (1997 Revision) (Revised with Nine Amendments)	Article 18 (Mental Patients), Section 1. (Crimes of Manufacturing and Selling Fake and Shoddy Goods): Article 141–148, Article 290 (Crimes of Disturbing Medical Order), Section 5. (Crimes of Endangering Public Health): Article 330–336, Article 339, Article 409	Issued: 14/03/1997; Effective: 25/12/1999	Health-related Crimes and Liability
Charity Law of the PRC	Article 63	Issued: 16/03/2016; Effective: 01/09/2016	Health and Charity
Counterterrorism Law of the People's Republic of China	Article 65	Issued: 27/12/2015; Effective: 01/01/2016	Victims and Relatives' Right to Health

Table 6.2 The domestic health-related legal regulations in China (continued)

Laws (People's Republic of China – PRC)	Related Articles	Date Issued/ Effective	Health-related Aspect
Civil Procedure Law of the PRC (2012 Amendment)	Article 73 (deposition exempted), Article 106, Article 206	Issued and Effective: 31/08/2012	Judicial Remedy
Construction Law of the PRC (2011 Amendment)	Article 47	Issued and Effective: 22/04/2011	Occupation Health
Coal Industry Law of the PRC (2013 Amendment)	Article 8	Issued and Effective: 29/06/2013	Occupation Health
Employment Promotion Law of the PRC (2015 Amendment)	Article 30	Issued and Effective: 24/04/2015	Occupation Health
Education Law of the PRC (2015 Amendment)	Article 45 (health facilities), Article 46/ Article 53 (governmental responsibility)	Issued and Effective: 27/12/2015	Children
Environmental Protection Law of the PRC (2014 Revision)	Article 39, Article 47	Issued: 24/04/2014; Effective: 01/01/2015	Public Health
Frontier Health and Quarantine Law of the PRC (2009 Amendment)		Issued and Effective: 27/08/2009	Public Health
Food Safety Law of the PRC (2015 Revision)	Article 10 (healthy lifestyle), Article 14, Article 24, Article 26, Article 45, Article 104, Article 123/Article 126 (sanctions and liability)	Issued: 24/04/2012; Effective: 01/01/2015	Healthy Lifestyle
General Principles of the Civil Law of the PRC (2009 Amendment)	Section 4 (Personal Rights: Article 98. Citizens shall enjoy the right of life and health)	Issued and Effective: 27/08/2009	The Right of Life and Health
Insurance Law of the PRC (2015 Amendment)	Article 91	Issued and Effective: 24/04/2015	Medical Fees and Occupation Health
Law of the PRC on Regional National Autonomy (Revised)	Article 11 (religious), Article 40/Article 42/ Article 50 (self-government organs' responsibility)	Issued: 31/05/1984; Effective: 28/02/2001	Ethnic Minority
Law of the PRC on the Protection of Disabled Persons (Revised)	Article 17/Article 18/ Article 48 (local governments' responsibility)	Issued: 24/04/2008; Effective: 01/07/2008	Disabled Persons
Law of the PRC on the Protection of Minors (2012 Amendment)	Article 11 (parents' responsibility), Article 19/Article 22 (schools' responsibility), Article 27/Article 32/ Article 33/ Article 38/ Article 41 (social and governmental responsibility), Article 68/Article 71 (liability)	Issued: 26/10/2012; Effective: 01/01/2013	Children

Table 6.2 The domestic health-related legal regulations in China (continued)

Laws (People's Republic of China – PRC)	Related Articles	Date Issued/ Effective	Health-related Aspect
Law of the PRC on the Protection of Women's Rights and Interests (2005 Amendment)	Article 17 (female adolescents), Article 26 (employers' responsibility), Article 28 (governmental responsibility), Article 38 (women's right to life and health), Article 51 (reproductive right)	Issued: 28/08/2005; Effective: 01/12/2005	Women and Children
Labour Law of the PRC (Revised)	Article 41/Article 42 (the limited working hours of employees and its exceptions), Chapter 6 (labour safety and sanitation), Chapter 7 (special protection for female staff and workers, and juvenile workers)	Issued: 05/07/1994; Effective: 27/08/2009	Occupation Health, Women and Children
Labour Law of the PRC (Revised)	Article 41/Article 42 (the limited working hours of employees and its exceptions), Chapter 6 (labour safety and sanitation), Chapter 7 (special protection for female staff and workers, and juvenile workers)	Issued: 05/07/1994; Effective: 27/08/2009	Occupation Health, Women and Children
Law of the PRC on Maternal and Infant Health Care		Issued: 27/10/1994; Effective: 27/08/2009	Women and Infants
Law of the PRC on the Protection of the Rights and Interests of the Elderly (2015 Amendment)	Article 15, Article 29–31, Article 34, Article 37, Article 49–50, Article 53, Article 56 (the elderly first as the principle of priority setting), Article 61, Article 69	Issued and Effective: 24/04/2015	The Elderly
Law of the PRC on Population and Family Planning (2015 Amendment)		Issued and Effective: 27/12/2015	Public Health and Reproductive Rights
Law of the PRC on Promoting the Transformation of Scientific and Technological Achievements (2015 Amendment)	Article 12 (government supports the advanced technology in health)	Issued and Effective: 29/08/2015	Health Technology
Law of the PRC on Tobacco Monopoly (2015 Amendment)	Article 5 (children), Article 17	Issued and Effective: 24/04/2015	Tobacco Control and Children

Table 6.2 The domestic health-related legal regulations in China (continued)

Laws (People's Republic of China – PRC)	Related Articles	Date Issued/ Effective	Health-related Aspect
Law of the PRC on the Protection of Consumer Rights and Interests (2013 Amendment)	Article 45, Article 49, Article 51, Article 55	Issued and Effective: 25/10/2013	Consumer's Health-Related Rights
Law of the PRC on Prevention and Treatment of Infectious Diseases (2013 Amendment)		Issued and Effective: 29/06/2013	Public Health
Labour Contact Law of the PRC (2012 Amendment)	Article 32, Article 40, Article 42	Issued and Effective: 28/12/2012	Occupation Health
Law of the PRC on Prevention of Juvenile Delinquency (2012 Amendment)	Article 3, Article 30–32, Article 52–54	Issued and Effective: 26/12/2012	Children
Law of the PRC on the Prevention and Control of Occupational Diseases (2016 Amendment)		Issued and Effective: 07/02/2016	Public Health and Occupational Health
Law of the PRC on Traditional Chinese Medicine		Issued: 25/12/2016; Effective: 01/07/2017	Medicine
Law on Practising Doctors of the PRC (2009 Revision)	The main body of the law remains the same as 1998 version except a minor change of Article 40	Issued and Effective: 6/26/1998	Medical Professionals
Law of the PRC on Blood Donation		Issued: 29/12/1997; Effective: 01/10/1998	Public Health
Law of the PRC on the Red Cross Society (2009 Amendment)		Issued and Effective: 27/08/2009	Humanitarian and Public Health
Law of the PRC on Protecting Against and Mitigating Earthquake Disasters (2008 Revision)	Article 50	Issued 27/12/2008; Effective: 01/05/2009	Public Health
Mine Safety Law of the PRC (Revised)	Article 31 (employers' responsibility)	Issued: 07/11/1992; Effective: 27/08/2009	Occupation Health
Mental Health Law of the PRC		Issued: 26/12/2012; Effective: 01/05/2013	Mental Health
Military Service Law of the PRC (2011 Amendment)	Article 21, Article 53, Article 57	Issued and Effective: 29/10/2011	Military
National Security Law of the PRC	Article 29, Article 31	Issued and Effective: 01/07/2015	Public Health

Table 6.2 The domestic health-related legal regulations in China (continued)

Laws (People's Republic of China – PRC)	Related Articles	Date Issued/ Effective	Health-related Aspect
National Defense Mobilisation Law of the PRC	Article 45 (a medical rescue and healthcare system which is applicable to both peacetime and wartime)	Issued: 26/02/2009; Effective: 01/07/2010	Public Health
Organic Law of the Villagers' Committees of the PRC (2010 Revision)	Article 7 (subcommittees for public health)	Issued and Effective: 28/10/2010	Health-related Organisation in rural China
Prison Law of the PRC (2012 Amendment)	Article 53, Article 54	Issued: 26/10/2012; Effective: 01/01/2013	Prisoners
Pharmaceutical Administration Law of the PRC (2015 Amendment)		Issued and Effective: 24/04/2015	Pharmaceutical Regulations
Social Insurance Law of the PRC	Article 38, Article 42, Article 48, Article 64, Chapter III (Basic Medical Insurance), Chapter VI (Maternity Insurance)	Issued: 28/10/2010; Effective: 01/07/2011	Medical Insurance
State Compensation Law of the PRC (2012 Amendment)	Article 34 (compensation on the infringements of citizen's right to life and health)	Issued: 26/10/2012; Effective: 01/01/2013	Remedy
Tourism Law of the PRC	Article 6, Article 15 (tourists' responsibility), Article 26, Article 66	Issued: 25/04/2013; Effective: 01/10/2013	Public Health and Tourists' Responsibility
Tort Law of the PRC	Chapter VII (Liability for Medical Malpractice)	Issued: 26/12/2009; Effective: 01/07/2010	Patient's Rights

Source: pkulaw, please refer to <http://en.pkulaw.cn/> (last accessed 24 March 2019). Also, please refer to http://www.cdcpf.org.cn/special/6dh/2013-09/15/content_30451989.htm (in Chinese, last accessed 24 March 2019).

attention to protecting vulnerable groups and expanding the accessibility and availability of healthcare services for all residents of China.

All in all, health-related laws and regulations in China have a characteristic of fragmentation. In some circumstances, the characteristic of fragmentation is designed for the sake of checks and balances. For instance, in some Western countries where goals suggested by policies are always achieved through enforcing related laws and regulations (Bledsoe & Prosterman, 2000, p. 3; Parmet, 2016), the fragmentation of health law may enhance the performance of health policies because the disparate parts of health law are likely to be more specific than a general legislation for governing the different aspects of healthcare issues. However, the goal of achieving checks and balances may be hard to attain in China because China maintains a tradition of launching new policies, instead of enforcing law, to reach the target of previous policies. Furthermore, the Chinese government issued a new reform plan,

Healthy China 2030, with a main goal of integrating the fragmented healthcare delivery. The integration direction of healthcare delivery calls for a coherent health law to secure the consistency of concrete policy measures.

6.3 THEORETICAL ARGUMENTS: AMERICAN DEBATE ON COHERING HEALTH LAW

In academia, much literature is centred on questioning and justifying the coherence of health law (Kennedy & Grubb, 2005; Bloche, 2003, 2009; Hervey & McHale, 2004; Elhauge, 2006; Parmet, 2009; Gatter, 2016). Arguments raised by American scholars are relatively straightforward and appealing, which generates advantages in practical applications. Prominent proposals include the law and economic approach from Clark Havighurst (1988, 1995), a trust-based paradigm from Mark Hall (2002), a rescue-oriented framework from Maxwell Bloche (2003), an international human rights framework from Wendy Mariner (2009), and the social justice perspective proposed separately by Rand Rosenblatt (1988) and Lindsay Wiley (2014, 2016).

6.3.1 Clark Havighurst's law and economic approach

Respecting and protecting individual choices are the core values underpinning Havighurst's framework. According to him, it is of great importance to consider the effects of market factors in reforming healthcare systems. Efficiency should be given priority because the instrumental value of health law is to maximise medical benefits. Yet, as Robert Gatter (2016, p. 1138) observes, Havighurst's law and economic approach is rational and practical, which provides sufficient justification for spheres such as health insurance and certain clinical decision-making processes, but it is unable to account for the entire scope of health law. For example, vaccination against rare diseases where beneficiaries are normally small groups of people. From a cost-effective point of view, this kind of vaccination has a low efficiency and should be abandoned no matter how desperate people are when suffering from those rare diseases. It is cruel and has been criticised by many scholars, such as Jonathan Montgomery (2006, p. 14) who argues in favour of legitimating health law by its potential function in preserving morality, and Maxwell Gregg Bloche who is strongly against abandoning patients by emphasising that the prime goals of health law should include 'rescue, support and comfort, personal dignity' (Bloche, 2003, p. 256) besides promoting and restoring health. As a response, Clark Havighurst (1988) defends his framework by denying that the missing parts are the essential elements of health law. Nevertheless, neglecting the missing parts, such as public health, is a major defect that devalues the whole framework in cohering health law.

6.3.2 Mark Hall's trust-based paradigm

According to Hall and Schneider (2004), the coherence of health law cannot be proved by one or more basic principle(s) but the disparate parts of health law can be integrated by sharing a thematic factor. In this regard, Hall proposes that the focus of lawmaking efforts should return to the core of healthcare services: the doctor-patient relationship. Restoring the trust between doctors and patients should be the key point for the coherence of health law. Addressing the importance of restoring trust is derived from 'therapeutic jurisprudence' developed by David Wexler and Bruce Winck (1992, p. 9; 1996, p. xvii). Therapeutic jurisprudence is an analytical framework with a main focus on analysing how the legal system affects the emotion, behaviour and mental health of people. Hall intends to implement and extend the therapeutic jurisprudence paradigm by exploring the role of trust in structuring health law. Therapeutic jurisprudence addresses the importance of caring for patients' feelings and clinical experience. Accordingly, Hall argues that lawmaking efforts should also take the performance of healthcare services into account. Compared with commercial activities, the fragile and insecure feelings of patients highlights the instrumental value of trust to the performance of healthcare services. Nevertheless, critics claim that trust cannot be used to justify the inherent coherence of health law because trust is also the essential element of other department laws.

6.3.3 Maxwell Bloche's rescue-oriented framework

Argued by Bloche (2003, p. 306), rescue should be one of the essential aims of healthcare delivery (and health law). He strongly criticises the argument that lawmaking activity should mainly focus on population-wide health maximisation regardless of the possibility of overriding any identified individual health interests (Bloche 2003, p. 306). The limited recognition capacity of human beings and the uncertainty of diagnosis and treatments would make it difficult to identify 'welfare maximisation' which would in turn impede the effectiveness of health law. Thus, he claims that healthcare lawmaking should be clear about the following issues: 'medical uncertainty, people's cognitive constraints and emotional needs, and persisting moral disagreements limit the possibilities for rational health policymaking' (Bloche, 2003, p. 254). He addresses that healthcare lawmaking should reflect people's real hopes and expectations and, more important, build a rich empathic relationship with people (Bloche, 2003, p. 304). Specifically, besides the goal of protecting and promoting health, healthcare lawmaking must carefully consider the following four goals: rescue, support and comfort, regard for the dignity of the vulnerable, and universal access to basic medical services (Bloche, 2003, p. 256, p. 304). Admittedly, curing and caring should be the essential aims of health services. Yet, lawmaking efforts for cohering health law should adopt a boarder perspective, otherwise it may neglect some indispensable parties in healthcare delivery, such as pharmaceutical companies and health insurance companies.

6.3.4 Wendy Mariner's international human rights framework

Notably, public health has a close relationship with human rights (Gostin, 2004, p. 511; Hervey & McHale, 2004, p. 234). In this regard, the international human rights law framework may perform the best in organising health law as a coherent legal field. Developed by the scholar Wendy Mariner (2009, pp. 70–78), this framework borrows three concepts from the international human rights law to set the scope of health law. These three concepts are actually three aspects of the state accountability in protecting and promoting the right to health: respect, protect and fulfil. This framework is designed to make health law clearer by acknowledging the norms shared with other legal fields (Gatter, 2016, p. 1137). However, the human rights discourse is incompatible with the market dimension of the healthcare system, such as for-profit medical institutions. As a consequence, health law based on human rights needs to be confined to a limited scope (Montgomery, 2006, p. 10). Recognising the limitation, Wendy Mariner (2014, 2016a, 2016b) defends her framework by narrowing her attention to the sphere of public health and social determinants in her recently published research. Nevertheless, there exists another defect. She previously agreed with Einer Elhauge (2006, p. 371) in terms of admitting that health law is a legal field dependent on tailoring the doctrines of other legal fields. Although both Einer Elhauge and Wendy Mariner hold the position that health law should be a coherent legal field, tailoring the doctrines of other legal fields *de facto* denies the legitimacy of the coherence and independence of health law.

6.3.5 Rand Rosenblatt's social justice perspective

Rosenblatt (1988) categorises the historical development of health law in America into three stages with their own distinct priorities. During the first stage, health law in America was designed and implemented with a focus on the professional autonomy of doctors because doctors, during that time, dominated the healthcare system and had a sort of privilege in deciding healthcare distribution owing to their powerful knowledge. During the second stage, lawmaking efforts gradually took patient rights and social interest into consideration. Health law in this stage gave a special attention to mitigating the conflicts between patients and other parties that arose from information asymmetry and unequal power status. This legislative priority implied that health law in this stage was likely to adopt a 'social contract model'. During the third stage, market forces were addressed for the sake of solving the low-efficiency issue and the infringement of individual rights. There is no better or worse approach, as each one has its own advantages and limitations. Yet, Rosenblatt (1988, p. 491) observes that there are four factors driving the development of health law in America: 'economic behaviour, individual self-determination, social choice, and social justice.' Based on it, Rosenblatt proposes the perspective of social justice as the new distinct priority in conceptualising health law. From the perspective of social justice, the focus of healthcare law-making should include but not be limited to improving the engagement of patients in healthcare, addressing the importance of consumerism in protecting self-determination and protecting the interests of vulnerable groups.

6.3.6 Lindsay Wiley's social justice framework

According to Wiley's (2014, 2016) social justice framework, health law and policy should mainly focus on decreasing health disparity, especially where disparity exists in accessing healthcare. Given that the social determinants of health (SDH)⁷⁷ are often regarded as key factors causing health inequalities (Sage, 2017, p. 10), Lindsay advises lawmakers to take SDH seriously when drafting new laws regarding health and healthcare. Considering that social determinants are also the key driving forces behind social justice, there must exist a kind of connection between health law and social justice. In this regard, Wiley (2014, p. 47) argues that health law is an instrument for achieving social justice. Furthermore, she argues that traditional health law often weighs more on protecting and promoting patient rights while inevitably falling short of addressing the protection of the common good (e.g. the sustainability of the healthcare system) (Wiley, 2016). Thus, she claims that healthcare lawmaking needs to be further improved in the following aspects: taking into account public interests when drafting the treatment plan, and securing the sustainability of the healthcare system before expanding the accessibility of certain health services.

Overall, each of the above proposals has appealing aspects and potential limitations. All meaningful points raised by each proposal equally deserve to be taken into account when cohering health-related laws and regulations.

6.4 PRACTICAL IMPLICATIONS FOR ENACTING A BASIC HEALTH LAW IN CHINA

As Porter (2010, p. 3477) argues, having a shared goal that could unite the interests of all involved parties is of great importance for performance improvement in any field. Thus, in healthcare lawmaking, recent literature regarding China's health law largely concentrates on exploring the fundamental value or the unifying theme (Dong, 2014; Wang, 2016; Liu, 2017).

6.4.1 A clear unifying theme for cohering health law in China?

Learnt from the above theoretical arguments, different values can be derived as unifying themes to link the fragmented health law, including efficiency, trust, rescue, human rights and social justice. Are these values, or any one of them, suitable for cohering the fragmented health law in China?

⁷⁷ Defined by the World Health Organization (WHO), SDH are the conditions in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. For more information on the social determinants of health, please refer to http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/ (last accessed 24 March 2019).

Efficiency. If value in healthcare in China is defined with a priority given to cost reduction, then China's fragmented health law should be consolidated encompassing efficiency. However, if taking efficiency as the unifying theme for law coherence, some treatment techniques for a minority population, such as orphan drugs, would be left entirely to the market without legal protection. As a consequence, the health interests of these minority groups would be clearly at stake and lawmaking efforts would be ultimately in vain.

Trust, as an essential attribute of a good physician-patient relationship, plays a vital role in enhancing the quality of healthcare (Hall, 2002, p. 470). Preserving and restoring trust has long been one prominent theme of health laws (Mehanic, 1998). Although restoring trust is of significant importance for reviving the current tense relationship between doctors and patients in China, it is still questionable to use trust to unite China's health law as it is also a central value for laws that govern other areas, such as commercial transactions. In order to defend trust, as the unifying theme, Mark Hall (2002, p. 471) explains the different roles that trust plays in healthcare and in the other areas by arguing that people are likely to have less control over decisions in healthcare than in other areas. This argument is gradually losing its point along with the increasing accessibility of medical information and the people's developing health literacy. As Chinese public hospitals are 'one-stop shops' and patients can access walk-in services, more and more people tend to search for the information about physicians first and then make their choice over the one they want to visit. The original source of trust in healthcare is similar to that in the field of business: patient/client decisions are made based on investigating previous evaluations. Thus, trust lacks a distinguishing force in cohering health law in China.

Rescue. In healthcare, the tension between cost-effectiveness and the 'Rule of Rescue' often raises serious questions for health policymakers, such as how to allocate public funding to competing health technologies, such as costly new cancer drugs versus lifesaving therapies.⁷⁸ Decisions have to be made explicitly for specific health policies. Yet, a general health law should be framed with a neutral framework, which essentially means that both cost-effectiveness and the Rule of Rescue should be taken into account and equally weighted. Thus, rescue only is not adequate for cohering health law in China.

Human Rights. To appeal to human rights often happens when there is a strong claim for having one's basic medical needs fulfilled. If the basic health law takes the human rights discourse as its unifying theme, major obstacles may be created for law enforcement. One major obstacle is created by the difficulty in defining 'basic health needs'. From Wilkinson's

⁷⁸ In literature, the tension between cost-effectiveness and the 'Rule of Rescue' has been extensively discussed in diverse contexts. For detailed analysis, please refer to Hadorn, (1991); Cookson et al., (2007).

(1999, p. 264) analysis about the difficulty of defining the ‘social value criterion’, defining basic health needs either in a subjective or objective way may raise different but equally hard questions.⁷⁹ Although the difficulty of defining basic health needs is not unique to China, it is likely to be even greater when taking into account the size of its population. Another related difficulty concerns patients’ unlimited health needs. By referring to human rights, patients or their surrogates could argue for accessibility for all services independent of degree of necessity within the population. It is not clear to what extent the unlimited health needs by patients create obligations on others to provide them.⁸⁰ Taking human rights as the unifying theme of the basic health law is likely to cloud, rather than clarify, its boundary. In most cases, it is the public health law that intertwines with the human rights discourse since it has a focus on protecting and promoting the population’s health. Controversial issues may appear when one turns to an individual’s focus of healthcare, the field of patient care which is governed by medical law (Mann, 1997). Although some research effort has been put into consolidating medical law and public health law (Ezer & Cohen, 2013; Peled-Raz, 2017), through the lens of human rights principles, more discussions on further justification are still needed. Given that the primary goal of enacting a basic health law in China is to link the Constitution to specific health laws and regulations (Meng et al., 2015, p. 18), the unifying theme should be framed in a broader way than the human rights discourse in order to cover both medical law and public health law. Thus, a human rights approach is likely to be unsuitable for cohering China’s health law.

Social justice. According to Lindsay’s analysis, health law and social justice have a close relationship through the lens of correcting health disparities. Social justice is a general term which can be extensively interpreted for the sake of covering every aspect of healthcare. Yet, due to the diverse possibilities of interpreting social justice, a context-based standard on what accounts for social justice needs to be developed first. Since the standard would be developed as a kind of context-specific standard, problems may occur when the context changes. Thus, it is likely to be impossible to generalise the approach of law coherence.

79 If one defines ‘basic health needs’ as necessities in health, one may easily fall into a ‘majority tyranny’ situation; that is, the chosen basic health needs are actually reflecting what the majority needs while failing to represent minority views. If one attempts to define basic health needs in the objective way, then one may confront a more controversial issue: procedural justice. Questions, such as who should decide and how to use procedural justice to justify outcomes, remain to be answered.

80 Although the General Comment No. 14, a comment on Article 12 of the ICESCR, specifies the content of the human right to health as containing ‘both freedoms and entitlements’ and correspondingly addresses the obligation of the state to facilitate its healthcare system towards the AAAQ standard of protection of the right to health, the issue of how to interpret and implement this General Comment is still no easy task, given that state parties to the ICESCR are at different stages of economic development with diverse cultures and values. For more analysis on this argument, please refer to Kinney (2001).

Besides these considerations that are derived from the American debate on cohering health law, are there any other considerations that need to be taken into account when cohering health law in China?

6.4.2 Traditional Chinese ethics as one essential consideration

Ethics has a great impact on the formulation of health law.⁸¹ It would thus generate a great deficiency if China's basic health law was drafted without any concern for traditional Chinese ethics. Greatly influenced by Confucian traditions, China attaches great importance to close family ties and the role of family in its healthcare system (Wong et al., 2009). Taking a new reform measure for example, a family-based general practitioner service has been expanded from pilot areas to the whole nation for the sake of strengthening primary healthcare in China. The GP system in China is designed quite differently from that of Western countries in terms of addressing the role of family. According to the system's design, it is each household rather than the individual patient, which is encouraged to contract with a GP who practises medicine in the neighbourhood. Such a reform measure implies that the role of family has been inherently suggested by reform policies in China. Using policies as instruments to implement themselves is not conformity to the 'rule of law'. The state, under the rule of law, should embody legal rules and regulations in concrete implementation. This is what the Chinese government has been doing and will continue to do. Ethical values, such as preserving the family ties, are not only important for framing health policies but also should be embedded in the basic health law in order to ensure the effectiveness of practical implementation. Lawmakers in China shall take the values of family seriously when drafting basic health law.

6.5 CONCLUDING REMARKS

Cohering health law in China is a complex process requiring careful attention not only to the intrinsic morality of law but also to the special value in healthcare. Before embarking on any substantial legislative actions, it is worth reminding lawmakers in China of at least two points. First, identifying a clear theme to ensure the consistency and coherence of health law. Learnt from the above practical implications, social justice is likely to be a suitable candidate. Yet, lawmakers in China need to develop a context-specific content of social justice. In this regard, family-oriented ethical values need to be well addressed. Second, being aware of the distinction between law and welfare policy in healthcare in China. Considering China's basic conditions, especially its large population, health law in China at the current stage should first fulfil its aim of deterring or reducing future harms rather than being a powerful tool enabling people to claim additional health benefits.

81 In literature, many discussions focus on studying the relationship between health law and ethics, for instance Montgomery (2000), Miola (2007) and Coggon (2012).

6.6 REFERENCES

- Bledsoe, D. J., & Prosterman, R. L. (2000). Policy, the rule of law, and rural land reform in China. *RDI Reports on Foreign Aid and Development #101*. Retrieved from: http://www.landesa.org/wp-content/uploads/2011/01/RDI_101.pdf (last accessed 24 March 2019).
- Bloche, M. G. (2003). The invention of health law. *California Law Review*, 91(2), 247-322.
- Bloche, M. G. (2009). The emergent logic of health law. *Southern California Law Review*, 82, 389-480.
- Cerna, C. M. (1994). Universality of human rights and cultural diversity: Implementation of human rights in different socio-cultural contexts. *Human Rights Quarterly*, 16, 740-752.
- Coggon, J. (2012). Would responsible medical lawyers lose their patients? *Medical Law Review*, 20(1), 130-149.
- Cookson, R., McCabe C., & Tsuchiya A. (2007). Public healthcare resource allocation and the Rule of Rescue. *Journal of Medical Ethics*, 34, 540-544.
- Den Exter, A. (2011) (Ed.). *International Health Law & Ethics*. Antwerp: Maklu Press.
- Dong, W. (2014). On fundamental health legislation: Values, systems, and principles (in Chinese). *Hebei Law Science*, 2, 2-14.
- Elhauge, E. R. (2006). Can health law become a coherent field of law? *Wake Forest Law Review*, 41, 365-390.
- Ezer, T., & Cohen, J. (2013). Human rights in patient care: a theoretical and practical framework. *Health and Human Rights*, 15(2), 7-19.
- Gatter, R. (2016). (Population) health law in theory. *Journal of Health Politics, Policy and Law*, 41(6), 1119-1136.
- Gostin, L. O. (2004). Health of the people: The highest law? *Journal of Law, Medicine & Ethics*, 32(3), 509-515.
- Hadorn, D. C. (1991). Setting health care priorities in Oregon: Cost-effectiveness meets the rule of rescue. *JAMA*, 265, 2218-2225.
- Hall, M. A. (2002). Law, medicine, and trust. *Stanford Law Review*, 55, 463-527.
- Hall, M. A., & Schneider, C. E. (2004). Where is the 'there' in health law? Can it become a coherent field? *Health Matrix*, 14(1), 101-105.
- Havighurst, C. C. (1988). *Health care law and policy: Reading, notes, and questions*. Westbury, NY: Foundation Press.
- Havighurst, C. C. (1995) *Health care choices: Private contracts as instruments of health reform*. Washington, DC: Aei Press.
- Hervey, T. K., & McHale, J. V. (2004). *Health law and the European Union: Themes and implications*. Cambridge: Cambridge University Press.
- Hylton, D. N. (1994). Default breakdown: The Vienna convention on the law of treaties: Inadequate framework on reservations. *Vanderbilt Journal of Transnational Law* 27, 419-452.
- Kennedy, I., & Grubb, A. (2005). *Medical law: Text with materials* (3rd ed.). New York, NY: Oxford University Press.
- Kinney, E. D. (2001). The international human right to health: What does this mean for our nation and world? *Indiana Law Review*, 34, 1457-1475.
- Li, Q., & Xie, P. (2013). Outpatient workload in China. *Lancet*, 381, 1983.
- Liu, C. (2017). On the name, legal orientation and primary institutions of China's basic medicine and health law (in Chinese). *Legal Science Magazine*, 38(4), 67-76.
- Mann, J. M. (1997). Medicine and public health, ethics and human rights. *Hastings Centre Report*, 27(3), 6.

- Mariner, W. K. (2009). Towards an architecture of health law. *American Journal of Law & Medicine*, 35(1), 67-87.
- Mariner, W. K. (2014). Paternalism, public health, and behavior economics: A problematic combination. *Connecticut Law Review*, 46(5), 1817-1838.
- Mariner, W. K. (2016a). Beyond lifestyles: Governing the social determinants of health. *American Journal of Law & Medicine*, 42(2-3), 248-309.
- Mariner, W. K., & Annas, G. J. (2016b). (Public) health and human rights in practice. *Journal of Health Politics, Policy and Law*, 41(1), 129-139.
- Mehanic, D. (1998). The functions and limitations of trust in the provision of medical care. *Journal of Health Politics, Policy and Law*, 23(4), 661-686.
- Meng, Q., Yang H., Chen W., Sun Q., & Liu, X. (2015). People's Republic of China: Health system review. *Health Systems in Transition*, 5(7), 1-246. Retrieved from: http://www.wpro.who.int/asia_pacific_observatory/hits/series/china_health_systems_review.pdf?ua=1 (last accessed 24 March 2019).
- Miola, J. (2007). *Medical law and medical ethics: A symbiotic relationship*. Portland, OR: Hart Publishing.
- Montgomery, J. (2000). Time for a paradigm shift? Medical law in transition. *Current Legal Problems*, 53(1), 363.
- Montgomery, J. (2006). The legitimacy of medical law. In S. A. M. McLean (Ed.), *First do no harm: Law, ethics and healthcare*, 1-16. Aldershot: Ashgate.
- Parmet, W. E. (2009). *Population, public health, and the law*. Washington, DC: Georgetown University Press.
- Parmet, W. E. (2016). Health: policy or law? A population-based analysis of the Supreme Court's ACA cases. *Journal of Health Politics, Policy and Law*, 41(6), 1161-817. doi: 10.1215/03616878-3665949.
- Peled-Raz, M. (2017). Human rights in patient care and public health – a common ground. *Public Health Review*, 38, 29.
- Porter, M. E. (2010). What is value in health care? *New England Journal of Medicine*, 363, 2477-2481.
- Rosenblatt, R. E. (1988). Conceptualizing health law for teaching purposes: The social justice perspective. *Journal of Legal Education*, 38(4), 489-497.
- Sage, W. M. (2017). Relating health law to health policy: A frictional account. In: I. G. Cohen, A. K. Hoffman & W. M. Sage, (Eds.), *The Oxford Handbook of U.S. Health Law*, pp. 3-28. New York, NY: Oxford University Press.
- Tamanaha, B. Z. (2004). *On the rule of Law: History, politics, theory*. Cambridge: Cambridge University Press.
- Wan, M. (2007). Human rights law-making in China: Domestic politics, international law, and international politics. *Human Rights Quarterly*, 29(3), 727-753.
- Wang, C. (2016). Taking protection of citizens' right to health as the foundation of health law. *Chinese Legal Science (English version)*, 5, 95-113.
- Wexler, D. B., & Winck, B. J. (1992). *Essays in therapeutic jurisprudence*. Durham, NC: Carolina Academic Press.
- Wexler, D. B., & Winck, B. J. (1996). *Law in a therapeutic key: Development in therapeutic jurisprudence*. Durham, NC: Carolina Academic Press.
- Wiley, L. F. (2014). Health law as social justice. *Cornell Journal of Law and Public Policy*, 24(1), 47-105.
- Wiley, L. F. (2016). From patient rights to health justice: Securing the public's interest in affordable, high-quality health care. *Cardozo Law Review*, 37, 833-889.

- Wilkinson, S. (1999). Smokers' rights to health care: why the 'restoration argument' is a moralizing wolf in a liberal sheep's clothing. *Journal of Applied Philosophy*, 16(3), 255-269.
- Wong, C. K., Wang, K., & Kaun, P. Y. (2009). Social citizenship rights and the welfare circle dilemma: Attitudinal findings of two Chinese societies. *Asian Social Work and Policy Review*, 3, 51-62.
- World Bank Group, World Health Organization, China's Ministry of Finance, National Health and Family Planning Commission, and Ministry of Human Resources and Social Security. (2016). Healthy China: deepening health reform in China. Retrieved from <http://www.wpro.who.int/china/publications/2016-health-reform-in-china/en/>. (last accessed 24 March 2019)
- Xue, H., & Jin, Q. (2009). International treaties in the Chinese domestic legal system. *Chinese Journal of International Law*, 8(2), 299-322.
- Yang, D. (2003). The development of intellectual property in China. *World Patent Information*, 25(2), 131-142.
- Zhang, W. (2011). *Jurisprudence*. Beijing: High Education Press & Peking University Press.

Chapter 7

**Conclusions: findings, reflections
and future directions**



7.1 INTRODUCTION

Chapters 2 to 6 of this thesis closely examine five crucial questions concerning the progressive reforms of the Chinese healthcare system (Table 7.1).

Table 7.1 Five subquestions of this thesis

Addressing Personal Responsibility for Health			
Health Reform Initiatives in China	Patient Empowerment and Engagement	<i>Q 1. To what extent should personal responsibility be addressed for the sake of advancing the reforms of the Chinese healthcare system?</i>	Ch. 2
		<i>Q 2. Given that empowering and activating patients is at the top of Healthy China 2030, how do we place personal responsibility in healthcare in China to make this health reform initiative more effective?</i>	Ch. 3
	Correcting Structural Injustice by Regulatory Interventions		
	Primary Healthcare	<i>Q 3. Will the implementation of general practitioner (GP) services strengthen China's primary healthcare delivery and how do we structure regulatory interventions to secure the successful nationwide implementation of GP services?</i>	Ch. 4
	Private Sector	<i>Q 4. Given the great influence of privatisation on the Chinese healthcare system, how does the Chinese government fulfil its role in measuring the rapid growth of private medical institutions (especially using legal/regulatory measures) from a human rights perspective?</i>	Ch. 5
Supportive Legal Environment		<i>Q 5. To what extent is the performance of the Chinese healthcare system tied to China's health law and how can a coherent health law be formed that will best meet China's new health reform initiatives?</i>	Ch. 6

The two major perspectives designed (personal responsibility and structural injustice) and three specific themes (patient empowerment, healthcare delivery and supportive legal environment) enable this thesis to ‘hang together’ these five distinct but equally crucial questions and, thereby, to tell a more coherent and compelling story surrounding the central question:

In the context of Chinese healthcare system reforms, how should the conflict between the protection of individual rights (e.g. satisfying patient needs) and the sustainability of healthcare resources from ethical and legal perspectives be mitigated?

In this final chapter, the findings in Chapters 2 to 6 will be briefly summarised. Thereafter, some reflections on the central question and the subquestions addressed by each individual chapter will be offered. Derived from these findings and reflections, future directions for research and national health policy will also be proposed.

7.2 A SYNTHESIS OF FINDINGS

‘A good analysis will attend both personal and structural factors’ (Nussbaum, 2011, p. xii) According to Young’s (2011, p. 4) argument about poverty, disadvantages are most likely to be rooted in both personal responsibility and structural injustice rather than merely one of these two. Thus, discussions in this thesis take both factors into account. As clearly presented in Table 7.1, Chapter 2 and Chapter 3 give special attention to addressing personal responsibility while Chapters 4 to 6 focus on correcting structural injustice.

In the general introduction (Chapter 1), discussions make it clear that addressing personal responsibility in healthcare generally means letting individual human beings be responsible for their own health, especially holding them accountable for their health-related choices. Raising the issue of personal responsibility in healthcare essentially aims at encouraging people to be more active in taking care of their own health and being more active in healthcare.

In Chapter 2, discussions reveal the reality and necessity of addressing personal responsibility in advancing the reform of the Chinese healthcare system:

- (1) The ageing population and the increasing burden of non-communicable diseases gradually change the goal of healthcare delivery from curing diseases to preventive care.
- (2) Advancing the Chinese healthcare system reform needs to escape from its back-and-forth feature by including driving forces other than the state and the market.

Given the reality and necessity of addressing personal responsibility, the question of concern is raised: *To what extent should personal responsibility be addressed in advancing the reform of the Chinese healthcare system?* To answer this question, discussions resort to three prominent philosophical theories – liberal egalitarianism, luck egalitarianism and communitarianism – and explore their policy implications for the Chinese healthcare system. Practical advice is summarised as follows:

- (1) Suggested by liberal egalitarianism, addressing personal responsibility in healthcare can be achieved through taxing unhealthy choices. Yet, taxing unhealthy choices needs more empirical evidence before implementing in China since it has generated controversial results in other nations.
- (2) Personal responsibility in healthcare should be addressed from an ex ante perspective. Meaningful lessons can be drawn from Germany’s experience in empowering its citizens to be more active in their own health and healthcare (e.g. launching health incentive schemes and enacting special laws).

- (3) Suggested by communitarianism, personal responsibility in healthcare should be addressed, compatible with the aim of fostering the shared value of the community such as China's long tradition of valuing family ties.

In Chapter 3, discussions further explore the policy implications revealed in Chapter 2 for addressing personal responsibility in advancing Chinese healthcare system reforms.

In 2016, the new health reform plan, Healthy China 2030 (WB et al., 2016), was launched with a special focus put on empowering and engaging patients in healthcare. Yet, this health reform initiative lacks detailed contextual elaboration which may limit its effectiveness. The question addressed by Chapter 3 therefore is raised: *Given that empowering and activating patients is at the top of Healthy China 2030, how do we place personal responsibility in healthcare in China to make this health reform initiative more effective?* Discussions in Chapter 3 argue that compared with the individual and community levels, empowering and activating patients at the household level is likely to be more compatible with the reality of national conditions of China (e.g. Chinese bioethics, household registration system, the integrated health insurance schemes and related domestic legislations).⁸² The preliminary idea behind engaging patients at the household level is to emphasise the patient's personal responsibility in managing their own health, while adopting family support as a supplementary consideration to prevent the individual patient from being abandoned by the healthcare system. To answer the question concerned, personal responsibility should be addressed together with the involvement of family for the sake of achieving the effectiveness of the targeted health reform initiative. Thus, different from what is recommended in Healthy China 2030, we try to approach the recommended areas by laying more emphasis on the role of the family. Corresponding recommendations for future reform efforts are as follows:

- (1) cultivating health literacy as a family asset;
- (2) emphasising family support in promoting a patient's self-management skills;
- (3) involving families in shared decision-making;
- (4) developing healthy families as a parallel pathway for creating the supportive environment for patient engagement.

Discussions hitherto mainly focus on exploring the personal factor, especially through the lens of personal responsibility, in advancing the reform of the Chinese healthcare system. In the second part, discussions switch to the other essential factor that a good analysis should take into account – the structural factor – and explore how to adjust it for the sake of advancing the reform of the Chinese healthcare system. The rapid ageing population and the increasing burden of non-communicable diseases have driven the Chinese healthcare system to transform from a profit-driven public hospital-centred model to an integrated high-quality and value-based model (Yip & Hsiao, 2014, p. 805). Prominent reform initiatives

82 The detailed analysis on the practical evidence for proving the feasibility of engaging patients at the household level in China is included in Chapter 3 of this thesis.

include strengthening primary healthcare, improving the referral system and encouraging the development of the private sector in delivering healthcare. To assess and enhance their effectiveness, Chapter 4 and Chapter 5 are designed to explore these initiatives from the regulatory perspective.

In Chapter 4, discussions mainly focus on assessing the effectiveness of the newly launched general practitioner services with special attention given to the regulatory aspect. Different from other countries, the general practitioner services in China are introduced with a strong context-based characteristic: household-oriented. Initial achievements are made in the pilot areas (Shanghai, Chongqing and Guangzhou), which encourages central government to consider a nationwide implementation. The question concerned is thus raised: *Will the implementation of general practitioner (GP) services strengthen China's primary healthcare delivery and how do we structure regulatory interventions to secure the successful nationwide implementation of GP services?* To answer this question, discussions compare the old model of primary healthcare delivery and the household-oriented GP services, and thereby indicate the necessity of using household-oriented GP services to strengthen China's primary healthcare delivery. Yet, the selected pilot areas are largely well-developed cities where people enjoy a higher level of social welfare, including education and medical care,

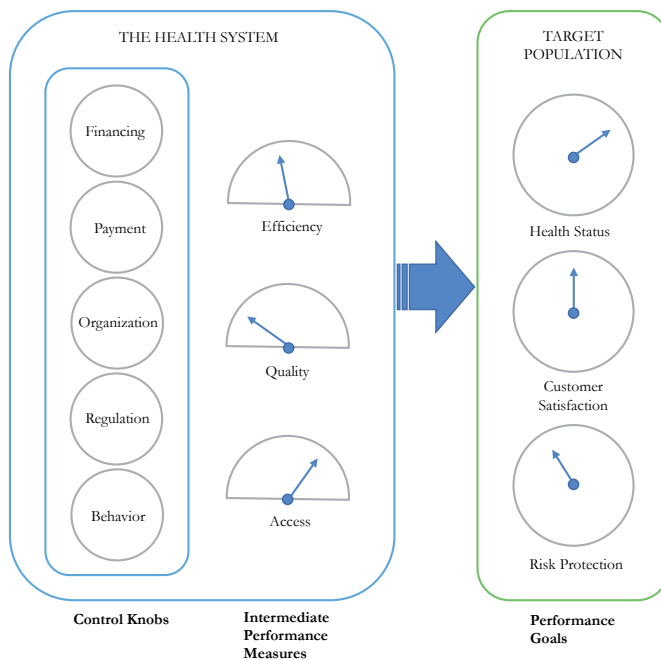


Figure 7.1 The control knob framework

Source: Adapted from Figure 2.2 in Roberts et al. (2004), p. 27.

than the average person in China. Situations will be more complicated when implementing GP services nationwide. Thus, key prerequisites such as appropriate regulatory strategies need to be fulfilled to secure and enhance the effectiveness of nationwide implementation of GP services. Based on the ‘control knob framework’ (Figure 7.1) developed by Roberts and colleagues, a comprehensive assessment of China’s current regulatory interventions for GP services is performed; that is, a thorough analysis of the internal factors (i.e. a set of related regulations and the legislative method) and the external factors (i.e. cultural attitude, government capacity and interest groups) that may influence regulatory success.

Results indicate that currently, China’s regulatory interventions for GP services are far from adequate. Major deficiencies revealed by the assessment include the problematic relationship between regulations and health policies, the lack of coherent laws, the low rate of social acceptance of GP services, and the lack of continuing support for GP services from both formal and informal interest groups. As a response, discussions recommend that, prior to the nationwide implementation of GP services, efforts should be devoted to, but not limited to, the following two directions: enacting a specific law, and creating an independent regulatory supervisory body.

Another prominent reform initiative, encouraging the development of the private sector in healthcare delivery, is the focus of Chapter 5. The motivation behind this reform initiative is to stimulate the efficiency of healthcare delivery by using private sector competition (Yip & Hsiao, 2014, p. 807). Nevertheless, without effective regulatory interventions, this reform initiative may not produce any enhancement for China’s healthcare delivery. Thus, the focus of discussions in this chapter is still primarily on structuring regulatory interventions to secure and enhance the effectiveness of this reform initiative. Furthermore, in order to develop a better understanding of this reform initiative, private medical institutions (PMIs) is chosen as a study subject for analysis. The question addressed by this chapter is: *Given the great influence of privatisation on the Chinese healthcare system, how will the Chinese government fulfil its role in measuring the rapid growth of private medical institutions from a human rights perspective?* Slightly different from that of Chapter 4, the question is mainly approached from the perspective of human rights which means the perspective on human rights set out in international human rights law. Thus, a study of international human rights law is included in discussions. Findings indicate that the state is required to assume an active regulatory role rather than play a ‘provider’ role in controlling and supporting the development of the private sector in healthcare delivery. To identify what can be improved, a comprehensive assessment (the diagnostic process, see Figure 5.1) of China’s current regulatory interventions for PMIs is performed.

Findings indicate that there are three major concerns regarding effective legal rules – weak coherence, inconsistency and legislative vacancy – and three difficult issues regarding government capacity – the negative effects of decentralised political structure, the low professionalism of bureaucrats and lack of reliability – that impede the effectiveness of China’s

current regulatory interventions for PMIs. Corresponding recommendations for addressing the regulatory role of the Chinese government are made in the following two aspects: enacting an ‘umbrella health law’ in which a separate section should be assigned to regulating PMIs, and establishing an independent regulatory body to manage the issues of PMIs in China. Further details on these two recommendations are summarised as follows:

- (1) Enacting an umbrella health law is of significant importance for strengthening the weak coherence of effective legal rules. The umbrella health law should include a separate section for regulating PMIs.
- (2) The PMI section of the umbrella health law should include legal rules to clarify the attribute of PMIs, especially for-profit PMIs.
- (3) The PMI section of the umbrella health law should include legal rules to ensure equal access to healthcare and other health-related services provided by PMIs.
- (4) Responsibility for monitoring the enforcement of related legal rules should be assigned to an independent regulatory supervisory body.
- (5) The PMI section of the umbrella health law and the independent regulatory body should aim at facilitating the transparency of the healthcare market.

Drawn from discussions in Chapter 4 and Chapter 5, there is a great need for enacting a basic law of healthcare to secure and enhance the effectiveness of China’s new health reform initiatives. The question in concern is thus raised: *To what extent is the performance of the Chinese healthcare system tied to China’s health law and how do we form a coherent health law that will best meet China’s new health reform initiatives?* By studying all relevant laws and regulations that govern healthcare in China, discussions identify that ‘health law’⁸³ in China has a characteristic of fragmentation and argue that the growing fragmentation is a serious problem that will limit the effectiveness of China’s new health reform initiatives because it is unlikely to be compatible with the integration direction of health reform in China. Thus, how do we form a coherent health law that could best meet China’s new health reform initiatives? To answer this question, we carefully examined six prominent proposals (i.e. the law and economic approach from Clark Havighurst, the trust-based paradigm from Mark Hall, the rescue-oriented framework from Maxwell Bloche, the international human rights framework from Wendy Mariner, and the social justice perspective proposed separately by Rand Rosenblatt and Lindsay Wiley) and their practical implications for cohering health law in China. In the end, three final remarks are made for lawmakers in China:

- (1) Cohering health law in China is a complex process requiring careful attention not only to the intrinsic morality of law, but also to the special value in healthcare.
- (2) It is of significant importance to first identify a clear theme of health law before embarking on any substantial lawmaking activities.

83 ‘Health law’ here refers to a wide array of laws and regulations that govern health and healthcare in China.

- (3) Be aware of the distinction between law and welfare policy; that is, considering the basic conditions of China, especially its large population, health law in China at the current stage should first fulfil its aim of deterring or reducing future harm rather than being a powerful tool enabling people to claim additional health benefits.

7.3 REFLECTIONS ON THE RESEARCH QUESTION AND SUBQUESTIONS

7.3.1 To mitigate rather than resolve the conflict

As Williams (2008, p. 650) has noted, ‘conflicts do exist over issues including funding, treatment, duties, rights and preferences.’ These conflicts cannot be simply resolved because patient need is limitless but healthcare resources are not, or even scarce in some cases. For most current healthcare systems, the scarcity of healthcare resources is likely to be permanent on account of the ageing population, the increasing burden of non-communicable diseases and the rapid development of advanced health technologies. These conflicts cannot be simply resolved also because not all of them generate bad consequences. Just as Tidwell (1998, p. 4) has argued, a given conflict may be good if it meets other desired outcomes. Thus, the general aim of this thesis is to mitigate rather than resolve the conflict between the protection of individual rights and the sustainability of healthcare resources.

7.3.2 The appropriateness of addressing personal responsibility is context-specific

Based on the historical review of Chinese healthcare system reforms, discussions in Chapter 2 reveal the reality and necessity of addressing personal responsibility in healthcare in China. Furthermore, in Chapter 3 where discussions focus on exploring policy implications, the feasibility of applying personal responsibility in healthcare in China is also justified by resorting to traditional Chinese ethics. As a consequence, addressing personal responsibility in healthcare is likely to be context specific which may limit its generalisation to other social settings. Yet, other nations can still draw useful lessons from the findings when similar problems occur.

7.4 LIMITATIONS AND FUTURE DIRECTIONS FOR RESEARCH DEVELOPMENT

I know and do admit that discussions in this thesis are not completely adequate in some aspects. From a positive perspective, however, potential limitations outlined below can also be viewed as defining areas for future study. First, discussions in both Chapter 2 and Chapter 3 may be challenged because they are largely rooted in the restoration argument. In both

Chapter 2 and Chapter 3, we intend to mitigate the conflict between the protection of individual rights and the sustainability of the Chinese healthcare system by raising the issue of personal responsibility. One key reason behind this intention is that people who live an unhealthy lifestyle may generate additional costs to their counterparts (i.e. people who maintain a healthy lifestyle) and it is unfair to let ‘innocent’ people pay for others’ unhealthy lifestyle choices. So as Wilkinson (1999, p. 256) makes clear in his analysis of smokers’ rights to healthcare:

So, to sum up, what the *restoration argument* says is that we ought to reduce smokers’ entitlements to healthcare because *not* to do so would mean unfairly making non-smokers ‘pay the price’ for smokers’ unhealthy lifestyles.

The restoration argument is appealing to libertarians partially because it merely focuses on preventing harm to people who maintain a healthy lifestyle while not forcibly preventing people from engaging in an unhealthy lifestyle (Wilkinson, 1999, p. 257). However, the argument of ‘additional costs’ is challenged by empirical evidence showing that people who live an unhealthy lifestyle may actually save healthcare resources by dying earlier than people who maintain a healthy lifestyle.⁸⁴ This controversial issue may result in conflicting health policies. Thus, it deserves to be further analysed with more empirical evidence.

Second, discussions that raise the issue of personal responsibility may be challenged because social bias may play an essential role in judging whether a behaviour is healthy or not; that is, greatly influence the attribution of personal responsibility. This concern is raised by Ubel (1997; et al., 1999) in his analysis of alcoholics and transplant allocation, and was further addressed by Friesen (2016) recently. Ubel (1997, p. 345) argues that if a behaviour is socially desirable, then people are highly likely not to resort to personal responsibility but may even agree to give that person a priority in receiving organs. Thus, he warns that health policies should be careful to adopt the principle of personal responsibility since such policies may merely reflect social bias on certain behaviours. Suggested by Friesen (2016, p. 57), further study needs be conducted either including certain kinds of socially desirable behaviours associated with health disadvantages, or explaining why those behaviours those behaviours are excluded.

Third, the proper concept of social justice needs to be further defined. In Chapter 6, we have studied six prominent proposals for justifying the coherence of health law, among which the social justice framework is likely to be most compatible with the Chinese context. Yet, the meaning of social justice needs to be clarified in order to unite the interests of all involved parties in law-making for healthcare, which raises more interesting questions that need to be explored. For instance, who should decide and through what kind of procedure?

⁸⁴ Related researches can be found in the following literature: Persaud (1995); Barendregt et al. (1997); Rezayatmand et al. (2017).

Can we rely on the justice of a procedure to determine the definition of social justice? So as Wilkinson (1999, p. 264) argues in his analysis about defining the ‘social value criterion’, we will encounter more questions where we either appeal to ‘what people in fact *value* (prefer, desire etc.) or to what is (objectively) *valuable*.’ Wilkinson explains his two concerns: if we attempt what we in fact value, we may easily fall into a ‘majority tyranny’ situation; that is, the chosen values and preferences are what the majority of us happen to have. If we attempt what is objectively valuable, then we need to figure out who should decide which behaviours are valuable and how to decide. Thus, we will potentially face similar questions when we attempt to define social justice. In this regard, further studies are needed.

Fourth, the ‘Accountability for Reasonableness’⁸⁵ (A4R) framework. Rather than struggling with the substantive principles of allocating healthcare resources, research on how to build a fair and equitable decision-making process is an alternative perspective which is based on the conviction that procedural justice is of vital importance in achieving the legitimacy of any substantive outcome. We have done research discussing this topic.⁸⁶ In that study, we use the A4R framework to evaluate the decision-making process used in the Chinese healthcare system reform (2006–2009). Nevertheless, as many studies have indicated, the A4R framework merely offers ground rules, not practical guidelines (Friedman, 2008). In practice, its four conditions need to be adapted, or even revised, in order to be compatible with different social contexts which also indicates areas for further study.

Besides these four directions, which are pointed out by the potential limitations of this thesis, there are also some interesting evolving themes of healthcare in China that are relevant to mitigate the conflict between the protection of individual rights and the sustainability of healthcare systems, such as to ‘nudge’ people for better health.

Fifth, adapting ‘nudge’ in the Chinese healthcare system. Nudge is a policy design with an aim of pushing individuals softly to opt for choices that are better for them without limiting their liberty.⁸⁷ One typical example of Nudge is organising the display of foods in school cafeterias. The display can be arranged according to different aims: maximising profits, most healthy for customers, or just randomly without any aims. Given that item arrangement influences people’s choices, Nudge will suggest to the person who is responsible for food display to arrange them with the aim of encouraging customers to make more healthy choices. In this regard, Nudge is likely to pave a third way besides coercive policies and laws to not only protect people’s health but also save money and resources. Thus, it deserves more attention from both policymakers and researchers.

85 The ‘Accountability for Reasonableness’ framework is proposed by Norman Daniels and James Sabin with an attempt to ensure the fairness and legitimacy of decisions by setting ground rules for a just procedural. For more detailed explanation, please refer to Daniels & Sabin (2002).

86 Please refer to Wei & Liu (2018).

87 For more about ‘Nudge’, please refer to Thaler & Sustein (2003, 2008), and Sustein & Thaler (2003).

Last but not least, given that this thesis is largely a context-specific analysis, future research may be conducted to include more comparative studies.

As a final remark, I would not be surprised if people hold different opinions, even critical arguments, regarding the questions discussed in this thesis. All I wish is to provide different perspectives and, thereby, to help people to think about the questions raised more deeply and thoroughly. This is what I intend to revive.

7.5 REFERENCES

- Barendregt, J. J., Bonneux, L., & Van Der Maas, P. J. (1997). The health care costs of smoking. *New England Journal of Medicine*, 337, 1052-1057.
- Daniels, N., & Sabin, J. (2002). *Setting limits fairly – Can we learn to share medical resources?* Oxford: Oxford University Press.
- Friedman, A. (2008). Beyond accountability for reasonableness. *Bioethics*, 22(2), 101-122.
- Friesen, P. (2016). Personal responsibility within health policy: Unethical and ineffective. *Journal of Medical Ethics*, 44(1), 53-58.
- Nussbaum, M. (2011). Foreword. In I. M. Young, *Responsibility for Justice*. New York, NY: Oxford University Press.
- Persaud, R. (1995). Smokers' rights to health care. *Journal of Medical Ethics*, 21, 281-287.
- Rezayatmand, R., Pavlova, M., & Groot, W. (2017). Patient payment and unhealthy behavior: A comparison across European countries. *BioMed Research International*. doi: 10.1155/2017/2615105.
- Roberts, M., Hsiao, W., Berman, P., & Reich, M. R. (2003). *Getting health reform right: A guide to improving performance and equity*. New York, NY: Oxford University Press.
- Sunstein, C., & Thaler, R. (2003). Libertarian paternalism is not an oxymoron. *The University of Chicago Law Review*, 70(4), 1159-1202.
- Thaler, R., & Sunstein, C. (2003). Libertarian paternalism. *The American Economic Review*, 93(2), 175-179.
- Thaler, R., & Sunstein, C. (2008). *Nudge: Improving decisions about health, wealth, and happiness*. New Haven: Yale University Press.
- Tidwell, A. C. (1998). *Conflict resolved? A critical assessment of conflict resolution*. London and New York: Pinter.
- Ubel, P. A. (1997). Transplantation in alcoholics: separating prognosis and responsibility from social biases. *Liver Transplantation and Surgery*, 3(3), 343-346.
- Ubel, P.A., Baron, J., Asch, D. A. (1999). Social responsibility, personal responsibility, and prognosis in public judgements about transplant allocation. *Bioethics*, 13, 57-68.
- Wei, Y., & Liu, Z. (in press). Towards a fair and accountable health policy making: Assessment on the decision-making process of the Chinese health care reform. *International Journal of Society Systems Science*.
- Wilkinson, S. (1999). Smokers' rights to health care: why the 'restoration argument' is a moralizing wolf in a liberal sheep's clothing. *Journal of Applied Philosophy*, 16(3), 255-269.
- William, J. R. (2008). The declaration of Helsinki and public health. *Bulletin of the World Health Organization*, 86(8), 650-652.

- World Bank Group, World Health Organization, China's Ministry of Finance, National Health and Family Planning Commission, and Ministry of Human Resources and Social Security. Healthy China: deepening health reform in China. Available at: <http://www.wpro.who.int/china/publications/2016-health-reform-in-china/en/> (last accessed 28 August 2018).
- Yip, W., & Hsiao, W. (2014). Harnessing the privatization of China's fragmented health-care delivery. *Lancet*, 384, 805-818.
- Young, I. M. (2011). *Responsibility for Justice*. New York, NY: Oxford University Press.

Summary

Samenvatting



SUMMARY

In the sphere of healthcare, there exists an inevitable conflict between protecting individual rights (e.g. satisfying the unlimited patient needs) and sustaining healthcare resources when taking the scarcity of healthcare resources into account. This conflict becomes particularly apparent in the context of the current Chinese healthcare system because of China's rapidly ageing population and the increasing burden of non-communicable diseases.

The general aim of this thesis is to develop proper strategies for balancing the protection of individual rights (e.g. satisfying patient needs) and the sustainability of healthcare resources in the context of Chinese healthcare system reforms. Special attention is given to drawing a fair 'cut' between personal responsibility and state accountability in order to make the reforms of the Chinese healthcare system more effective. Thus, the central question is as follows: *In the context of Chinese healthcare system reforms, how should the conflict between the protection of individual rights (e.g. satisfying patient needs) and the sustainability of healthcare resources from ethical and legal perspectives be mitigated?*

This thesis is composed of seven chapters. Beside the general introduction (Chapter 1) and the conclusion (Chapter 7), Chapters 2 to 6 are independent but interrelated papers, which closely examine five crucial questions concerning the progressive reforms of the Chinese healthcare system. These five questions are further categorised into two parts of this research (personal responsibility and structural injustice).

Part I (Chapter 2 and Chapter 3) provides theoretical reflections on addressing personal responsibility in healthcare in China. Discussions in this part reveal the reality and necessity of addressing personal responsibility in advancing the reform of the Chinese healthcare system. Chapter 2 mainly provides a theoretical understanding of the importance of addressing personal responsibility in healthcare while Chapter 3 examines the policy implications of the theoretical understanding and proposes a feasible way of addressing personal responsibility to advance China's healthcare system reform.

Part II (Chapter 4, Chapter 5 and Chapter 6) is framed with a special concern given to the role of the state in correcting the structural injustice of the healthcare system in China. Discussions in this part mainly explore how to adjust structural factors for the sake of advancing the reform of the Chinese healthcare system. Among reform initiatives, strengthening primary healthcare, improving referral system and encouraging the development of the private sector in delivering healthcare are the prominent ones. To assess and enhance their effectiveness, Chapter 4 and Chapter 5 are designed to explore these reform initiatives from the regulatory perspective. The aim of these two chapters is to emphasise the importance of regulatory interventions in securing and enhancing the effectiveness of this reform initiative. Chapter 4 evaluates the regulatory sector for the effectiveness of the nationwide implementation of GP services while Chapter 5 focuses on exploring the regulatory sector for China's ever-growing private medical institutions. Drawn from discussions in Chapter

4 and Chapter 5, there is a great need for enacting a basic law of healthcare to secure and enhance the effectiveness of China's new health reform initiatives. Therefore, how to draft basic health law that could best meet China's new health reform initiatives becomes the main question of Chapter 6. Chapter 6, therefore, reviews all health-related laws and regulations on both national and international levels, draws lessons from representative theoretical debate on the coherence of health law, and thereby makes corresponding recommendations.

As a concluding chapter, Chapter 7 provides a synthesis of all findings, makes reflections on the research question and five subquestions, summarises the potential limitations of this thesis, and points out some interesting evolving themes of healthcare that are relevant to balance patient rights and the sustainability of China's healthcare system as future directions for research development.

SAMENVATTING

Wanneer de schaarste van gezondheidszorgvoorzieningen in aanmerking wordt genomen, kan op het gebied van de gezondheidszorg worden gesproken van een onvermijdelijk spanningsveld tussen de bescherming van individuele rechten (bijvoorbeeld voorzien in de ongelimiteerde behoeften van patiënten) en behoud van gezondheidszorgvoorzieningen. In de context van het huidige Chinese zorgstelsel komt dit spanningsveld vooral tot uiting door de rap vergrijzende bevolking van China en de stijgende last van niet-overdraagbare ziekten.

Het algemene doel van dit proefschrift is om in de context van de hervorming van het Chinese zorgstelsel goede strategieën te ontwikkelen om de bescherming van individuele rechten (bijvoorbeeld voorzien in de behoeften van patiënten) in evenwicht te brengen met de duurzaamheid van gezondheidszorgvoorzieningen. Er wordt met name gezocht naar een redelijk evenwicht tussen persoonlijke verantwoordelijkheid en de verantwoordingsplicht van de staat met als doel de hervorming van het Chinese zorgstelsel effectiever te laten verlopen. De centrale vraag is derhalve als volgt: *Hoe kan, in de context van de hervorming van het Chinese zorgstelsel, het spanningsveld tussen de bescherming van individuele rechten (bijvoorbeeld voorzien in de behoeften van patiënten) en de duurzaamheid van gezondheidszorgvoorzieningen vanuit een ethisch en juridisch perspectief worden verminderd?*

Dit proefschrift bestaat uit zeven hoofdstukken. Naast de algehele inleiding (d.w.z. hoofdstuk één) en de conclusie (hoofdstuk zeven) zijn hoofdstuk twee t/m zes op zichzelf staande maar met elkaar samenhangende artikelen, waarin vijf cruciale vragen met betrekking tot de geleidelijke hervorming van het Chinese zorgstelsel nauwkeurig worden onderzocht. Deze vijf vragen worden verder onderverdeeld in de twee delen van dit onderzoek (d.w.z. persoonlijke verantwoordelijkheid en structurele onrechtvaardigheid).

Deel I (hoofdstuk twee en drie) biedt theoretische beschouwingen over het belang van persoonlijke verantwoordelijkheid in de gezondheidszorg in China. In de discussies in dit deel wordt in het kader van de hervorming van het Chinese zorgstelsel de realiteit rond persoonlijke verantwoordelijkheid belicht alsook de noodzaak om hier invulling aan te geven. Hoofdstuk twee biedt in de eerste plaats een theoretische duiding van het belang van persoonlijke verantwoordelijkheid in de gezondheidszorg terwijl in hoofdstuk drie de beleidsimplicaties van de theoretische duiding worden onderzocht en een voorstel wordt aangereikt voor een haalbare manier om persoonlijke verantwoordelijkheid te bevorderen teneinde de hervorming van het Chinese zorgstelsel te kunnen bewerkstelligen.

In deel II (hoofdstuk vier, vijf en zes) draait het vooral om de rol van de staat bij het wegnemen van de structurele onrechtvaardigheid binnen het zorgstelsel in China. In de discussies in dit deel wordt met name verkend hoe structurele factoren kunnen worden aangepast om de hervorming van het Chinese zorgstelsel gestalte te kunnen geven. De voornaamste hervormingsinitiatieven zijn gericht op het versterken van de primaire gezondheidszorg, het verbeteren van het verwijzingssysteem en het stimuleren van de ontwikkeling van particu-

liere instellingen die gezondheidszorg verlenen. Om de effectiviteit van deze initiatieven te kunnen beoordelen en vergroten worden deze hervormingsinitiatieven in hoofdstuk vier en vijf vanuit een regelgevingsperspectief verkend. Het doel van deze twee hoofdstukken is te benadrukken dat regulerende interventies een rol van grote betekenis spelen bij de totstandkoming van dit hervormingsinitiatief en het verbeteren van de effectiviteit ervan. Hoofdstuk vier bevat een evaluatie van de regelgevende sector toegespitst op de effectiviteit van de landelijke invoering van huisartsendiensten; in hoofdstuk vijf wordt de regelgevende sector verkend in het kader van het steeds verder toenemende aantal particuliere medische instellingen in China. Uit de discussies in hoofdstuk vier en vijf komt naar voren dat er een grote behoefte is aan basiswetgeving inzake gezondheidszorg om de effectiviteit van de nieuwe hervormingsinitiatieven op het gebied van gezondheidszorg in China te kunnen bewerkstelligen en te verbeteren. De belangrijkste vraag van hoofdstuk zes is derhalve hoe een basiswet inzake gezondheidszorg kan worden opgesteld die het meeste recht doet aan nieuwe hervormingsinitiatieven op het gebied van gezondheidszorg. In hoofdstuk zes wordt dus alle wet- en regelgeving op het gebied van gezondheidszorg onderzocht, zowel op nationaal als op internationaal niveau, worden lessen getrokken uit het representatieve theoretische debat over de samenhang van de wetgeving inzake gezondheidszorg en worden bijbehorende aanbevelingen gedaan.

Hoofdstuk zeven, de conclusie, bevat een synthese van alle bevindingen. In dit slothoofdstuk wordt gereflecteerd op de onderzoeksvraag en de vijf subvragen, worden de potentiële beperkingen van dit proefschrift samengevat en wordt gewezen op enkele belangwekkende thema's met betrekking tot gezondheidszorg die zich beginnen af te tekenen en die van belang zijn bij het vinden van een evenwicht tussen de rechten van patiënten en de duurzaamheid van het zorgstelsel in China, en die wijzen op toekomstige richtingen voor de ontwikkeling van onderzoek.

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Ziyu Liu
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PORTFOLIO

Education

- 09/2014 – 06/2019 **PhD** in Law & Health Care, Erasmus University Rotterdam, the Netherlands
Erasmus School of Health Policy & Management (ESHPM)
- Supervisor: Prof. Dr M. A. J. M. (Martin) Buijsen
 - Thesis: Using Ethical and Legal Analysis to Better Shape China's Healthcare System Reform
 - Intensive course 'Justice and Priority Setting in Health Care' in KU Leuven
 - Summer school 'Health Law & Ethics' in Erasmus University Rotterdam
 - Coursework: English academic writing for PhD candidates; Project management for PhDs; Doing literature review; Philosophy of social sciences and humanities; Philosophy of human rights; Self-presenting: present yourself and your research; Health ethics and integrity; Refwork; Basic teaching course; Issues of health law in the US: President Obama's health reform.
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- 09-2011 – 07/2014 **LL.M.** in Legal Philosophy, Jilin University, China
School of Law c/o The Center for Jurisprudence Research of Jilin University (JRC)
- Supervisor: Prof. Xianzhong Song
 - Visiting student at Hertford College, Oxford University in 2012
- 09/2007 – 07/2011 **LL.B.** in Law, Qingdao University, China
School of Law
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Awards and Scholarships

- **'Arvid Frihagen' PhD Award**, 2017, University of Bergen
- **Young Scholar Award**, 2017, Nuffield Department of Population Health, Keble College, University of Oxford
- **Young Researcher Award**, 2016, China Health Law Association
- **Erasmus Trustfonds**, 2015
- **CSC & EUR Joint Scholarship**, 2014–2018, Ministry of Education of China and Erasmus University Rotterdam

Publications

- **Ziyu Liu**. Regulating Private Medical Institutions: A Case Study of China, *Health Economics, Policy and Law*, in press.
- **Ziyu Liu**. Patient Engagement at the Household Level: A Feasible Way to Improve the Chinese Healthcare System Towards People-Centered Integrated Care, *Cambridge Quarterly of Healthcare Ethics*, 2018; 27:1-13.
- **Ziyu Liu** & Martin Buijsen. Reaffirming Individual Responsibility in Distributive Justice: A Case Study of the Chinese Healthcare System, *International Journal of Social Science Studies*, 2017; 5(4): 14-23.
- **Ziyu Liu**. A Unified Law-Making Model for the Chinese Healthcare: Lessons from US (in Chinese), *Medicine and Philosophy*, 2017; 38(7A): 43-46.

- **Ziyu Liu** & Martin Buijsen. Legal Reflections on the Evolving Role of General Practitioner in China's Primary Care: An Assessment of Regulatory Strategies, *Primary Health Care Research & Development*, 2018; 20(e9):1-8.
- **Ziyu Liu**. Cohering Health Law in China: Problem and New Development, *Medicine and Law*, 2018; 37(3):449-476.
- Yi Wei & **Ziyu Liu**. Accountability for Reasonableness: An Assessment on the Decision-Making Process of the Chinese Healthcare System, *International Journal of Social Systems Science*, in press.

Invited conference and seminar presentations

2018

- *Health Law workshop* in The Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School, Cambridge, USA.
- *Putting Patients at the Center of Research: Opportunities and Challenges for Ethical and Regulatory Oversight*. The Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School, Cambridge, USA.

2017

- *Silk Road International Young Scholars Symposium*, Xi'an, China.
- *Oxford Global Health and Bioethics International Conference*, Oxford, UK.
- *6th Annual Conference of European Association of Health Law*, Bergen, Norway.
- *Symposium 'When is it too expensive'*, February 2017, Rotterdam, the Netherlands.

2016

- *China Health Law Annual Conference*, Changsha, China.
- *Symposium 'EU-Sino Health Law'*, November 2016, Groningen, the Netherlands.
- *ICSJ 2016: International Conference in Social Justice*, January 2016, London, UK.
- *5th European Conference on Health Law*, October 2015, Prague, Czech Republic.

2015

- *The Expert Meeting of Human Rights-based Approaches and Domestic Legal Responses to NCDs: Lessons Learned*, The Hague, the Netherlands.

Professional Activities

- 2019 Peer reviewer, *Journal of Bioethical Inquiry*.
- 2019 Peer reviewer, *Primary Health Care Research & Development*.
- 2019 Peer reviewer, *Global Health Research and Policy*.
- 2018 Peer reviewer, *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*.
- 2017 Peer reviewer, *Primary Health Care Research & Development*.
- 2017 Peer reviewer, *Primary Health Care Research & Development*.