Privatisation of Health Care in Transitional China: A Study of Private Clinics at the County Level

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ABSTRACT

The thesis examines the privatisation of China’s health care since the 1980s, focusing on the privatisation of primary health care at the county level. The research chooses private clinics as research objects, includes a brief historical description of private health care evolution and the existing health care system in China; based on the empirical data collected in the field work, it provides a current picture of private clinic and its privatisation process in a Chinese city, discusses the problems in private medical practice and challenges private clinic faces, and the influence of privatisation on health sector performance.

The thesis notes the privatisation of primary health care by private clinics supplies an alternative way for health care services. It plays a significant role in compensating public system and promotes more equal health access, although the radical privatisation of all health sectors undermines the accessibility and quality of health services in general. Currently the private health sector in China is still small and yet to form a mature market, and there are multiple challenges for its further development, but it can be expected that the private sector in the health care area will expand rapidly, and China could hopefully find a suitable way of public/private mix under the new health reform.

Key Words: Privatisation, Health Care, Private Clinic, Public/Private Mix, China
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Chapter 1: Introduction

In China, health sector has experienced fundamental change since 1979 when China adopted its economic reform and open policy. With the shift from centrally planned economy to market-based economy, health system was transiting from fully state run and financed health care towards more private financing and delivery of health care. This radical health care privatisation led to soaring medical fees, poor access to affordable medical services, low medical insurance coverage and large disparities of health services etc., which compelled the government to consider launching the new round of health reform. After years of designing, the final health reform blueprint for the next decade was officially published in April 2009. According to the blueprint, one way to improve the equity and accessibility of health care and to alleviate the burden of medical costs is to ‘improve services of grassroots medical institutions, especially hospitals at county levels, township clinics or those in remote villages, and community health centers in less developed cities’, ‘clinic construction would be encouraged’, ‘qualified doctors will be allowed to work in more than one facility and open their own clinics’. All these could potentially influence on the development of private clinics in both rural and urban areas.

1.1 Research Object

Private clinic (ge ti zhen suo) is small health facility operated by self-employed individual medical practitioner, devoted to the care of outpatients and charges services on a fee-for-service basis, often in a community. “Private” is based on the ownership of health care facility (not government-owned or employed).

The private sector of health care in China is mainly provided by private hospitals and private clinics. The number of private hospitals is comparatively limited while the number of private clinics is uncountable. Private clinics have been the main source of primary health care for most people. As a market-oriented medical institution, private clinic has its particular operation system. Opened by one or two individual medical practitioners, it integrates traditional health practices with the western approaches, maintains its master-prentice system in transmitting medical knowledge, and operates with close interpersonal interaction in acquaintances society. Although health care in private clinics is considered poorer than in public ones, it develops quickly and is

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6 The name of private clinic in Chinese Pinyin, the following particular names will express in the same way.
welcomed by large populace, especially by the disadvantaged groups. However, little information is available about private clinics in China. The few existing researches in private health sector are mainly focused on private hospitals, seldom notice the health care provided by private clinics. Hence, this project chooses private clinics as research objects, investigates the privatisation process of clinic health care and its functioning in the transitional Chinese society.

1.2 Research Questions

Privatisation in health care is a process in which non-governmental actors\(^7\) become increasingly involved in the financing and provision of health care services. (Jeffrey Muschell, 1995) The privatisation of health care in China started from 1979, till 2009, thirty years has past, how the privatisation process has happened and experienced ups and downs over the last 30 years? This thesis chooses private clinics as research objects, investigates the privatisation process of clinic health care and its functioning in the transitional Chinese society. With reference to the experiences of a specific city at the county level, the research describes the existence and operation of private clinics there, discusses the broader social and political process that involved in the health care transformation, and explains how the national health policy is implemented in the local setting and impacts on the privatisation process of health care in practice.

Based on these investigations, the thesis further explores what problems have been taken by the health care change from all public to more private services, and how the changes have influenced health sector performance. The recent Chinese health scheme tries to reform health sector through increasing public expenditures, expanding health insurance to the formerly uninsured majority, and rebuilding the collapsed public system in providing basic health care. Under the new health scheme, would people continue choose private health service? What about the possible future development of private health sector? The research tries to inquire into these questions.

The thesis first outlines the Chinese context of private health care by introducing the historical evolution of private health care and the existing health system in China; then presents the research location, methods and process; the fourth chapter discusses the key concept—privatisation in the general setting, in the Chinese context, and interprets the rapid privatisation experience of health care in the specific Chinese city; the fifth section presents the recent situation and actual functioning of private clinics in the local city, considers the problems and challenges related with the private medical practices; the final part discusses and concludes the Chinese experiences of health care privatisation, and highlights some lessons that can be learned from the

\(^7\) Non-government actors here mainly refer to the private sector, not only the civil society such as NGOs, which only take very small part in health care sector in China.
empirical experience of the local city and the implications for future research.
Chapter 2: The Chinese Context of Private Health Care

Private clinics have a long history and deep tradition in supplying health care in China. This part mainly reviews the historical background of private health care and the role of private clinics in the existing health care system.

2.1 The Historical Evolution of Private Health Care

China has one of the longest recorded histories of medicine, its methods and theories have developed for over two thousand years. In this long history, health care was mainly provided by the private sector including private clinics and private non-profit health institutions (e.g. health care in temples, charity medical society) to general population. There was no systemic public health network except the exclusive health care supplied by central hospital (tai yi yuan) and government health station (guan fu yi suo) for emperor families, government officials and armies. Medical consultation—and most medical care itself—was for those who could afford it; the ordinary peasants only turned to local healers with a smattering of knowledge and folklore when they were ill (Penny Kane, 1984). In general, the private medical practitioners were the folk doctors (lang zhong) who opened their own outpatient clinics while selling herb medicines or doctors saw patients in pharmacies (zuo tang yi sheng), and traveling medical peddlers who sold medicine and treated patients in ambulatory (you yi). The immobilized private clinics/pharmacies and the ambulatory medical peddlers set up the basic healthcare network for the populace (Yang Nanqun, 2006, p 246). From 18th century, many missionary hospitals began to operate in China by churches from western countries. Prior to 1949, there were about 520 private hospitals, which outnumbered the 248 hospitals run by the government; and there were more than 200,000 private medical practitioners (Liu Yuanli et al, 2006). The provision of health care, by then, was dominated by private sector (Meng Qingyue et al, 2000).

After 1949, the foundation of People’s Republic of China, the ministry of health was responsible for all healthcare activities, and public health care system began to set up. The provision of health care was determined by the extraordinarily high commitment given by the government (Penny Kane, 1984). In this period, private practice and private ownership of health care facilities were considered incompatible with socialism and were put on the agenda of elimination. After 6 years’ socialism, in 1956, all private hospitals, including 243 private mission hospitals, were transferred into public ones, and doctors engaged in individual private practices in urban areas were also gradually recruited into the public health facilities (Gordon Liu et al, 1994). The nationalization of medical human resources progressed through two lines: the absorption of private practitioners into state employment and the complete control of education and employment of new practitioners by the state (Yang Jingqing, 2009). The Cultural Revolution, started in 1966, accelerated the speed of private sector
elimination. By 1967, the private health sector including individual and group practices and private hospitals had been completely eradicated as capitalist residues (Gordon Liu et al., 1994). The predominant role of the private health sector was totally replaced by publicly owned health system. The government owned, funded and ran all hospitals from large specific facilities in urban areas to small township clinics in the countryside to supply universal medical coverage (David Blumenthal & Willam Hsiao, 2005). China developed perhaps the largest national public medical network and the largest public health workforce in the world (Xiaohui Hou & Joseph Coyne, 2008).

Then from 1979, with the launch of economic reform and open policy, China began to marketize health care sector and re-legalize private health practice for the shortages of public health services in both rural and urban areas. Private ownership was no longer seen as the enemy of socialism. In 1980, the Ministry of Health issued Report on the Granting of Permission for Solo Private Medical Practice which recommended legalizing private medical practice while regulating it strictly. Then in 1985, the government approved the Report on Regulations Regarding the Reforms of Health Work which encouraged collectively operated medical institutions and supported individual practice. In 1987 the state granted permission to public sector health professionals to own and operate private medical clinics after their retirement from public service. (Lim Meng-Kin et al., 2004a) Private health practices and health facilities revived quickly. In rural areas, many village clinics turned from a collectively-owned one to a private one overnight. In urban areas, the private hospitals and clinics proliferated in a seemingly unregulated speed. As of 1998, there were officially 126,068 private health care institutions in China (accounting 40.1% of all medical institutions), employing 164,727 health care personnel that took 3.7% of the national total. Later in 2005, the number of registered private health institutions (for-profit-institution) increased to 156,000, more than the number of public ones (132,000) by 24,000. Not to mention the uncountable un-registered private facilities (many of which are called “black clinics”).

According to the Report on the Granting of Permission for Solo Private Medical Practice, private health care was mainly operated by four types of practitioners prior to 1980s: first, individual private practitioners who had been granted licenses before the Cultural Revolution; second, medical personnel who had been made

From these numbers--126,068 private health institutions, 164,727 private health personnel, it can be estimated most of these private health institutions are private clinics that operated by self-employed individual medical practitioner with only one or two health personnel in each clinic.


redundant/rejected by public employers; third, Traditional Chinese Medicine practitioners who were family trained or practiced medicine as a hobby; fourth, retired practitioners, mostly comprised of Traditional Chinese Medicine doctors and dentists. After 1980, private medical practice was legally granted but limited into three groups: those who held private practicing licence issued before Cultural Revolution and not currently in employment; those with medical knowledge but not employed for various reasons; and those who had worked in the public sector but were in retirement. (Yang Jingqing, 2006a) In practice, since the post-1980s health reform, large number of previous public health professionals such as “barefoot doctors” became private and took the main role in private medical practice, and approximately one-third of the private doctors were unlicensed and concerned with fraudulent activities. (Sheila Hillier & Xiang Zheng, 1990) Later, new practitioners graduated from medical school but not employed within the public system also joined the private sector. However, more “high-tech” clinics and virtually all hospitals with excellent professionals are still government-owned. In general, the majority private practitioners are personnel who are not considered employable by the public system, and are the medical work forces float outside the formal and orthodox employment (Yang Jingqing, 2006a).

At the same time, the users of private health care are mainly populaces who do not have health insurance and have little or inconvenient access to expensive public medical services, contrarily, the state and collective employees with insurance would use public medical services easily. By 2006, the employee-based basic health insurance scheme covered only about 27% of urban residents due to the dismissal of large numbers of employees under the change of public enterprise to private; in rural areas, after the collapse of Cooperative Medical System, health insurance coverage dropped from approximately 70% of the population in 1981 to only 20% by 1993, and has rebounded only after the implementation of New Cooperative Medical Scheme in 2003. Out-of-pocket payments by Chinese patients increased from 20.4% of total healthcare expenditures in 1978 to 49.3% by 2006. (Karen Eggleston, Jian Wang & Keqin Rao, 2008) The shift from public financing to private financing, particularly the increasing out-of-pocket spending leads to the widening health disparities. The wealth of consumers became a critical predictor of people’s access to services and the quality of services, which limited the health access of poor families and exposed people to financial risk when ill or injured; the burdensome user fees imposed by severely underfunded public health care providers resulted in many patients turning to private practitioners who offered cheaper care (Lim Meng-Kin et al, 2004b).

The increasing emergence of private medical practice within the thirty years (1979-2009) indicates the failure of the state to provide universal public health care to its citizens. However, public health practices still take the main role in supplying health care, while private sector plays a complementary part and is restrained in some extent. Generally, doctors in the public health system are constrained to one work unit, like government officials. If doctors open their own clinics outside public health system, they will be labeled as “illegal practitioner”. (Yang Jingqing, 2006b) Besides,
individual private practices are regulated strictly since the exposure of medical accidents and fraudulent behaviors in private clinics. However, in the new health reform blueprint published in 2009, qualified doctors will be encouraged to work in more than one facility and open their own clinics. The cultural and social tradition of private health practice, coupled with economic motivation and favorable government policy together create a promising environment for private clinics.

2.2 The Present Health System and the Role of Private Clinics

In China, public health care is provided through a three-tiered system. In rural areas, the three tiers consist of village health stations, township health centers/hospitals, and county hospitals. In urban areas, the three tiers are neighborhood (community/street) health stations and clinics, district hospitals, and municipal hospitals. Hospitals, located at the upper level of the hierarchy, provide inpatient, outpatient and emergency care services, are the most pivotal to the system. At the lower level, village/community health station and community health center composed the community health system that provides prevention and primary health care to residents (Hassan H. Dib et al, 2009). The first contact of a potential patient is usually with community health station and clinic, if the patient’s problem is beyond the scope of the station and clinic, he/she will refer up to the next-level of health institutions (xiao bing dao she qu, da bing jin yi yuan). However, in practice, the primary health care at the community level are generally privatised, particularly in the middle and small size cities. The private sector of health care includes private hospitals and private clinics. The private clinics reside at the same tier with community health stations as primary health provider. They aim at curing minor and chronic diseases, perform health promotion at the most basic level, and could be easily accessed by lower-class patients, thus they replaced the role of public community health institutions. (See Figure 1)

Researches show the difficulties of getting health service in China lie in this vertical structure three-tiered system which manifest in two aspects. First, the difficulty in getting access to general hospitals in the upper level, which include long waiting list for registration; long waiting time for treatment, test, payment and medication; short duration of communication with doctor; high cost in medicine and examination; and difficulty in transferring from community health center to hospital. Second, difficult to see doctor in community health station and rural health institution at the lower level, which is caused by shortage of experts, low skill of practitioners, lack of basic instruments and equipments, etc., the poor facilities restrain the ability to accept patients. (Chen Xiaohong, 2007; Yu Guangjun et al, 2007) The public health system has broken down in rural areas, urban community health care has not equipped enough to meet people’s needs, patients flock to big hospitals, overwhelming the upper level medical centers in cities, make the access become even difficult. The demand of health service in different levels could not be satisfied, then, at the primary
level, many people turn to the cheaper substituted health care provider—private clinics.

**Figure 1: Health System Pyramid**

Private clinics have the potential to play a positive role in improving the performance of health system. A survey in 2007 showed that in rural areas 31.30% patients went to private clinics to see doctor, which takes the biggest proportion, while 31.18% went to village health station, 22.10% went to township health center and 2.87% to city hospital; in urban areas, people had the tendency to see doctor in cheap, convenient, near-home place, but only 49.97% patients would like to see doctor in community health station, instead many seek health service in qualified private clinics (Chen Xiaohong, 2007). Hospital care was avoided as much as possible for admission was mostly bound up with costs that could not be easily afforded (Gerald Bloom & Shenglan Tang, 2004, p 117). Individuals would use their savings accounts for out-patient care in clinics (p 70), especially for the large number of migrants and marginal populations. The easily available and affordable private clinic health care improves the accessibility of health service, and plays an increasing role in health provision for the low-middle income self-paying patients.

In spite of critics on private clinics about their poor quality care, patient safety issue, fraudulent treatment, and “blind proliferation” fail to meet basic standards etc. Empirical researches show that qualified private clinics are not inferior to public clinics in providing health services. Private practitioners are commonly considered better than public ones concerning courtesy, respect and attitude components of treatment; and consumer satisfaction seems higher with regards to certain dimensions.

12 All the figures in this thesis are self-drawn.
of the private than public (Gordon Liu et al, 1994; Meng Qingyue et al, 2000; Liu Yuanli et al, 2006). Survey in Guangzhou shows that 79% of the people interviewed gave a “very good” rating to private doctors’ attitude, 11% “above average”, 3% “average”, and only 2% “blow average” (Peter P. Yuen, 1992). Moreover, private practitioners tend to compete with public suppliers for traditional Chinese medicine that most private practitioners use has advantages in dealing with some very specialized illnesses, especially chronic and rare cases such as bone-setting and maternal care, which public health institutions have relatively less competence (Gordon Liu et al, 1994).

Figure 2: Network of Health Care Provider

From the above figure, it can be seen that private clinics serve as complement in providing health service and supplement the areas that the hierarchical public network and other private institutions could not cover. They meet the shortage of public provider and increase the coverage of health care in general.

13 The private hospitals are included in the central system of health providers.
Chapter 3: Methodology

3.1 Research Design: An Ethnographic Study

This ethnographic study aims to trace the health care changes and observe the privatization of health clinics in a specific city. It applies a mixture of methods: interview, participant observation, and analyzing a corpus of written documents etc. Interview is the main research method while participant observation and analyzing documents supply background and complementary information.

12 health professionals were interviewed including 5 private clinic doctors in the city, 2 in the village, and 5 public health professionals (administrators or staffs in public health institutions). (See Appendix 1) Interviews with the private doctors bore on the general condition of their private clinics (size, equipment, bed number, outpatient numbers etc), the developing history of the private clinics, the personal history of the private doctors and other private health workers (their medical training experience, their past working experience, why they choose to open or work in private clinics? etc.), the perceptions of the private health work and perceptions toward the health care transition (how the Chinese private health professionals feel about themselves, their work, and what they think of the Chinese health care system, the health care transition, the future development of private health sector) etc. (See Interview Guide in Appendix 2) The 2 interviews with the rural private clinic doctors were used to compare with and complement the city clinic interviews. Interviews with the professionals in public health institution and government health officials employed similar questions, to see their attitudes and values regarding the private health care, the local private health regulations, and the existence and development of public and private health institutions in the city, etc.

Participant observation was done in the private clinics of the interviewed doctors to observe the function of clinics, medical practices, interactions, and the day-to-day work of clinic staffs: What happen in private clinics? Who are there (doctors, nurses, other assistant, patients, patients’ friends or family member etc.)? How about the private health work there? Etc. During the participant observation, I talked casually with the patients in private clinics to get some general ideas about their attitudes toward private health care. Videos and field notes were taken to record talks, behaviors and body languages of health professionals and patients, as well as the clinic settings. Observation was also done in one public hospital for comparison.

Analyzing of documents was done by reviewing official documents and clinic records to gain an understanding of the contextual background of private health practice in the local setting: the general situation and history of health care and health system in the city; local health policies and regulations related to private health practice; the general condition and development history of private health care and private clinics in the city.
(e.g. number of private doctors, private hospitals, private clinics, categories of private clinics, out-patient number etc.); data about the researched private clinics etc. The documents gathered from county health office, local library, archives and private clinics; the county annals and local medical chorography were used in particular to trace the health care change in the city.

During the research, comparative studies were done between urban private clinics and rural private clinics to contrast the experience of transition and operation; between private clinics and public health facilities to find their historical unfolding, the advantages and disadvantages of each; between the local privatisation process and the national general trends to see the implementation of government policies into the local context. Since past researches on private health sector in China are mostly resting on consideration at an abstract level, the empirical investigation of this master thesis could hopefully give a more accurate picture of the privatisation of health care in practice.

3.2 Research Location

China being such a huge country with large varieties of regional units, this research confines in a specific geographic part and centers in a city at the county level. I choose the county S\textsuperscript{14} of the Southwest China Sichuan Province (See Figure 3), as the research location, and collected the empirical data there.

In China, the ongoing urbanization process assembles more and more people into towns and cities. In the recent three years (2009-2011), the population work in urban areas will be over 400 million and urban residents will be over 700 million, more than the number in rural areas.\textsuperscript{15} Besides, the aging population becomes larger than ever. The raised population and changed age structure make the health care demands in cities increase dramatically, and medical institutions face great pressures. The rising number of private clinics in cities takes significant role to supplement health care that public health system could not cover, but researches concern more about private clinics in rural area, seldom notice urban private clinics.

This research confines to urban areas at the county level (less-developed cities and small cities which develop quickly and assemble large populations from rural areas) since there are over 2000 counties in China, and each county may have over 100 private clinics in its city area. The more than 200,000 private clinics (not including the numbers in rural areas and big cities) are generally left out by the health system and

\textsuperscript{14} In view of the privacy of the local government and doctors, I uses the letter “S” (the first letter of Sichuan) to represent the studied county in Sichuan Province. The name S is referred to the whole county, as well as the city (the county town), which commonly shares the same name with the county in China. To clarify, I uses S county to represent the whole county and S city to specify the county town.

by research\(^{16}\). Besides, in the administrative divisions\(^{17}\), county lies in the middle, connects the rural and urban areas. It is a vital level in health care delivery to both rural and city residents, and could fully unveil the disparities between rich and poor, rural and urban divisions. The research location is in the southwestern China—Sichuan Province, which has big number of private clinics—14,665 registered ones (non-registered not included)—that take 30\%-40\% of the market share (Lim Meng-Kin \textit{et al}, 2002). Sichuan Province embraces a population of 88.15 million and 181 counties\(^{18}\), medical resource and health development there are generally lower than the national level, particularly obvious when compared with the eastern developed areas. As an indicator, in 2005, the infant mortality and child mortality rate of Sichuan Province are 27.9‰ and 42.9‰ respectively\(^{19}\) while at the national level the numbers are 19‰ and 22.5‰ respectively\(^{20}\).

\textbf{Figure 3: Research Location—A County in Sichuan Province}

The chosen county \textit{S} has a population of 1.04 million with 250,000 (a quarter) urban residents\(^{21}\). According to the county health department report\(^{22}\), until the end of 2007,

\(^{16}\) Researches about health care in urban areas are mainly in big cities, while in rural areas researches focus on villages and small towns. The small cities in the middle are generally missed out.

\(^{17}\) China’s Administrative divisions have five practical levels of local government (from bigger to smaller): the province, prefecture, county, township, and village. The level of county locates in the middle of the division, with middle and small size cities as its center, and is the connection zone of rural and urban areas.


\(^{19}\) Protected Reference


\(^{21}\) Protected Reference

\(^{22}\) S County Health Department Report, ‘The Work Summary of Building Advanced Traditional Chinese Medicine County in Rural Areas, S county, Sichuan’ (\textit{Sichuan shen S xian nong cun zhong yi gong zuo xian jin xian jian})
there were 1087 health institutions in S county, including 2 county hospitals—People’s Hospital and Hospital of Traditional Chinese Medicine, 1 County Center for Disease Control and Prevention, 1 Maternal and Child Health Center, 1 Health Supervision Institute, 30 township health centers, 2 township traditional medicine hospitals, 810 village health stations, 4 private hospitals, 236 private clinics. Like thousands other counties in China, most of the health institutions are located in the city area—the administrative center, with the exception of 32 township health institutions, 810 village health station and some private clinics in the countryside. All these facilities are administered by the County Health Department, which receives budget from the government. And all the health institutions are public except the 4 private hospitals and 236 registered private clinics. However, in practice the 810 village health stations are mostly operated like private clinics by private doctors (most of whom are prior “barefoot doctors”) and there are many unregistered private clinics in rural areas. For the registered 236 private clinics, more than half are located in the city. It is estimated there are more than 150 private clinics in practice in the city area\(^23\). These city private clinics are what I focus in this research.

To the end of 2007, S county had 3268 health professionals\(^24\) including 1616 traditional Chinese medicine professionals, and 2070 beds in total.\(^25\) Using the 1.04 million populations, the county had 3.14 health professionals and about 2 beds per thousand people. In the national level, at the end of 2007, there were 5,904,000 health professionals and 3,701,000 beds,\(^26\) calculate with the national population of about 1.321 billion in 2007, the average health professional number was about 4.47 per thousand, and the bed number was approximately 2.8 per thousand population (the bed number in 2005 was 2.4 per thousand population\(^27\)). Apparently S County has fewer professionals and bed numbers compared with the national level.

### 3.3 Research Process

The procedure of this research includes pilot study by literature review, informal interview, and participant observation within private clinics; then analysis the data collected in pilot study and form primary interview syllabus; next, narrowing the

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\(^{23}\) The number comes from the estimation by many interviewees in the field work; the accurate number within the city is hard to obtain since standard definition and categorisation of clinics are lacking.

\(^{24}\) Health professionals include both physician and other health related workers. Since the number of physician in the county is simply not available, I uses the number of health professionals as an index to compare with the national level.

\(^{25}\) S County Health Department Report, ‘The Work Summary of Building Advanced Traditional Chinese Medicine County in Rural Areas, S, Sichuan’ (Sichuan shen xian nong cun zhong yi gong zuo xian jin xian jian she gong zuo zong jie), July 8\(^{th}\), 2008.


research focus by ascertaining the health professionals for interview and health institution for observation; then, formal research through participant observation, semi-structured interview and analyzing of documents; finally analysis and data interpretation. (See Figure 4)

**Figure 4: Research Process**

The field work was done in July-August, 2009. I was familiar with the culture and language, and had good connections in the field location which enabled me to fully participate in the research. During the fieldwork, the selection of private clinics and interviewees were based on the social network since private clinics and private doctors were still a little sensitive to discuss in the local setting, without introduction by the mediator, there was no way to get access into private clinics. Considering the similarities of private clinics in the local city, the selected 5 urban private clinics and 2
rural private clinics could be representative. During the interview, I let the interviewees, particularly the interviewed private doctors, freely narrate their stories and experiences without the limitation of interview guide. In the analysis, all the audio-recorded interviews were transcribed verbatim, I read several times of the transcriptions to get familiar with the information, and then put them into different subtitles which related with the research topic. The description and analysis in the thesis are based on the interviewees’ experiences, concepts, languages, and systems of classification.

3.4 Ethical Implications

According to the *AAA Statements on Ethics—Principles of Professional Responsibility*, this research has implemented on the precondition of being permitted by the respondents. The aim of the research was explained in research process, and participation was completely voluntary. The data collected from interviews was handled in anonymous to protect the integrity of the respondents. Audio-video taping and photographing were taken after permission and the information obtained would be treated with privacy and confidentiality. Moreover, under the new passed favorable health reform policy, research into private clinic health care would not be prohibited, or violate any regulation although it was still somewhat sensitive in the local setting. And to protect the privacy of the local government, an anonym name was used for the research location. In general, all surveys have taken place under complete permission and the information got has been handled with privacy.

28 I did not employ the coding process to analyse the interview text since the local Chinese language was so changeable that it was difficult to assign key words to the text, for example, two interviewees could speak in two ways with different words about the same topic. So I chose to give subtitles to the interview content after reading it many times, although there are some shortages to use this method.

Chapter 4: Health Care Privatisation

This chapter briefly looks into the background and concept of health care privatisation to arrive a systemic conceptual framework to analyse the Chinese health care privatisation. Then it generally introduces the Chinese privatisation background to understand the conditions in which the health care privatisation occurs, and applies the conceptual framework to the analysis of the local experiences of health care privatisation.

4.1 Central Concept—Privatisation

Privatisation in health care is a process of the retreat of state management in health sector, while non-governmental actors become increasingly involved in the financing and provision of health care services (Julian Le Grand & Ray Robinson, 1984; Jeffrey Muschell, 1995). Privatisation can happen in three ways: reduction in state provisions, reduction in state subsidy and reduction of state regulation (Julian Le Grand & Ray Robinson, 1984). Den Hoed (1986) specifies three types of privatisation: complete termination of public tasks (termination), contracting out of public tasks (contracting out) and independent performance of public tasks (self governance). Hans Maarse (2006) further explains: termination means the government reduces the scope of public intervention, the tasks and responsibilities that were formerly defined as a public responsibility are shifted to the private sector; as the case of contracting out, the government does not reduce the scope of public intervention, retains its political responsibility, but contracts with private agents to accomplish public task; Richard Janssen and Jan van der Made (1990) add that in self governance, responsibility and performance remain public, but with more freedom in the performance of its tasks. Richard Janssen and Jan van der Made (1990) employ these three types of privatisation with the three aspects—service provision, financing, and policies, form a matrix to analyze the health care privatisation in Netherlands (See Table 1). I adopt this matrix to conclude and categorize the Chinese privatisation of health care in order to give a clear picture about the privatisation process.

Table 1: Possible Types of Privatisation in Health Care

<table>
<thead>
<tr>
<th>Aspects of Health Care</th>
<th>Termination</th>
<th>Contracting-out</th>
<th>Self-governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing</td>
<td></td>
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<tr>
<td>Supply</td>
<td></td>
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<td></td>
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<tr>
<td>Policies</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Richard Janssen & Jan van der Made, 1990

30 Because there are not much empirical references about the Chinese privatisation of health care, this research uses an explorative way, in this part, I do not give large review on the past research about privatisation of health care, just try to come to a frame work to conclude the local privatisation process.
In recent decades, health sector reforms have happened all around the world, which commonly include the privatisation of health care. Decades ago, a number of advanced market economies (e.g. U.S., Britain) and Eastern Europe countries have implemented structural changes and privatisation of health services. The experience in these industrialized countries strongly influenced the design of health reform in low and middle income countries. In recent years, many developing countries have decentralized their public health services in an effort to improve their equity, efficiency and effectiveness. Private health care is growing rapidly in many places.

However, before that, health care policy in most countries has emphasized the development of government-owned health services, largely financed by government tax revenues over long period. Especially the command economies and ex-colonies countries in Africa and Asia, most of their public health services have functioned as bureaucratic state enterprises although some also had formal and informal sector private providers (Gerald Bloom & Gu Xingyuan, 1997). In fact, many developing countries have established similar systems of peripheral clinics and health workers, integrated community health centers, and a tiered system of public hospitals under the recommendations of international agencies like WHO (Kara Hanson & Peter Berman, 1998). But in recent years, the appropriateness of this organizational model is increasingly being discussed and many countries have embarked to reform the relationship between government and health service providers (Andrew Cassels, 1995).

With the transition from a planned economy to a market economy, China has also reformed its health sector, experienced rapid health care privatisation in the last decades. It is fascinating and important to see the Chinese health care evolution—“first in establishing centrally planned and managed health services, and then in changing the organization of these services radically” (Gerald Bloom & Gu Xingyuan, 1997). The unique Chinese privatisation experience in the last three decades could hopefully give substantial rethinking of health sector strategies in the lower and middle income countries, and contribute to the reform of health care system in other developing countries.

4.2 The Chinese Privatisation Approach

In China, the term privatisation is called *si ying hua* or *si you hua*. Before 1980s, privatisation was a taboo and regarded as incompatible with the communist society. In the west “private” was commonly linked to the idea of autonomy, of actions pursued by individuals and groups outside the reach of the state, but in China “private” had connotations of selfishness and disregard for the public good, “to privatise” suggested an acceptance of capitalism and bourgeois liberalization, and hinted at abandonment of governmental responsibility. (Linda Wong, 1994) Because of such sensitivities, “private” did not find its way into the official lexicon. The private medical institutions in general were called social medical institutions (*she hui yi liao ji gou* or
people-operated medical institutions (min ying yi liao ji gou); private clinics were officially named as individual-operated or solo-operated clinics (ge ti zhen suo).

The emergence of the private health sector in China is a very recent phenomenon (Yanrui Wu, 1997). Before 1979, China had developed an extensive health care system, under which, health services were provided to virtually all people at very low cost. Since 1979, private medical practice was becoming more and more popular. The motivations for the privatisation of health care were different in 1980s and 1990s. In the early 1980s, there was a big shortage of health care services (Wang Shaoguang, 2003). After three decades of command and paternalistic management, health care stayed at the low level, the technology and products were outdated, health service did not have economic effectiveness. The transition of health sector was driven by several more significant forces: the increasingly large health expenditure that the state cannot afford; the change of demographic factor (more population and aging people) led to the raise of health care needs; the emergent needs to establish health services to peasants with the dismantle of rural cooperative medical system; and increased economic growth brought about increased spending on health care and diversified consumer demand for health services (Yanrui Wu, 1997). Needs were far too numerous for the state to tackle by itself, hence the state tried to expand the supply of health services; joint responsibility and diversification became the guiding principle in the provision, funding, and regulation of services (Linda Wong, 1994) and private medical practices were officially allowed since then.

In 1990s, needs have been largely satisfied, the reform goal by then was to set up the market economy (Wang Shaoguang, 2003). Health sector went through the marketisation process with the orientation to modernize China’s healthcare system, alter the structure of health services, and decentralize central government’s role to the local government. The state retreated its management; the role of the government in financing, organizing, and delivering public health services has been weakened, leading to an under-funded and fragmented public health-care system. Autonomy was given to public health institutions—hospitals at both county and township level were urged to become self sufficient without public finance; at the primary level, a plurality of systems of ownership and competition among health care units was encouraged. (Xiang Zheng & Sheila Hillier, 1995; Zhu Chen, 2009) Privatisation then was seen as a solution for the state to discharge public obligations, and enhance both efficiency and public satisfaction of health care.

As a result of the health reform, the Chinese health care has undergone extensive changes that private health care rapidly expanded. For the hospitals, the reduction of public support led to the privatisation of hospitals services which rely more on the sale of services in the markets to cover their expenses. In practice, medical professionals have been encouraged to contract public health units or clinics, or take secondary jobs for extra income (Yang Jingqing, 2006b). The privatisation of hospital services provision has not fundamentally changed the ownership structure of China’s
hospital sector, less than 2 percent of public hospitals were privatised between 1995 and 2005 (Tam Waikeung, 2010). Although state ownership was broadly retained in public hospitals, other types of ownership were emerged with increasing private hospitals and private clinics. Particularly obvious was the privatisation of primary health care. In the rural areas, the cooperative medical system collapsed in most localities with the coverage of this system reduced from 80% of rural residents in 1975 to less than 10% by 1984. (William L. Aldis, 1989; Sheila Hillier & Xiang Zheng, 1990) The township health centers and township hospitals were gradually sold to private operation. Most of the unfinanced village health workers and township professionals changed to private health practitioners and opened their own clinics. Until 1990, there were 160,000 private doctors of which 70% worked in the rural areas, a threefold increase since 1983. (Sheila Hillier & Xiang Zheng, 1990) Later, with the urbanization process, more and more private doctors concentrated into the urban areas to open their own clinics. Now the primary health care in the local level is largely under private control.

4.3 Health Care Privatisation in the Local Setting

This part outlines the changes taken place in the health sectors of S county during the last decades to see the shape and extent of privatisation. It first describes the arrangements of health sector in S county before 1980s; then comes to the analysis of health care privatisation since 1980 in the local city.

4.3.1 Health Care Arrangement Prior to 1980s

According to the county annals and local medical chorography, before 1949 and the following few years, all rural health care professionals and the majority urban health workers were private practitioners, they used traditional Chinese medicine to treat common illness or frequently encountered diseases in S county (SCCEC, 1990, p 934). Since 1949 after the long-term chaos, the society became stable and began to revival in every aspect, including health and medical services. In 1951, there were 241 medical shops in the whole County—229 Chinese medical ones and 12 western medical shops—most of which had private doctors over the counter specially prescribing drugs and giving medical advices (zuo tang yi sheng). Among these medical shops, 46 were located in the city area with 40 selling traditional Chinese medicine and 6 operated western medicine. Then a series of political movements and reform measures aimed at reduce private profiteering activity and eliminated

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31 Since the economic reform in 1979, the introduction of household responsibility system led households in rural areas reverted to individual production, rural agricultural communes dissolved and no longer contributed collectively to health care cost, without finance, the rural cooperative medical system could not sustain anymore, and gradually collapsed.

32 Since there was no record about private clinics in the county, I use medical shops as an example to show the practices of private medical care, since medical shops at that time mostly had private doctors work there, and operated like private clinics—both sell medicine and treat patients.

33 Such as 1951 san fan (or "three anti") and wu fan (or "five anti") movements ("three anti" are anti corruption, waste, and bureaucratism and "five anti" are anti tax evasion, bribery, cheating in government contracts, thefts of
capitalism function, were employed, leading to the quick decrease of private medical practices. In rural areas, individual private clinics were gradually replaced by joint clinics, since 1957, private medical practices began to be forbidden in the local county. (SCCEC, 1990, p 934) Private doctors were largely recruited into the public system and became “barefoot doctors”. In the city area, the 46 private medical stores reduced to 21 in 1953, the number continually reduced to 16 in 1956, and only 8 were left in 1959 all of which were transferred to public ownership. In 1962, the local health authority formally designed The Interim Measures on Management of Medical Workers (yi wu ren yuan zhi ye guan li zan xing ban fa cao an) to further enforce the administration and banning on private medical practices. (SCCEC, 1990, p 944) Officially, the legalized private health sector have all been eliminated in the county, but illegal private practices secretly progressed with many fraudulent behaviors since the “Cultural Revolution” (1966-1976) which took great social disorder and government disfunction. Only after 1979, with the market economic reform, private medical practices were legally permitted and gradually increased.

While the private health services have rapidly reduced since 1949, the public system developed quickly. In 1950, the county health center—the only public health institution in the county, was moved to the present city area from the old city town34 with only 8 health professionals, 8 beds, and 31.8 outpatients per day. Later the county health center was renamed as the People’s Hospital, some social health institutions and private doctors were integrated into the county hospital, the buildings were enlarged, new medical equipments were imported, soon it became the biggest health institution of the County with outpatient number 315.8 per day in 1962. In 1985, it already has 381 health professionals, 300 beds, with the daily outpatient number 928.3 persons. Besides, the Hospital of Traditional Chinese Medicine was founded in 1958 by 6 traditional medical doctors with daily outpatient number 94.1 at first. Later in 1962, it increased to 28 health professionals, 15 beds, and 145.6 outpatients per day. Till 1985, there were 162 health professionals, 200 beds and 725 outpatients per day in this hospital, the second biggest medical institution in the county. (SCCEC, 1990, p 932) Moreover, in the city, the Maternal and Child Health Center was established in 1953, and a County Red Cross Hospital was founded in 1958 (SCCEC, chapter 8, unpublished). In the rural area, township health centers and village health stations were widely established. Until 1985, 84 township health centers were founded and village health stations were broadly established in every village. It is worth to note that the village health professionals came to a peak in 1977 with 1868 “barefoot doctors” and 4880 primary health workers in the county. (SCCEC, 1990, pp. 935-936) In general, the public health system in S county has expanded dramatically from only 1 health institution, 5 beds, and 6 health professionals in 1949 to 720 health institutions, 1983 beds and 3332 health professionals in 1979 (See Appendix 3). And

34 The city center of the county used located in another town before 1949, after the establishment of the new government, the city center moved to the current city town.
with the development of county hospitals, township health centers/hospitals and village health stations, a three tiered health network was completely formed in the county linked the village, township and county health units vertically together.

Moreover, a medical school has been founded in the city since 1958, which was a secondary vocational school responsible for the training of health workers in the whole Prefecture. During all these years, it has trained many hospital doctors, barefoot doctors and other medical workers, has been the central source of medical personnel in the county. Before that, nearly all the health practitioners were trained through the traditional master-prentice system, which centred on traditional Chinese medicine. Since 1986, the school has changed its aim, focused on the training of the primary health workers like nurses and rural health workers; it also gave short-term training and continuing medical education for the existing health professionals.

4.3.2 Health Care Privatisation in Post-1980 Society

In the health sector, the local government has implemented a series of reforms since the mid 1980s. This section mainly analyzes the health care privatisation from three aspects: service provision, funding, and policy regulation in the local context.

Privatisation in Service Provision

To increase efficiency and productivity of health service provision, since the beginning of 1980s, the local government has allowed private medical practices, given increasing autonomy to public health institution, suggested the public health institution to contract operation and partly outsource the services etc. In rural areas, village health stations were sold or contracted to individual, township hospitals were closed or sold to private practitioner, public health facilities reduced quickly with rapid expansion of private medical care. Since 2000, the local government further encouraged the reform of health property right (wei sheng chan quan zhi du gai ge) that health stations in 526 villages of the county’s total 591 villages have been privatised to individual operation, most health centers in the townships have also been privatised except 11 central township hospitals (SCCEC, chapter 4, unpublished). In the city area, the health authority required public service unit to try multiple channels, multiple owners, and multiple means (duo qu dao, duo zhu ti, duo xing shi), and encouraged public personals to go into personal business. Under these proposals, public hospitals have been forced to operate increasingly under market conditions,

35 Prefecture is located in the second level of China’s Administrative divisions (from bigger to smaller: the province, prefecture, county, township, and village), which include several counties. The secondary vocation schools aims at train middle level or primary health workers, unlike the tertiary medical institutions (e.g. university) aim at training high level health personnel.

36 Protected Reference.

37 S County Health Department Report, ‘Implementation Measures on the Transformation of Health Units’ Internal Management Mechanism’, (S xian zhuan huan yi liao wei sheng dan wei nei bu jing ying ti zhi de shi shi ban fa), May 1994.

even separate the operations of ownership and management; autonomy was given to
public agents, and some spaces were created to allow public doctor move to private
sectors that they began to contract and rent health units/clinics in the public hospitals,
or open an autonomic clinic outside under the name of their hospitals.\textsuperscript{39} For the urban
community heath facilities, they were unstructured, poorly resourced, and staffed by
under-trained persons in large cities, but in the small city like S, urban community
health stations were actually never established, the primary health care were generally
covered by private clinics. Health care in the city could be broadly defined to include
only upper level public hospitals and basic level private clinics. Medical care
organizations have kept increasing in the county with the majority in private sector.

On the insurance part, before 1980s, rural population in the county was universally
covered by Cooperative Medical System which supplied free or low-cost health care,
and urban population was broadly covered by labor insurance medical care or
government employee insurance. However, since the early 1980s, the rural
cooperative medical insurance system has collapsed, only 5.4% of China’s 940,000
villages had cooperative medical care in 1985 and 15% in 1994, though this figure
was approximately 90% in the late 1970s (Yanrui Wu, 1997). The dismissal of large
numbers of employees with the enterprise reform led to the reduced insurance
coverage of urban citizens. The public failure encouraged private sector. The private
health insurance (also called commercial insurance) emerged alternatively. Many
people now have to buy health insurance to meet increasing medical costs or go
without healthcare. Without insurance, both rural and urban people switch to
fee-for-service medical care, in the cheaper private health sector.

\textit{Privatisation in Financing}

Privatisation has been frequently used to reduce the financial burden of the public
service. Privatisation in health care financing could be measured in monetary terms as
a shift from public to private spending or as a decrease in the public fraction in health
care spending (Hans Maarse, 2006). In S county, with the decentralization of financial
responsibilities at the national level, cuts have been made in subsidies to public health
service from the central government. There was also a reduced involvement of the
local government in health expenditure coverage. In the countryside, the abolition of
communes destroyed the collective finance to the cooperative medical system,
without funds to pay for rural health workers, health personnel in the village declined
rapidly. Financing in major hospitals also greatly reduced although the hospital sector
has absorbed the majority of health resources and funds.

With the deep cuts in government and collective funding, the health sector has
stepped up the exploitation of new sources of funds. The policy was to encourage
“multiple level, multiple channels, and multiple means” (\textit{duo ceng ci, duo qu dao, duo
xing shi}) of financing, by multiple levels meant both vertical tiers (central government,
province, county/city, xiangzhen/stree organizations, village/resident committees) and horizontal sectors (state, collectives, groups, and individuals) in the welfare nexus; multiple channels referred to diverse sources of funding, and multiple means denoted various methods of raising money (Linda Wong, 1994). The local government has allowed the private finance invest into the public health institution, and encouraged all levels of health facilities to rely on user fees to support their operations. Now in rural areas of the county, the collective financing of health care has given way to predominantly private payment, the majority of rural households need to pay out-of-pocket money for health services. Township health centers and county hospitals are also largely financed by fee-for-service. Thus, the burden of financing health care costs is largely shifted from public providers to household individuals.

The state role is still important, the government investment on health sector has increased gradually in the total amount year by year, but the percentage has reduced. The contribution of non-state financing has become more significant since 1979. Today, China spends 5% of GDP on health, which is relatively high for countries at comparable levels of income, but public spending on health amounts to less than 2% of GDP (UNDP, 2005, p 63). From this perspective, health financing has been privatised.

**Privatisation Policy/Regulation**

The advent of privatisation in health service provision and financing reflects changes in policy orientation and preferences. After the issue of *Report on the Granting of Permission for Solo Private Medical Practice* in 1980 at the national level, the Sichuan provincial government followed published the *Interim Measures on the Administration of Individual Medical Practices in Sichuan Province* (sichuan sheng ge ti kai ye xing yi ren yuan zan xing guan li ban fa) in 1981, restored the legalization process of private health practices. In implementation, the county health department ratified some qualified private medical practices. The local authority denoted the ratified individual medical practitioner was limited in fixed place to do specified medical practices, and was not allowed to sell medicines; pharmacies could employ certificated doctors (*zuo tang yi sheng*) to prescribe drugs and treat patients. (SCCEC, 1990) In 1983, all health professionals were required to take examination, through which 367 health practitioners became licensed “village doctor” and 1201 got certificate as primary health worker (in 1977 the total number was 1868 barefoot doctors, and 4880 health workers) (SCCEC, 1990, p 933). Some of these licenced health professionals went into the private medical sector. Till 1985, the county had 267 registered private medical practitioners including 24 who operated in the city area (SCCEC, 1990, p 934).

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41 From S County Chorography Edit Committee (SCCEC) (eds.), *S County Chorography (S Xian Zhi)*, 1990, volume 25, Chapter 3, Section 5. Since the page number is missed in the scanned material, I denote the section of the source here.
However, it was not easy to get the licence through passing all the examinations, particularly for the non-institutional trained medical practitioners. This prevented some old doctors, barefoot doctors and rural medical practitioners from publicly open their clinics. Most of these doctors and medical workers then changed their jobs or took private medical practices illegally. And due to the incomplete legislation and unregulated market, many traveling medical peddlers (you yi) reemerged in the market since 1980s. Only in the city areas, there were about 40 to 50 ambulatory medical stalls every market day with uneven skilled practitioners and unqualified medications, not to say the uncountable numbers in the rural and small town areas (SCMB, 1988, p 102). While forbidding these unqualified medical peddlers, the local health authority embarked to openly give examination to all those who apply to open private clinics since 1989, in 1990 set up the personal records archives for all the private doctors and eliminated those without licence. In 1993, the local health department further stepped in to relax the approval of private health practices, and there were already 327 solo-operated private doctors opened clinics in the county from the 1994 report. Although the national reform proposed to give greater staffing autonomy for public health facilities and encouraged public personals to go into individual business, in the local county it still strictly forbade public health professionals to open or work in private clinics. Those who open private clinics would be regarded as resigned from the public employment, and would never come back to the public system (SCCEC, chapter 13, unpublished).

In 1990s, two significant national policies were released. First, *The Medical Institution Governing Regulation* in 1994 required all health institutions to get the Medical Institution Practice Licence. The local county began to examine, approve and register every medical institution in the county, and issue the Medical Institution Practice Licence for the qualified ones from the flowing year. Second, *The People’s Republic of China Medical Practitioner Act* in 1998 launched the doctor license system. It clearly indicated all doctors were required to get the Medical Practitioner Licence before taking part in health practices, and clarified the requirements of the license examinations, licensing procedures, as well as the rights and obligations of doctors. Since then, only the private clinic with both Medical Institution Practice Licence and the Medical Practitioner Licence could legally operate in the local county, state medical workers were still explicitly prohibited from private medical practices. Besides, a health supervision team was organized in the same year to generally supervise the health related services and remove the unlicensed private medical institution. In 2005 alone, 53 unlicensed private health institutions (private clinics) were banned in the county (SCCEC, chapter 6 & chapter 13, unpublished). In 2007,
the provincial government suggested the local authorities to further open the health market to private sector.\textsuperscript{46} The policy generally tends to relax the public control and encourage private investments.

Table 2: Empirical Observation of Privatisation in S County\textsuperscript{47}

<table>
<thead>
<tr>
<th>Aspects of Health Care</th>
<th>Termination</th>
<th>Contracting Out</th>
<th>Self Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Provision</td>
<td>Village health stations stopped or individual operated;</td>
<td>Contract out hospitals clinics or public health units; Public health professionals individually open clinic outside under the entitlement of their hospitals.</td>
<td>Increased autonomy.</td>
</tr>
<tr>
<td></td>
<td>Township health centers/hospitals sold or closed;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>City community health care privatised; Public health insurance coverage</td>
<td></td>
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<tr>
<td></td>
<td>reduced with the emergence of commercial insurance; Rural cooperative</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>medical system dismantled.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financing/Funding</td>
<td>Deep funding cuts with reduced state and collective financing.</td>
<td>The private finance invest into the public health institution; Fee-for-service to supplement the public financing.</td>
<td>Decreased reliance on State funding; Self-sufficient.</td>
</tr>
<tr>
<td>Regulation/Policy</td>
<td>Legalize private health practices; License private medical institution and private doctors.</td>
<td></td>
<td>Decentralization decreased central government control; Relaxed Policy Control.</td>
</tr>
</tbody>
</table>


As a conclusion (See Table 2), in S county, first, there was a termination of public primary health service provision (including village health stations, township health centers and city community health care), the public hospitals in the city also contracted out their services; public insurances were reduced with notable decrease in rural cooperative medical system. Secondly, the financing of health care has largely changed with reduced state and collective funding, and increased private investment and out-of-pocket payment. Finally, the policies tend to relax on the private medical practices, grand licence to the qualified health institution and qualified doctors while strictly regulated the illegal medical practices and public health professionals. In general, there was a shrinking role of the state, and rapidly enhancing role of the private sector in health care.

With the broad health care privatisation process, how the private medical practices actually arranged? How the private clinics indeed operated and implemented? What challenges and opportunities the private medical practices presented for the health sector? The following chapter tries to picture out the arrangement of the Chinese-style private health care in a specific local city.
Chapter 5: Private Clinics in the Local City

Based on the data collected in the fieldwork, the chapter outlines the arrangement of private clinics in the city S. It describes the existence and functioning of private clinic in detail, discusses the problems and challenges private clinic encounter in its implementation. The aim is to see the particular features of the health care privatization in the local setting, how the national policy was implemented in practice, and how the organizational changes had influenced health sector performance in the local city.

5.1 The Functioning of Private Clinics in the Local Setting

This section employs the descriptive analysis to outline the private health practices in the local context and address some of the key features of the private clinics through the interviewees’ views and experiences.

5.1.1 Health Professionals—the Sectoral Maldistribution of Personnel

China’s health workforce and trainings could be categorized into three levels: on the top are the senior medical personnel such as senior doctors and nurses that trained in tertiary institutions like university; at the middle level are those as midwives, junior doctors and nurses that trained mainly in secondary or vocational schools; at the bottom are technicians and other junior personnel such as primary health workers trained basically through continuing education, in-service training and brief pre-service training (Yanrui Wu, 1997). Private health professionals in the local city mainly locate in the middle and bottom levels of the health workforce, and are trained in two ways: the traditional master-prentice training and the local medical school education. Since the small cities like S could not attract large numbers of medical human resources from other places, the local city relies on the mobilizing of local resources to cultivate medical professionals.

Private Doctors

Since 1949, there was a typical lack of trained doctors in China, the total health workers in the country were just 520,000 in 1949 (Penny Kane, 1984). This was also the case in S county. The traditional master-prentice way of doctors training in the county was impossible to supply sufficient doctors while there was an urgent need to improve health care. This led first to the training of paramedical workers to handle the most basic care. Many paramedical workers were trained, some of whom substitute for qualified medical practitioners were named as “barefoot doctor”. During and after the Cultural Revolution, very large numbers of paramedical workers were already trained in the local county with the numbers of 1868 barefoot doctors, and 4880 primary health workers by 1977 (SCCEC, 1990, p 933). The training of these barefoot
doctors and primary health workers was shortened considerably compared with regular medical training. Usually they started with a six-months initial course about rudimentary and preventive medical care. Further in-service training was an integral feature of their work, which might be achieved by their working with a qualified doctor doing a period of work in the countryside, or by secondments to a hospital, or by courses arranged by teaching hospitals (Penny Kane, 1984). The county S is famous for its traditional medical practices and master-prentice medical training, thus the training of health professionals has combined the school education and the traditional training. Most local health professionals or “barefoot doctors” have already got basic traditional medical training from their families or older doctors before enrolled in school course. Barefoot doctors were chosen from these half-trained people, then educated again in the local medical school shortly for preventive and western medical knowledge, and returned to work in their communities afterwards. Since the dismantle of rural heath system in the early 1980s, there was no public funds support these medical professionals anymore, most of them either left for other business or turned to private medical practices. The private medical practitioners in the city are largely from these rural barefoot doctors. Among the 7 private doctors in the research, 5 of them have been “barefoot doctor” or work in township health facilities.

Doctor Huang (Interviewee 2) learned his traditional Chinese medicine skill from his father who had been doctor for 60 years, after that, Doctor Huang was chosen to be trained and became a barefoot doctor work for the Rural Cooperative Medical System for 8 years. In 1981, with the dismantle of the cooperative medical system, the public health facility he belonged to was sold to individual, Doctor Huang has no place to go, but opened his own clinic while continuing his western medical study through correspondence course. In 1990s, he moved his business to the city which started from a small medical stall in the park. In 1999, he opened his current private clinic.

Doctor Yang (Interviewee 4)’s father and older brother both were traditional Chinese medicine doctors in the county, he studied with them before went to the local medical school, and did his internship in the county hospital of Traditional Chinese Medicine for several months. Since 1960s, he became a barefoot doctor and worked for the rural Cooperative Medical System for several decades. After the breakdown of the rural health system, he became a private doctor in the countryside. In 1997, he moved to the city and opened the present clinic.

Rather than remain a permanent crop of paraprofessionals, barefoot doctors are to be upgraded, certified, and paid wages for full-time medical work in a process of slow professionalization, and many of the original barefoot doctors eventually became fully qualified professionals (Marilynn M. Rosenthal & Jay R. Greiner, 1982). In the 5 previous barefoot doctors in the research, 2 of them finally became professional doctors of the public hospitals. But some of these fully qualified doctors still lost their jobs and became private practitioners after the privatisation of township/district
Interviewee 7 (Doctor Du): “I studied traditional Chinese medicine and basic western medical knowledge from my father, in 1982 my father retired from the district (township) hospital, I took over his shift, worked there. In this period, I went to the local medical school and the county hospital of Traditional Chinese Medicine continued studied for two years, and back to work as a full doctor till 1994. This year our hospital was sold (to private management), I opened this private clinic in 1995.”

In the county, there were more than 400 people like Doctor Du who came out from public hospitals after the reform, although later, the government recruited about 200 of them into the public system, there were still many unsolved health professionals, most of whom opened private clinics. Besides, since the reform, some of the full time public doctors directly resigned their public employment and became private doctors. In the research, Doctor Tian (Interviewee 3) and his wife (a gynecological doctor) are such examples (the case is described in the next section). For the younger private doctors, most of them finished their training from the medical school, through self study or master-prentice training, and opened their private clinics if they could not find a better job.

Doctor Wu1 (Interviewee 1) got his traditional Chinese medical training in 1980s through the master-prentice way: “I began to study with Doctor Luo in 1980s, the tuition fee was 100 Yuan for a year (equal to 1000 Yuan now, the average month salary of the city), in the festivals, I also bought some gifts for my master. Everyday, I needed to clean the clinic, cook, do every assistant work, the master gave me some old books to transcribe, I had to memorize and recite all the books, sometime I also bought books.” After several years’ study, he took part in the certificate examination, got the licence and opened his clinic, now his clinic has already operated for two decades.

Doctor Liu (Interviewee 5) began his medical training by self-study and became a pharmacist in hospital, later he continued self study, took part in the certificate examination, and did internship in the Chengdu Traditional Chinese Medicine College, after that he opened his clinic: “now many young people begin to open clinics, they do self-study or follow a master, but no matter how, at least, they will go the North Sichuan Medical College to study for a period and take the examination afterwards.”

In contrast with the private health sector, public health institutions such as hospitals are usually staffed with university trained doctors or formally educated practitioners of both Traditional Chinese Medicine and Western-style medicine. For instance:

Interviewee 10 is a health professional of the county Center for Disease Control and Prevention. He got his basic medical knowledge from his father who was a traditional doctor. He then attended the Chengdu Traditional Chinese Medicine College to study for a period and take the examination afterwards.

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48 One of the most famous traditional Chinese medicine doctors in the county.
49 Both Chengdu Traditional Chinese Medicine College and North Sichuan Medical College are the university level medical schools in Sichuan Province.
Chinese medicine doctor. In 1977 the first Chinese university entrance examination resumed since the interruption of Cultural Revolution, he passed the competitive examination and went to the medical school specially studied for several years, after that he worked in the Center for Disease Control and Prevention. In the following years, he took part in two more long-term school training courses under the arrangement of his work unit, and every half year, he would get a short-term training.

Obviously the requirements for public health professionals are much higher than that for private doctors. The local authority tries to improve the quality of private health services, upgrade and certify the private doctors since 1980s. In the last few years attempts to upgrade and examine the private doctors have become more stringent and the least effective ones could not get licence and have been weeded out from the city (but the rural areas still have many unlicensed private medical practices). Now, the training through master-prentice way is not enough to become a qualified doctor, even education in the local secondary medical school is not qualified enough. For the private doctors who already get license, they are required to participate in the short-term medical training every year. In 2007 alone, 215 private health institutions with the number of 354 medical staffs took part in the continuing medical training/education (the total number of registered private health institutions in the county was 240 with 434 registered private medical staffs).50

Other Private Health Workers

Private clinics are usually operated by one or two individual doctors alone, but in most cases, there are also one or two assistants like nurse, pharmacists, medical technicians, or accountants etc. The size and personnel number of private clinics are largely determined by the business—the outpatient number. Among the five city private clinics in the research, two are opened by one private doctor alone; two are operated by one doctor and an assistant: one clinic assistant is the doctor’s wife, the other clinic is assisted by the doctor’s son—a new graduate from medical school; the last clinic has 7 personals, including two doctors, one nurse, one assistant (student/prentice), two pharmacists, one accountant, and occasionally there are internship students from medical schools work in the clinic as assistant. Private clinics in the city are usually difficult to attract qualified paramedical workers, especially the young medical school graduates:

Interviewee 1: “I am trying to employ a qualified nurse for a long time, however, all the people come to the interview were nurse graduates with only graduate diploma, no Practice Certificate, the one who has the certificate would directly go to the big hospitals, not consider our private clinics.”

Comparatively, in the public health institution, nearly all the health workers are from medical schools. In 2008, the county hospital of Traditional Chinese Medicine 50 S County Health Department Report, ‘The Yearly Report Form of Continuing Medical Education of Sichuan Province, S County’ (Sichuan sheng ji xu yi xue jiao yu nian du biao biao, S xian), December 28th, 2007.
enrolled 19 new health workers with one postgraduate student, 10 university graduates, and 8 college graduates.\textsuperscript{51} In general, the state-run medical work unit has remained the prevailing institution that employs the majority of doctors and best health professionals, especially in urban areas. Higher level health professionals tend to work in the public institution while lower level and poor quality health professionals go to the private one. How to attract good medical workers in the private sphere is a problem.

Since 1949, China has taken advantage of its ancient, indigenous medical practices, combined the use of traditional Chinese and Western medical services to meet the huge medical needs, the combination has profound influence till today. In S county, there are 3109 recorded health professionals from a 2007 census, the number of western medical professionals is 1641 which takes 53\% of the total, while the number of traditional Chinese medical professionals is 1469, 47\% of the total. From Table 3 below, we can see most of the traditional medical professionals have worked in the lower level and the primary institutions like village health stations or private clinics. In this research of 7 private doctors, 5 of them are specialized in traditional medicine, while the other two younger doctors are in western medicine. The private clinics are mainly staffed by the traditional health professionals.

Table 3: Health Professionals in the Local County

<table>
<thead>
<tr>
<th></th>
<th>Western Health Professionals</th>
<th>Traditional Health Professionals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Level</td>
<td>590 (73%)</td>
<td>194 (27%)</td>
<td>719</td>
</tr>
<tr>
<td>Town Level</td>
<td>631 (59%)</td>
<td>437 (41%)</td>
<td>1068</td>
</tr>
<tr>
<td>Village Level</td>
<td>485 (37%)</td>
<td>837 (63%)</td>
<td>1322</td>
</tr>
<tr>
<td>Total</td>
<td>1641 (53%)</td>
<td>1468 (47%)</td>
<td>3109</td>
</tr>
</tbody>
</table>

Data Source: S County Health Department, 2007\textsuperscript{52}

5.1.2 The Operation of Private Clinics

General Condition of Private Clinics

Private clinics are categorized into different types due to the speciality of the private doctors. Broadly speaking, private clinics in the local city are put into two categories\textsuperscript{53}: Chinese Internal medicine clinic and Western Internal medicine clinic, besides, there are a few clinics specialize in Acupuncture and Moxibustion, Bone-Setting etc. All these categories do not require high tech equipments that private clinics usually can not afford. In this county, the Chinese Internal Medicine clinics take up the majority

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\textsuperscript{51} Information comes from Interview 11. In China the university graduate normally study in medical school for 5 years, including an internship year, and the college study generally takes 3 years.

\textsuperscript{52} S County Health Department Report, ‘Statistical Overview of Western and Traditional Health Professionals in the County’ (quan xian zhong xi yi ren yuan tong ji qing kuang), April 29, 2007.

\textsuperscript{53} Dentistry clinics are not included in these categories since this research mainly focus on the general private clinics.
with the estimation of more than 60% of all the private clinics. In the 7 studied private clinics, 5 are Chinese Internal medicine clinics while 2 are Western Internal medicine clinics. The national regulation indicates medical practice in private clinic should be limited to its categorization, if Chinese Internal medicine clinic do Western medical practice or vice versa, it will be regarded as ultra vires practice. However, in actual practice, private doctors use both Chinese and western medical practices, which hardly separate with each other.

Private clinics are always locate in the street corner or near market place, where have a large population flow; people could easily recognize the private clinic or get access to it conveniently. Each private clinic has just one or two rooms that face street like a shop. In the researched 5 private clinics in the city, four clinics are operated within a room space, commonly the room is separated into front and back part, the front part is used to see patients, and back part for stocking and infusion. The other one clinic (the biggest one in all the researched clinics) has two rooms, one is used for registration and selling medicine, the other is for doctor diagnosis and treatment (giving shot). Private clinics in rural areas are not so commercially organized as urban clinics to face street, country doctors usually have clinics in their own homes. One of the two rural private clinics in the study is opened in the doctor’s own home.

The equipments in private clinics are very simple, for the Chinese Internal Medicine clinics, they would have a Traditional Chinese Medicine cabinet with more than hundred small drawers, each drawer contains one or two kinds of Traditional Medicine (see Picture 1), this cabinet is the symbol of traditional clinic and pharmacy. For the western medicine clinics, they also have a smaller modern medicine cabinet. The other medical equipments in private clinics are just the simple necessaries for doctors like stethoscope, injection set, sphygmomanometer, and thermometer etc. Some clinics also have one or two beds. In the national level, for-profit medical institutions (private health institution) have only 133,000 beds in total while public medical institutions have 3,204,000 beds, although for-profit medical institutions largely outnumber non-profit public medical institutions by 24,000 (156,000 private health institutions and 132,000 public ones in the end of 2005). Generally, hospital resources are much better furnished than private clinics.

**Clinic Operation and Health Provision**

Private clinics generally aim at minor, mild or moderate illnesses; focus on commonly encountered, frequently-occurring diseases, and chronic diseases, although different clinics and doctors have slightly different specialities. Most of the diseases are easy to treat, medicine could be cheap and effective, and traditional medical practices have some advantages on the treatment. Since private clinics are simple and do not have high-tech equipments, they do not aim at the big and complicated diseases. And to
reduce risks and accidents, private doctors always suggest the patients to big hospitals once they found patients were in severe condition or they were incapable to cure the disease.

Private doctors describe their medical practices as business, to open a clinic is like to open a shop. Traditionally, private clinic combines health practices and medical selling, it is convenient for patients to see doctor and get medication, finish all the health seeking process in one small place. Although in big cities, private clinics began to be organized in a stricter western standard without medicine selling, in small city and rural areas, private clinics still operate traditionally with private doctors cover all clinic works, and are allowed to sell medicine.

Interviewee 9: “In big city, the density of private clinics is less than our small city. The national policy begins to employ measures such as separate the medicine selling from private clinics, limit the private doctors’ practice in medical analysis and treatment, other works like injections need to be done by nurses. But these happen only in big cities. Here we do not do that considering the local condition. The private clinics need to be best convenient for patients.”

Every private clinic has its own purchase channels for medications and health products, usually it’s the medical supply company send the medicine directly to private clinics. Private clinics try to order the cheapest products to guarantee the low patient charge while making some profits.

The process of seeing a doctor in private clinic is very simple. In the clinic of Interviewee 3, there are two rooms, patients come into the first room of the clinic to register, then come to the doctor in another room for medical diagnosis, after that doctor gives patients prescription with which patients get the medication and pay the fees in the first room, sometimes the patients would take the medicine back to the doctor to ask for the taking tips or precautions and say goodbye. In the other 4 clinics, the process is even simpler, there is no registration, patients go to the clinics see doctor directly without waiting or a short waiting, then the doctor or his assistant gives medication to patients, and charge the fees. The whole process would take within 10 to 20 minutes.

Medical encounter in private clinic is not one-to-one interaction, but one or two doctors face several or a group of patients at the same setting (doctor see one patients while the other patients and their proxies are around), the private clinic is like a collective place with many public encounters (meeting). In the public medical encounter, patient’s privacy becomes a problem. While the public hospitals embark to employ one-to-one medical interaction between doctor and patient, the only way to protect privacy in private clinic is to lower down the enquiry voice when come to the sensitive question, or do medical check at the back of clinic. But private clinics mainly treat the minor and common diseases which are not sensitive in most cases. In
In fact, many patients in private clinics denote the public encounter of health professionals with many patients supplies as a way of health education that spread health knowledge un-purposely to the patients around; and the co-existing of other people gives patients more comforts instead of pressure to face the illness since people surrounded always discuss and exchange the experience of illness with each other. The Chinese way of collective medical encounter in private clinic last for so long and still exist in private clinics today.

5.1.3 Health Utilization

In S city, health care could be broadly defined to include upper level public hospitals and basic level private clinics. Since the health transformation with the proliferation of medical fee-charging, ability to pay has become a potent means to negotiate access to public service, thus there is a decline in the use of expensive public health service, instead people transfer to the cheaper private service.

The User of Private Service—Who Comes to Private Clinic?

People who come to the private clinics are usually not rich, most of them do not have health insurance and have difficulty in accessing to public health services; consequently they use their saving account to get treatment in the private clinics. Sometimes patients with good financial condition or have insurance also come to private clinic due to its conveniences and advantages. Generally, the young people tend to use hospital care more often, while the middle-aged and old people prefer to go to private clinics for small and chronic diseases. Moreover, with the collapse of rural cooperative medical system, large number of health professionals left the rural areas to the city. Lack health resources in rural area, many rural patients also come to the city to seek medical treatment in private clinics.

Usually the first time to choose a specific private clinic is through social network. People are introduced by their relatives or friends, or just try the clinic in the nearby place of their community. Once they are satisfied with the doctors’ treatment, they will come again in the future. Although most private doctors are general doctors, they still have different specialities; people would go to different private clinics according to different diseases. But for the famous and excellent private doctors, they attract patients with various diseases, and from all over the county, even other cities.

Interviewee 2: “I accept all kinds of patients: people in the nearby place, other places in the city, or rural areas. My clinic closes to some government units, many of my patients come from the public units like police office, judicial bureau, construction bureau etc, mostly are introduced by the cured patients, friends or relatives. A few days ago, there was a patient from Henan province, his relative in our city took him some of my medicine last Spring Festival, now he felt much better and asked his relative came again

55 From the casual talks with the patients during the participant observation in private clinics.
to prescribe some medicine and post to him. Occasionally, there are also patients from Xinjiang or Chongqing introduced by their relatives.\textsuperscript{56}

The outpatient numbers of private clinics vary from one to another. Some less popular clinics have only about 10 patients per day while the popular ones could have more than 50 patients per day. In the researched 5 city clinics, Doctor Wu’s clinic (Interviewee 1) has 40-50 patients per day, Doctor Huang (Interviewee 2) has 30-50 patients daily, Doctor Yang (Interviewee 4) receives 10-20 patients per day, and Doctor Liu (Interviewee 5)’s clinic has 15-20 patients, Doctor Tian (Interviewee 3)’s clinic is the one of the most popular private clinics in the county with outpatient number of 100-200 per day.

\textit{Health Seeking Behavior—Why Choosing Private Clinic?}

Studies in developing countries have shown that patients’ preferences are influenced by a variety of factors such as cost, quality, convenience, and service attitude of the providers; the final choice is determined by trade-offs between these factors (Lim Meng-Kin \textit{et al}, 2004a). In the local city, there are multiple influencing factors that make private clinic popular.

(1) Cost

Cost is the main factor in influencing people’s health seeking decision. The people come to the private clinics are usually not rich and do not have health insurance. Uninsured people tended to have a shorter stay in public health institution and were charged more for items of treatment, hence some people did not seeking healthcare despite needing it (Xiang Zheng & Sheila Hillier, 1995; UNDP, 2005, p 63). Besides, the growth in fee-for-service led to a rise in costs and a reduction in the availability of hospital care, further stopped people from seeking hospital services. Contrastively, market competition made the charge in private clinics much cheaper than public hospitals and any other health institution. In the local city, medical charges vary from one private clinic to another, and different from individual patient to individual. Most of the time, private doctors just have an estimation of the price, and tend to reduce the charge moderately if the patients were their friends, relatives or acquaintances. But in general, the charges in the private clinics are cheap, and do not have great disparities between clinics.

Interviewee 7: “The profit of medication is about 10% to 20%, for example, this Soothing Balm (\textit{feng you jing}) I get it at about 1.6-1.7 Yuan, sell it at 2 Yuan, I just give an estimation of the price. If I sold too expensive, people will not buy it here.” “Usually I charge less for the close relatives or friends, for the very very poor patients, sometime I do not charge any money.”

\textsuperscript{56} Henan, Xinjiang and Chongqing are provinces outside Sichuan. From the local point of view, these places are far from the local city.
Interviewee 3: “The fee in our clinic is much cheaper (than hospital), the Chinese medicine and western medicine all together are only about 10 to 20 Yuan, the doctor consultation fee was 0.2 Yuan in the beginning, later 0.5 Yuan, then 1 Yuan, we go with the national level change. Now it is 4.5 Yuan, this is based on my professional rank.”

In most private clinics, the doctors do not charge the consultation fee, or just charge one or two Yuan. On the other hand, the unfixed price gives private doctors free space to charge randomly, especially for strangers. But in the acquainted society of the small city, people are close and familiar with each other, and private clinics are very competitive, private doctors would not cheat on the local citizen for the long-run consideration. Patients are practical, once the cost is cheap and the treatment is effective, the private clinic will be welcomed.

Interviewee 4: “First you need to cure the disease with cheaper money. Hospitals aim at severe illness and health check, what we do is prevention and primary care, if you caught a cold, just come here and cost several Yuan or dozen Yuan, it will be cured, in big hospitals it will cost approximately hundred Yuan. Once the disease is cured, and cost is cheap, people will come again.”

(2) Convenience

Private clinics usually locate in the community, near market place or street corner; they close people’s home or at the place people always pass by, patients can come to see doctors conveniently in the clinics. For rural patients, they could also easily get access to private clinics when they come to the city market for trade. People also denote private clinics are always open whenever patients go there. In the researched 5 private clinics in the city, 3 of them open from 8 o’clock in the morning to 9 o’clock at night, one is operated even early at 6 o’clock in the morning. Private doctors stay in the clinics for a whole day, do not close their clinics on weekend or any public holiday, some even set their home in the second floor or at the back of the clinics. Even for the clinic by interviewee 3 who leave from public hospital and operate his clinic as the routine in hospital, it still open half time on every Saturday and Sunday, and prolong the working time to finish all the registration patients every day. Sometimes, patients come to the clinic register in the morning before going to work and back for the medical diagnosis in the late afternoon after work. Comparatively, the outpatient service in the hospital is only accessible from 8-12 in the morning and 15-18 in the afternoon. The staff in the public health institution also admits the private clinics have some advantages that the hospitals could not guarantee.

Interviewee 12: “The private doctors work so hard in an unfavorable environment, they deserve to earn more money. They stay in the clinic for a whole day, never leave, the patient number accords with their time invested.”

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57 Interviewee 3 is a famous doctor and locates in the higher level of the medical professional rank and title.
In addition, public hospital environment is more complex and crowded than private clinic, its routines concern hygiene and order, each of these separated procedures requires patients to wait in long queue which is weary and time consuming. Unlike the public hospital, private clinic is more casual and efficient with quick speed of delivery of patients, and it tries to provide health service from the perspective of patients. As interviewees mentioned:

Interviewee 9: “For minor disease, it will be more convenient to go to private clinic, all the medical process—doctor diagnosis, getting medication, pricing and payment are in the same place and finished quickly, unlike hospital, you need first register, then go to doctor, then pricing, paying, and getting medicines etc., each in different department.”

Interviewee 3: “Sometimes patient registered several days ago, but not came on time, we still keep the registration for him/her. According to the national regulation, the registration is only validated within 24 hours, but we treat the patients even after a week later. If there are too many patients, we will prolong our open time till night, it's not easy for the patients, especially some of them come from rural areas or far-away places that catch a long way to be here, if we close the clinic on time, they will come in vain and waste money on transportation.”

(3) Attitude and Communication

Open private clinic is regarded as doing business, good attitude is necessary to attract customs. It is generally accepted that traditional/private doctors show more understanding and possess more empathy and compassion for patients, have more contact and spend more time with patients. The public hospitals on the other hand try to suppress the emotional factors in order to get on with the work in an organized way, treat the greatest number of patients in the shortest possible time. Private clinics seem much closer and more accessible compared to public hospitals. Patients can come for a casual talk with the doctor in their free time, or just have a rest in the clinic. During the observation within the clinic of Doctor Huang (Interviewee 2), several patients came from rural areas stayed there chat and rest while waiting for the rain to stop, when one old lady left the clinic, the doctor naturally said “take care, old sister!”, a local way to say goodbye between friends or acquaintances. In the clinic of Doctor Tian (Interviewee 3), the doctor often ask a few questions about patients’ family when doing diagnosis: “where your daughter/son study now?”, “how about your mother’s health recently?” etc. The humanized, emotion-attached medical practice and the “family-like” atmosphere in semi-acquainted private clinic setting makes patients feel conformable.

Private doctors also tend to provide health care in terms of patients’ cultural outlook. They tell patients some knowledge about everyday care, explain patients’ illness in an understandable way, which public hospital doctors do not usually do. In Doctor Tian (interviewee 3)’s clinic, the doctor replies all kinds of questions from patients about what food to eat, how to keep healthy lifestyle etc., and try to encourage patients to be
happy and optimistic. The private doctor is like patients’ friend or relative. The patients often share their worries and problems of their family with the doctors. The private doctors know the illness may be attributed to more than just the sick person, but something with which the whole family was involved, they always comfort the patients with simple words like “don’t worry, not angry, it will be good for your health”. These simple words could easily make patients feel warm and been cared, satisfy the psychological needs of patients.

Interviewee 3: “Patients always say our attitudes are good. On the one hand, it’s about affection: when the patients became familiar with us, they regard us as their relatives or friends that threat them with affection. On the other hand, we have an idea the patents has already suffered from the illness, certainly we should be nice to them and care about them, when the doctor concern about patients, the patients could be comforted psychologically.”

Interviewee 7: “I know 99% of these patients, the old people, old women in particular often come to my clinic sit there (point a long bench near the door), chat with me about their family affairs, sometimes I am too busy to talk with them, but just listen (laugh).”

(4) Trust

Patients’ health seeking choices are largely influenced by doctors. People tend to choose the private clinic which they are familiar with the doctor. During the casual talks within the private clinics, patients frequently mentioned about “trust” or “faith” to the doctor. They believe the specific doctor will give them good quality medicine, clean medical injection etc., not cheat or have fraudulent behavior on them. The choosing of familiar doctors is a way of self-protection in an incomplete legalized market for the unfavorable patients who do not have much financial resources or insurances to get access to public health care. Many patients also said they could only get used to the medicine of a specific doctor or only this doctor’s medicine could be effective on him/her. Patients believe the particular doctor could cure their disease, and feel assured and safe with this doctor. And once the belief between patient and private doctor has been established, the private clinic business would never stop.

Interviewee 3: “When patients get used to seek treatment from a doctor, they will have belief on this doctor. Some of my patients are from four generations of a family, over the long time, they have affection and belief on me. Sometimes they felt uncomfortable after taking my medicine, they would think ‘my family has seen this doctor for generations, there should be no problem’, then they controlled the problem by themselves psychologically. If the patients do not believe the doctor, as long as they drink the medicine (traditional medicine) and feel uncomfortable, they will blame the doctor prescribed the wrong medicine. The construction of confidence between patients and doctors need decade’s time.”

Interviewee 2: “When I first moved my business to the city, I operated a medical stall in
“In the park, there were only a few patients a day. After years’ operation, I opened this clinic in 1999, now ten years has passed, more and more patients come to my clinic. The base has been set up step by step, patients’ confidence on my clinic has also been built through the long process.”

In brief, the advantages of private clinics in cost, convenience, service attitude, communication, and trust toward the private health provider all together make the private clinics largely accepted and widely used by many people. In the transformation process, patients are abandoning public services, “voting with their feet” by choosing private health care.

5.2 Problems and Challenges with Private Clinics

In the health care change from all public to more private services, private clinics do not go smoothly, but face unfavorable conditions and multiple challenges; also, they take some problems to the existing health sector. This part identifies the problems and challenges private clinics encounter.

5.2.1 Unfavorable Conditions for Private Clinics

Private clinics face many unfavorable conditions in their development in the city: the fierce competition with other health institutions, the various fees payable for the health administration offices, the uncovered insurance for private doctors, and the conflicts between private medical practice and public policy.

*Competitions, Fees and Insurance Problems*

Since 1980s, many surplus health professionals came out from the public system and opened their private clinics. In the local city, the private clinics seems over concentrated, on a single hundred meter street, 7 to 8 private clinics are opened intensively, even door to door with each other. Accordingly, the operation of private clinics faces fierce competition and extreme pressure. However, generally the professional number and bed number in the county are much lower than the national level, and there is a quick increase in the population. In 1960s after the political unrest and natural disaster, there was only about 400,000 to 500,000 population in the county, 58 and most were in the rural areas. Now it has a population of 1.04 million with 250,000 urban residents alone, the urban residents are continually increasing year by year. Moreover, people nowadays tend to see doctors more often when they get sick. The increased population and improved public health awareness greatly increase health care demands, more health services and professionals are needed in the city. Consequently, once the private doctors are qualified and have specialities,

58 Data comes from interview 10.
they should not worry about the business, and could earn more money in private clinics than in public hospitals.

Interviewee 9: “In the past, many people saw doctors only when they were really serious, now health is the first priority, people see doctor even with very small sickness. You go out and have a look, although so many private clinics are opened beside the street, they are not excess but function well, this is people’s health demand. Not only private clinics, drug stores and pharmacies are also opened everywhere around the city. The waiting queues in some private clinics are even longer than hospitals.”

Interviewee 1: “Although we charge little money for each patient, we can earn back the costs if there are 10 to 20 patients each day, once there are more patients, we could make some profits. In the future, there should be more patients, people nowadays easily get sick with the effects of increasing pressure, environment pollution, accidents etc. We should not worry about the patient number.”

While the high income of qualified private doctor is an incentive for public doctor to open private clinic, there indeed are difficulties for the young private doctors and professionals without specialities. The young or middle-aged doctors are usually less professional and have fewer patients while they have more financial burden to raise their families. The ones, who cannot sustain their clinics, would change their job or migrant to the costal areas searching for job (da gong). Also, the local health authority encourages the health professionals to work in the remote areas like Xinjiang province where health resources are scarce. Rather than stay in the local city, the new medical school graduates tend to migrate to big cities look for jobs in private health institutions where they can earn more money. As the private doctors illustrated:

Interviewee 5: “There are many clinics, I think most of them could sustain their business. But I do have many pressures to operate the clinic—the rent of the shop room, the cost to raise my child and family, the different kinds of fees for the health bureau etc.”

Interviewee 4: “I have been doctor for decades. If I could not continue the job, I don't know what I could do. In the city, private clinics are even more numerous than restaurants, some of them should be difficult to make a living. For me, I am old and do not have many ambitions, it’s enough for me to earn some money to buy food. But for the middle aged doctors, they need to raise children and support the whole family, it must be burdensome. I hear Doctor Guo in another town59 could not make a living by his clinic, so he bought an electro-tricycle to drive passengers at night and open clinic in the day.”

Interviewee 2: “The business in some clinics were not good, they (private practitioners) closed the clinics and went to work in big cities. My son (new graduate from medical school that work as assistant in the clinic)'s classmates went to places like Zhejiang,

59 A township of S county that near the city town.
Shanghai and Guangdong work for others, still do health practices, but earn 3000 to 10,000 Yuan a month, more income than here. Here, some clinics could only sustain the basic needs.”

Interviewee 3: “The function of private clinic is not easy. To make the business go on wheel and attract more patients, the doctor needs to advance his/her knowledge and skill, and improve the service attitude, only for this, there are a lot of work to do. Not to say the policies and fees.”

At the same time, there are fees payable to the local health department and health administrative agency. In the interview, private doctors widely mentioned the health department charged less money nowadays than before. A few years ago, the private clinics paid several thousands Yuan per year; recently the health department has gradually changed to be positive and supportive to private clinics, and the fees have reduced to less than thousand Yuan.

Interviewee 2: “Now the tax has been reduced for us. In the past there were 8 kinds of fees to pay; now we only pay the hygienic expense. The health department used to charge near 2000 Yuan a year, now it is about 600 Yuan.”

Interviewee 3: “The health department is nice, sometimes it tries to protect our private clinics’ interests. A few years ago, each person needed to pay more than 2000 Yuan when renew the certificate, now it is several hundreds Yuan. Sometimes we need to pay 120 or 150 Yuan per person for the meeting or training, this is understandable, we accept it.”

However, the health administration offices, such as the Food and Drug Administration, the Center for Disease Control and Prevention, who regularly inspect the private clinics’ medicine quality, hygiene condition and neatness, charge some extra fees. Private clinics generally feel unsatisfied and stressful about these charges:

Interviewee 3: “Every year, they (the Food and Drug Administration) come to pick two kinds of medicine for test, we need to pay 400 Yuan, 200 each, for the test fee. Then, the Center for Disease Control and Prevention come to take the Betadine or other disinfectants to test the quality, we need to pay 200 per test again. Every year they come and charge fees, although we use the same medical products for many years. For us, 400 Yuan equals all the profits from medical injection. We need to hire the certificated nurse to give shot for patients, the pure profit for each shot is 0.2 Yuan, we need to give 2000 shots in order to earn 400 Yuan. They take away our profits, but we need to take the responsibilities and risks of medical practices without any protection from them.”

Moreover, private doctors’ insurance has been a long discussing problem. Many private doctors used to be the “barefoot doctors” or public professionals. Since the

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Zhejiang, Shanghai and Guangdong are proveniences in the eastern costal areas that are much developed than the inner province of Sichuan.
breakdown of the public health system in the 1980s, hundreds health professionals in
the county departed from the public health sectors without insurance or retirement
allowance. Some of the public professionals could be covered by the social insurance
(\textit{she hui bao xian}) when they continued their insurance accounts by self-paying all the
premium (SCCEC, chapter 4, unpublished), but for the prior barefoot doctors, they do
not have any insurance or pension, which has been a national problem for many years.

Interviewee 4: “The life of barefoot doctor in 1970s was difficult, we had a rough time
and worked even at the midnight. We contributed and suffered a lot, but did not get any
compensation, now we do not have the retirement pension. In the city, most of the
private clinics are opened by the people like me.”

Interviewee 7: “In our county, there are more than 400 doctors like me, we worked in
the public system but had to find our own solution after the reform, our insurance
problem is not solved, we cannot retire from the public system and get pension.”

The ones who resigned their public employment to open private clinic also have
problems with their insurance. Public health professionals’ insurance is covered by
government employee insurance (\textit{ji guan shi ye bao xian}) by their work units (\textit{dan
wei}). But if a public doctor leaved the work unit to open a private clinic, his/her
insurance will be stopped. The doctors who buy their own retirement insurance and
accident insurance would pay a lot.

Interviewee 3: “We (interviewee and his wife) worked in the public institution for 30
years, the endowment insurance premium\footnote{Which is largely supported by the company or public unit, and employee only pay small part from their salary each month.} we accumulated before was still in the
saving account, what we should do was continue pay the entire premium by ourselves.
But when we went to the Insurance Bureau of Public Service Unit (\textit{ji guan shi ye bao
xian ju}) to continue pay the insurance premium, they refused us. So the only way for us
was to buy the social endowment insurance\footnote{It is for the individual citizens who do not work in the companies or public service units (do not have a fixed job), the individual pays the entire insurance fee out-of-pocket for years, when they come to the retirement age, they could get monthly pension from the insurance bureau for the rest of life.} from the Social Insurance Bureau. A few
years later, the policy clearly indicated on the insurance problems of previous public
professionals (who leave public employment go into personal business)\footnote{The regulation could be found on Item 7, CPC Sichuan Provincial Committee, Sichuan Provincial Government, ‘Policy Suggestions to Further Accelerate Private Economy’ (\textit{guan yu jin yi bu jia kuai min ying jing ji fa zhan
Bureau of the Public Service Unit then told us we could continue pay the premium.
During these 13 years since we left the county hospital, we two have paid approximately
100,000 Yuan. Finally we have total insurance now.”

In short, private clinics face fierce competition in the market which forces them to
lower their medical charge; at the same time, they need to pay a lot of fees to the
health administration agencies. Plus many private doctors do not have insurance or
have do buy insurance by themselves, which further stand them at an unfavorable position.

*Confliction between Public Control and Privatisation*

Since the beginning of reform in 1980s, the state has been trying to decentralize the government system on public health providing and give greater economic and staffing autonomy for public health facilities. In 1996, the Sichuan provincial government suggested public service unit to try multiple ownership and operation to increase efficiency, and encouraged public personals to go into personal business. With the new policy, some spaces were formed in which public doctors can enter the private sector with unprecedented freedom. In the local context, public professional in the public hospital began to contract and rent public health units/clinics, or open an autonomic clinic outside under the entitlement of public hospital.

On the other hand, the local officials are still uneasy about “privatisation”. In 1997, one year after the provincial government suggested multiple operation of health sector, health officers in the government still regarded the private clinics as enemies to the public system, and talked about the elimination of all the private clinics in the local city. In practice, the authority tries to avoid changing the “foundation of the work unit system and the doctors’ state employee status” (Yang Jingqing, 2006b), and only allows limited legal space for privatisation in health care—public health professionals could not freely move from public to private, and have little chance to open their own clinics. The local authority tries to put the best health human resources in the public sector, secure the key role of public service. Even the retired public doctors are not allowed to open their own clinics or do private health practices in the local city although the national policy has granted public sector health professionals to own and operate private medical clinics after their retirement since 1987. In the city S, there are several famous doctors relinquishing their state employee statues, set up private medical businesses, but with many institutional barriers, Doctor Tian (Interviewee 3) is such an example:

Doctor Tian’s Clinic

Doctor Tian worked in the county hospital of Traditional Chinese Medicine, was a famous Traditional Chinese Medicine doctor there. In 1996, Doctor Tian, like some others doctors, signed a contract with his hospital to open an independent clinic in the market under the name of the hospital for 3 years as an affiliated clinic, if he failed, he

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64 The 1996 document was mentioned many times by interviewees, but the author did not find out the documents from internet since many government documents before 2000 were not published on line. A further similar document in 1997 was found: CPC Sichuan Provincial Committee, Sichuan Provincial Government, ‘Policy Suggestions to Further Accelerate Private Economy’ (guan yu jin yi bu jia kuai min ying jing ji fa zhan ruo gan zheng ce de yi jian), July 1997, available at http://www.ybkj.gov.cn/news/print.asp?newsid=272, accessed May 15, 2010.

65 Information comes from the interviews with the private doctors.

66 The story is compiled from the information get in the interviews, especially the detailed narration of Doctor Tian himself.
would come back to the public hospital. Doctor Tian took out his wife—a gynecological
doctor in the same hospital, and 3 other assistants from the hospital to work in the clinic,
and was responsible for their salaries. The clinic was opened in 1996 as a Chinese
Internal Medicine clinic: Doctor Tian focused on patient treatment, his wife was
responsible for clinic management and saw patients occasionally, one accountant took
charge fees and accounting, two assistants picked and prepared medicine, the clinic
employed two more assistants for nurse work and prescription note taking, sometimes,
there were internship students from medical school work temporarily in the clinic. The
clinic business was so good that the outpatient number in a single year was 40,000, more
than 130 patients per day. At the best time, there were even 220 to 230 patients per day,
and 5 internship students taking the prescription note for Doctor Tian. The good
business lasted less than 3 years till 1998. During the 3 years, a new director of the
county hospital replaced the old one, and began to ask all the contracted-out doctors
return to the public hospital in 1997. However, Doctor Tian and the Hospital Director
could not agree on how to handle the clinic equipments and medicines which cost
Doctor Tian large amount of money from bank loan. Since the 3 year contract has not
finished, Doctor Tian refused to go back to the hospital. Conflict between the hospital
and the clinic lasted for months, the hospital threatened to fire the clinic professionals,
then Doctor Tian and his wife handed their own resignation letters, and were officially
resigned from the hospital in the end of 1998. Since then the health department refused
to give licence to the clinic. Without licence, the medical practices became illegal, and
the clinic had only to be closed in the early 1999. In the following months, Doctor Tian
wrote many letters and reports to government officials, even to the provincial health
department to ask for licence. After months’ appeal and discussion, the local health
department came to a compromised solution: the licence would not be granted to Doctor
Tian’s clinic, but he could apply employment in other health institutions. In the end of
1999, Doctor Tian contracted a clinic within the County Population and Family Planning
Center, an alternative way as employment, paid administration fee for the center and
operated the clinic autonomously there, but with a much smaller scale and fewer patients.
Then in 2001, with the more relaxed policy for private medical practice, Doctor Tian
finally got the licence and moved his clinic out from the center to the current place till
now.

The case indicates once public doctors opened their own clinics, they will be
eliminated from the public system, and there are multiple obstacles during the
operation of their private clinics. On the one hand, the resigned public doctor felt
unfair and questioned “even my students and prentices could get the licence to open
clinic, how I cannot get the licence?” (Interviewee 3), after the open of private clinic,
they intentionally simplify their clinic equipments and decorations to be unobtrusive:
“if our clinic looks poor in the appearance, the health officials will not come to
disturb us so often.” (Interviewee 3) On the other hand, the public officials explained:

Interviewee 8: “Certainly the local government first of all protects the interests of public
hospitals, the famous public doctors have abundant clinical experience and large
numbers of long-term patients, once they move out to open their own private clinics, the business of public hospitals will be negatively affected. In the local city, the patients’ choices are largely determined by doctors, the famous doctors are so few, we do not allow them to open their clinics, even the retired famous doctors are not allowed to open clinics.”

Interviewee 10: “Even though you resigned from public employment and gave up everything, e.g. insurance, welfare, pension…, they (health department) will still prohibit you. You are the famous doctor, if we granted licence to you, the other excellent doctors will also leave the public hospital and ask for licence, famous doctors are scarce and will attract many patients away from public hospitals, interfere with the business of public hospitals, even change the public ownership! Who responsible for this? It’s the state educated you, the hospital trained you, you should not work against the hospital.”

From the statement above, we can see individual professionals’ knowledge and skills are generally regarded as public property, public doctors are regarded as “owned” by public medical facilities. Their education, knowledge and skills have been granted by the state, so doctors can only use their knowledge and skills to serve the state and are not allowed to bargain the latter (Yang Jingqing, 2009). Public health department worries about the “brain-drain” of public medical professionals, and fears private medical practices threaten the work unit’s ownership of medical personnel. Besides, there is always a moral stance against private medical practices that open self-managed private medical facility is deemed as an absence of loyalty to the public institution and a lack of commitment to public duties. Because of these obstacles from public system, setting up private practice is not considered by most public doctors.

On the other hand, the local health office has more relaxed policy to grant the financial unfavorable or surplus health professionals to do private health practices. The local regulatory framework for private clinics is developing, but incomplete. The interpretations of the principle of legislation by public officials play an important role in operation of the regulatory (Jing Fang, 2008). Thus some grey areas are produced for private medical practices.

Interviewee 8: “If we found the retired doctor sit in the pharmacy treat patients (zuotang yisheng) due to the financial reason, we will not prohibit it, the national policy changed in the local city, because we need to protect the local public health institution, as well as give the deprived doctors a way to make living.”

Interviewee 3: “Some people have done health profession for a whole life, they are old, do not have physical ability to do other works, the government still need to grant them, at least give them a way to make living. There are some measures illegal, but reasonable.”

In general, the public health sector is still highly protected in the local setting. Private medical practices are limited to the surplus medical practitioners or low level doctors.
that the public system do not employ, not apply to the public health professionals, particular prohibition is given to the high level public doctors.

5.2.2 Medical Accidents and Professional Ethics

Private clinic, in general, is considered poorly in its sanitation condition, low quality medicine, over-prescription and treatment without long term health consideration etc. The low quality health care in private clinics could easily lead to medical accidents. One month before the fieldwork, a medical accident happened in a private clinic of S city which aroused wildly discussion. All the interviewees have mentioned about the accidents and expressed their opinions about this case:

A Death in Private Clinic

The private clinic is opened by Doctor Cai, a 65 years old woman, who specializes in gynecology. She worked in the district hospital for decades until the hospital was sold to private practitioner. Then she opened the current private clinic in the city in 1990s. The clinic has been operated for more than ten years. Two assistants—her daughter-in-law (35 years old) and the sister of her daughter-in-law (about 30 years old) work in the clinic, and learn the gynecological surgery form Doctor Cai. Sometimes, the two family assistants practise the operations on patients although they do not have any licence or certificate. One day, a young woman came to an abortion. The two assistants did the surgery as usual under the direction of Doctor Cai and finished the operation smoothly. Then they told the patient to have a rest, and walked out. Half hour later, when they came to check the patient, the woman had already died. Acknowledged the severe consequence of the accident, the doctor and her assistants quickly closed the clinic, called the local health department and the police. Soon all the family and relatives of the dead (almost 20 persons) came to the health department ask for compensation, the doctor was separated in the police office to avoid violence from the victim’s family. After several days’ dispute and negotiation, the doctor agreed to compensate the victim’s family with 350,000 Yuan, which was enough to buy a house and a car in the local consumption level, and was the highest medical compensation in the history of the city. Although later autopsy showed the death was attributed to the complication from the use of anaesthetic—lobar pneumonia, the disease the victim originally has, not directly related with the surgery practice, the doctor still had to take the full responsibility due to the use of unlicensed assistants.

From this case, we can see private clinic has many potential risks: the use of unlicensed professional, the simple equipments, the inability of beforehand test, the incomplete consideration and preparation, etc. As one of the health administrators indicated:

Interviewee 9: “The (private) doctors do not care about the dosage of medicine. To

67 This health accident case comes from the narration by interviewees, almost all the interviewees have talked about the accident in the interviews.
attract patients and make profits, private doctor often overdoses medicine to make the treatment take effects in a very short time, but for the long run, it is not good for people’s health.”

The case also shows the high risks of the profession as private doctors. Especially these days, with the wildly use of media, the increasing values toward personal life, and the improvement of the legal system, private doctors need to take full responsibility of their medical practices, and have danger to be sued or hurt by patients since people incline to regard death or accident as the failure or mistake of private doctors.

After the accident, the local health department gave even closer monitor on private clinics. Five years ago, there was no accident insurance for the private clinic, and any medical incident may result in the loss of business. In recent years, the professional indemnity insurance has been gradually established in the city, the health department encourages every private clinic to buy the insurance which could compensate the clinic up to 100,000 Yuan in case medical accident. With the insurance, private doctors are more secured now, but still doctors have large pressure and responsibility for risks, such as the case above, the doctor need repay the victim for 350,000 Yuan, even with the compensation from insurance, the majority burden still lies on the private doctor alone. To reduce the risk of medical accidents, private doctors are particularly prudent. They refuse to see the severe cases, and suggest patients go to big hospitals once patient’s condition deteriorates.

Interviewee 5: “Hospitals are big and strong to face the risks, but we private clinics do not have any protection if involved in medical dispute or accident. Some patients do not tell us fully about their illness history, if we prescribed the medicine and triggered their old diseases, they also come to argue with us. The big hospitals have high tech equipment, so they always require patients to take physical examination before treatment. We private doctors could only be very careful.”

Interviewee 2: “Medical accidents could easily happen in private clinics. So I do not accept the really server cases. I can not cover all the disease, once the patient’s condition deteriorate or I am incapable to cure the disease, I will suggest them go to the hospital. We do not have emergency rescue equipments like oxygen apparatus, which are too expensive to buy. Our private doctors need to be particularly cautious, once accident happen, we will be in prison.”

Because of the scare toward accidents and risks, private doctors face dilemma on their medical ethics: they focus on small and safe disease, are reluctant to try their best to cure the difficult cases, although the doctor professionalism requires them to best alleviate the patients’ problems.

68 Information comes from the interview with private doctors and public professionals.
Interviewee 3: “When I was young (work as ‘barefoot doctor’ and later in public hospital), my only idea was to relieve patient’s pain and cure the disease. I tried various ways and used variety of methods till the patient became better, at that time, I did solve many difficult cases, cured some rare illnesses. Now, I am a private doctor, and will retire soon, I need to be cautious in balancing cure disease and safety. I could not care only about illness treatment.”

Traditionally, the Confucian philosophy influenced on the Chinese medical ethics with the encouragement of love and benevolence—doctors show love for their patients by healing them, neither disrespecting nor causing harm to the patients and treating patients equally regardless of wealth or social status. The national Doctor Professional Ethic Criterion combines the traditional ideas, indicates Chinese medical professionals must follow seven basic rules: use all means available to help the dying and wounded; treat all patients equally; behave politely; practice medicine with honesty; protect patient’s privacy; work collaboratively with colleagues; and constantly work on improving medical skills. But, for several generations of Chinese physicians since 1949, loyalty to the state and communist ideology replaced professionalism as an ethical framework (Lim Meng-Kin et al., 2004a). But now with the breakup of public system and the marketisation process, private doctors face moral crisis with the loss in both the communist ideology and traditional ethics. In the local city, in spite of the profit incentive of private clinics, most of the old traditional Chinese medicine doctors still hold the traditional ethic of professionalism. Particularly in the acquaint society of the small city, citizens are familiar with different doctors, fraud behavior could not last long.

Interviewee 2: “We should be honest and polite to patients. If I promised to cure every disease, but failed to treat the patient, it will ruin my reputation, the business can not last long.” “Traditionally we say there are three kinds of patients: the rich ones, the poor ones, and the cheaters. The rich ones come for treatment and pay us full fees; the cheaters come for one or two times without payment, but are afraid to come again; the poor ones usually own some debts in the clinic, if not repay the debts, they will feel too embarrassed to come again. No matter what kind of patients come, we need to treat them all, as my older generation told me, doctor—save society, live people (ji shi huo ren).”

But for the younger private doctors, the easily distortions of the incentive to make money may lead to random medical charge and unregulated medical behaviors. In the market economy, an ethic of professionalism is essential to ensure private doctors protect the interests of patients, provide care of reasonable quality, use safe and

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71 Here I combine the information of the seven medical ethic rules from both footnote 69 and 70 to give an accurate translation.
72 The doctor’s father is also a traditional Chinese medicine doctor who died in 1985.
appropriate drugs, and avoid fraud behavior etc. Consider there is a lack of professional self-regulation under the great social change, doctor ethics should be rebuilt, and the medical professionalism should be strengthened. Future regulation or legal system should also be constructed on doctor legitimate behavior, and legal organization should be encouraged to protect the interests of both private patients and private doctors.

5.2.3 Challenges—New Health Reform

Now thirty years have past since the open policy in 1979, China has gained great achievement in economy, but also faced the challenge of market and the growing public health inequalities. To reduce disparities and increase equality, the government has set up to regain its responsibility in health supply. In the early 2009, the state officially launched a new round national health reform aimed to achieve universal coverage of primary health services by 2020. As an indicator of government commitment, 850 billion Yuan (US$125 billion) has been budgeted over the next 3 years to support the reform, an increase of public financing for health by about a third. The reform has four components: medical insurance, public health, service delivery and essential drugs, within which the rebuild of public health system and the new health insurance scheme could possibly take new challenges to the development of grass-rooting private clinics.

In the health reform, health care in the primary level is put as a priority, special emphases have been made to improve the basis of community health care services—the building of the urban and rural community health care service network with community health centers as the main body, and funding to grassroots health services has been improved. In small cities at the county level like S, the community health system has never been constructed before, the basic health care was mainly provided by private clinics. But now the city enlarged and population increased under the ongoing urbanization process, S city also planned to build the community health station that aimed at minor and chronic disease. As early as 2008, the local health department has embarked on the building of its community health system. The development of urban community health care has been accelerated, the township hospitals and village health station has been gradually rebuilt, and the public institutions began to recruit the previous disbanded doctors, some of whom have operated as private doctors. The local health department indicated minor diseases would be taken by community health system, severe diseases for upper-level hospitals, illness recovery and chronic rehabilitation go back to community care (xiao bing dao she qu, da bing jin yi yuan, kang fu hui she qu). The objective of community health

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75 S County Health Department Report, ‘The Arrangement Planning of Community Health Institution in the
system is precisely what the private clinics currently aim at. Under this arrangement, the public health service will be improved at grassroots level, and private clinics face new challenge and competition from the public system.

In addition, the new health insurance reform had begun several years ago, trying to expand health insurance to the formerly uninsured majority. In rural areas, the New Cooperative Medical Scheme started from 2003 offers subsidized basic insurance which has already covered 89.7% of the rural population up to 2008, the Urban Employees’ Basic Health Insurance designed for urban employees covered 44.2% of urban employees, and the Urban Residents’ Schemes for urban unemployed covered 12.5% of urban unemployed residents (Weiwei Xu & Wynand P.M.M. van de Ven, 2009). Besides, there is the Medicaid system for urban and rural poor people. The funding level will also be raised with government allocation increased to 120 Yuan per head in 2010 (Zhu Chen, 2009). The new health care reform intends to reach 90% health insurance coverage by the end of 2010 and universal coverage of essential health-care by 2020. Although the out-of-pocket payments still constitute the majority of growing health expenditure, the extending insurance coverage could possibly influence the private health sector since the insurance is only applied to the public health services. If people seek health care in the private sector, they will not be refunded. Currently in the new Cooperative Medical Scheme, each rural resident pays only 20 Yuan per year for the premiums (the other majority will be subsidized by government), when they are hospitalized, they will be refunded approximately half of the medical fees. The patient number of public hospitals has increased dramatically since the implementation of the new health insurance, while the business of some private clinics has been negatively influenced.

Interviewee 11: “Now the new health insurance system has been implemented for two years, the insurance networking has been installed in our hospital (the county Hospital of Traditional Chinese Medicine), our patients increased dramatically. Two years ago, our inpatient number was about 200 per day, now it is more than 300, the outpatient number is even bigger because the outpatient fee is also partially covered by insurance from now on. These new measures are good for our hospitals, although the purpose of these measures is to make the health care more accessible for the public.”

Interviewee 3: “After the implementation of the new health insurance system, the hospital outpatient numbers have increased 30-40%, but the businesses of private clinics near hospitals are not as good as before. In this continuing change course with more insurance coverage, private clinics are left to live or die on their own; some private clinics will certainly close down by themselves.”

Interviewee 12: “Patients in our hospital (the Maternal and Child Health Hospital) have

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increased 30% to 50%. Before that even doctor persuaded the patients to be hospitalized, some patients would refuse, now their fees could be largely covered by the insurance, they would like to be better cured through hospitalization.”

Unlike public hospitals in the big cities that are over crowded by patients, public hospitals of the small city are not difficult to get access. Even these days with the quick increase in patient number, the county hospitals still have the ability to accept all the patients although patients need to wait sometimes. The two county hospitals are in continuing expansion which could hopefully accept even more patients in the coming years. Facing intense competition from the public health sector, many private doctors worry about their future. But some private doctors are very optimistic, they think there are always patients with small illnesses would like come to the hand-reaching private clinics, especially when the minor diseases cost little and are not covered by health insurance (the insurance emphasizes on payment for catastrophic illnesses), and some private doctors, in particular the traditional ones, usually have certain special skills that public doctors do not have.

Interviewee 2: “As long as you have speciality, people will always come. Some people would rather pay by themselves if only the doctor cured the disease. The western medication is not good at some illnesses compared with our traditional way, sometimes the patients got infusion from hospital for half month, all kinds of tests have been done, large amounts of money have been cost, but the sickness still not turn better, then they come to my clinic take two sets of herb medicines.”

Interviewee 5: “He (patient) is not cured in the public institution, he will still come to the private clinic have a try. Patients choose this doctor because they have confidence and belief on the doctor’s skill, no matter public or private.”

For the good and qualified private doctors and the ones with special skills, their clinics are popular in the market, and they are not scared about the new changes:

Interviewee 3: “For us (doctor and his wife), we have medical skills, never worry about patient (number). Sometimes we even hope there could be fewer patients in order to have more free time. We are too busy in the whole year to enjoy life.”

Interviewee 2: “Different clinics have different way to make profits, each doctor has his/her own speciality and character, and each one has his/her friends and acquaintance circles (potential patients), they can always find a solution.”

Overall, the expansion of public health service and insurance coverage does take some challenges to private clinics, particularly to the unqualified ones. However, to the good private doctors, the challenges would not deteriorate their business. The increasing health needs always require private medical practices.
Chapter 6: Discussion and Conclusion

After three decades reform, health sector in China has experienced fundamental change. What the Chinese experience suggests for the health care provision? This chapter discusses the implicated problems related with privatisation, and summarizes the major lessons that can be learned from the empirical experience of the local city.

6.1 Reflection and Discussion

With the privatisation process since 1980s, many prior barefoot doctors or prior public health professionals transferred to private health professionals. Most of them specialize in Traditional Chinese Medicine and are regarded unemployable in the current public system. But with their cheaper medical charge, convenient health care, good service attitude and effort to accumulate patients’ trust, private doctors become welcomed in the local city. The private clinics accept large numbers of people, especially the financial unfavorable and uninsured patients. However, private clinics also face many problems and challenges in their operation: fierce competition, various fees to pay, uninsured private doctors, conflicts with public administration, medical accidents, professional ethics and challenges from new health care reform that aggravate the unequal competition with public health institutions, etc. Some private clinic doctors express worries about their future development, however, for the qualified private doctors particularly the ones with specialities, they are confident about their clinics and optimistic to the ever-extending free market. With the increasing operation of private clinics, privatisation related issues about health equality/inequality and the role of state/market need special attention.

Equality and Inequality

In the early years, universal access to health care was a top priority in China, since 1980s the shift toward the marked-oriented system has meant the demise of guaranteed health care access. The commercial orientation of the health sector on the supply-side and lack of health insurance coverage on the demand-side lead to significant disparities in health care. The deprived and uninsured residents may not be able to pay for health services. The radical privatisation of health care system in both upper level hospital and lower level community care all together brought to the rising inequality and carried enormous risks for the health of citizens.

For private clinics, as the grassroots health facilities, they take up the role of the dismantled public community health care in the basic level of the three-tired Chinese health hierarchy. The primary health care in private clinics, on one side provides as a complement for the un-covered area of public health care to the comparative poor or marginalized population. Its potential side effects or problems in view of the medical
quality and safety lead to the stratification of health service: poor health services serve deprived patients. On the other hand, empirical evidence in the local city shows that the private medical practices supply the lower level doctor a way to make living, at the same time, satisfy the health care needs of the marginalized population, at least give them a way to access health care, or else they may have no place to go once get sick. From this perspective, the private clinics in fact increase the accessibility of health care services and reduce the inequality.

It is unreasonable to simply correlate all private health care with inequality in China, but consider different health services differently. Broadly speaking, the health sector privatisation as a whole that lead to increased out-of-pocket payment and reduced insurance coverage dose accelerate the inequality, particularly for the access to upper level public hospital care. But at the lower level, the privatisation of primary health care largely reduces the pressure of public sector, and increases the accessibility of health care services, hence instead increases inequality, it promotes more equal health accesses.

**State and Market**

Successful transition requires a balanced government role. Before 1980s, the state took all the responsible to supply health care for its citizen, after 1980s, the state tries to reduce its role and rely on the market to allocate health services. Privatisation as a way to compensate the increasing needs in 1980s, and as a gradual retreat of the state in service provision in 1990s, redefines the roles of the state and market—the redistribution of task and social responsibility in health provision from state to market. Civil society like health related NGOs is still under-developed in China, so health care is generally supplied by the state and market. Government policy aims at promoting a partnership between the public and private health care sectors, and state’s role has been greatly undermined.

But the government is still hesitant about whether medical service and the medical work force should be completely marketised or freely privatised (Yang Jingqing, 2006b). One the one hand, the market requires the free allocation of health resources, the state tries to mobilize more resources for expanding the health sector which imply a rise in private health service. On the other hand, the communist government hesitates to totally open the health market which supply unfavorable condition for private health practices. The local government of S county has long facing the dilemma between market reform and public management. In their published report, it denotes once the government tighten the administration, the health institutions would be over-restricted without efficiency; but if loosen the restriction, private health sector tends to proliferate randomly out of control (yi guan jiu si, yi fang jiu luan)77. Currently, instead totally relying on the market to allocate medical resource, the

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77 Protected Reference.
government still prioritises resources into public sphere. The best doctors stay in the public sector, the surplus and lower level doctors could go into private sphere.

But in view of China’s sheer size of population, regional health disparity, and diversifying health needs, health care is necessary to combine both private and public provision. Especially for primary health care, the privatisation has made significant inroads in its delivery. Since neither market nor state alone could cover all the health care problems, we need a new balance in state-market contribution—the market to promote efficiency and the state to secure equality. In the new health reform, it also intends to work out a multi-source health investment mechanism and a balanced development with the government playing the dominant role. And recently, there is a gradual acceptance by the public that health professional knowledge and skills are private property, not public owned. In 2002, the Ministry of Health released the “Development Outline for Health Human Resources in 2001 to 2015”, indicating the transfer of public medical professionals from work unit persons to social persons by 2015. The report suggested a form of regulated, full privatisation of professional knowledge and skills which may be developed in the coming future. Later public concern and academic research give hot discussion on turning doctors into “independent professionals” (zi you zhi ye zhe) or “liberal doctors” (zi you yi sheng) (Yang Jingqing, 2006b). In the longer term, the grip of the state will further relax and more freedom will be given to health professionals and private medical practices, which could hopefully promote more dynamics to the Chinese health care sector.

6.2 Conclusion—the Chinese Experience of Health Care Privatisation

Since 1949, China has experienced momentous changes in the health sector from most private services to all public ones, and to increasing private health care these days, along with the political, economic and social transformation. The current privatisation process since 1980s is still in progress, and private medical practices have been more and more prevalent in the country. In the county S, over the last 30 years, private health care has greatly increased: in health service provision, the primary health care in both rural and urban areas has been largely privatised while the public insurance services have been greatly reduced; in health financing, the decreased state and collective funding in health sector has lead to increased private investment and out-of-pocket payment; and in the policy aspect, the public policies tend to relax regulation on the private medical practices, grand licence to the qualified health institutions and qualified doctors while strictly regulate the illegal medical practices and public health professionals. In general, there is a shrinking role of the state, and rapidly enhancing role of the private health care in the local county.

Research in S city shows the private clinics develop to occupy market niches that ignored and underdeveloped by the public sector. The privatised primary health care operated by the lower level or surplus health professionals, as a complement to the public system, is used mainly by the comparative poor people, leads to improved performance of local health services in terms of cost, equity, and accessibility. Private primary health care in the small cities plays an important component in health care system, and contributes to a better access to health service. On the other hand, the experience of S county illustrates a need for caution in developing private clinics considering its potential side effects and problems in service quality, safety, medical ethic etc. in the incomplete legislated market. Overall, the privatisation of primary health care by private clinics supplies as an accessible alternative way for health services, although the radical privatisation of all health sectors undermines the accessibility and quality of health services in general.

In the operation of private clinics in the local city, there are many unfavorable conditions: the fierce competition with both public and private health institutions, the various fees pay for the health administration offices, the uncovered insurance for private doctors, the conflicts between private medical practice and public policy, and multiple challenges from new health care reform, etc. The local health department adjusted national policies into the local context with much stricter regulation to forbid the public doctors open private clinics while give more relaxed environment for lower level or surplus health professionals. The public health sector is still dominant and highly protected in the local setting.

Now China is at the crossroads in transforming its health care system in order to make it more effective, efficient, and accountable. The experience in S county provides that it seems plausible to privatise the primary health care in the small cities. The small cities at the county level are the connection between the urban and rural areas with big health care demands from both rural and urban residents; at the same time, the health resources in the small cities are generally scarce compared with bigger cities although most of the county resources are concentrated there. Private clinics could play a significant role in prevention and primary care in these small cities. Based on the analysis above, I argue instead of forbidding the private clinics, policy should deal with the problems related with private clinics, consider how to better operate, support and administer the private clinics to improve its services, make it better play the role in reducing the burden of public sector and increasing health accessibility. The government should continue to open the market, allow doctor to freely work in different institutions or choose from public to private, and give more free space for qualified private medical practices. Currently, the private sector is still small in terms of the scale of services it provides, and is yet to form a mature market, and there are multiple challenges for its further development. However, it can be expected that the private sector in the health care area will expand rapidly as income rises and consumer demand for health services increases and diversifies. Now under the new health reform, China could hopefully find a suitable way of public/private mix and a
balanced and shared role of the state/market that best fits to the Chinese society.

6.3 Significance and Future Implication

Research Motivation and Significance

Privatisation is an important issue in health care analysis. The inquiry into private clinic health care is crucial for both academic work and policy practice. Academically, private health care in China, particularly private clinics have seldom gone into the sphere of social science research. At present, there is little literature regarding privatisation of health care clinics in China. The past researches on private health sector are mostly abstract, draw data from media and literature, the firm empirical information is hard to find. The strength of this research is the empirical study of privatisation of clinic health care in a specific city. The empirical investigation could unveil facets that can be otherwise diluted in the general and abstract researches. Hopefully this can give a more accurate picture of private clinics’ operation in the local setting, and from this small spot to see the general trend and shed lights on the further research of private health care and private clinics in the transitional Chinese society.

Practically, research into the privatisation of health care in China could contribute in figuring how to make health services available for the whole society. Especially the study about health care in private clinics, which are one of the main sources of health care for disadvantaged groups, could enlighten on the reduction of health inequality and promotion of health accessibility. Besides, with the more open policies, the number of private clinics as well as private health service is expected to continually expand and becomes more prevalent. And as the income rises and consumer demand diversifies, the private sector also has tendency to expand toward the upper level. The evidence-based information about private clinics health care could give some illuminations on the development of other private clinics and the growth of private health service, since there are many problems and criticisms concerning “black clinics” and private medical practitioners these days. Moreover, the study on the privatisation of health care in transitional China could be of considerable interest to understand how health care changes during the course of economic transition. The Chinese experience could hopefully illuminate other developing countries that also experience rapid transition.

Limitation and Shortage

Due to the scarcity of past research and the unfavorable position of private clinics in the health sector, there are paucity of detailed records, specific definition and clear categorization of private clinics. In the local health reports, the data about private health care (such as number of private practitioners, private doctors, and private clinics) are inconsistent with each other, probably caused by the misclassification of
types and levels of data; some of the unofficially operated clinics and private practices are not counted in the government data. Hence, there is a potential underestimation of the size of private sector. Besides, there are many possible useful data I could not get access to, such as the local insurance coverage and financing on health sectors. The lack of accurate data and clear information is a constraint on the analysis.

Another limitation of the research arises from the choosing of research object—private clinics. Due to the sensitivity of private problems, many private clinic doctor refused for interview, the 5 private clinics in the city were not randomly choosing, but accessed through the social networks. Although private clinics in the local county are similar with each other in many ways, the 5 chosen clinics could possibly not cover all the characters of private clinic health care in the city.

The transcriptions of the interviews may also pose as a limitation, since the translation of the interviews from Chinese (Sichuan Dialect) to English with my limited words, may not be accurate enough to show the original meanings and tones of the interviewees.

**Future Implication**

After decades of uncertainty and instability that made the formal studies about private health care difficulty, the privatisation of health care is becoming an increasingly attractive academic topic. This research departs from the perspective of health care provider/health institution; further exploration could be done from the dimension of health care receiver—the patients: how they think about private health care? How the privatisation of health care impact on people’s health and well being? Besides, the increased mobility of population in China, millions of migrants move from rural areas to big cities seeking for jobs. Usually they do not have medical insurance, and rely on private sector for health care, particularly the private clinics, which usually pose some problems concerned with fraudulent activities. How the private clinic health care operates in big cities? How it relates with the health care of millions migrants? The increased mobility of population requires a more flexible health system, hence it will be meaningful to further research on the private health care in big cities.

In addition, the retreat of the state has aggravated significant regional (eastern/western), rural/urban and social class (rich/poor) disparities in health care. How the privatisation of primary health care in particular, relates with the health equality/inequality in the regional, rural/urban and social class scopes? The current and potential position and contribution of private health provision in improving health can be better understand only if it is seen in a broad context of political, economic, and social forces. And the idea of the need of “rebuilding doctor’s ethics” as an outcome of greater social changes, as well as the agency of the private doctors themselves, is a topic that could be further developed. The transformations of the communist ideology and the tensions with the market-led-thinking could be a fascinating topic. Moreover, the changing doctor identity from “public professionals”
whose knowledge and skills are “state owned” to more private doctors with individual and independent practices and fully freedom, could also be interesting to future discuss. In a world, I hope this small research could stimulate more interesting and deeper enquiries into the transforming health care of the Chinese society.
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Protected Reference

Foot Note 19

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## Appendixes

### Appendix 1: Basic Information of Interviewees

#### Private Doctor in City

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Profession</th>
<th>Clinic Type</th>
<th>Date</th>
<th>Location</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Doctor Wu1</td>
<td>48</td>
<td>Male</td>
<td>Internal</td>
<td>Chinese medicine clinic</td>
<td>August 14, 2009</td>
<td>At Doctor Wu1’s Clinic</td>
<td>Both Doctor Wu and his wife were in the interview context, his wife expressed her idea occasionally.</td>
</tr>
<tr>
<td>2</td>
<td>Doctor Huang</td>
<td>57</td>
<td>Male</td>
<td>Internal</td>
<td>Chinese medicine clinic</td>
<td>August 16, 2009</td>
<td>At Doctor Huang’s Clinic</td>
<td>Interview was responded by Doctor Huang alone, although Doctor Huang’s son and two patients were in the context.</td>
</tr>
<tr>
<td>3</td>
<td>Doctor Tian</td>
<td>61</td>
<td>Male</td>
<td>Internal</td>
<td>Chinese medicine clinic</td>
<td>August 19, 2009/August 21, 2009</td>
<td>On the Doctor Tian’s way back home</td>
<td>Doctor Tian was very busy, the only free time for interview was the time he walk back home, interview was taken in two days on his way back home, and was responded by Doctor Tian alone.</td>
</tr>
<tr>
<td>4</td>
<td>Doctor Yang</td>
<td>60</td>
<td>Male</td>
<td>Internal</td>
<td>Chinese medicine clinic</td>
<td>August 20, 2009</td>
<td>At Doctor Yang’s Clinic</td>
<td>Interview was responded by Doctor Yang alone, while two people were beside—one patient was there taking an intravenous injection and chatting with her friend.</td>
</tr>
<tr>
<td>5</td>
<td>Doctor Liu</td>
<td>35</td>
<td>Male</td>
<td>Internal</td>
<td>Western medicine clinic</td>
<td>August 20, 2009</td>
<td>At Doctor Liu’s Clinic</td>
<td>Interview was responded by Doctor Liu alone without anyone around.</td>
</tr>
</tbody>
</table>

#### Private Doctor in Village

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Profession</th>
<th>Clinic Type</th>
<th>Date</th>
<th>Location</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Doctor Wu2</td>
<td>58</td>
<td>Male</td>
<td>Internal</td>
<td>Chinese</td>
<td>August 15, 2009</td>
<td>At Doctor Wu2’s Clinic</td>
<td>Doctor Wu2, his wife and a patient were in</td>
</tr>
</tbody>
</table>

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80 To protect the privacy of interviewees, the names of the doctors are shown only with their family names in order to refer them in the thesis, and the public health officers and staffs are anonymous. It is necessary to indicate here that a specific family name is widely used by many people in China, and is normally used together with people’s profession, for example there are two Doctor Wu in the interviewed 7 private doctors, hence it is impossible to recognize the person from their family names, which is different from the Western countries that family name is more easy to identify people.
<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Place of Interview</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Western Internal medicine clinic</td>
<td>Doctor Du Female, Age 48 Western Internal medicine clinic August 16, 2009 At Doctor Du's Clinic Interview was responded by Doctor Du alone, during the interview, two patients came to ask for medicine.</td>
</tr>
<tr>
<td>8</td>
<td>Officer in the Local Health Department Male, 45</td>
<td>Officer in the Local Health Department Male, 45 August 19, 2009 At the Officer’s Bureau Interview was responded by the Officer alone, radio recording was prohibited, interview was taken by hand and memory recalling.</td>
</tr>
<tr>
<td>9</td>
<td>Staff of the People’s Hospital who is also a teacher in the Local Medical School Female, 49</td>
<td>Staff of the People’s Hospital who is also a teacher in the Local Medical School Female, 49 August 21, 2009 At the Office of the Local Medical School Interview was responded by the staff/teacher alone without any disturbance.</td>
</tr>
<tr>
<td>10</td>
<td>Staff of the local Center for Disease Control and Prevention Male, 52</td>
<td>Staff of the local Center for Disease Control and Prevention Male, 52 August 23, 2009 At the Interviewee’s Home Interview was responded by the staff alone without any disturbance.</td>
</tr>
<tr>
<td>11</td>
<td>Administrator of the Hospital of Traditional Chinese Medicine Male, 26</td>
<td>Administrator of the Hospital of Traditional Chinese Medicine Male, 26 August 24, 2009 At the Office of the Hospital of Traditional Chinese Medicine Interview was mainly responded by the administrator, during the interview, some patients came for health insurance reimbursement certificate and expressed their ideas.</td>
</tr>
<tr>
<td>12</td>
<td>Doctor of the Maternal and Child Health Hospital Female, 42</td>
<td>Doctor of the Maternal and Child Health Hospital Female, 42 August 24, 2009 At the resting room of the Maternal and Child Health Hospital Interview was responded mainly by this doctor while another doctor worked by and joined in the interview occasionally.</td>
</tr>
</tbody>
</table>
Appendix 2: Interview Guide

I. Background Information of Interviewee

1. Age:
2. Gender:
3. Education Level:
4. Occupation:
5. Insurance (Yes/No):

II. Interview Questions:

1. General Condition about Private Clinics
   (1) The general condition of this private clinic/private clinics in the city (size, type, equipment, bed number, outpatient number etc)
   (2) What kind of diseases, what kind of patients?
2. Privatisation Process
   (1) The developing history of the individual private clinics
   (2) The personal history of the private doctors/staffs (where you got your medical training? how about your past work experience? why you choose to open or work in private clinics? etc.)
3. Perceptions of the private health work and perceptions toward the health care transition
   (1) How you (Chinese private health professional) feel about your profession as a private doctor/professional? How you think about your work, your clinic and the private health services?
   (2) Why patients come to your clinic? Why patients choose your services?
   (3) How you think about the local health regulations? The health administration institution?
   (4) What you think of the present Chinese health care system, the change in health care, the existence and development of public and private health institutions in the city, etc?
   (5) Do you have any idea about the future development of private health sector/private clinics, e.g. risks, challenges and new trends etc?

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This interview guide is for private clinic doctors; I used similar questions in interviewing public health professionals by changing the questions accordingly.