Governing Informal Payments by Market in the Chinese Healthcare System

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Introduction

Informal payments refer to cash or in-kind contributions that patients give to doctors beyond formal payments in the course of seeking medical services in predominantly public health institutions. The practice is endemic in many developing countries, and is particularly widespread in former and current socialist countries in Asia and Central and Eastern Europe (Lewis 2010) where informal economies have existed for decades (Morris and Polese 2015). Given their nature of secrecy and informality, they are considered illegal or at least illegitimate, and thus have become a major concern of health authorities in these countries. China is one of those countries undergoing market transition, although it remains a socialist state, at least in name. While its market reform has been largely successful and commendable in other sectors, its market-based health reform has been predominantly a failure acknowledged even by the authorities (Ge and Gong 2007). A main adverse outcome of the health reform is the prevalence of informal economies, of which informal payment is a major component. The Chinese government has made long-term and persistent efforts to

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contain the practice. Apart from resorting to a hierarchical regulatory structure, it has made even greater efforts to establish a market model to lift the efficiency of healthcare and the morale of health professionals, and has introduced some particular market-based mechanisms to curb informal economies. But the result is apparently not satisfactory.

This chapter aims to evaluate the governance of informal payments through market mechanisms in the Chinese healthcare system, analyzing why the market is unlikely to be a feasible solution to the problem.

Informal payments, which are called red packets (*hongbao*) in Chinese, emerged in the late 1980s, and have since become increasingly widespread. Today, the practice of giving red packets to doctors has become a deep-rooted social norm for hospitalized patients. An investigation conducted between 2008 and 2009 in ten cities surveyed 4,000 patients who had been hospitalized in recent years. The results showed that 54.4 % of them gave red packets to doctors (Kong et al. 2011). Almost everyone who received operations gave red packets to their surgeons. Only 4.7 % of patients gave their red packets as a token of gratitude. Over 95 % of them were motivated for reasons other than gratitude. The study thus concluded that giving red packets had become a "latent norm" and "a rule of the profession", although 73.5 % of patients believed it was not right for doctors to take red packets from them. Other studies also confirm that informal payment has been so ubiquitous that it has become a social norm (Bork et al. 2011; Eggleston and Yip 2004; Hong 2012; Huang 2004; Lu et al. 2010; Zhou and Zhang 2004).

Given the prevalence of informal payments and other forms of misconduct in the healthcare system, there is little wonder the government has been under constant criticism for not doing enough, in spite of the fact that it has always taken a firm stance against misconduct and has made tremendous governance efforts to contain this in the healthcare system since the early 1990s. Generally speaking, two models of governance have been employed. One is usually termed as "government" in which the power and control is hierarchically exercised from the top down (Kjær 2004). The other is the market, in which the governance of informal payments is exercised through market-based mechanisms. Accordingly, criticisms have concentrated on two aspects: hierarchical regulation and marketization.

In terms of hierarchical governance, scholars almost unanimously call for the government to step up its efforts to strengthen regulatory and supervisory devices and institutions to control informal economies in hospitals. But, as I have pointed out elsewhere (Yang 2015), the criticism is largely misplaced. There is ample evidence that the party-state has put

in tremendous efforts, mobilized considerable resources from both the Chinese Communist Party (CCP) and the government and established complicated and omnipresent hierarchical governing structures to regulate and redress medical misconduct. The problems which have led to the poor performance and outcomes of the party-state's regulation lie less in its regulatory efforts than in the flaws in the institutional design of the hierarchical governance.

Throughout the reform era, however, the Chinese government and health authority, aligning health reform with the market-oriented economic reform that has dominated the transition inaugurated in the late 1970s, have favored market more than hierarchy as a governance solution to informal economies in the healthcare system. As Wang Shaoguang notes, the Chinese government has a superstitious belief in the almighty power of economic growth and the market, embracing them as the elixir for social and political problems (Wang 2003). But scholars are divided on whether the market is a culprit or a solution for informal payments. One opinion blames marketization for some endemic problems that haunt the Chinese healthcare system today. Blumenthal and Hsiao (2015), critics of healthcare marketization in China, note that since 1984, the Chinese healthcare system has undergone three major stages of reform. During the stage between 1984 and 2003, the healthcare system experienced drastic free market reforms featuring the retreat of the state from financing public health insurance and facilities, decentralization and privatization, leading to widespread public outcries and discontent. From 2003, the government introduced some modest insurance schemes to cover rural populations and urban employees in the private sector and unemployed residents, but these schemes were not successful as the party-state was reluctant to make significant financial commitment to healthcare. In the latest, ongoing round of reform starting from 2008, the government, realizing the drawbacks of a healthcare system based on market principles, attempted to abandon market-oriented incentives and commit to "providing affordable basic healthcare for all Chinese people by 2020" (Blumenthal and Hsiao 2015, p. 1283). But hospitals resisted the reform efforts, forcing the government to continue to rely on market mechanisms.

Informal payments are believed to have emerged in the context of market-based health reforms. Since for-profit activities are encouraged and incentivized, medical professionals naturally take advantage of their dominating market position in their relationship with patients and maximize their personal gains. As salaries for medical professionals are controlled by

the state and are set at a low level, a black market has emerged in which doctors receive informal extra payments from patients to compensate their low incomes (Bork et al. 2011; Cao 2010; Chen 2006a; Xu 2006; Zhou and Zhang 2004). As a result, the scholars of this view advocate that the state must be brought back to dominate the organization and delivery of healthcare—only thus can problems and corruption in the system be solved (Ge and Gong 2007; Li 2005; Xu 2006). However, these scholars usually overlook the fact that the state has always been heavily involved, especially in the hierarchy that governs illegitimate economic behaviors of practitioners in public hospitals, but corruption and misconduct are nonetheless endemic. The theory is also weak in explaining why informal payments have to be transacted in a "black" market if the healthcare system has been marketized.

The above view has been vehemently challenged by scholars who argue that blaming the failure of health reform on "marketization" is unwarranted, as no genuine market has ever been established in the healthcare system; or the so-called "market" has been so underdeveloped or heavily intervened in by the state that it can hardly be considered as a market (Fan 2010; Gu et al. 2006; Wong 2010; Wu 2007; Chen 2006b; Zhou 2008). In spite of the fact that public hospitals receive barely any funding from the government and rely predominantly on patients' out-of-pocket payments to survive, they operate in a "market" that is largely closed to private competitors and their market monopoly is heavily protected by the state. Scholars of this view believe that this closed and underdeveloped "market", coupled with excessive regulation in some areas, such as salaries of public doctors and prices for basic services, and insufficient regulation and supervision in other areas, such as pharmaceutical products and highly decentralized hospital management, is the origin of the problems and corruptions that haunt the healthcare system. In other words, they do not believe that genuine marketization would have allowed these problems. It is the state, they argue, that is the culprit. As a result, they claim that a genuine, well-governed healthcare market is the solution to healthcare problems, including informal payments. Some scholars explicitly propose competition (Fan 2010; Peng 2004; Wang and Kuai 2008) and differential pricing (Kong 2004; Lu 2011; Wang 1998; Wang and Kuai 2008; Chen 2006b) as the appropriate market mechanisms to weed out informal payments and other misconduct in public hospitals.

Scholars of this view have demonstrated a better understanding of what the market is, to what extent the Chinese healthcare system has been marketized, and what negative roles the government has played in what

they believe is a process of pseudo-marketization. But the solutions they propose may not be the right answer to the problems. Market-based competition and differential pricing have long been implemented in the public healthcare system to boost efficiency and morale, and to fight informal payments. The outcomes of these methods, however, are far from satisfactory. Advocates for market solutions are yet to answer why market elements have failed to produce the intended results.

It is true that the health "market" in China is excessively regulated and closed to private providers of medical services, and is thus highly underdeveloped. Meanwhile, it is also evident that healthcare is highly commercialized as the government has made great and consistent efforts since the mid-1980s to establish market elements in the public healthcare system to boost efficiency, quality and ethics, and, more importantly, to unburden its financial commitment to both the population and public facilities. It is also evident that market mechanisms have been adopted as a major approach to redress informal and unhealthy behaviors and economies in the healthcare system, but these devices are far from successful.

Limited by space, this chapter will not probe what has given rise to informal payments and why the hierarchy has failed to rein in the practice, but will focus on why governance by the market is unlikely to be the solution. In the following text, I will evaluate two leading market mechanisms that have been employed to control informal payments. One is competition, the other differential pricing.

Competition and "Patients Choose Doctors"

The year 2000 is crucial to market-oriented health reform thanks to the promulgation of several important policies. In February the State Council approved a guideline to deepen the reform to the urban healthcare and pharmaceutical systems (State Council Economic Restructuring Office et al. 2000), promising further opening up in both sectors and the establishment of an urban healthcare system that was more compatible with the socialist market economy. A major move in the reform is that public hospitals were encouraged to implement internal competition mechanisms (Ministry of Health and State Bureau of Traditional Medicine Administration 2000). A scheme, called "patients choose doctors" (*bingren xuan yisheng*) which was designed in light of competition principles, was implemented to reshape doctor–patient relationships. Through the promotion of fair competition in every department and in every post within

a hospital, medical employees' attitudes and the quality and efficiency of services were expected to improve significantly. It was demanded in the policy that all employees within a public hospital participate in competition, and that their incomes would be determined by their performance in competition against each other. Those who came last in the competition would be disqualified from their medical posts.

What doctors competed for was the patronage of or selection by patients. In general, patients cannot choose their doctors. If they are covered by public insurance, they are not even allowed to choose their hospitals. The reason that the "patients choose doctors" scheme was promoted as a ground-breaking policy lies in the fact that it empowered patients, granting them the right and privilege to choose whatever doctors and nurses they liked, without additional charges. Medical employees, with their incomes linked to the number of patients they served, were pressured to improve their service quality and attitude. Otherwise they would not only face declining incomes, but also the threat of losing their practicing qualification or even unemployment (Zhao 2000, 2001a).

The health authority was not unaware that patients' choice was limited by information asymmetry. To overcome the barrier to information, hospitals were instructed to make easily available and accessible every single doctor's qualification, professional title, specialty, photo and any other relevant information to facilitate patients making their choice. Medical service guides were also appointed to help patients choose appropriate departments and doctors (Ministry of Health and State Bureau of Traditional Medicine Administration 2000). The ministry apparently believed that this would be sufficient for patients to exercise their power of choice.

The decree did not explicitly state that the scheme was intended to target informal payments, but an anti-corruption purpose was doubtlessly embedded in it. As doctors had to curry favor from patients to survive, they would not dare to take, still less solicit, red packets. Based on this assumption, the government has also attached more importance to competition than to hierarchy as an efficient and enduring solution to red packets. In 2004, the Ministry of Health launched a country-wide campaign against improper conduct. One of the major targets was informal payments. Although the ministry specified disciplinary punishment for eight examples of organizational and individual misconduct (taking red packets being one of the individual instances), it emphasized more constructive approaches toward the general ethos of the healthcare system, and undertook to strengthen professional ethics through education and

supervision. But, more importantly, it promised further and deeper reform to the system by encouraging fair and orderly competition and advancing the "patients choose doctors" scheme (Ministry of Health 2004). The comments of Ma Wen, one of the leading figures in China's disciplinary hierarchy,[1] were more telling about the government's preference for competition. When looking back at the development of the work of controlling unhealthy tendencies, she noted that since 1997 the government had employed both constructive and rectifying approaches to strike at both the roots and the effects of unhealthy tendencies. "Patients choose doctors" was highly commended as one of the constructive methods striking at the roots of misconduct in the healthcare system (Ma 2008). As a result, there is little wonder that the scheme was considered as the right direction for health reform (Guo 2007).

In spite of the vehement promotion by the government, however, public hospitals were not enthusiastic about the scheme. In 2000, the scheme was pushed through the entire public healthcare system. The health bureau of every province formed local "patients choose doctors" policies in light of the guidance of the ministerial decree, and the majority of public hospitals had implemented or were about to implement the scheme (Zhao 2001b). But in 2007, when a vice minister of health reasserted that the scheme remained the direction of health reform (Guo 2007), many public hospitals had quietly abandoned it. For example, in Nanjing, the scheme was vigorously promoted and implemented in all public hospitals in 2001, but in 2007 only two major hospitals claimed they were still running it, and in a limited form, so limited that even patients were not aware of its existence (Zhou and Chen 2007).

The reason the "patients choose doctors" scheme has been abandoned by hospitals lies in market failures, especially imperfect information and limited competition (Stiglitz 2000, pp. 308–310). What marks medicine as a profession rests on its command of a body of esoteric and scientific knowledge and on "its exclusive mandate to apply this knowledge to the care and treatment of the sick" (Daniel 1990, p. 1). Patients "must rely on the doctor's judgment as to what medicine is required or whether an operation or other procedure is advisable. Because they lack medical expertise, patients cannot effectively assess and evaluate their doctors' advice" (Stiglitz 2000, p. 309). But the "patients choose doctors" scheme is based on the assumption that the former possess sufficient medical knowledge about their illness and are provided adequate information about the doctors they are to consult. When they come to a hospital, they are supposed

to already know the nature of their health problems. Then by reading doctors' biographical data publicized somewhere in the hospital, patients should be able to find the right doctors to consult. If they are still not sure which doctors to go to, service guides will provide sufficient information to assist selection. It must be noted that the Chinese healthcare system does not have GPs. Doctors in hospitals are all specialists in a sense. The service guides are usually staffed by nurses who are not qualified to provide medical advice. They only direct patients to the doctors that they think appropriate.

Chinese patients, however, are not smarter or more learned in medicine than those of other countries. In most cases, they do not know what the causes of their illnesses are. That is why they go to doctors to seek help. But, as many critics have pointed out, under the "patients choose doctors" scheme, patients are supposed to first know what their problems are through self-diagnosis, and then go to hospitals with the knowledge of which doctors are able to help. In reality, patients can hardly make sound self-diagnosis due to lack of expertise. Even if their self-diagnosis is accurate to some extent and they go to the right specialties to seek treatment, choosing the right doctors is another hurdle that can hardly be overcome by reading doctors' information or seeking advice from service guides. In short, patients have knowledge of neither their illness nor their doctors (Liu 2000; Yuan et al. 2003; Zhang 2000). Then how do they choose?

It has been widely reported that, due to information asymmetry, many patients make their choice irrationally. Firstly, they choose by the looks of doctors, selecting the good-looking ones or those who look learned or friendly (Li 2001; You 2000; Yuan et al. 2003; Zhu 2002). Secondly, patients may check each doctor's office first, and then choose the one whose office is crowded or has the longest queue (Liu 2000; Shi 2001). Thirdly, and far more frequently, patients choose senior doctors. This is the uttermost concern of both hospital management and doctors.

Public doctors have four professional ranks—doctor (*yishi*), responsible doctor (*zhuzhi yishi*), associate chief doctor (*fu zhuren yishi*), and chief doctor (*zhuren yishi*). Doctors holding the last two ranks are considered senior doctors, and constituted only 12.3 % of the entire medical profession in 2001 (*China Health Year Book* Editorial Board 2002). As patients usually do not have the information of the competence of each doctor, and are not equipped with the knowledge to distinguish the subtleties of doctors' specialisms within the same department, what they trust is what they understand, namely, professional ranks. They naturally believe that

senior doctors are more experienced and competent than middle-rank and junior doctors. For the same amount or slightly higher consultation fees, patients flock to senior doctors (Shi 2001; You 2000; Yuan et al. 2003; Zhu 2002).

Hospital managements are deeply concerned about the imperfect competition and its negative effects on the profession that the scheme entails. Firstly, it is unfair to middle-rank and junior doctors as much fewer patients choose them (Gao and Yang 2003; You 2000; Yuan et al. 2003). The lack of patronage is not because they are incompetent or the quality of their services is not up to standard, but solely because they are in the early or middle stages of their careers and patients usually do not trust young doctors as much. Doctors of lower ranks thus have fewer opportunities to build up their medical experience and skills and prepare for higher-rank positions. In addition, as doctors' salaries are determined by the number of patients they serve, fewer patients means less income. Lacking in opportunities to practice and decline in income may compel young doctors to quit their medical jobs and seek career opportunities and higher incomes in other sectors.

Secondly, as patients are granted the power to choose for no additional charge, they tend to choose senior specialists for even minor illnesses such as common cold (Yuan et al. 2003; Zhang and Xu 2007; Zheng 2007; Zhu 2002). This creates tremendous pressure and unmanageable workloads for senior doctors who are always in high demand. To ensure all patients who choose them are served in a timely order, they have to work longer and shorten the time spent on each patient, which inevitably leads to work fatigue and decline of service quality (You 2000; Zhang and Xu 2007; Zhou and Chen 2007). For the hospital management, senior doctors, especially reputed and eminent doctors, doing work that a junior or middle rank doctor can competently accomplish, is a complete waste of human resources (Zheng 2007).

More importantly, the "patients choose doctors" scheme failed to contain informal payments. On the contrary, it fueled the "latent norm". Information asymmetry and imperfect competition doubtlessly push up the demand for the services of senior doctors. Empowered patients found that they are actually in a seller's market and are not that powerful. Due to the spiraling demand, the services of senior and particularly eminent doctors become increasingly scarce. As patients are not charged additional fees for choosing senior specialists, they found that they still have to pay informally to the latter to compete with other patients for scarce preferential

services in order to ensure attention and quality. Only now informal payments are concentrated in the hands of senior doctors, leaving doctors of lower ranks losing both formal and informal incomes. This becomes a source of tension between senior doctors and their junior colleagues.

Given the drawbacks of the scheme, there is little wonder that hospitals are not enthusiastic about implementing it and many have phased it out in spite of the insistence of the ministry. This does not necessary indicate that public hospitals resist the market and are unwilling to give patients power of choice. On the contrary, they are keen to empower patients, but they do not want to give the power of choice for free. Fully aware of their monopolistic position in the healthcare "market" and the scarcity of senior and eminent doctors, public hospitals want patients to pay for their choosing power and therefore prefer another market mechanism—differential pricing.

Differential Pricing and "Operation by Nomination"

Differential pricing has a name in the Chinese healthcare system—special medical services (*texu yiliao fuwu*). It was an initiative of the health authority. In 1992, the Ministry of Health promulgated a decree which gave public hospitals the permission to offer special medical services providing that basic medical services were adequately supplied (Ministry of Health 1992). The purpose was to provide choice medical services to meet the increasing demands of well-off patients, and to break the egalitarian income distribution system that employees of the public healthcare sector had been subject to for a long time. Guided by market spirit and the law of value, the decree promised to decentralize the pricing power in special medical services, allowing the prices of such services to float or to be determined by the industry or hospitals themselves.

The ministerial policy was endorsed and reinforced in 1997 by a central government decree which launched an overall reform to the healthcare system in an attempt to make it more adaptive to the socialist market economy (Central Committee of the Chinese Communist Party and State Council 1997). Differential pricing was adopted as a key mechanism to motivate health organizations and personnel. The central government promised relaxation of the regulation of pricing on medical services for special voluntary needs, and clarified this promise in a decree jointly issued by the Ministry of Health and the National Planning Commission (2000).

The decree demanded the market competition mechanism was put to full use. The central government was no longer involved in setting prices for medical services, the responsibility of which was devolved to local municipal governments. Municipal price bureaus were demanded to follow market competition principles, set guidance prices in light of the categories of hospitals and ranks of doctors, and to relax the regulation of pricing of special medical services. Special medical services were embraced by the government as a major policy initiative to bring healthcare in line with the market reform that was making significant progress in other sectors.

Hospitals have been more enthusiastic about special medical services and embraced them eagerly since 1992 as a major source of revenue to compensate for the ever decreasing government funding. Special medical services is the general term for several services, including "operation by nomination" (*dianming shoushu*), "expert outpatient consultation" (*zhuanjia menzhen*), "special wards" (*texu bingfang*) and "special care" (*texu huli*). Expert outpatient consultation allows eminent specialists to charge significantly higher fees for advising outpatients. Special wards refer to expensive, "luxurious" wards that are usually lavishly furnished and better equipped, and contain fewer beds than ordinary wards. Special care is comprehensive full-time care provided by nurses so that relatives of patients do not have to stay in hospitals to provide care.

What is relevant to the current research is the scheme of "operation by nomination" which is explicitly designed to curb informal payments in the healthcare system. The scheme was first adopted by some public hospitals in Beijing and Shanghai in the 1980s (Shu and Wen 1993). With the ministerial endorsement on special medical services in 1992, it became a widespread "standard" service of public hospitals, especially major hospitals. The scheme, which allows patients to choose senior surgeons they prefer by making extra payments for their preferential and prompt services, was designed with an explicit intention to formalize informal payments (Meng and Liu 2004; Shu and Wen 1993; Yuan 1995). As patients were always under the pressure to give red packets to their surgeons, why not formalize them so that both patients and surgeons did not feel guilty of giving and taking (Ni 1993; Shu and Wen 1993; Ye and Liu 1993)? More importantly, the scheme would encourage competition among doctors, especially senior doctors, as only those with excellent skills and good attitudes and manners would be selected by patients. To attract patients, surgeons were compelled to improve their skills and provide quality services to increase their incomes.

Throughout the 1990s, however, the provision of the "operation by nomination" service was chaotic. Even right after the scheme was endorsed by the Ministry of Health, a vice minister of health complained that some hospitals turned basic medical services into special services or forced patients to choose their own surgeons. The scheme also caused confusion and conflicts in the collegial relationship among doctors and hampered the orderly operation of hospitals (Yin 1993).

With the devolution of pricing power to local municipal government, Beijing Price Bureau and Health Department took the lead in 2001 to control the chaos and to regulate special medical services. They decreed the abolition of three special services, namely, after-hour operations, one-on-one care and accompanied delivery, while retaining three special services, including A-class wards, operation by nomination and children's health centers. Surgical operations for which patients were allowed to choose their own surgeons were strictly limited to difficult, complicated and serious cases, and their "special" status must be approved by the experts at each hospital. Only senior surgeons were qualified to provide the service. The maximum annual number of "operations by nomination" must not exceed 30 % of the total number of surgical operations of a hospital. The extra fees for the service that hospitals were allowed to charge were limited to 50 % of the normal fees, with a ceiling of 800 yuan per operation (Beijing Price Bureau and Beijing Municipal Health Department 2001).

The outcome of the regulation, however, was not satisfactory. The Beijing Municipal Government had to ban the scheme from public hospitals entirely in 2006 (Beijing Municipal Commission of Development and Reform and Beijing Municipal Health Department 2006). The reasons that the authorities gave were that the scheme generated more concerns than benefits. Firstly, the scheme disrupted normal surgical arrangements which had been decided by categories and degrees of complexity. As in the case of the "patients choose doctors" scheme, information asymmetry induced patients to choose senior surgeons to do all types of operations, irrespective of degree of complexity. Although it was stipulated that only difficult and complicated operations were qualified for the special surgical service, in reality, the hospital management was inclined to yield to the demands of empowered patients. As a result, senior surgeons always had full schedules of operations, and thus had little time for ward visits, professional development and supervision of junior doctors. In the meantime, junior and middle-rank surgeons lost the opportunities to perform surgery that they were qualified to do. Their careers and incomes suffered as a

result. Secondly, the health authority was concerned that the scheme had increased the economic burden on patients. Thirdly, the scheme attracted patients from all over China to seek medical services in Beijing where they could find more medical experts than anywhere else and choose their own surgeons despite additional fees. The surging number of patients created huge pressure on Beijing's healthcare system and prolonged the waiting lists of senior surgeons (Li 2006).

What the government was reluctant to admit was that the "operation by nomination" scheme, which had been intended to turn under-the-table deals above-board via market mechanisms, failed to contain informal payments. Even if patients paid formal nomination fees to the hospital, they still had to pay extra informally to surgeons (Li 2006; Liu 1994; Wang 2006a; Yan 2006; Yuan 1995). The persistence of the practice under the scheme was contributable to patients' distrust of the bureaucratic medical system. Formal nomination fees were paid to the hospital, which in turn paid part of the fees to surgeons formally. Patients viewed this process as an official arrangement and thus it did not serve the purpose of motivating doctors privately. Patients intended red packets to personalize their relationship with surgeons as they believed that only personalized relationships could obligate public doctors. The distrust drove savvy patients to continue to offer red packets even if they had paid additional fees formally for the special service. Moreover, the nomination rates were capped, and only a small share went to surgeons. Surgeons did not feel particularly incentivized, and their incomes did not increase significantly (Li 2006; Wang 2006b). It was reported that on hearing surgeons only took 30–50 % of nomination fees, some patients felt unsettled and voluntarily offered red packets in private to compensate for the surgeons' loss. Consequently, despite the scheme to formalize red packets, informal payments had never disappeared (Yang and Ding 2006; Yuan 1995; Zhang 2006).

A significant change in healthcare ideology also contributed to its falling into disfavor with the government. Unlike "patients choose doctors" which demanded doctors serve patients better and equally, differential pricing, with its emphasis on profit, encouraged hospitals to discriminate against patients and provide unequal services accordingly. This market rationale is incongruent with the CCP's ideological commitment to "serving the people" (Yang 2009). Since 2005 when the failure of health reform was openly admitted and blamed on marketization, the government gradually shifted the kernel of its healthcare ideology from market-based efficiency to social justice and equality. The new health reform plan

announced in 2009 distinguished itself from previous reforms with its emphasis on the non-profit nature of public medicine and health, and on its mission to promote equity and fairness (Central Committee of the Chinese Communist Party and State Council 2009). This may explain why the "patients choose doctors" scheme is continuously promoted while the "operation by nomination" scheme was abandoned.

Although the government banned the "operation by nomination" scheme, it did not abolish all special services based on the differential pricing principle. Special services have always been a major source of revenues to compensate for insufficient government funding. As the government is unable to increase investment significantly to cover the operational loss of public hospitals, it has to allow them to continue to provide special services for the sake of generating revenues and balancing the accounts. In the 2009 reform plan and the latest 2015 reform plan, public hospitals are allowed to keep no more than 10 % of wards for special services (Central Committee of the Chinese Communist Party and State Council 2009; General Office of the State Council 2015), which has been interpreted as the government's reluctant concession to hospitals' demands for profit and their preference for differential pricing (Cao 2015; Chen and Du 2010; Du 2010).

"Operation by nomination" as an independent category of special service is no longer offered in hospital, but it has been combined into other types of special services, especially the "special wards" service, and has survived until today. "Special wards" is a euphemism for "luxurious wards" or "VIP wards". They are usually spacious and decorated like five-star hotel rooms. More importantly, special wards are staffed by senior and eminent specialists and the most competent nurses of a hospital, and equipped with the most sophisticated medical technology. Of course, the prices of such wards are remarkably higher than ordinary wards. For example, in 2014, a major public hospital in Guangzhou set up a "five-star delivery service" which offered special wards for about 3000 yuan per day (in comparison, ordinary delivery wards cost about 100 yuan). Would-be mothers hospitalized into special wards could not only enjoy luxurious accommodation and hotel style services, but also pick any obstetricians and nurses as they liked (Yuan 2014). "Special wards" services in public hospitals have been widely and vehemently criticized for encroaching on public resources, making senior doctors less available to ordinary patients and exacerbating health inequality (Bai 2015; He and Jin 2015); but in the foreseeable future, public hospitals are unlikely to give up special services.

Conclusion

Competition and differential pricing are policy initiatives that demonstrate the government's determination to follow market principles to combat informal payments in the healthcare system, but they suffered different fates. The health authority apparently favors competition and the "patients choose doctors" scheme as it ideally combines market mechanisms and the CCP's ideological commitment to equity. But the scheme is not attractive to hospitals. What hospitals are enthusiastic about is differential pricing and "special services" which are more efficient in generating profits. As differential pricing worsens health inequality, however, it has been increasingly disfavored by the CCP, which has been reasserting its devotion to the socialist principle of social justice and equality in healthcare in recent years.

More importantly, the schemes, which were intended to govern informal economic activities by market mechanisms, failed to contain red packets. Both schemes grant choosing power to patients, who are supposed to exercise it rationally in selecting doctors and thus encourage competition and improvement of service quality. But market failures hinder their choice. Due to information asymmetry and imperfect competition, patients usually surrender their choosing power to senior and eminent doctors. Their "irrational" choice only reinforces the professional power and market position of the latter. In other words, these market mechanisms unintentionally push up the demand for senior and eminent doctors, especially eminent surgeons, and exacerbate the scarcity of their services. To compete for their services, patients still have to offer red packets. Senior and eminent doctors thus benefit both formally and informally from market mechanisms to the detriment of the interests of both their patients and colleagues of middle and junior ranks. As a result, market mechanisms do not solve or even abate the problem of informal payments, but just concentrate them in the hands of elite doctors.

It is evident that the market-oriented reform has not established a genuine market for medical services, and therefore it is unfair to blame the prevalence of red packets and other profit-driven misconduct on marketization. Meanwhile, it is still too early to assume that a genuine market would solve the problems of unhealthy tendencies. Health policymakers in China have overwhelmingly focused on reform to health insurances and public health organizations. Little attention has been paid to the governance of doctors as a profession. Perhaps it is time for the Chinese government to shift its policy focus. At the end of the day, it is doctors who serve patients, and it is doctors who take red packets.

Note

1. Ma Wen was the Vice Secretary of the Central Committee of Disciplinary Inspection, Minister of Supervision, and Director of the State Council Office of Rectifying Unhealthy tendencies, all of which were the top disciplinary organs of the party-state.

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