

PERSPECTIVE

When Incentives And Professionalism Collide

The Chinese experience holds a grave lesson: incentives have a powerful effect on physicians' behavior.

by William C. Hsiao

ABSTRACT: As Jin Ma and colleagues observe, an unfettered market approach in China has reduced access to care, increased patients' financial burden, and reduced emphasis on prevention and may have caused declines in quality and outcomes. A major driving force was that perverse incentives altered physicians' behavior toward self-interest at the expense of patients, even where professional ethics dictated otherwise. Other nations, including India, are grappling with the profit motive and its consequences. Chinese leaders are attempting to deal with these problems by expanding public investment and reducing perverse incentives. However, profit motives remain a powerful, potentially offsetting feature of a reformed system. [*Health Affairs* 27, no. 4 (2008): 949–951; 10.1377/hlthaff.27.4.949]

THE PAPER BY Jin Ma and colleagues lucidly documents several serious consequences of the Chinese health system transformation of the mid-1980s.¹ This transformation changed the system from a prevention-centered, publicly financed system to one dominated by profit-driven hospitals operating in a “free” market, with services largely paid for by patients.² Ma and colleagues show that this caused reduced access to care because of the rising cost of health services and lack of insurance protection, and may also have caused a decline in the quality of care. A World Bank study shows that health outcomes have also been adversely affected.³ Medical impoverishment is now a serious problem as well, with around 4 percent of Chinese households falling below the poverty level each year because of health expenses.⁴

The Chinese experience holds a grave lesson: incentives have a powerful effect on physi-

cians' behavior—more powerful than would be thought for professionals whose behavior should be guided by professional ethics. Chinese medical school graduates are taught professional responsibility to both patients and society, and they take an oath much like the Hippocratic Oath. Furthermore, they are indoctrinated in the communist ideology of devoting their lives to serve society and the people. The Chinese Medical Association and the Ministry of Health repeatedly publicize the exemplary life of Norman Baisun, a Canadian physician who lived in China for decades and served his patients selflessly. Despite these efforts, however, new and unfettered opportunities for hospitals and physicians to obtain higher incomes have caused financial pursuits to triumph over professional responsibility and ethics for most physicians.⁵

■ **Revenue targets instead of care quality.** Instead of focusing on the quality of pa-

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tient care, most Chinese hospital directors focus on setting revenue targets for each service department, which then sets revenue targets for its physicians. Bonuses are tied to revenues and profits. Because profits are earned from drugs and tests, physicians overprescribe drugs and expensive tests. More than a third of Chinese drug spending goes toward unnecessarily prescribed drugs.⁶ Chinese hospitals and physicians have turned themselves into profit-seeking entities, and professional ethics have largely evaporated.⁷ As a result, people find medical care unaffordable, and many have become impoverished from medical expenses, as Ma and colleagues state in their paper.

■ **Kickbacks Instead of prudent prescribing.** Providers are not the only ones exploiting the profit-making opportunities created by the health system transformation. Pharmaceutical and medical supply companies offer kickbacks to hospitals and physicians for using their products. The profit motive also drives many surgeons and senior specialists to accept under-the-table payments from patients, who offer these payments to ensure that they receive adequate care. When these corrupt practices reached their height a few years ago, however, the government imposed severe regulations and punishments and curbed this behavior.

■ **Reduced budget support for public health.** The transformation of public facilities into for-profit entities was not limited to hospitals. When the government reduced its budget support for public health, it also reduced its support for the Chinese Center for Disease Control and Prevention (China CDC), maternal and child health (MCH) stations, township health centers, and village clinics, forcing these entities to turn to the market to survive.⁸ The China CDC, instead of focusing on prevention, opened outpatient clinics for personal medical services. By 2005, 50 percent of its revenue was derived from charges.⁹ MCH stations built hospitals and clinics instead of concentrating on prevention and home visits to newborns and their mothers. Village doctors became profit-seeking private practitioners. Although the government designated village

doctors to be the front-line troops for prevention, immunization, health education, and basic treatment, it offered them little or no salary. As a result, village doctors now earn most of their income from prescribing and dispensing drugs; indeed, more than 75 percent of patients suffering from the common cold are prescribed antibiotics.¹⁰

■ **Financial incentives elsewhere.** Financial incentives have powerful effects on physicians' behavior in other countries as well. For example, India, like China, underfunds its public health services and keeps physicians' salaries relatively low. India allows public-sector physicians to earn additional income by running private practices on the side. This dual-practice mode is common. Fees charged in the private sector are unregulated, so Indian physicians often work in public facilities only in the morning, spending their afternoons and evenings in their private clinics. Queues can be long in public facilities, and physician-patient contact time is short. Necessary drugs and medical supplies are often unavailable because of underfunding, and patients have to buy them from outside pharmacies. Patients who want shorter queues and better-quality care go to private clinics. Public physicians often refer their more affluent patients to their private clinics for service. This corruption and the creation of a two-tier system are sanctioned and tolerated. China does not permit its public-sector doctors to have dual practices but does allow physicians to alter their clinical decisions to obtain higher incomes.¹¹

China and India followed different strategies when their governments did not adequately fund the public health sector. In China, financial incentives triumphed over professionalism. In India, professionalism has been weakened. Which strategy has produced worse health and other outcomes? The paper by Winnie Yip and Ajay Mahal in this issue offers some answers.¹²

■ **Overcoming the profit motive.** Chinese leaders are committed to reforming the health care system with a large infusion of public funds for prevention and health care.¹³ The principal problem is how to transform the new

money into effective services when public hospitals and clinics are so driven by profit motives. Financial incentives can be changed by paying physicians high salaries. However, once professionalism has been so weakened, how much do physicians have to be paid before they will give priority to patients' welfare? Under the current fee-for-service payment system, physicians induce demand to obtain higher incomes. But under a salary-based payment system, physicians may lessen their workload by reducing quality of care, referring patients elsewhere, or demanding more staff support. Surgeons can easily accept under-the-table payments from fearful or grateful patients.

Chinese policymakers are painstakingly trying to establish an efficient and effective health system, and to prevent various deviant behaviors such as overprescribing profitable tests. But with no proven effective solution, the government is leaning toward experimentation whereby multiple but coordinated changes would be tried in various cities and counties. For example, to separate purchasing and provision functions, local health departments would be reorganized to finance and regulate public hospital services. A new, separate organization would administer hospitals. To remove the incentives to overprescribe drugs and tests, hospitals would turn their patient revenues over to a new central authority that would reallocate them to hospitals and physicians based on clinical performance. An essential drug list would be established for each level of health facility. The drugs would be centrally purchased through competitive bidding and distributed to each facility. Facilities would only be able to charge the factory price with no markup. Most important, the government would fund the basic salaries of physicians, village doctors, and support staff who provide preventive and primary care services.

THE NEED FOR ADDITIONAL public financing in China and India is only one part of a larger picture. The fundamental problem is how to change the motivation of hospital directors and physicians once they become driven by profit motives.

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NOTES

1. J. Ma, M. Lu, and H. Quan, "From a National, Centrally Planned Health System to a System Based on the Market: Lessons from China," *Health Affairs* 27, no. 4 (2008): 937-948.
2. China regulates prices while largely leaving the quality of health care and drugs unregulated. Its irrational price regulation underpays for services (visits, surgery, hospital days) while overpaying for drugs and high-technology tests. The government expects hospitals to make up their losses from performing services with profits derived from drugs and tests.
3. M. Lindelow and A. Wagstaff, "China's Health Sector—Why Reform Is Needed," Rural Health in China: Briefing Notes Series (Washington: World Bank, 2005).
4. E. van Doorslaer et al., "Effect of Payments for Health Care on Poverty Estimates in Eleven Countries in Asia: An Analysis of Household Survey Data," *Lancet* 368, no. 9544 (2006): 1357-1364.
5. D. Blumenthal and W. Hsiao, "Privatization and Its Discontents—The Evolving Chinese Health Care System," *New England Journal of Medicine* 353, no. 11 (2005): 1165-1170; and W. Yip and W.C. Hsiao, "The Chinese Health System at a Crossroads," *Health Affairs* 27, no. 2 (2008): 460-468.
6. Ibid.
7. X. Liu and A. Mills, "Evaluating Payment Mechanisms: How Can We Measure Unnecessary Care?" *Health Policy and Planning* 14, no. 4 (1999): 409-413.
8. P. Smith, C. Wong, and Z. Yuxin, "Public Expenditure and the Role of Government in the Chinese Health Sector," Briefing Notes Series (Washington: World Bank, 2005).
9. China National Health Economics Institute, *China National Health Accounts Report* (in Chinese) (Beijing: China NHEI, 2005).
10. R. Zhou, "Responsible Utilization of Antibiotics Should Be a Societal Responsibility," Sanmenxia Central Hospital Paper no. 223 (in Chinese), http://www.smxzxyy.com/Article_Print.asp?ArticleID=213 (accessed 15 January 2008).
11. China allows public-sector doctors to do contract work for other hospitals on their days off.
12. W. Yip and A. Mahal, "The Health Care Systems of China and India: Performance and Future Challenges," *Health Affairs* 27, no. 4 (2008): 921-932.
13. Yip and Hsiao, "The Chinese Health System."

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