

Lund University

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**Marketization of the Public Health Care in response to the
Economic Reforms in China**

: A decrease in the government's responsibilities and growing risks
and insecurity among individuals?

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Master Thesis WPMM42

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Supervisor: Antoinette Hetzler

ABSTRACT

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Since 1978, China has experienced a series of economic reforms, transitioning from a centrally planned economy to a liberal market economy. Correspondingly, the economic transformation has left a profound impact on the health care system. Universal free health care provided by state-owned enterprises was gradually replaced by modern social medical insurance schemes. The government dramatically decreased its spending on public health care. Moreover, in response to the economic reform, health care in urban China is fastly moving towards marketization. Public hospitals are endowed with great economic autonomy and thus becoming profit-driven entities. As a result, the proportion of out-of-pocket payments for medical treatment and drugs in total health expenditure becomes incredibly high. This master's thesis aims to examine the consequences of marketization of the public health care and the reasons why China is unable to provide access to affordable health care treatment and pharmaceutical drugs to its urban citizens even though they have been included in the national medical care schemes. A theoretical framework based on the East Asian model and the mixed economy of welfare is built to offer a deeper understanding of the mechanisms of different sectors in welfare provision. Documentary analysis, a secondary review of official statistics as well as semi-structured interviews are used to answer the research questions. The findings show that with insufficient public-spending and regulation, public hospitals become over commercialized during the marketization process. And high profits are made by offering expensive medical treatment and pharmaceutical products. Meanwhile, the reimbursement level of social medical insurances remains low. As a result, risks of health care in terms of a high proportion of out-of-pocket payments are shouldered by urban citizens and thereby closing access to affordable health care.

Key words: health care; urban citizens; social medical insurances; marketization; public hospitals; medical treatment; drugs

List of abbreviation

CCP	the Communist Chinese Party
CNSB	Chinese National Statistics Bureau
BMIUE	the Basic Medical Insurance Scheme for Urban Employees
BMIUR	the Basic Medical Insurance System for Urban Residents
GDP	Gross Domestic Product
MH	Ministry of Health
MAPUA	the Medical Assistance Programme in Urban Areas
NRCMS	the New Rural Cooperative Medical Scheme
OECD	the Organization for Economic Co-operation and Development
SOE	State Owned Enterprises
WB	the World Bank
WHO	the World Health Organization

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Introduction

1.1 Problem area: the dramatic economic transformation promoted the health care reforms in China. A decrease in the government-spending?

The whole world is witnessing the incredible economic development of China. Through reforming its economy and adopting the opening up policy introduced by Deng Xioping in 1978, China has been experiencing one of the longest economic expansions in the history with annual economic growth of nearly 10 percent for three decades.¹ The reforms and the opening up policy refer to the introduction of changes in the economic system to alleviate the contradiction between the growing material and cultural needs of the people and a backward social production. The result of the reforms was a new Constitution of the Communist Chinese Party (CCP) in 1992 and four modernizations of agriculture, industry, science and technology and the military. The result is what some refer to as the greatest poverty-reducing program in history. At the time of the reforms the per capital Gross Domestic Product (GDP) in China was 381 Yuan (\approx US\$ 60)² and by 2010 it was US\$ 4,428³.

Correspondingly, the liberalization and marketization of economy had a profound impact on the existing structures of welfare provision. Deng's government gave the priority to economic growth by improving its flexibility and competitiveness. As a result, when it referred to the welfare provision, it implies a government withdrawal and "a focus on cost containment at the expense of those that did not benefit from the unleashed dynamics of free markets" (Sander et al, 2010:7). As for the health care system, there are a number of significant changes in terms of financing and provision which are associated with economic reforms and leads to cost escalation of medical care and drugs (Meng, 2006:6; Haiso, 1995; Gu and Tang, 1995; Liu et al, 1999; Liu and Haiso, 1995; Liu et al, 1195; Dong et al, 1999; Fielding et al, 1995). To be specific, the central government shifted its responsibility for urban health care provision to the local authorities. Also, state-owned hospitals were endowed with substantial autonomy for their own economic situation and hence were gradually transformed into profit-oriented entities. As a result, the government's spending on

¹ Deng Xioping's Economic Reforms <http://factsanddetails.com/china.php?itemid=79>

² according to Bank of China, 1 yuan \approx 6.3 US dollar

³ data.worldbank.org/indicator/NY.GDP.PCAP.CD

public health care experienced a dramatic decline. The total health care expenditure as a percentage of overall government expenditure experienced a decline from 3.1% to 2.3% from 1985 to 1995. The shares of public spending from the government budgets in total health care expenditure dropped from 28% to 14% from 1978 to 1993 (Sander et al, 2010:7; Chan&Ngok&Phillips 2008:119). In terms of financing of the public health care, the health services were transformed from free health care financed by the government to fee-for-service type, which results in a great increase in out-of-pocket payments. In terms of provision, hospitals gradually took the place of street clinics for primary care. Therefore, the number of street clinics for primary care experienced a substantial decline. In some regions, street clinics even ceased to exist (ibid; Saich 2004:284-287).

The marketization in China's economic reforms as well as public health care system leads to rapid increase inequalities in the Chinese society due to the reduced input from the government. It was not until the late 1990s did the Chinese government increasingly begin to realize "the destabilizing potentials of the severe income disparities and the highly unequal distribution of the aggregate welfare gains from growth" (ibid:11). The basic medical insurance scheme for urban employees (BMIUE)⁴ was established in 1998, which is regarded as the symbol of the modern national health care scheme. Also, the new rural cooperative medical scheme (NRCMS)⁵ for the rural residents, the medical assistance programme in urban areas (MAPUA)⁶ as well as the basic medical insurance system for urban residents (BMIUR)⁷ has been set up in recent years successively. In the last three decades, China has transformed its economy from a socialist economy to a market economy. During this process, China's health care services have also been moving towards marketization and "converted from social and public goods to market goods without government planning or intervention" (Hu, 2004:480), which makes the health care gradually unaffordable. China's health financing system was ranked as one of the world's most inequitable health financing system by WHO in 2000, ranking 188th out of 191 countries (OECD, 2011:220; MH, 2005). This made the Chinese government very ashamed and recognized that immediate action was needed to reform the health care system.

⁴ *Decision to Establish the Basic Medical Insurance Scheme for Urban Workers by the State Council, 1998*

⁵ *Decision to Establish the New Rural Cooperative Medical Scheme by the State Council, 2002*

⁶ *Decision to Establish the Medical Assistance Programme in Urban Areas by the State Council, 2005*

⁷ *Decisions to Establish the Basic Medical Insurance System for Urban Residents, 2007*

The outbreak of the severe acute respiratory syndrome (SARS) in 2003 revealed the poor public health care system of China. It was not until then that the Chinese government realized how vital it is to strengthen its responsibility in the public health care (Li et al, 2008:7). It has recognized the importance of increasing public investing in health care services, which has become a key element in the economic development plans. By improving the financing and provision of health care, China is aiming to establish a health care system which provides both health protection and social protection for its population, in terms of improved access to and utilization of services as well as reduced poverty caused by illness (Hu, 2004:482). It is reported by the Chinese government that around 1.3 billion Chinese citizens have been included in the social medical care schemes so far on the Fifth Press Conference of the Eleventh National People's Congress⁸. However, there is much more that remains to be done. Especially, over the thirty years of economic liberalization and marketization, public hospitals became commercialized and driven by profits and access to care became uneven. The reimbursement levels of social medical insurances “are often woefully low, while the health insurance schemes are limited in scope and fail to address the key issue of how health-care providers are paid for their services” (Parry&Cui, 2008:821) which results in high levels of out-of-pocket payments (Hu et al, 2008:68). Dr Hans Troedsson, WHO's representative in China says that “WHO is pleased to see that the Government of China has made a firm commitment to universal coverage of essential health care”, “however, China has a long way to go in terms of improving equity in financing and provision of essential health care for all” (Parry&Cui, 2008:823).

1.2 Study interest and research questions

Health care has become one of the most significant concerns of Chinese people, according to a survey of 101,000 households in 5,000 communities in January 2008 (Hu et al, 2008:68-70). Since 2003, the Chinese government has been rolling out to improve its public health care system. There has been a substantial increase in the central government's spending on health, “after languishing for many years at exceptionally low levels compared with that in other countries” (ibid). However, the out-of-pocket payments as a percentage of the total health expenditure of China is still among the highest in the world. According to a national survey which was conducted after SARS, around 90% of the Chinese citizens were not satisfied with the public health care system (Li, 2007:1). The sharp increase in the cost of health services is a major barrier for patients. Many people reduce their access to medical services mainly for financial reasons. Issues about the Chinese health care system

⁸ Premier Wen's government work report, 2012

have been greatly discussed and studied from different perspectives by researchers and scholars from both home and abroad for a long time, especially since the outbreak of SARS.

China's 1.3 billion people comprise a fifth of the world population. It is both interesting and challenging to study in which way China can offer the huge amount of population an affordable health care system on the basis of efficiency and equity under its unique socialist market economy structure with Chinese characteristics⁹. As for this master's thesis, it is concentrated on illuminating and increasing the understanding of a series of related partial research questions surrounding the paradox of why given increased wealth China is currently unable to provide access to affordable health care treatment and pharmaceutical drugs to its urban citizens even though they have been included in the national health care schemes (BMIUE and BMIUR). The series of questions examined within the thesis are:

- 1) Following the economic transformations, the health care system has been experiencing constant re-shaping. In which way have the government and the hospitals' roles in health care provision changed during the health care reforms? What are the consequences resulting from the authorization of economic freedom for public hospitals to set prices and priorities of both treatment and choice of medicine?
- 2) Do the on-going reforms designed to enlarge the health care system increase insecurity among urban Chinese citizens because of the commercialization of the public health care? Is the access to medical treatment thus getting limited? If so, why are they anxious about the costs of health care even though they are enrolled in national medical care insurance programs?

Differences in economic growth and in financing, organization and resources between urban and rural regions have made China a country with two health care systems. The urban health care system is allocated with more resources and is better organized, "but is faced with major financing and organization issues and concerns about cost-containment" (Hu, 2004:480). While the rural health care system is not well organized, confronted with a lack of resources as well as concerns about difficulty of access (ibid). Taking this into consideration, my study is focused on the relatively developed urban areas of China which enjoy relatively mature social medical insurance schemes. Correspondingly, the research objects are the residents in the urban areas who are covered

⁹ More details refers to this term can be seen in following Historical Background part.

by the basic social medical insurances (excluding civil servants and migration workers)¹⁰ due to the limitation of time and personal capacity. It helps me to build a better and clearer foundation for the analysis part by narrowing down my topic and research focus. Also, before 2000, social development was only one of the internal needs of economic development rather than having an independent status in the public policies in China, as argued by Professor Gu from School of Government at Peking University. It was not until 2003 that the Chinese government tried to break out of its GDP-first model. Improvement of basic human rights, especially the construction of the social security system, has been put into an important place in the government's agenda (Gu, 2010:74). Hence, my documentary research is mainly aiming at the health care system after 2003 since there is grand amount of data for me to research. But to give an overall picture of China's health care reforms in the last three decades, first of all, historical background of the economic transformation in China is given, which explains the changes in the roles of the government and the public hospitals in the health care provision. This is followed by presenting a theoretical framework to better understand the health care system. In the thesis, I use two theoretical models. One is that advanced by the East Asian Welfare Model to understand the little public input in health care from the Chinese government. The other theory is the Mixed Economy of Welfare, serving as a starting point to understand why using public hospitals as commercialized enterprises for providing health care and treatment can yield unintended consequences. As for the methodology part, both qualitative and quantitative research methods are used. The quantitative part of the thesis is based on a secondary review of the official statistics produced by the Chinese National Statistics Bureau (CNSB) and some big international organizations such as the World Bank (WB), the World Health Organization (WHO) and Organization for Economic Co-operative and Development (OECD). Statistics such as the proportion of government spending on health care and the proportion of out-of-pocket payments for the Chinese population are selected. To give a better illustration, international comparisons are made. Statistics from some western welfare states and some east Asian countries exhibit that the Chinese government has low funding for its public health care. These show why there is an increasing burden of health care on Chinese citizens living in urban areas. The qualitative part of the thesis uses the analysis of documents to understand the historical development of current urban health care system in China on a macro level. The changes or adjustment of the roles of different health care sectors are discussed. Government documents and scientific articles, as well as results of previous studies are sorted and analyzed. In addition,

¹⁰ Chinese civil servants still enjoy full-amount reimbursement in health care. Health care for the migration workers in the cities is another big issue which is too wide to study for this thesis.

findings from a number of interviews with Chinese citizens are presented, which shows the micro level of created anxiety among the urban medical care consumers. The thesis concludes with a summary of the analysis and reasons why a better type of state regulation is needed if access to medical care and treatment is a policy goal of reform in China.

1.3 Historical background of the health care reform in China: from Maoism to Dengism

During the pre-reform era, urban citizens were included in a free universal health care system in China. They were offered jobs in the state-owned enterprises (SOE) under a centrally planning economy and welfare were provided by their work-units. As mentioned above, China's economy experienced a dramatic transition from a planned to a market economy in 1979. During this, the free health care system was faced with a financial crisis in the 1990s and therefore became an institutional barrier to the marketization and privatization of SOEs (Gu, 2010:197). Hence, the Chinese government started rounds of health care reforms to transform it into a new health care insurance system. To lay a solid foundation for my study, knowledge of the significant socio-economic changes in China during the economic transition is needed and is presented in the following context. The historic background introduces how the health care system has been re-organized by the Chinese government under different leaderships, from Chairman Mao to Chairman Deng.

The core contextual changes which have greatly influenced social policy-making in China is the abrupt shift in the economic regime from highly planned by the government to a liberal socialist market economy. As a consequence, the government's role in financing and regulation has diminished and that of the market has been more active. To be more concrete, the postwar political and socio-economic development in China can broadly be divided into two very distinct phases: the Maoist period was from 1949 to 1976, which can be characterized by "anti-market ideology" (Bogg, 2002:11). The Dengist period started from 1978 onwards, representing "a modernization of China, a commitment to the market philosophy and an acceptance of widening gaps in the income and wealth between the coastal areas and the interior of China. The market replaced political decision-making in resource allocation and priority-setting" (ibid).

1.3.1 The Maoist era: free universal health care by SOE work-units

During the Maoist era, the health care in urban China was regarded as an integral part of the planned economy, “manifesting many characteristics of what Kornai calls ‘classical socialism’ while displaying Chinese characteristics in other aspects” (Gu and Zhang, 2006:49; Kornai and Eggleston, 2001:135-140). Similar health care regimes can be found in the Soviet Union and some former socialist countries in Eastern Europe. However, unlike these countries, in the urban areas of China, SOEs directly provided and delivered health care rather than the state itself (Gu and Zhang, 2006:49).

“The SOE work-units were originally the administrative cell of a hierarchically organized urban society that was labelled ‘intrusive, supervised, molded, centrally planned, totalistic’ (Gu, 2010:198; Bernstein, 1982:160). Apart from fulfilling the functions of political communication and social control (ibid; Shaw, 1996), they evolved to serve many economic and social functions for the state from production through family planning to the arbitration of disputes” (ibid; Whyte and Parish, 1984:25). During the Maoism era, nearly all urban residents in China were provided with universal lifetime jobs in SOEs in the Communist economy system (Sander et al, 2010:6). At that time, free health care provision covered nearly the entire population in urban areas under a highly unified system run by the government. The SOE work-units acted as mini-welfare states and had a key role in the provision of health care (ibid).

As for the delivery perspective, in urban areas, the organization of health-care provision followed “a three-tier structure”. It consisted of street clinics which provided outpatient services and district hospitals that provided “more sophisticated treatment” as well as city hospitals at the top to which “the most complicated cases would be transferred” (Sander et al, 2010:6; Chan& Ngok&Phillips, 2008:115-117; Saich, 2009:268- 274, Gu&Zhang, 2006:49-51). All the doctors and nurses as well as other staff working in the health care sector were state-employee. Their salaries were decided by the central government. The provision of health care services was “largely for free or at extremely subsidized” (Sander et al, 2010:6-8), which meant that almost all the residents in the urban areas could enjoy comprehensive health care services (ibid).

The universal health care provided by SOE work-units successfully improved the overall health condition for urban residents. However, it shared many problems with other kinds of free health care systems, “namely shortages (crowded hospitals and long waiting times for treatment), low quality

of health care service (less responsive to the demands of patients) and no freedom of choice for patients, and sluggish technological development” (Gu and Zhang, 2006:49). Thus, following by the trend of an emphasis on efficiency, reforms towards the old health care regime have been carried out on two fronts from the mid-1980s onwards (ibid).

1.3.2 The Dengist period: era of reforms towards marketization and commercialization

During the Dengist era, the reformers believe that “Maoist economic policies had created a system marred by serious inefficiencies, thereby retarding China’s economic development” (Wedeman, 2003:28). The economy was gradually transformed into a commodity-based one, despite the high levels of key industries which today are still state-owned (ibid). The economy transition started in the reforms in SOEs in the early 1980s. The urban enterprises were endowed with “substantially increased autonomy in management decisions and eventually acknowledged the economic potential of privately owned enterprises, by legalizing private ownership of businesses” (Sander et al, 2010:7; Wei, 1997: 1080-1084; Chan&Ngok&Phillips, 2008:27-32). “Deng and his allies created an economy that they dubbed ‘socialism with Chinese characteristics’. It was no longer socialist but was not yet capitalism, and instead stood awkwardly between the old Maoist command economy and the market” (Wedeman, 2003:5). This ideological breakthrough of socialist market economy structure was officially announced on the Third Plenum of the Fourteenth Party Congress in November 1993, which could be regarded as a major step forward in China’s economic reforms. Since then, the Chinese government decided to “greatly expand market forces and to transform SOEs to be autonomous competitors in an open market” (Chan et al, 2008:34).

Since 1980s, issues related to health care reforms have been greatly debated more than ever. Many countries in the world began to launch health care reforms to improve the efficiency of their health care systems and market-orientation of health sector is seen as a significant strategy. The efficiency-related key elements includes “privatization, decentralization, management autonomy and professionalization, separation of purchaser-provider roles, contracting of services, strengthened patient roles, rational priority setting and reforms of financial flows” (Bogg, 2002:6-13). For the health care system in China, the previous regime was expected to provide cradle-to-grave-services for the urban residents by SOE work-units. And it was proved not to be fit for a market-oriented economy which is based on competition and efficiency (Sander et al, 2010:8). As a result, “the Dengist deregulation of the command economy and price controls extend to the health sector. The

Dengist health reform encompassed: reductions of public financing and increased scope for fee-for-service revenue; decentralization of management responsibilities; introduction of incentives for hospital management and doctors in the form of bonus systems; reform of the medical price system” (ibid). A reform research group produced a draft titled ‘A Plan to Reform the Medical Insurance System’ in March 1988. According to the statement given by Dr. Chen Minzhang, then Minister of Health:

the way to reform the free medical care system is to change it into a comprehensive social medical insurance system, strengthening gradually people’s ‘sense of cost’ and getting more efficient use of the state’s medical funds”

“A key objective was better control of the rapid escalation of costs in the government health insurance system” (ibid). The above statement implies a withdrawal of the government spending on health care from the government and an increase in individuals’ responsibilities with considerable co-payments and co-insurance to shift the financial burden shouldered by the government.

As for the health care provision, during the 1980s, there were only minor reforms with health care providers. Starting in 1989, the state-owned hospitals began to be endowed with financial autonomy in their operations. Following the trend of marketization, the state-owned hospitals were transformed from non-profit to revenue-maximum organizations to occupy a place in the health care market. However, “the relationship between the government and health care providers is still marked by the legacies of the old regime, resulting in a situation in which, on the one hand, health care providers are not managed by managers but by officials, but on the other hand, the health care market lacks many regulatory measures” (Gu and Zhang, 2006:50).

During the marketization and privatization of urban SOEs, competition was regarded as the key element of China’s economic reform. In 1990s, a large number of SOEs were made into “financially independent and downsized” (Chow, 2006:4). Hence, they began to have difficulty in financing and providing free health care for their employees (ibid). Especially, a bankruptcy law was passed in 1986, allowing SOEs with low efficiency to declare bankruptcy (Yu, 2006:7; Lee, 2000). “Owing to poor management, bearing heavy responsibilities for looking after a huge number of retirees and keen competition from the private sector, half of them either are loss-making or have become bankrupt” (ibid:8; Saunders and Shang, 2001). Moreover, contract-based employment system was implemented to improve efficiency in urban areas. SOEs were allowed to employ or sack workers on contracts. This broke the lifetime employment model in the Communist economic system. As a

result, “besides employing fewer new workers than the private sector does, SOEs sacked a number of their employees” (Yu, 2006:8). It was believed that SOEs were no longer able to provide the same level of universal welfare including free health care as before. Additionally, workers in the private sector are no better off. There is no guarantee that they can receive sufficient protection. Hence, there was fastly increased insecurity of losing jobs and lacking health care protection among urban employees (ibid; Leung, 2003;Wai Kam Yu, 2006).

Under this situation, the government decided to conduct a series of health care reforms in order to form a risk-pooling mechanism to offer employees in urban areas basic protection. *BMIUE* was established in 1998 and officially implemented in 1999 after nearly a decade of planning and trials in different cities in the 1980s (Gu and Zhang, 2006:50). Since then, a new social health insurance system combined with individual accounts and social pooling accounts replaced the free health care system provided by SOE work-units (ibid). The new insurance system is based on contributions both from employers and employees (Chow, 2006:4). “There are pre-defined caps on per capita health expenditure and workers have to make individual payments to contribute to costs of treatment” (Sander et al, 2010:9). This marks a new chapter of the modern Chinese health care system.

The British Sociologist Bill Jordan, Professor of Social Policy at Huddersfield University, in his book *Social Policy for the Twenty-first Century*, puts China’s health care reform as an extreme case of the transformation of health care: liberation and marketization of the health care system and a big decrease in the state’s public provision that leads to a growing increase in out-of-pocket payments for citizens. During the Mao’s era, the Chinese government “achieved considerable success in improving the life-expectancy and general health of the population in the 1950s and 1960s, depending on ‘support-led’ human development. Mao’s successors, in turing to a growth-led strategy based on export-orientated manufacturing, also chose to switch from basic, labour-intensive approaches, supplied through local co-operative systems, to one based on payments by patients” (Jordan, 2006:95).

When China liberalized its economy from a highly government planned to a market-based system, the health care system was greatly changed by following the trend of marketization. The individual medical savings account system took the place of the employment-based health insurance system for urban employees in 1998. The Chinese government dramatically reduced its funding for disease

prevention and public health, along with subsidies for public health facilities. By the early 1990s, government subsidies only accounts for 10% of the public hospitals total revenues, forcing these public facilities to rely on incomes from user fees (Hsiao, 2007:242-243). This leads to a fast increase in medical treatment costs as well as pharmaceutical prices. Consequently, the out-of-pocket payments as a percentage of total health expenditure rose from 20% in 1978 to almost 60% in 2002 (ibid; Smith P., et al, 2005). The above introduction part is divided into three sections. The first section gives a full picture of the problems of the current health care system in China, followed by specific study interests and research questions. The historical background part is served as a literature review which explains the significant changes in public health provision during the economic transition. This chapter offers necessary knowledge of the marketization of China's public health care system and its consequences.

Theoretical framework

To understand the health care system in China and examine the research hypothesis, a theoretical framework is of great importance. It is very difficult to directly apply traditional western welfare theories into China's case due to the differences in socio-economic development. Hence, the East Asian welfare model is used to understand the mechanisms of the state, market, community and household in the welfare provision. Starting from this, the mixed economy of welfare is developed in a deeper way from different perspectives to understand the shifts from state to market in health care. In this way, it builds a clear theoretical framework for the following sections of this thesis.

2.1 The East Asian welfare model

Similar with other social sciences, traditional western theories of social policy are rooted in the western political philosophy of rich industrial and post-industrial countries. These theories are built on the basis of capitalism and a relatively autonomous state. "It has fundamentally addressed the problem of ensuring security of welfare under the uncertain life-chance conditions of capitalist, market-based societies" (Gough and Wood et al, 2004:4). In a world of globalization, researches on social policies and humans well-being are no longer limited to western societies. "In more successful parts of the developing world, rapid capitalist development has eroded absolute poverty, but frequently at the same time heightened insecurity and vulnerability" (Wood and Gough, 2006:

1696). Development of social security nets and welfare provision in the eastern countries have drawn increasing attention from scholars and researchers.

However, due to a totally different economic, political and culture structure, it is very difficult to use traditional western welfare theories to study the developing countries' welfare model. Thus, the amount of systematic research remains relatively low. Taking China for example, "while the economic transition took an incredibly quick pace and has been monitored closely by scholars worldwide (and from a variety of disciplines), systematic knowledge of Chinese welfare and social security scheme is scarce, particularly concerning its development over time" (Sander et al, 2010:11). Resulting from a lack of democratic institutions and an organized labour movement, none of the western classical theories of social policy can easily be applied into China's case (ibid; Lin 1999). Few attempts have been made to identify China's conception of welfare as well as the values and goals underlying this concept. Even though researchers and scholars agree that China does not fit into any of the traditional welfare state clusters, "developments in China have still constantly been monitored along the lines of developments in European welfare states" (Sander et al, 2010:1-3). It was not until the 1970s that the research on the East Asian welfare model started, which emphasizes "Confucianism and the central role of family and kinship ties are held responsible for constraining a development more in line with Western welfare patterns" (ibid; Jones 1993; Goodman et. al 1998). However, despite of sharing similarities in terms of socio-economic development with some east asian countries, China has its unique and complex characteristics and features. Nonetheless, there has been no definition of Chinese welfare regime so far (Sander et al, 2010:1-3).

Hence, to understand the welfare model of China, it is reasonable to start from the East Asian countries which shares relatively similar situation- fast economic growth and increasing needs on social welfare development. However, when referring to western welfare models, the concept of welfare state regime is used. It typically followed the logic of industrialization and democratization (ibid:12). Also, Therborn (1983) defined "welfare states as those states where more than one-half of all government expenditures are devoted to social policy, as opposed to the economy, the military, law and order, infrastructure and other traditional functions of the state" (Gough and Wood et al, 2004:26). Hence, the concept of welfare regime is developed by the Bath research programme

‘Social Policy in Development Contexts’¹¹. It serves as an heuristic entry point into research on social policy in the developing and poor countries.

Even though China is excluded from the definition of East Asia, China has a lot of in common with these fast developing countries. From the economy perspective, these countries are beneficiaries of the economic openness and market-friendly policies. From the human well-being perspective, public social expenditure remains low on a world scale due to the over-focus on GDP growth (ibid: 169-195). It is of great importance to use the East Asian model to build a theoretical framework to explain who is financing and delivering the welfare.

De-commodification has less meaning in societies with significant agricultural and informal labour with few statutory protections or substitutes and is not systematically measured in East Asia. Opportunities to participate in the labour market are a key feature of the East Asian welfare regime. The government usually gives priority to economic growth and the proportion of education, medical care and social security in the total state fiscal expenditure is very low on a world scale. For healthcare, individuals pay for the biggest proportion. As for the objects who receive welfare, commonly, civil servants, teachers and militaries have great priorities in enjoying welfare treatment. The government provides social investment rather than social protection. From the aspect of the market, it puts interest in the first place and whether to buy private social insurances is depending on the wealth and savings of the families. For the community and NGOs, they play a very weak role in the distribution of welfare system. For family-household, the extended family persists as a provider, saver and redistributor, despite rapid economic development and urbanization. The level of savings is extremely high to mitigate risk by ‘self-insuring’ (ibid).

In terms of weak government input and high proportion of household provision of welfare, the similar situation can be also found in Japan: “relatively low public spending; greater reliance on family, community and corporations; an emphasis on social policy as investment in the economically productively element of the society, i.e. the state spending on education and public health is to maintain a productive work force rather than providing a safety net for those who can not contribute to national wealth” (Seeleib-Kaiser, 2008:100). Moreover, a majority of the population is lacking recognition of the concept of citizenship in relation to social welfare. Issues

¹¹ led by Ian Gough, Professor of Social Policy at the University of Bath and Geof Wood, Director of the Institution for Policy Analysis at the University of Bath

related with citizenship and citizen rights are rarely discussed in the Japanese society. Public welfare institutions lack of investment due to “little investment in social work profession to argue on behalf of marginalized groups in society” (ibid).

“It is common in most of the developing countries that social policy is subordinated to other policy objectives, notably economic policy and the pursuit of economic growth. Social Policy is primarily driven by the changing requirements of economic development policy” (Gough and Wood et al, 2004:183). The welfare provision is realized ‘by people’ rather than ‘for people’. The equality in welfare treatment and the sustainability of human development is questioned today.

2.2 The Mixed economy of welfare

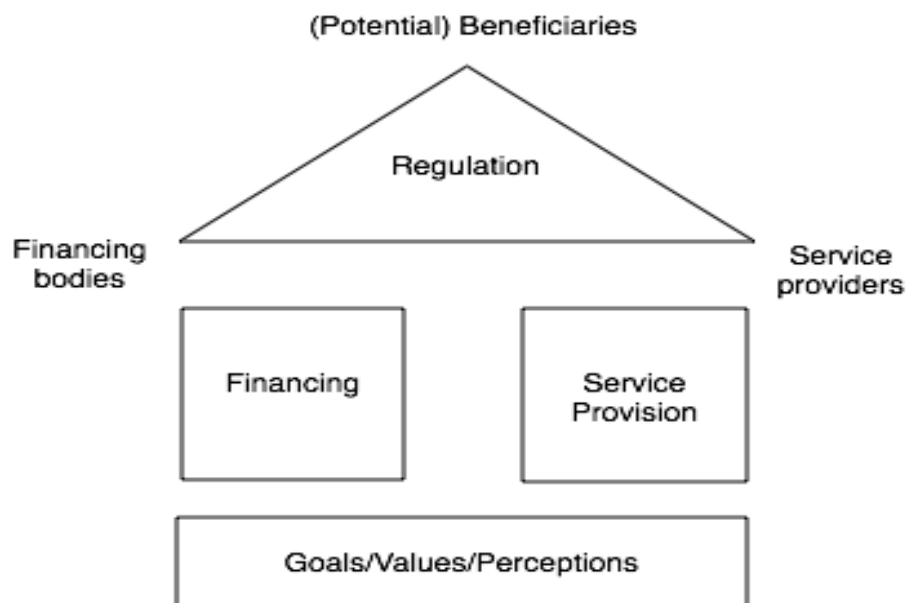
To understand the re-shaping of health care provision, the theory of public-private mix in welfare system is needed for building a theoretical framework. As mentioned above, it is difficult to directly use western theories in analyzing the welfare system in China. However, the mixed economy of welfare theory can be used as a starting point to look into the shifts flowing between the state and the market since transformation of welfare provision has become a global issue.

“During the golden era of welfare state capitalism, direct public provision of social policy was perceived as the core element for the realization of social citizenship. Social integration or the reduction of poverty by a majority of political actors and social scientists in Western Europe” (Seeleib-Kaiser, 2008; Marshall, 1950). “State was and still is considered as the main financier and provider of social policy despite of the increasing power of market, family and community. However, with globalization, aging societies and individualization, adjustments in the welfare states become unavoidable” (ibid:1). During the 1970s, direct welfare provision from governments both locally and centrally was considered a threat to the efficiency and liberty of the market. Since 1980s, the trend of privatisation and marketization extended into the welfare system in terms of financing, provision and regulation. Great changes have taken place in the ownership of welfare provision. “This traces the way in which welfare responsibilities that were previously accepted by the state have been transferred out of the public sector, and into the hands of individuals, new forms of provision and conventional private companies” (Powell, 2007:41-66). Provision of welfare with higher efficiency offered by the market or private providers is needed.

With the above historical development of the shifting from the state to the market, there is one question that remains to be answered to understand the public-private economy of welfare: What stands for 'public' and what stands for 'private'? Does the government provision refer to 'public' while the market provision refers to 'private'? "The arguments presented so far demonstrate the need to look beyond conventional conceptualization of public social policy. Direct state provision might not only be complemented, but substituted by publicly financed and or regulated "private" service provision. Public services do not necessarily have to be identical with state services" (Seeleib-Kaiser, 2007:10-11). 'Public' and 'private' can have very different meanings in different national settings. As for a welfare system where risks get highly collected, regulated and redistributed, we call it 'public' because the "governance within this domain primarily relies on democratic, legal and professional peer accountability while the "private" can not provide the same degree of certainty" (ibid). However, it is not easy to define 'public' and 'private' in real life with the different modes of social policy intervention. In order to capture the various possible shifts in the public-private mix, it is suggested to analysis based on three modes of policy intervention namely financing, provision and regulation (ibid).

At the beginning, scholars put forward one-dimensional analysis, focusing on the single issue of provision. However, "this move 'from state to market' does not differentiate between the dimensions of production, finance and regulation" (Powell, 2007:10-14). In addition to health care, Salter (2004) suggests two dimensions of provision and finance, "with respect to state and private, resulting in a four cell matrix-public provision/public finance; public provision/private finance; private provision/public finance and private provision/private finance, and public and private provision and funding" (ibid; cf Keen et al, 2001). The problem with these two-dimensional accounts is that boundaries are "permeable and ambiguous" (ibid; Hill and Bramley, 1983). Definitions of sectors are not without controversy and the margins are blurred. A three-dimensional framework is built on three perspectives of provision, finance and regulation. "State ownership or provision is not the only, or necessarily the best, method of state intervention. The state can finance or subsidize non-state providers to ensure that users have access to goods or services at zero or reduced price. The state can intervene without ownership or finance by using its legal authority to regulate prices or standards" (ibid). An analogy of a house is presented in the book *Welfare State Transformation: Comparative Perspectives* by Martin Seeleib-Kaiser, Professor of Comparative Social Policy and Politics, Fellow of Green Templeton College as follows:

Figure 1: three-dimensional framework



This figure is used in the analysis of health care system. “It depicts financing and service provision as the major pillars. The regulation dimension builds the roof and therefore relates to the pillars by which aspect of the health care system is regulated. The fundamental relationships between financing agencies, service providers and beneficiaries are subsumed, whereas at its base, goals, values and perception from a normative foundation” (Seeleib-Kaiser, 2007: 133; Rothgang et al, 2005, 2006). I shall develop this model with my own understanding based on the health care system in China as a starting point for the analysis part (as seen in p. 24).

The theory part consists of two theoretical models. The East Asian welfare model offers a possibility to give an overall review of welfare provision through the combination of western welfare theories with east Asian socio-economic environment. The mixed economy of welfare model opens a way for my study to analyze the Chinese health care system in a systematic way from three different dimensions. The following parts are developed on the basis of the research methodology presented below.

Methodology

“Research methods are core to scientific activity. They constitute an important part of scientific curricula and provide a means through which intellectual development and understanding of

phenomena are enhanced” (May, 2011:1). To answer the research questions, proper methods are of great importance for collecting and presenting data and other information. My hypothesis which is built on the base of my research questions is: during the health care reform in China, the majority of the urban population have now been covered by social medical insurance schemes. However, the government has decreased its input in public health spending and the hospitals have been gradually changing their nature from ‘public’ institutions to economic entities with ‘private’ characteristics who pursue maximum incomes. As a result, there are risks (increasing out-of-pocket payments for medical treatment and medicines) being shifted to the individuals, and the current health care system is actually making it gradually unaffordable for urban citizens to go to hospitals.

To examine the validity of my hypothesis, both of quantitative and qualitative research methods are needed. Specifically, the quantitative part is based on a secondary review of the official statistics produced by CNSB, WB and WHO. The qualitative part concludes both documentary analysis of the information which is related to the health care reform in China and interviews of urban Chinese citizens’ opinions towards the current health care system. The order of my thesis methods follow from the macro to the micro level, from the national to the individual level. As a result, documentary analysis is served to give an overall description of the selected important policies and regulations about the health care reforms, followed by concrete statistics and conversations from the interviews which give evaluations of the re-shaped public health care system. By collecting and sorting the information and data through the above methods, there is a clearer picture of whether or not risks are being shifted from the government and hospitals to the individuals. The following parts of this chapter give a more detailed discussion of the research methods which are selected.

3.1 Documentary analysis

Documentary analysis is crucial to improving understanding through the ability to situate contemporary accounts within historical context. With the wide variety of sources including governments’ reports, content of mass media as well as books and the Internet, this research method tells people a great deal about the way in which events are constructed, the reasons employed, as well as providing materials upon which to base further research investigations. It also tells people about the “aspirations and intentions of the periods to which they refer and describe places and social relationships at a time when we may not have been born, or were simply not present” (ibid: 191-195). To give a full picture of the changes in the health care system during continual reforms, I

choose documentary research which is very helpful for a better historical review and further understanding of my study.

The documentary analysis is used as the starting method to lay the foundation for the later quantitative part and in-depth interviews. To start with, what I am concerned with is the development of the two social medical insurance schemes in urban China (BMIUE and BMIUR), which is included in the research questions. Both related domestic and international documents, reports and other materials are found and will be analysed later. I prefer to collect information about significant government decisions on the health care system in urban areas in a time order as my first research step. Only with a good knowledge of the marco level can I understand the adjustment of roles of different health care sectors during the reforms. The documentary part will also go through the whole research part, working together with the secondary review of health care data and interviews. Hence, based on my research questions and hypothesis, specific questions should also be developed in this part. I read and sort the materials under the previous theoretical framework, information from the perspective of financing, provision and regulation in health care in urban areas are highlighted in this part of study.

3.2 Official statistics

The term ‘official statistics’ is normally used to refer to data collected by the state and its agencies, but may also include larger areas such as the European Union. Official statistics represent an extensive source of data on changing attitudes to particular social issues. The amount of material routinely collected by the government and its agencies provides a rich source of data for the social researcher. With access to data sets via the internet now available, technology has afforded researchers greater access to information and with that, more opportunities for secondary data analysis (ibid:74-77). Applying this method to my study, the data related to the health care presented in the National Statistic Yearbook of 2011 of China (this is the newest version available on-line so far), which is officially authorized by the Chinese government are selected.

However, importantly, as said in the book *Social Research, Issues, Methods and Process (4th edition)*, “while official statistics represent rich data sets, it has also been argued that they represent only what is seen as of importance to officialdom” (ibid; A. Dale et al. 1988:18) and “issues continue to exist in terms of the relations between government secrecy and confidentiality” (ibid; A.

Dale 1999). “These are fundamental political issues as many government seek to cloud their activities in the presentation of favorable and restricted measure of so-called ‘success’” (ibid). Considering this, to enhance the reliability and validity of my study, I also use related statistics from the reports and publications of big international organizations such as WHO, WB and OECD which publish extensive data. These studies usually related to a specific topic that is the purposes of providing background data but also with the aim of increasing understanding within the area of concern (ibid; A. Dale et al, 1988:9). “This information provides the government and social policy formulators with data upon which to base their decisions, as well as the means to forecast and evaluate the impact of new social policy provisions” (ibid; Berridge and Thom, 1996). Since the economic transformation and the implementation of the opening-up policy, China has become one of the biggest developing countries and its basic human rights constructions have caught increasing attention from the international society. Also, China has been actively participating in various international cooperations. Consequently, there is a lot of relevant data from publications and evaluation reports about the current health care system from the international organisations which I can use together with the data from CNSB.

To answer my research question of whether there are any health care risks being shifted from the government and hospitals to the individuals or not, concrete statistics of the changes in public institutions and in individuals’ health expenditure will be direct and convincing proof. I picked up following statistics closely related to my research questions and theoretical framework to see the re-shaping of the financing structure of health care in urban areas from 1995 to 2010, which almost covers the important period of the construction of the current health care:

- 1) To examine whether there has been a decrease in public spending on health care in China, data of the annual percentage growth rate of GDP, the total health expenditure as a percentage of GDP as well as the public health expenditure as a percentage of GDP are collected. In order to give a more explicit description of the level of the input that Chinese government spends on public health care system from the international perspective, same catalogue of data of three types of classical welfare states such as Sweden, Germany, USA; data of India, one of the biggest developing countries which is facing very similar situation with China; data of countries such as Malaysia and Thailand, which are also belonging to the East Asian Model are presented for comparison.
- 2) To examine whether there has been an increase in out-of-pocket payments of medical treatment and medicines for urban residents in China, data of the average expenditure on health care for the

urban residents and the proportion of health care as a percentage of urban residents' total consuming expenditure are needed. Moreover, during the globalization and economic recession, a lot of western countries have decreased or intend to decrease the fiscal funding for public health care. It is very interesting to see that whether the rise in the involvement of private sectors or the market has led to increases in the out-of-pocket payments or not. In the book *Welfare State Transformation: Comparative Perspective*, it divided the European countries into several big clusters according to their geographic positions. Based on this, it discussed the welfare transformations of countries such as the Czech Republic, Italy, Denmark and the United Kingdom in these clusters. I apply this division into this section and data of the proportion of individual spending on health care of these countries is selected. Also, data of Malaysia, as the very typical East Asian Model country is chosen for further comparison with China.

- 3) To examine whether there are risks being shifted from the hospitals to the individuals and what is the reason for this, it is very important to see the income structure of the hospitals. For example, whether there has been a rapid increase in the proportion of medical treatment and the pharmaceutical income in recent years.

By sorting the above essential statistics, several figures, charts and tables are going to be presented in the analysis part for a vivid understanding. The quantitative part will work closely together with the qualitative part to support each other and form a triangulation research system.

3.3 Semi-structured interview

3.3.1 Selection of interview type

While the quantitative part is used for more objective research based on the fixed data, the qualitative part serves as a more subjective evaluation of the current health care system. The second qualitative research method I choose is interviews, "which yield rich insights into people's biographic, experiences, opinions, values, as pirations, attitudes and feelings" (ibid:135). To examine my hypothesis in this thesis that the increasing out-of-pocket payments for medical care and treatment make it gradually unaffordable for people to go to the hospitals, urban residents' attitudes and experiences are significant. And by conducting problem-focusing interviews I can obtain their opinions in an efficient way.

There are different types of interviewees and I prefer to use a semi-structured interview for my study because of its qualitative depth. “It not only enables the interviewer to have more latitude to probe beyond the answers and thus enter into a dialogue with the interviewee, but also allows the respondent to answer without feeling constrained by pre-formulated questions with a limited range of answers” (ibid: 134-149). As also proved in German psychologist and sociologist Uwe Flick’s book *An Introduction to Qualitative Research (Fourth Edition)*, by conducting semi-structured interviews the interviewed subject’s viewpoints are more likely to be expressed than by using highly-structured interviews or questionnaires. Moreover, an openly designed interview situation, compared to a standardised interview or a questionnaire, is considered more suitable for a study of this kind where we want to capture the informants’ views on the problematic (Flick 2006:145-165). “The flexibility of semi-structured interview represents an opening up of the interview method to an understanding of how interviewees generate and deploy meaning in social life and make them involved in the ‘monitoring, reflection and resultant change process’” (May, 2011: 135; MaKie 2002: 270). When conducting semi-structured interviews, it is more important for me, the interviewer, to ‘listen’ rather than to ‘teach’ the interviewees because they are the beneficiaries in the social medical insurance programmes and their evaluations on the changes in the public health care system are of great importance for the empirical study of this thesis.

3.3.2 Questions preparation and selection of interviewees

Based on my own research interest and hypothesis, as well as the information and data from previous documentary analysis and quantitative part, the interview questions are divided into following themes with around 11 questions which are initially developed, followed by some basic questions such as age and occupation to open up the conversations with my interviewees:

- * Interviewees’ understanding and opinions about the social medical insurances they are covered in, such as the level of the reimbursement system;
- * Interviewees’ recent experiences in the hospitals. For example, whether they have been persuaded to have unnecessary medical checks or to purchase high expenses of imported medicines which actually contributes to the doctors’ bonuses and the hospitals’ incomes;
- * Interviewees’ preferences on big hospitals which has much higher degree of marketization and community hospitals which are more ‘pure public’;

* Interviewees' attitudes on the up-dating health care reforms and evaluations on the current health care system. For example, do they think feel it is more expensive or cheaper to go to the hospitals nowadays when they are included in the social medical insurance programs.

More detailed questions refer to Appendix B.

Since I choose semi-structured interviews, I pay more attention to the flexibility of the interview questions. As said in the book *Feminist Research Practice*, a list of written questions will help to have some control during the interviews but more importantly, new questions are going to be asked according to the informants' response (Hesse&Sharlene, 2007:115-118). The idea that interviewees may be 'answering' questions other than those we are asking them, and making sense of the social world in ways we had not thought of, lies behind many qualitative interview strategies. The logic that we should be receptive to what interviewees say, and to their ways of understanding, underpins much of the 'qualitative' critique of structured survey methods. Hence, it is very important that the interviewer has good ability of controlling the conversation and adjusting the interview questions during the 'listening' process. When it comes to the specific questions, it is noted that the qualitative interview uses three kinds of questions: main questions that begin and guide the conversation, probes to clarify answers or request further examples, and follow-up questions that pursue the implications of answers to main questions. But, equally important, the qualitative interviewer remains flexible and attentive to the variety of meanings that may emerge as the interview progresses. "This open stance includes being alert to developing meanings that may render previously designed question irrelevant in light of the changing contexts of meaning" (Gubrium & Hoistem, 2002: 87). When actually conducting the interviews, a lot of adding complementary interview questions arose and some questions were removed according to the responses from the interviewees. However, in general the main themes I wrote above were covered to a great extent.

As for choosing the interviewees, I used the 'snowball' method: one respondent is located who fulfills the theoretical criteria, then that person helps to locate others through her or his social networks (ibid; Arksey and knight 1999:4; Biernacki and Waldorf 1981; Weiss 1994: 25). Since my research objectives are limited to the residents in urban areas, I decided to interview 4 parents of my universities' classmates who come from Shanghai, Wuhan, Wuxi and Suzhou respectively. One classmate's friend who is suffering Leukemia from Shenzhen was willing to be interviewed, which gives rich information for this study. I choose these several cities because they are quite developed big cities in China and have been enjoying relatively mature social medical insurance programme.

Furthermore, these five selected cities are covered by an excellent communication system such as internet and telephones and thus makes it possible for me to conduct the study. When almost finishing the interviews, I asked the interviewees whether they know anyone around them, especially people who are suffering chronically or have been experiencing any life-threatening diseases, if it is possible for me to interview them. By this way, I found the rest of my interviewees. Based on different gender, age, education background, occupation and residence places of the interviewees, information from 11 interviews is used in the analysis part.

Due to the limitation of time and expenditure, I conducted the interviews by telephone. The length of interviews varies, ranging from 27 minutes to 1 hour. Before asking the interview questions, I give a short introduction of myself to build the first step of trust for the interviews. Also, all interviewees were informed that anonymity would be guaranteed as one of the academic regulations before I started the interview part, even though all of them said that they had no reserve in being disclosed in relation to their interviews. With the agreements from the interviewees, all the interviews were recorded by digital recording device for later transcription use. More details can be found in Appendix A and B.

3.4 Reliability and validity

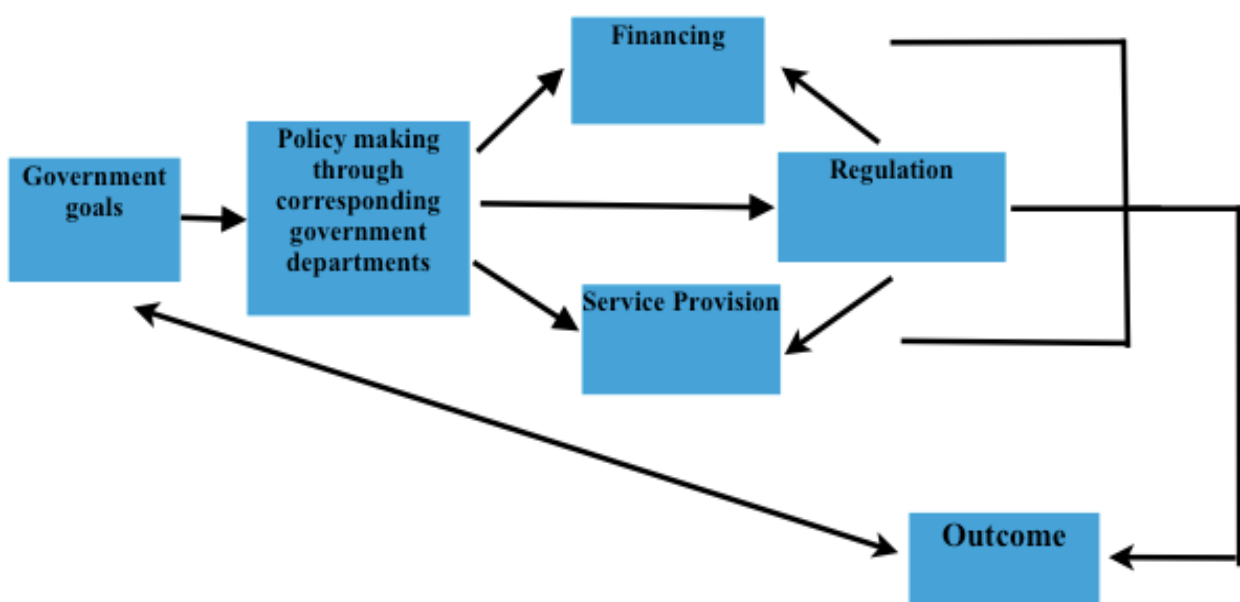
In order to enhance the reliability and validity of my empirical study, the source of all the materials quoted in the documentary analysis and data presented in the quantitative part are indicated and all the interviews were recorded with digital device. The language might be a problem which is related to the validity because some of the governments' documents I use and all the interview transcripts are in Chinese. Although there might be unavoidable mis-interpretation of the original meaning due to my English level during the translation process, I try my best to be objective and respect all the empirical material and transcripts and make them readable in English without changing their original meanings. Despite the possible slight errors due to the language problem, the order from documentary analysis to secondary review of official statistics to semi-structured interviews follows from macro national policy level to micro individual welfare level, which helps to build a clear structure for the following analysis part. The use of both qualitative and quantitative methods forms a triangulation research system in which different empirical findings complement and examine each other. This turns out to be useful in generating a comprehensive and deep understanding of the health care reforms and current health care system as well as examining my initial hypothesis that whether

there are risks being shifted to urban residents due to the changes in health care sectors during reforms. A clear and systematic methodology framework helps to improve the objectivity and validity of my study.

Analysis

Based on the findings from conducting above research methods, a systematic analysis after selecting and sorting useful data is developed in this section. The Chinese government launched a new round of health care reforms in 2003, in order to solve problems related to imbalance and incentives. Generally, the coverage and the use of medical facilities has been greatly improved with an increase in the government investment. Nonetheless, the risk pooling at the national level still remains quite low. Chronic illnesses and catastrophic diseases continue to push people into poverty. The poorer the region is, the worse the situation becomes (OECD, 2010:209). The hypothesis of this thesis is that the commercialization of the public health care system during the marketization leads to cost escalation for medical services and pharmaceutical products. Despite the great efforts that have been made by the Chinese government to improve the equity of the health care system, there are increasing risks being shifted to citizens in urban areas even though they are covered by the social medical insurance schemes. To examine this, I would like to build the following model (as seen in Figure 1) to set a framework to develop the analysis chapter of this thesis.

Figure 2: Analytical framework



The government's goals for health care are presented with relevant governmental documents and policies as well as an evaluation report produced by OECD. Since my research interest is mainly in urban areas, important references related to the development and problems of the BMIUE and the BMIUR are given priorities. Based on the theory of the mixed economy of welfare, three dimensions, namely financing, service provision and regulation (Seeleib-Kaiser, 2007:11) are analysed with official statistics, relevant documents as well as responses from the interviews. And in this part, the roles of the different components of the health care system such as the state and individuals or their families (Powell, 2007:14) in these three welfare dimensions are the focus of my study. Lastly, the final part is to examine the outcome of the current health care system. A comparison with the initial government's goals is made for a final evaluation, which serves as the conclusion of this study.

4.1 Development of the two major social medical care insurances in urban areas:

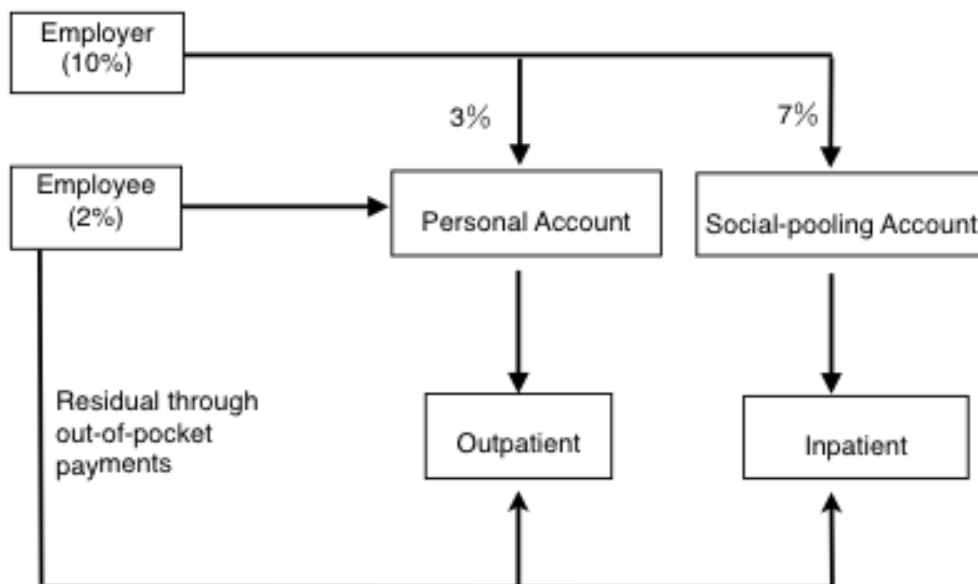
As mentioned in the introduction part, the Chinese government issued a document to establish a unified urban medical care scheme which is compulsory for all urban employees (BMIUE), regardless of the type of enterprise in 1998. It is a combination of social pooling accounts and individual accounts. It requires both employers and employees to pay payroll-based contributions. By the end of 2003, around 109.02 million people in the urban areas had participated in the basic medical insurance program, including 79.75 million employees and 29.27 million retirees¹². In order to address the problem of health care for the rest urban residents who had not been included in the employment-based social medical care scheme, the central government has introduced a pilot program in 2007. BMIUR was established, which is targeted at including those “without work and flexible work patterns, the large group of uninsured migrant workers, and impoverished children” (Sander et al, 2010:9). It builds a voluntary system in which the urban residents pay a certain amount of money to purchase a social medical care insurance that is partly subsidized by the government.

BMIUE is employment based. As mentioned in the introduction part, this social medical care scheme features two components: a social pooling account and an individual saving account. The former one is mainly for inpatient expenses and the latter one is mainly for outpatient expenses. It needs contributions both from employers and employees. On average, the employer pays 8% of the

¹² www.chineseculture.about.com/library/china/whitepaper/bl2004social04.htm

total wage and the employee pays 2% of his or her individual wage. However, this is just a general pattern and the actual contribution rate differs in different urban areas according to the economic development and consumption level. The individual saving account is fed by the individual's 2% contribution to the basic insurance system and 2% of the employer contribution. Outpatient costs are met through this account. The rest of the contribution from the employer goes to the social pooling account which is used for inpatient expenses. Figure 3 gives an example of the contribution components of Shanghai's BMIUE. As for the reimbursement level, "hospital costs are subject to a deductible equivalent to 10% of the local average annual wage. If expenses are less than four times the annual local wage, 85% of the cost above the deductible is paid by the insurance. This ceiling was raised to six times the local salary in 2009" (OECD, 2010; Wagstaff and Lindelow, 2008). In urban areas, employees are encouraged to contribute to a supplementary medical care system. However, there is still an upper limit on payments. Once the costs of medical treatment and pharmaceutical products exceed the threshold, the patient has to pay 100% of the excess himself or herself. "This scheme does not seem to have reduced catastrophic medical expenditure and may have increased the financial risk from a hospital stay, as hospitals tend to subject insured patients to more procedures" (ibid).

Figure 3: Shanghai's BMIUE contribution model



Source from: Shanghai's government website

(<http://www.shanghai.gov.cn/shanghai/node2314/node3124/node3125/node3127/u6ai269.html>)

By conducting the interviews, the finding is that based on different occupation and salary, the money received in the personal account differs among the interviewees. The following statements are part of two interviews which aims at employees in Shanghai. Mrs. Qiu works in a very famous state-owned enterprise and enjoys quite good welfare treatment while Mrs. Pei works for a private company and receives much less money in her personal account for health care.

“For the BMIUE, around 3,000-4,000 yuan will be put into my medical insurance card every year. It depends on how long you have been working and your previous salary. If I finish all of it, after 1,600 yuan of out-of-pocket payments for the medical costs, the government pays 60% and the individual pays 40%. In Shanghai, we also have an additional medical insurance called the Social Pooling of Medical Costs for Catastrophic Illness. I pay 50 yuan every year. Before it cost 30 yuan. I think they raised the fee from last year. But the good thing is that if you get serious diseases, 80% of the medical costs can be reimbursed, as the government says...” (Mrs. Qiu. Phone-interview. February 3rd, 2012).

“I am covered by BMIUE and around 1,000-2,000 yuan will be put into my medical insurance card every year. However, there are a lot of drugs that I can't pay for with my medical insurance card, which means I have to shoulder the payments myself. But for my husband who is working in a large-scale state-owned enterprise, he can get reimbursement for almost all the items. After 1,500 yuan of out-of-pocket payments for medical costs, the government pays 60% and the individual pays 40%.” (Mrs. Pei. Phone-interview. February 21st, 2012).

“In order to build a harmonious society, a marked change in government policy started in 2003. The conspicuous shortcomings of the financing arrangements led the government to progressively introduce three new financing systems including BMIUR” (OECD report, 2010:225). Compared to BMIUE which is employment-based and compulsory, BMIUR's membership is voluntary and the central government provides subsidies for each participant and the local government is encouraged to match. Hence, the total amount of government subsidies varies in different cities. For the urban areas, the central government currently pays at least 40 yuan per year. Taking Wuxi (city name) for example, according to the local government's document Notice for *Wuxi's Basic Medical Insurance for Urban Residents*, the payment for purchasing BMIUR is as follows:

1. The collective fund for students and local residents under 18 years old is 280 yuan every year. Hereinto: 200 yuan from fiscal subsidies and 80 yuan from individuals' payment;
2. The collective fund for other local residents is 420 yuan. Hereinto: 270 yuan from fiscal subsidies and 150 yuan from individuals' payment.

Mr. Gao is one of the interviewees for this study. He lives in Wuxi and joined BMIUR in 2010. He is unemployed since almost five years back. Without any stable income, he was really worried about his future health situation especially before the local government implemented this new social health insurance. Now insured by BMIUR, he feels less stressed.

“I have been searching for jobs for several years. But I am not included in the unemployment system because I was self-employed before, according to the regulation of the government. That means I am not able to receive any unemployment insurance, nor pension or health care insurances. But now I can purchase the social security insurances under the new policy. Take health care for example, now I am purchasing the BMIUR programme. If I go to see the doctors in the designated community health centers by the government, I will get 50% reimbursement for the medical payments. If I don't remember wrong, the reimbursement is limited to 35,000 yuan. And if I suffer any catastrophic illness and the community health centers are not able to treat. After they give an approval, I can go to the big hospitals and then the reimbursement is limited to 60,000 yuan.” (Mr. Gao. Phone-interview. March 2nd, 2012).

The social medical insurance schemes have been expanded in recent years and almost all of the urban population are covered. However, “coverage provided through these programmes is very small, in terms of both the service benefit package and the financial protection provided” (Zhu, 2010:60; Chen and Gao, 2008). Especially, “the inpatient services leave patients with significant costs (co-payments, deductibles, or additional fees) to bear. As a result, access to primary care for poor people has not really improved, and financial protection against high health care expenses remains very restricted” (Hu et al, 2008: 70). The lack of equity in the financing and the rise in out-of-pocket payments have hardly been mitigated. Therefore, there has been increasing insecurity among urban citizens who are suffering chronic or life-threatening diseases. The following conversations come from the interviews and give a good example.

“I have been suffering from high blood pressure for some years. The pills I am taking now cost me around 700 yuan every year. It is almost equal to the amount I receive in the health care account

every year. This means that if I suffer from any other illness and have to go to the hospital, there will be out-of-pocket payments for medical treatment and drugs. Even though some of them can be reimbursed through BMIUE, but nowadays it is so expensive to see the doctors and the reimbursement level still remains quite low. I don't want to go to the hospital until I really feel bad." (Mr. Shi. Phone-interview. March 2nd, 2012).

"My grandfather was living in the hospital for several months last year. He was diagnosed with acute cerebral hemorrhage (disease name). I don't really know how much it cost in total. I just remember that my mother got different bills every day and had to frequently withdraw money from the bank to pay the hospital. And only a small part of the payments could be reimbursed through my grandfather's BMIUE account. One of my neighbors was diagnosed with stomach cancer two years ago and his families finished almost all the savings to purchase medicines for him. At last, his wife had to sell their house to collect money for the operation." (Mr. Xiao. Phone-interview. February 18th, 2012).

"I am pretty healthy now and I think I have enough money in my health care account every year. But I am very stressed with my daughter's disease. She was diagnosed with chronic diabetes when she was in primary school. At that time, there were no possible social insurances for her at all, nor any commercial insurance because they don't cover this kind of chronic diseases in a long term. Although now she studies in university and enjoys a certain type of social health insurance paid together by the government, universities and students, none of the drugs (insulin for example) or syringes are listed in the social reimbursement catalogue. There is a doctor who introduced the pharmaceutical provider to us and it is cheaper to buy directly from the factory without going through the hospitals. It still costs us around 1,000 yuan every month, for almost 15 years. It is one of the heaviest burdens for my family." (Mrs. Wu. Phone-interview. January 20th, 2012).

By greatly increasing the public input in medical infrastructure and enlarging the coverage of social medical insurances, the Chinese government effectively solved one of the major problems of limited health care resources. However, the high proportion of out-of-pocket payments for health care remains to be the most significant concerns for urban citizens. To give a deeper understanding of the increasing insecurity of economic risks in paying for the health care, the following part is divided into three sections. A further analysis based on concrete statistics from three perspectives,

namely financing, provision and regulation is give to examine why the Chinese government is unable to offer an affordable health care system to urban citizens even they have been insured.

4.2 Financing

To give a better analysis on the development of the current health care system in China, results from the quantitative research is given as follows. The first section is about the financing system, which is being discussed the most when referring to the health care because “health care financing involves the basic functions of collecting revenue, pooling resources and purchasing goods and services” (Zhu, 2010:53; WHO 2000). I go from both of the government’s spending and out-of-pocket payments for individuals to illustrate how the risks of health care are shared in China.

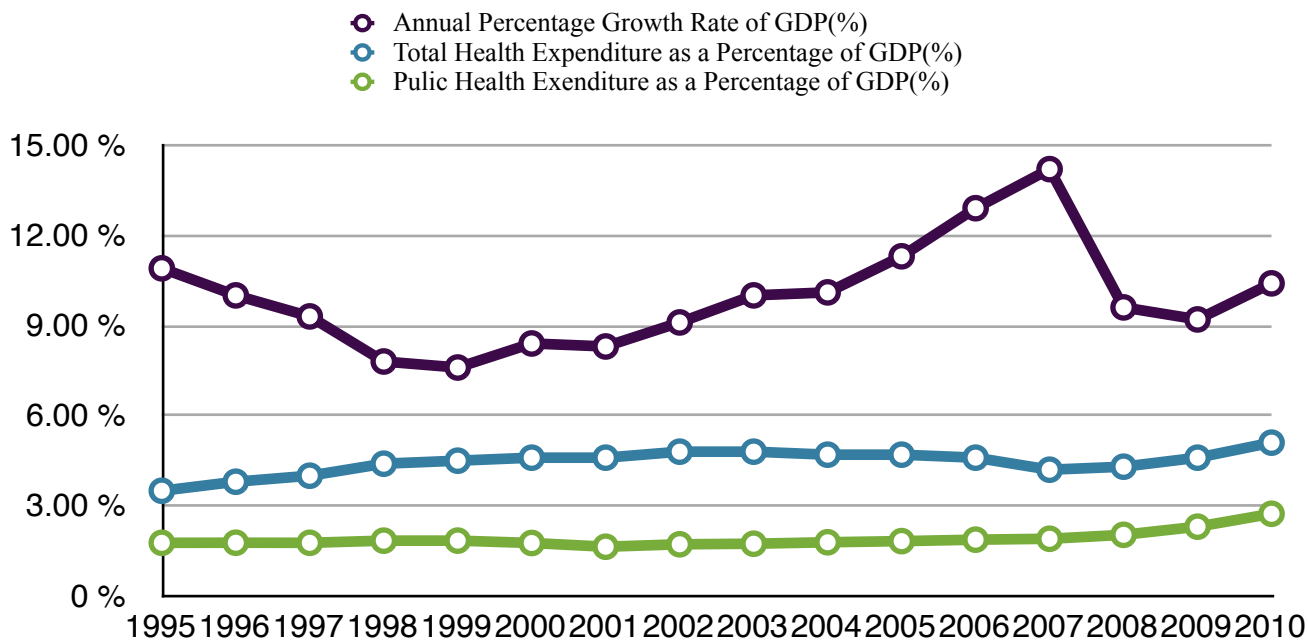
4.2.1 The public spending

For the Chinese government, there are three major challenges regarding China’s health-care financing structure: “how to raise the money, how to pool what is raised and how to reimburse service providers” (Parry&Cui, 2008: 821). Since the economic reform, China has been enjoying a remarkable economic boost. As most of the developing countries, especially the East Asian countries, GDP growth has been put in the first place of the government’s agenda. These developing countries have achieved rapid rises in national income per head of population without corresponding improvements in the health, education and other welfare of their citizens. The disparity between economic growth and indicators of human development is enlarged (Jordan, 2006:21). The outbreak of SARS in 2003 exposed China’s fragile public health care system and the Chinese government realized that the patchy health insurance coverage was a problem. However it was not until 2006 that “health officials recognized that reinforcing the health system was just as important as prevention and treatment of infectious diseases” (Parry&Cui, 2008:821).

In order to examine the Chinese government’s input in the public health care compared to the priority given to the economic growth, the following chart is made with figures of the annual percentage growth rate of GDP, the total health expenditure as a percentage of GDP as well as the public health expenditure as a percentage of GDP during 1995-2009. The time limitation

(1995-2009) is considered upon two reasons: the availability of the official statistics from WB and the year (1998) the Chinese government officially launched BMIUE.

Chart 1: Comparison between GDP growth and public health expenditure growth of China (%)



statistics source: the annual percentage growth rate of GDP, the total health expenditure as a percentage of GDP and the public health expenditure as a percentage of the total health expenditure are directly from World Bank, 2011¹³

As the above chart shows, the annual percentage growth rate of GDP is increasing at an amazing speed despite of fluctuations. It experiences a gradual decrease from 1995 to 1999 and after that it modestly increases every year. It reaches the highest point of 14.2% in 2007, followed by a sharp decline by 4.6% in 2008. However, the GDP growth still remains high and increases to 10.4% in 2010. On the other hand, the growth rate of total health expenditure especially the share of public-spending, remains very low compared to the growth rate of the economy. The public health expenditure accounts for 1.77% of GDP in 1995 and it slightly rises to 1.84% in 1999, followed by a gentle decrease for two years. Since 2003, it steadily ascends every year and there is a relatively substantial increase since 2009, where the statistic reaches at 2.3% and it continues to grow by almost 0.43% to the end of 2010. Generally speaking, both of the GDP and input in public health expenditure remains growing despite fluctuations during this period. However, it is obvious that the average growth of GDP is much faster than the average growth of government input in public health expenditure. These statistics vividly indicates that the Chinese government’s activity is greatly focused on economic development. As a result, basic human rights such as health care have fallen

¹³ data.worldbank.org/indicator

behind. However, it can be also seen that the Chinese government has been increasing its efforts in public health care in recent years, remarkably since 2008.

In order to give a better illustration of the above findings, more comparison from an international perspective is made and shown in the following table. It is built on the same indicators but of different countries during the past five years.

Table 1: Comparison of the public-spending in health care among different countries (%)

Here: GGR= the Annual GDP Growth Rate, PHE= the Public Health Expenditure as a % of GDP

Country	2006		2007		2008		2009		2010	
	GGR	PHE	GGR	PHE	GGR	PHE	GGR	PHE	GGR	PHE
China	12.7	1.87	14.2	1.90	9.6	2.04	9.2	2.30	10.4	2.73
France	2.5	8.48	2.3	8.39	-0.1	8.50	-2.7	8.96	1.5	9.26
Netherlands	3.4	7.33	3.9	7.29	1.8	7.45	-3.5	8.35	1.7	9.42
Germany	3.7	7.81	3.3	7.75	1.1	7.83	-5.1	8.55	3.7	8.94
Sweden	4.3	7.17	3.3	7.13	-0.6	7.34	-5.2	7.78	5.6	7.79
UK	2.6	6.95	3.5	6.89	-1.1	7.19	-4.4	7.77	2.1	8.05
Denmark	3.4	7.68	1.8	7.78	-0.8	7.93	-5.8	8.17	1.3	9.70
USA	2.7	6.87	1.9	6.97	0.0	7.27	-3.5	7.87	3.0	9.50
India	9.3	1.13	9.8	1.21	4.9	1.36	9.1	1.38	8.8	1.20
Malaysia	5.8	1.92	6.5	2.00	4.8	1.90	-1.6	2.15	7.2	2.44
Thailand	5.1	2.52	5.0	2.68	2.5	3.05	-2.3	3.26	7.8	2.93

statistics source: the annual percentage growth rate of GDP, the total health expenditure as a percentage of GDP and the public health expenditure as a percentage of the total health expenditure are directly from World Bank, 2011¹⁴

The above table consists of two clusters of countries. One cluster consists of some developed western welfare states and the other one includes several developing Asian countries including China. As it is illustrated in the table, the cluster of western welfare states have relatively low GDP growth before suffering the global economic crisis since 2008. The majority of these countries have experienced a negative GDP growth for over two years and the numbers seems quite high, ranging from -2.7% for France to -5.8% for Denmark. Nevertheless, even under this situation, none of them have decreased the share of public-spending on health care expenditure. The trend shows that the

¹⁴ data.worldbank.org/indicator

spending on social health care remains increasing despite slight fluctuations in some of the western countries' statistics during the last five years. In 2010, with the recovery of economic situation, all of these countries reach their highest points of public-spending in health care. Remarkably, the public health expenditure as a percentage of GDP of Denmark rises from 7.68% to 9.70% by 2010 during this period, which is highest among the above listed countries. Also, the public input in health care of the United States achieves the fastest growth by almost 2.63% compared to other welfare states in the table.

Comparing with these statistics, despite of the amazing economic growth, China has very low input in public health expenditure, growing from 1.82% to 2.3% of GDP. A similar situation can be found in the three selected Asian countries. All of them especially India, show promising economic growth, despite that Malaysia and Thailand were affected by the economic crisis in 2009. However, the growth in the public health expenditure is much lower than the growth of GDP, which is resulted from these governments regarding public health improvement as a by-product of economic growth rather than an integral part of a overall strategic approach (Jordan, 2006: 99). Compared to China, India and Malaysia, Thailand seems to have the highest growth - around 1% of GDP more in public-spending in health care during these five years. In 2009, its statistic reaches 3.26%, but it is still less than half of that of any above selected developed western country. It is not difficult to notice that in these developing countries, especially China and India, economic growth has been put in the much more significant place in the governments' agenda than the equalization of incomes, life chances and opportunities and resources among populations.

However, it can be also seen that the Chinese government has been increasing its efforts in the public health care in recent years. "In 2007, the central government began to subsidize community health-care services in central and western China at the level of 3–4 yuan per urban resident, which the local authorities are required to match," says Dr Lei Haichao of the Department of Health Policy and Regulation at China's Ministry of Health. Public financing of health care is increasing, according to Lei. There has been a dramatic change in the government budgetary financing on the public health care, rising from 15.9% to 18.1% of the total health care spending from 2001 to 2006 (Parry&Cui, 2008:821). Especially, in April 2009, the Chinese government launched a new round of health care reforms, which aims at building a basic social security system with universal coverage. Concrete measures for achieving this have been formulated and presented in this official proposal, consisting of "expanding the coverage of enrollment, raising-up of financing level, improving

benefit structure, reforming payment modes, and promoting government reforms of public insurance agents” (Gu, 2010:84). Meanwhile, “this programme involves extra outlays of 850 billion yuan over 2009-2011, which is equivalent to 0.8% projected GDP over that period. Local authorities are expected to fund 60% thereof. The cost of the transfer to the rural health insurance and urban schemes plus the cost of public health provision will amount to about 160 million yuan annually (0.5% of GDP and 60% of total outlays)” (OECD, 2010:227). The remaining money will be spent on staff training and construction of infrastructure for primary care which is based on community health care centers. A majority of the interviewees have relative optimistic attitudes towards the increase in public-spending in health care despite of concerns with cost escalation and low level of reimbursement.

“I am pretty ok with the health care system because I am still very healthy and almost never go to the hospital. The money I receive in my health care account is enough for purchasing some ordinary medicines. I think the social medical insurance schemes are good and we can see the government is still improving them. But if comparing China’s health care system to some western countries especially in terms of government’s responsibilities, I feel too much insecurity about my future health if I become really ill.” (Mr. Zhou. Phone-interview. February 5th, 2012).

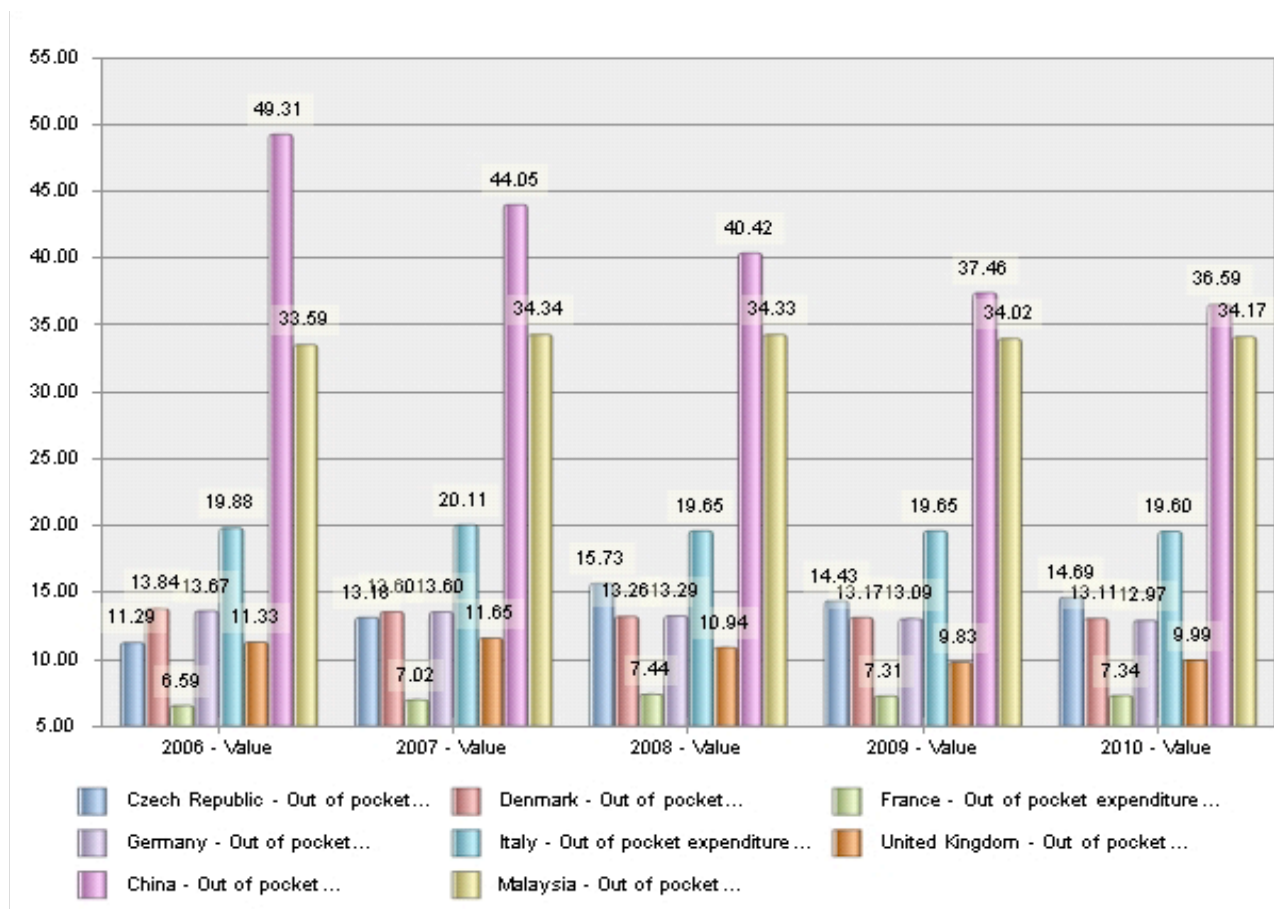
“I think the BMIUR policy is really good for us unemployed citizens. It builds a security net for us and the health risks are shared together by the society and individuals, which lessens the burden for the families. However, I hope the government can invest much more money into the public health care and reform the public hospitals into non-profit institutions. I guess if now I am suffering from any life-threatening diseases, I will just make complaints here about the low security level of BMIUR. But fortunately, I think the Chinese government is on the way to build social protection for its citizens.” (Mr. Gao. Phone-interview. March 2nd, 2012).

4.2.2 The individual spending

Following the above study of the public-spending in health care, the proportion of households’ payments is analyzed in this section. According to the OECD, out-of-pocket payments for health care should not exceed 30% of a person’s income (Parry&Cui, 2008:822). However, in contrast with the strong GDP growth, public spending on health care is insufficient in China. The high level of out-of-pocket spending by average households is an important sign of insufficient risk pooling

and public funding for health (Zhu, 2010:57). In 2005, the out-of-pocket payments for health accounted for 61.2% of a Chinese’s average annual income. In 2007, the out-of-pocket payments that households paid for medical services were almost more than 19 times what they were in 1990 (ibid). According to a national survey conducted by MH in 2007, 38% of the sick people were not treated, 70% refused hospitalisation due to financial problems and over 54% of patients “discharging themselves against medical advice cited cost as the reason for their action” (OECD, 2010; MH, 2009). “In urban areas, the gap between the hospitalisation rate for the patients in the lower and upper income quintile has been estimated to have widened from 15 to 24 percentage points between 1993 and 2003” (OECD, 2010; WHO, 2005). The public health care system is supposed to reduce financial barriers to health care and serves as a protection of households from incurring catastrophic medical expenditure (Zhu, 2010:57). However, in China, the sharp increase in the costs of medical care services and drugs became a major barrier for patients, even when they are covered by social medical insurances.

Chart 2: Comparison of proportion of out-of-pocket payments among different countries (%)

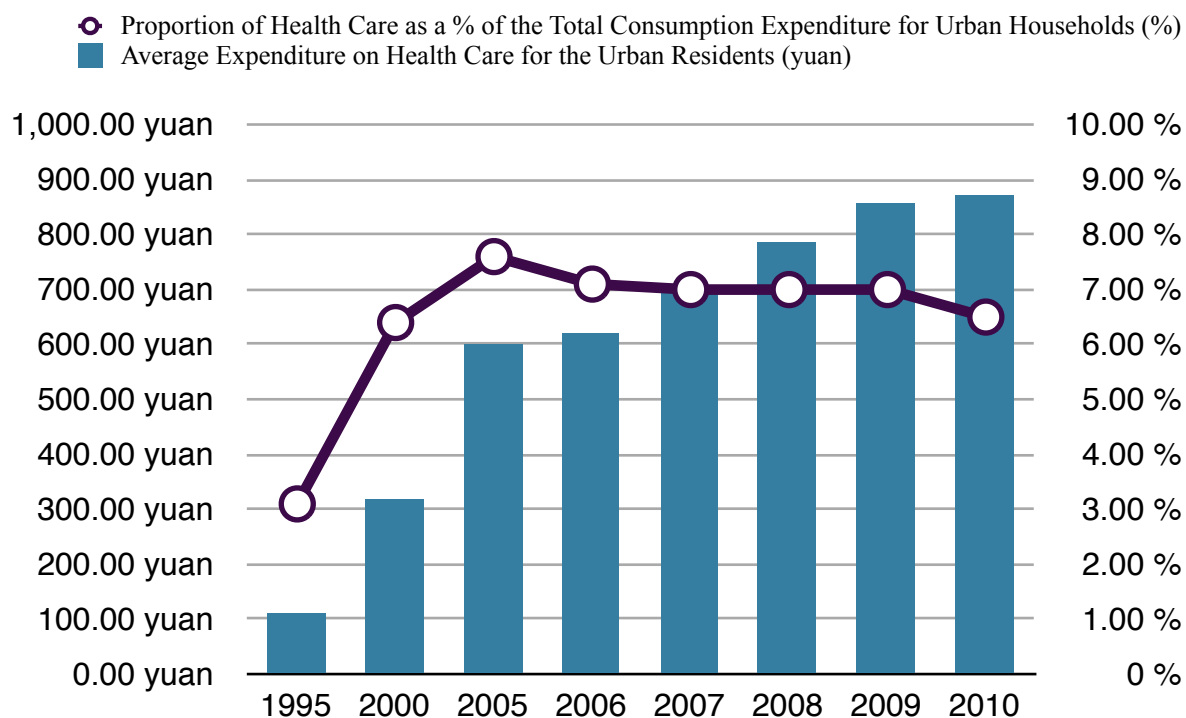


Source from: World Health Organization National Health Account database <http://apps.who.int/nha/database>

The above chart shows the out-of-pocket payments expenditure as a percentage of the total health care percentage among selected countries. As mentioned in the previous analysis, traditional western welfare states enjoy high level of public-spending in health care. Thus, countries like France, United Kingdom, Denmark and Germany have relatively low proportions of out-of-pocket payments. Especially, France has the lowest statistics among the above countries, despite a slight increase in the last five years. Italy has the highest statistics in the above European countries due to its economic recession. But still, compared to China and Malaysia, Italy's statistics are almost half of those of the two countries. From authoritarian to democratic and pluralistic political system, the Czech Republic also experienced an abrupt shift from a centrally planned economy to a market economy (Seeleib-Kaiser, 2008:79-90). "The changes in health care have largely been characterized by retrenchment and the public health funds operating now mostly as public insurance schemes severely limit the services they pay for" (ibid; Ferge, 2001). Many types of prevention and a long list of pharmaceuticals have been excluded from public funding, which severely contributed to the high level of dissatisfaction with the performance of the public health care system (ibid). Nonetheless, in the last five years, the proportion of out-of-pocket payment of Czech people is still much lower than that of China. Malaysia, one of the typical East Asian model countries, also has quite high statistics due to inadequate public-spending on health care. However, the statistics are lower compared to those of China. In 2006, China's statistic is 49.31%, almost 7 times higher than that of France. Since 2008 when the draft of the official proposal for a new round of health care reforms was realized for public examination, the out-of-pocket payment as a percentage of total health expenditure has been decreasing by almost 3.8% in two years, and around 12% less compared to the statistics of 2006. However, the statistics still remains very high compared to other selected western countries.

"The Chinese government argued that the burden is reduced because out-of-pocket payments as a percentage of total health expenditure have been reduced," says Dr Henk Bekedam, director of health sector development at WHO's Office for the Western Pacific Region in Manila. "It's an achievement, it's good, but it's not sufficient information to argue that people are paying less. You also have to look at other indicators, such as health-care spending as a proportion of total household expenditure" (Parry&Cui, 2008: 822). Inspired by the above statement, the following chart is made to give a deeper understanding of the individual's spending on health care.

Chart 3: Expenditure on health care for residents in urban areas



statistics source: Yearbook of Chinese Health Statistics, 2010. Hereinto: the statistics of 1996-1999 are not available in the yearbook.

Chart 3 illustrates the proportion of health care as a percentage of urban households' total consumption expenditure. As we can see, from Year 1990 to 2005, there is a dramatic increase on health care payments. The average costs on health care per head grows from 25.7 to 600.9 yuan. Compared to Year 2010 where the number is 871.8 yuan, the average health care costs increased almost 40 times during the last two decades. Accordingly, the proportion of health care as a percentage of the total consumption expenditure for urban households grows from 2.0% to 7.0%, which shows there are great risks being shifted to individuals and make them shoulder increasing pressure under the current health care system in China. With the dramatic increase in public-spending according to the new health care reform, the statistics falls from 7% to 6.5% from 2009 to 2010. However, the number still remains quite high. Health care occupies the third biggest proportion of daily consuming expenditure after housing and education in urban China¹⁵. How to offer affordable health care remains to be solved.

In China, illnesses especially chronic and catastrophic diseases, have a major impact on individuals' incomes (OECD, 2010:221). For a Chinese citizen a single hospital admission can have devastating effects since the average cost is almost equal to the average annual income per head.

¹⁵ theory.people.com.cn

And for the lowest earning part of the population that is estimated to be around 20% of the total population, a single hospital admission can cost more than two times of their average income (Hu et al, 2008;68). “Deterioration in an individual’s assessment of his own health from average to poor, or any other two-step drop is associated with a 12% fall in income” (OECD, 2010:221; Lindelow and Wagstaff, 2005). Additionally, it can take two decades to recover economically from a life-threatening disease in China (ibid; Yan, 2009). Taking these facts into consideration, it is not difficult to understand why costs for medical care and treatment is a notable cause of impoverishment for Chinese citizens. It is perceived as the second major cause for individuals falling below the poverty line. According to one study, the poverty rate was raised from 7% to 10%, resulting from people pushed below the poverty line due to medical expenses (ibid; Liu et al, 2003). More than 35% of urban residents and 43% of rural residents do not have access to affordable health care. These people are not able to pay for the costs or are impoverished by the costs (Hu et al, 2008: 68).

“I am registered with BMIUE. Both of the enterprise and me pay for some money every month. But to be honest, it is not helpful when it comes to my disease (Chronic Lymphocytic Leukemia (CLL)). I tried to ask people who are working in the social security department and they say since I am a registered resident in Shenzhen, I can get 90% of the medical costs reimbursed theoretically. But if I go to the designated hospitals in Guangzhou (probably I will stay there for quite long time later because of the operation), I can get 70%. However, if later my disease becomes more active and aggressive and I have to go to the big hospitals in Beijing or Shanghai, then I can’t get any reimbursement. I was told that some costs for hospitalization such as fees for beds and drugs which are listed in the Catalogue of Essential Drugs of Basic National Medical Insurance as well as some routine examinations are covered. But unfortunately, almost all of the drugs I am using now are imported and are not listed in that catalogue. Also, the checkings I usually have to go through do not belong to the routine checkings. I think only for the checkings, they cost me around 250-300 yuan every day. And every time there are always some ‘unknown’ fees appearing in my medical bills, and they usually cost several hundred yuan a day. Most importantly, if I do the bone marrow transplantation later, the operation fees can not get any reimbursement by BRIUE. The doctor told me it usually costs 500,000 yuan at least. These are out-of-pocket payments. How is it possible for me to get so much money for it. This big disease really pushes me to poverty.” (Mr.Yiqiang, Phone-interview. February 10th, 2012).

Also, knowing from Mr. Yiqiang's case, more than 90% of Leukemia patients he has met so far are not able to pay for the medical treatments especially operations. The social medical insurances have very little effect on reducing the costs of medical treatment and drugs for them. To get treatment, these patients are undertaking incredibly high proportion of out-of-pocket costs. Almost all the patients have to borrow money from relatives or friends, or sell their houses or other assets. Some of them are lucky, receiving donation from the society and charity organizations. But a big part of them have to give up the operations and wait for death because of the unaffordable medical payments.

4.3 Provision

This section gives a picture of the changes in provision of the health care in China. As mentioned in the historical background part, the Maoism organization of health-care provision that followed a three-tier structure was broken during the health care reforms. Big hospitals took the place of street clinic to offer primary care (Sander et al, 2010:6; Chan& Ngok&Phillips, 2008:115-117; Saich, 2009:268- 274, Gu&Zhang, 2006:49-51). Hence, medical resources such as fiscal funding have been re-allocated according to the scale of facilities. The number of beds owned by very large hospitals (with more than 800 beds) increased around six times. Their shares in the total amount of beds in all medical facilities rose from 4% to 12% by 2000. Meanwhile, the number of medical facilities at local level such as township health centers and other kinds of clinics decreased by almost 20%. "Secondary and tertiary hospitals receive a much larger share—609 billion yuan (65%) of a total health expenditure of 937.4 billion yuan, in 2005—than do primary health and preventive or promotional services" (Hu et al, 2008:69-73; MH, 2007). In 2005, around 10.8% of total health expenditure was allocated to all of the community health centres in urban areas and township health centres in rural areas (ibid; Zhao et al, 2000:759-761). As a result, hospitals took the place of street clinics and became the dominant suppliers of both primary and ambulatory care in urban areas. "Overall, they produce nearly 80% of the value of all first-level medical consultations" (OECD, 2010:215). "The over-reliance on outpatient services is evidenced by the number of outpatient visits per hospital bed, which in 2009 stood at 1048 per year, against 313 in English hospitals" (ibid). "Moreover, hospitals treat many illnesses for which they are over-equipped. One survey found that 20% of outpatient visits were for colds or gastroenteritis" (ibid:215; Lim, 2002).

As for the development of the private hospitals in China, they still have very limited shares in the health care market today. There were no private hospitals in the Maoism era. The legalization of private practice of public hospitals in urban areas started in 1985, following the trend of privatization and marketization of SOEs during the economic transformation. However, the privatization has had very little impact on the health care in urban China during the marketization. The growth of private hospitals have been rather slow, in terms of quantity and shares in the market. The amount of state-owned institutions accounts for almost half of the total health care institutions. However, their provision occupies more than 90% of total health resources and “account for an overwhelming market share” (Wang, 2009:599). Generally, the organizational structure of the health care providers in urban areas has experienced little change during the last two decades (Gu and Zhang, 2006:62-64). The non-state involvement in health care provision remains very limited.

State-owned hospitals still occupy the dominant status in health service delivery system in urban China. Even though during the marketization of state-owned hospitals they were endowed with substantial autonomy in using their private revenues, governance from the central or local governments continues to follow the old public-sector administration model. “Fiscal fundings for the hospitals from government budgets are still allocated and controlled by the government hierarchy. Personnel management is still subject to central public sector controls over staffing structures and grades. Intervention from higher levels of government continues despite autonomous status” (WB, 2009:3). There is little competition among health care providers resulting from a lack of plurality in hospital provision (ibid). Hence, the state-owned hospitals occupy a relative monopoly role in the provision and delivery of health care in China. Due to insufficient government intervention, they became over commercialized and profit-oriented during the marketization process, which results in a series of unintended consequences.

The central government realized that the over-reliance on hospitals not only results in inefficiency when allocating resources, but also leads to the dramatic escalation of medical payments, which is thereby gradually closing the access to medical services and treatment for urban residents. Hence, the new insurance-based scheme (BMIUR) was established and “accompanied by a strategy to orient people to existing new urban community health centres at the level of the neighborhood committee” (OECD, 2010:223). The re-development of community health services is aiming at mitigating the cost escalation of expensive hospital-based treatments. In recent years, the central government has treated community health as “public welfare oriented, rather than profit-

oriented” (Chan et al, 2008: 124; *China Daily*, 2006). This shows that the Chinese government has been gradually changing its attitudes towards public health care. As a result, the utilisation of community health centres in urban areas has been greatly improved, with “a five-fold rise between 2002 and 2008” (OECD, 2010:223). Especially, the draft of the official proposal for a new round of health care reforms was issued for public examination in October, 2008. In this draft, it highlights the importance of reconstructing the community health care services from the planned economy era, thereby reforming the current health care system to solve the problem of fast increase in out-of-pocket payments (Gu, 2008; 196). Since the implementation of the new health care reform in 2009, the total amount of community health centers and clinics have grown at a high rate. According to the statistics from CNSB, in 2010, there were 5,359 community medical service centres and 16,737 community clinics in urban areas (CNSB, 2011). In 2006, the number was around 3,400 and 12,000 respectively (Chan et al, 2008:124).

However, the scale and quality of community health centers still remains to be improved. According to the statistics from CNSB, state-owned hospitals accounts for 2.06 million out of 2.30 million beds in all medical institutions in urban areas, with a bed utilization rate in state-owned hospitals of 89.40% in 2010. The number for primary health care institutions including community health centres and service stations is only 0.13 million, 6.17%. Also, the number of registered doctors and nurses in community health centres and service stations accounts for 0.37 million nationwide compared to 3.89 million working in hospitals (CNSB, 2011). Furthermore, “although nearly all the doctors are employed by various forms of government agencies on a salaried basis, either in hospitals or in health care centres. The pay and qualifications of the staff generally decline with the prestige of the unit. The best qualified doctors are found in major hospitals in provincial capitals. At the other end, in township health care centres most doctors have just three years of training” (OECD, 2010:218). Also, the community health centers are cheap-price oriented and only offering basic medical care, which implies that the doctors are not able to improve their salaries by promoting expensive drugs. This leads to the lack of incentives for the doctors working in community health centers. As presented in the report from the OECD, “currently, however, community health centres lack credibility with the population. Patients prefer to go to hospitals, as the doctors offering primary care have low levels of qualification. Many doctors are reluctant to move to primary care because the salaries are low and there is no long-term career path” (OECD, 2010: 220-215). The findings from the interviews also indicates above statement. Almost all the interviewees are satisfied with the ideology of re-construction of community health centers in terms

of low prices and convenience. However, with the concerns about service quality (in terms of qualification of doctors and nurses, diagnose equipment and technics as well as range of drugs), they still prefer to go to hospitals when they feel sick. The following conversations are from four different interviews to show their attitudes toward preferences on the health care services.

“I think it is very wise for the government to promote the community health centres. It is very convenient and cheap to go there, especially for the old people like my father. He has high blood pressure and usually go there and purchase some pills. It only takes less than 5 minutes to walk from his apartment. And the doctors there are usually not busy and offer some free basic checks for my father.” (Mrs. Dong. Phone-interview. February 18th, 2012).

“There is a community health center in my neighborhood and I think it is pretty good. I like it because there are not so many people and you don’t need to wait for long compared to the big hospitals. The doctors are not so busy and usually they are very patient. Most of the doctors are retired from big hospitals or doctors who don’t care about high salaries. They always have very good attitudes. They treat you very patiently and sincerely. It is sad that most of the young doctors prefer to work in big hospitals where they can get much higher salaries. But the community center still has its limitation such as its poor devices. So if I feel seriously sick, I will still go to the big hospitals.” (Mrs Qiu. Phone-interview. February 3rd, 2012).

“The community health centres are cheap services and drugs oriented according to the government’s aim. However, they usually just offer a very limited range of medicines for ordinary diseases such as coughing and stomach disordered. As far as I know, some of the medicines they sell are more expensive than the same ones in the pharmacy stores, which I think needs to be improved. Moreover, last time I went there for Amoxicillin (medicine name) which costs 19 yuan. They didn’t have it in the health centre. Instead, the doctor said that they have another brand with the same effectiveness and it costs 38 yuan. I was doubting since they are both effective then why don’t the health center purchase the cheaper one. I asked the doctor and she told me that the medicines you can find in all Wuxi’s health centres (city name) are the same. They are purchased uniformly according to the results of the public bidding organized by the local government. The health centres don’t have the right to purchase any other medicines.” (Mr. Gao. Phone-interview. March 2nd, 2012).

“I had terrible experiences with the community health centre! I didn’t have prejudice on it from the beginning. When it was built, I went there several times but I was really disappointed with their service! Once my son got stomach disordered and I went there with him, the doctor there said that my son got appendicitis(disease name) and needed an operation. But as you know usually the health centres are too small-scaled to do operations. So we were suggested to go to a big hospital. After we went there and did some checks, my son was diagnosed to have acute gastroenteritis (disease name) and prescribed to have some pills. Another time when my son caught a cold and was coughing a lot, we went to the health center to get some pills for it and the doctor there said my son needed drops with some antibiotic composition. I was really angry with the doctor and thought that he was not responsible at all. It was just a normal cough and why should my son take such a strong medicine! I just feel like the doctors in the community health centers are not responsible for their patients, maybe it is because they earn much less money than the doctors in the big hospitals. So I still prefer the big hospitals even though they are much more expensive, but at least they are more reliable.” (Mrs. Pei. Phone-interview. February 21st, 2012).

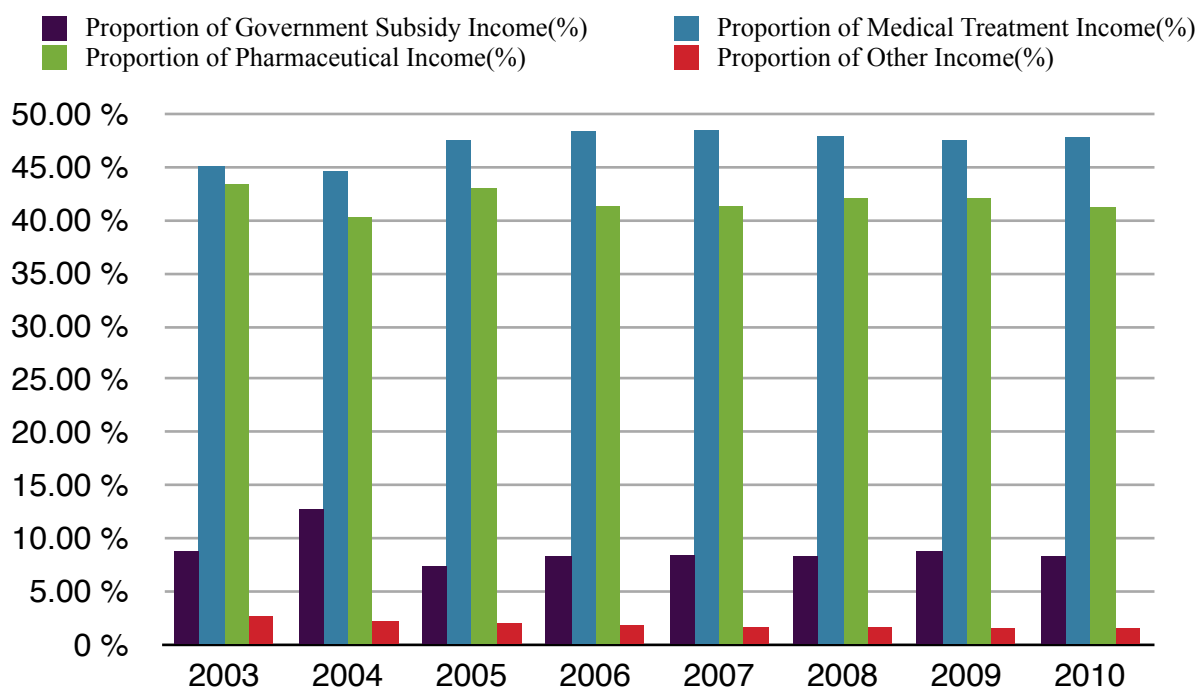
4.4 Regulation

During Mao’s planned economy era, medical resources were allocated and health care providers were funded by the central government in urban areas. All the hospitals were state-owned and administrated by the government. Also, the prices of medical services and drugs were under tough control imposed by the government. As for the personnel management, “the positions of all health care professionals and their wage levels were incorporated into the state manpower planning” (Gu and Zhang, 2006:64). In the pre-reform era, health care services were not regarded as a kind of economic activity and thus remaining non-productive. During the economic reforms, marketization became the key word for institutional changes. The role of the government in a majority of public goods provision was gradually replaced by the market. Efficiency and competition mechanisms extended into the public health care system, which dramatically changed the nature of hospital management and incomes of hospital staff. Hospitals were endowed substantial autonomy for their economic activities and were under much less government intervention and control. Additionally, in order to minimise its financial burden, the central government decentralised welfare provision including health care. “Accordingly, local authorities were granted the autonomy to allocate resources to different levels of local administrative units. Unfortunately, health services were not a

top priority in many local authorities” (Chan et al, 2008:119). As a result, hospitals didn’t receive enough fundings and had to increase their revenues from medical services.

There were two consequences from the marketization of the public health care. One is a dramatic withdrawal from government’s subsidies on hospitals and the other is re-orientation of public hospitals from non-profit to maximum-revenue organizations. The changing role of the government in health care has been clearly seen from its share in the total health expenditure, as discussed in the previous financing part. Also, the government’s subsidies as a proportion of total hospital incomes fell dramatically. Chart 4 illustrates the composition of public hospitals income from 2003 to 2010. The government’s subsidies remains very low despite of slight increase in recent years. In 2010, the number stops at 8.4%, which is much lower than 21.4% in 1980 (Chan et al, 2008:119). Interestingly, the Chinese government started a new round of health care reform in 2009 and has greatly increased its spending in the public health care. However, from the statistics shown in Chart 4, there is around a 0.4% decrease in the government’s subsidies to public hospitals from 2009 to 2010. However, in the proposal of new health care reform, there is no explicit explanation or resolutions towards the reform of the public hospitals. And if this problem can not be solved, it is very difficult to control the fast increasing costs of medical service, as argued in the one of most influential books among Chinese academic publications *Blue Book of China’s Society: Society of China: Analysis and Forecast* by Chinese Academic of Social Sciences (Gu, 2009:81).

Chart 4: Composition of public hospitals income in China (%)



statistics source: Yearbook of Chinese Health Statistics, 2010

Affected by the New Public Management Theory which emphasizes “work motivation, management efficiency and financial independence” (Chan et al, 2008:120), the Chinese government attempted to apply these economic values to improve state-owned hospitals’ efficiency and productivity. The responsibility system for the management of hospital chief executives were introduced with the issue of the hospital operation ordinance in 1982 (ibid; MH, 1982). In 1997, another document was published and encouraged “social agencies and individuals to run health care services based on independent management and being responsible for their own profit and losses” (ibid; CCPCC and SC, 1997). Gradually, hospitals were pushed to be more financially independent. The surplus revenues that the public hospitals acquire can be used for purchasing of new medical devices as well as paying bonus to the doctors and other staff. Even though these health care providers are still considered to be state-owned and continue to receive fundings from the government, the main part of their revenue comes from operational earnings. Therefore, in reality, they gradually became “service-for-fee organizations” (Gu and Zhang, 2008:65) and their major sources of revenue come from service fees and drug sales. As we can see from the chart, revenue of public hospitals is mainly made up by medical treatment income and pharmaceutical income from user fees for services, which occupies almost 90% in total income of the public hospitals from 2003 to 2010. Despite the two rounds of health care reforms in 2006 and 2009 respectively, the problem of over-reliance on user fees has not been relieved. Due to a lack of governmental involvement in hospital regulation, *“irrational use of health technologies, such as prescribing unnecessary diagnostic tests and medicines, and referring more patients for hospital admissions are, as observed, part of revenue-driven approaches used by the Chinese service providers to make more money that can be used to increase the income level of doctors and other staff”*, as said by Dr Tang Shenglan, health and poverty adviser at WHO’s country office in Beijing in an internal report on China’s health-care system (Parry&Cui, 2008:823). In spite of the establishment of BMIUE and BMIUR which have been introduced to reduce unnecessary services, hospitals and doctors “still have strong incentives to overuse some services” (Hu et al, 2008:69-73). “The distorted income composition of public hospitals often results in wealthier patients receiving unnecessary services, while poorer patients are unable to access the health care they need” (Parry&Cui, 2008:823).

Currently, the Chinese government is in favor of hospitals’ purchasing high-tech devices. To be more competitive in the health care market, hospitals use their surplus revenues to import advanced medical devices in order to be more equipped. At the same time, this implies that hospitals will

charge more from their patients to balance their accounting sheets. Also, the government permits hospitals to balance their revenues with new drugs and tests as well as high-tech devices. Providers are allowed to sell drugs with profit margins of 15 percent (Hsiao, 2007:243) or “30 percent if they purchase directly from the manufacturer. Often, these mark-ups are exceeded considerably, rising to as much as a ratio of 10” (OECD, 2010:219). With this 15% or 30% mark-up on drug prices, the public hospitals prefer to purchase expensive products rather than focusing on the cost performance of the pharmaceutical products. An easy example is given here to give a better understanding:

Hypothesis: Medicine A and Medicine B have the same effect on healing coughing. A costs 50 SEK while B costs 100 SEK. Now the hospital has a free choice to purchase one of these two medicines with a 15% mark-up on the price,

Choice A: $50*(1+15\%)=57.5\text{SEK}$ hereinto: profit= $57.5-5=7.5\text{SEK}$

Choice B: $100*(1+15\%)=115\text{SEK}$ hereinto: profit= $115-100=15\text{SEK}$

Under this condition, driven by maximum profits, the hospital is more willing to purchase the more expensive Medicine B.

Due to the over-commercialization, hospitals can earn more income through purchasing the pharmaceutical products with high prices and selling them with high prices. According to a CNSB’s survey, the mark-up on drugs covers 5% of the medical costs (OECD, 2010:219; Health Statistics Yearbook, 2008).

“The government modified its salary-based system of compensating hospital physicians to include bonuses determined according to the revenue the physicians generate for their hospitals” (OECD, 2010:219). Currently, revenues of public hospitals are heavily dependent on sales of profitable new drugs and technologies. This results in an explosion in sales of expensive pharmaceuticals and high-tech examinations. To make it worse, this kind of hospital management “gives a rise to over-prescribing, which can be dangerous” (ibid). As a direct consequence, there has been a dramatic increase in medical care costs. Under this condition, even urban citizens who are covered with social medical insurances feel reluctant to go to hospitals due to high premiums. The quick increase of out-of-pocket payments resulting from incomplete regulation on pharmaceutical prices leaves the Chinese people outside the system. All the interviewees disclose the biggest concern which stops them from going to hospitals is the high prices of medical treatment and drugs. Most of the interviewees use their money in health care accounts to purchase some ordinary medicines in case of unexpected illness. When they feel sick, they choose to self-diagnose or check on the internet

first. Then they usually take some medicines according to their experiences. Not until really necessary, they are not willing to go to hospitals due to the fear of high prices.

“It is expensive to go to the hospital even though I am covered by BMIUE. Now the medical costs are out-of-control because hospitals want to earn as much money as possible. If you go to see the doctor when you catch a cold or cough a little bit, it can cost 200 to 300 yuan! They always tell you to do checks such as the blood test, which is very unnecessary if the doctors are professional and patient enough. Actually for the same sickness, if you have the doctor as your friend, he or she will probably prescribe you a medicine that costs less than 10 yuan. Otherwise there is a high chance that he or she will trick you into buying the much more expensive medicines which have the same effect. The more the doctors succeeded in promoting those drugs, the more bonuses they get. Under this situation, I have to control the costs myself.” (Mrs Lu. Phone-interview. February 3rd, 2012).

“ I think the high prices of medicines should be immediately controlled by the government. Driven by profit, the doctors are very good at promoting expensive drugs instead of using cheaper drugs which have the same effects. My mother lived in the hospitals for two years before she passed away. She had cerebral infarction (disease name) and gradually lost the ability to walk. The doctors there always asked me whether I wanted ‘better medicines’ or the ‘normal medicines’. At the beginning I was so worried about my mother that I even didn’t understand what ‘better medicines’ meant. Then I got a long bill of incredibly expensive medical treatments and drugs. I was shocked and went to ask the doctors about it. They just told me that the medicines were imported and could not be reimbursed through my mother’s BMIUE account. For one kind of injection my mother usually had to take, the imported ones cost around 10,000 yuan per injection and the cost for the domestic produced ones ranged from 80 to 300 yuan. I asked the doctors what the difference was. The doctors said these imported ones were better and had less side-effects. I asked what side-effects she might suffer if I purchased the cheaper ones. The doctors said that they were not sure because the effect differed among patients. Later I began to choose the cheaper ones and there were no differences. At the beginning my mother didn’t recover after using large amount of ‘better’ ‘imported’ ‘less side-effect’ medicines and she was still lying there when using the cheaper ones. I think the health care reforms in China is a big failure. It is so wrong to make public hospitals commercialized. When you buy higher profit drugs, the doctors usually have much better attitudes towards you because this is how they get their bonus.” (Mr. Shi. Phone-interview. March 2nd, 2012).

“During my father’s stay in the hospital, what I always got were long bills of expensive treatment and drugs. I had to make fake bills to show my father that it didn’t cost as much as he was worried about. Today people know that it is so expensive to get treatment when you have a catastrophic illness, so did my father. I had to ask all the doctors and nurses not to tell my father the real prices of the checkings and medicines otherwise for sure he would refuse to receive any treatment or take any medicines. Once my father knew that the tube which made it easier to give the injection cost around 1,000 yuan by accident. He was lying in the bed and crying. He was not able to talk at that time. Instead, he was just waving his arm to refuse to use it with all his strength. I don’t remember how many times that the doctors tried to promote those unaffordable medicines to me. Even my father received certain amount of money in his BMIUE account, majority of the medical consumptions are paid by the savings of my family. Once, a doctor from one of the most famous hospitals even persuaded me to buy ‘magic’ medicines for lung cancer from India. I am really confused by the current health care system. Where are the doctors’ occupational responsibilities? Why can’t our public hospitals sell lower price medicines with good performance? Excluding all the out-of-pocket payments for hospitalization and medical treatment as well as drugs, there are too much invisible payments. For example, the special daily nutrition meal cost around 1,000 yuan every day and the nursing 3,000 per month. All the costs really pushed my family to poverty. There is too much to be done to fix the orientation of public hospitals in China.” (Mr. Qing. Phone-interview. February 24th, 2012).

It is very sad to hear their stories. The marketization of public health care seems to go to the wrong way. Public hospitals are supposed to serve as non-profit organizations. However, due to the dramatic withdrawal of the government’s subsidies and endowed autonomy, hospitals are operated with an aim for maximum profits in a monopoly market. As a result, risks are being shifted to individuals and their families. Even with the enlargement of social medical coverage, increasing insecurity will continue to spread among urban residents if the public hospitals can’t change their roles in health care provision. It is high time that the Chinese government have stronger intervention in public hospitals’ operation and more strict regulation on the prices of pharmaceutical products.

Conclusion

The conclusion is a summary of the analysis presented above. Guided by research questions and the theoretical framework, I used documentary analysis, a second review of official statistics as well as semi-structured interviews to collect and sort empirical materials for the analysis part. The analysis produced a number of findings that are presented below.

The economic transformation from a government planned economy to a liberal market economy has left a profound impact on the public health care system. During the Maoism era, a free universal health care was provided by SOE work-units and delivered mainly by street clinics. Effected by the New Public Management Theory, the efficiency of direct public provision is doubted. Since the 1980s, marketization and privatization have been one of the fundamental elements in welfare reforms in the world. No exception for China. As most of the developing countries, Deng's government put the economic development, especially the GDP growth, in first place. As shown in the international comparisons, China enjoys much higher GDP growth than most of the western countries. By contrast, China is among the countries which have the lowest public spending on health care in the world. Not surprisingly, the Chinese population have been shouldering incredibly high proportions of out-of-pocket payments. The statistics of individual spending on health care in China are even higher than those of East Asian model countries such as Malaysia in recent years.

One of the most significant reasons that lead to unaffordable health care for urban Chinese citizens is the low reimbursement level of BMIUE and BMIUM. Since the outbreak of SARS in 2003 which exposed the vulnerable public health care system, the Chinese government has been re-considering its responsibility. Since 2006, it began to have more strict control on the prices of pharmaceutical products. Especially in 2009, a new round of health care reforms was announced, as part of China's 11th-five-year plan, aiming at building a universal, safe, affordable and effective basic health care system by 2020. Great efforts have been made by the Chinese government in enlarging the coverage of BMIUE and BMIUR. Theoretically, insured by BMIUE or BMIUR, patients pay much less than before. However, a long list of pharmaceutical products and operation fees which usually cost the most can not be reimbursed. The findings show that patients who are suffering chronic diseases are stressed with the medical fees. The limited money they receive in their health care cards every year merely covers one kind of common chronic disease, for example, high blood pressure. This means there will be high proportions of out-of-pocket payments if they suddenly suffer any other disease.

Additionally, patients with diabetes and other not very common chronic diseases can barely receive any reimbursement through BMIUE or BMIUR. The situation gets worse when it comes to more acute life-threatening diseases which need operations and hospitalizations. Especially, when serious cases are sent to higher-level hospitals, patients get reimbursement with lower rates. The benefit declines with the seriousness of the disease and truly catastrophic illness such as Leukemia are hardly covered by the social medical insurances. Most of the patients refuse to receive any medical treatment because of their fear of high payments. It is common for families of the patients with catastrophic diseases to sell their houses or other assets to collect money for the operations or other kinds of treatment. Poverty caused by catastrophic illness remains a major concern for urban residents.

Moreover, the current social medical insurance schemes lack equity in access to public health care. In general, BMIUE and BMIUR represent two social groups: residents with jobs and residents without jobs respectively. As shown in both documentary analysis and interviews, BMIUE is based on employees' salaries. Even in the same city, urban employees with higher incomes obtain much more money in their health care accounts than employees with lower salaries. Employees in SOEs usually receive much better welfare treatment including higher reimbursement level of medical care compared to their counterparts who work for private companies. Furthermore, BMIUR is aimed to offer social protection to the vulnerable groups including unemployed residents in urban areas. These residents usually don't have stable incomes or are even under the poverty line. They receive very little money in their health care accounts compared to residents insured by BMIUE. Also, BMIUR was established with the hope of strengthening the role of community health centres. The reimbursement level gets lower if beneficiaries go to hospitals. When they suffer any chronic or catastrophic diseases, the big proportion of out-of-pocket payments becomes the biggest barrier for their access to medical service.

During the economic transition, there have been dramatic withdrawals of government spending in public health care especially in the subsidies to hospitals. Correspondingly, these hospitals are endowed with economic autonomy and are responsible for their own revenues. The total proportion of government subsidies has fallen to only 7%-8%. The remaining part of the hospitals' revenue is made up by incomes from medical treatment and pharmaceutical products, which serves as another crucial reason for the high proportion of individual spending on health care. The marketization of public health care system indicates that the government tried to shift the financial burden and

responsibilities to the hospitals. This leads to the re-orientation of public hospitals. They have become commercialized and profit-driven within the fee-for-service system. At the same time, the bonus system has greatly changed the composition of doctors' salaries. Doctors get bonuses by selling patients high-profitable pharmaceutical products to improve their salaries. And hospitals enlarge their revenue by charging high prices for medical treatment and drugs. The economic interests between hospitals and doctors are closely related. As a result, the financial burden for health care has been shifted from the government to hospitals and finally falls on the shoulders of Chinese citizens. Almost all the interviewees are not satisfied with the operation mechanism of public hospitals and the bonus system. Concluded from the interviews, the high prices of pharmaceutical products has been the vital factor of the unaffordable health care currently. Nearly all the interviewees have been experiencing consistent promotions of "better", "imported" and "with less side effects" drugs from the doctors. Usually, these drugs are not listed as reimbursement items but they are highly profitable for the hospitals. Despite the great efforts made by the Chinese government in enlarging the coverage of social medical insurance schemes, there has been no substantial increase in the fiscal funding for public hospitals. Instead, the government's subsidies on public hospitals even fell by 0.4% since the new health care reform from 2009 to 2010. As a result, no significant change has been taken place in the incentives for hospitals and their staff. They continue to pursue maximum incomes. It is difficult to see how the Chinese government is going to reform the public hospitals back to 'public welfare oriented' organizations. If this can not be solved, the medical care might continue to be unaffordable for the majority of China's urban citizens.

Owing to changes in life-styles, deteriorating environmental conditions as well as a series of food safety problems, death rates from chronic and catastrophic diseases have risen quickly. However, the current health care system is oriented toward curing rather than preventing chronic diseases. The large investment in the re-construction of community health centres in recent years shows the government's intentions of changing the hospitals from 'market-oriented' organizations with little government intervention to 'public non-profit-oriented' organizations under stronger regulations. The expansion of community health centres in urban areas could be served as a new way to offer cheaper treatment for ordinary and common chronic diseases. However, the range for pharmaceutical products they can offer is still very limited compared to hospitals. Also, the community health centres need to be further improved in terms of quantity and qualification of personnel and devices.

Due to the dramatic withdrawal of government spending in public health, a series of consequences have occurred during the last two decades. The public hospitals have been driven by maximum profits and became over commercialized, which is far from the definition as a non-profitable welfare provider. Risks have been continually shifted to urban residents and increasing insecurity have been rising among them. It is important that the Chinese government, especially the central government becomes more involved in the financing of the public health care and the regulation of hospitals. Reimbursement levels of both BMIUE and BMIUR need to be increased so that out-of-pocket payments can be more affordable to a larger section of the Chinese population. By using the Mixed Economy of Welfare Model for looking at unintended consequences of health reform in China, it became clear that both financing and regulation have to be re-organized so that the provisions provided by the three-tier system of local clinics, small hospitals and special hospitals can be fully used by the Chinese population.

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<http://theory.people.com.cn/GB/49154/49155/8770074.html>

Appendix A- Identification of Interviewees

1) Name: Mrs. Qiu

Age: 42

Education: High School

Occupation: working for a state-owned enterprise

Residence Place: Shanghai

Covered by the Basic Medical Insurance for the Urban Employees and the Social Pooling of Medical Costs for Catastrophic Illness

2) Name: Mrs. Pei

Age: 50

Education: Middle School

Occupation: working for a private enterprise

Residence Place: Shanghai

Covered by the Basic Medical Insurance for the Urban Employees and the Social Pooling of Medical Costs for Catastrophic Illness

3) Name: Mrs. Lu

Age: 40

Education: High School

Occupation: working for a state-owned enterprise

Residence Place: Shanghai

Covered by the Basic Medical Insurance for the Urban Employees and the Social Pooling of Medical Costs for Catastrophic Illness

4) Name: Mrs. Wu

Age: 48

Education: Middle School

Occupation: self-employed

Residence Place: Wuxi

Covered by the Basic Medical Insurance for the Urban Employees

5) Name: Mr. Gao

Age: 52

Education: High School

Occupation: waiting for employment

Residence Place: Wuxi

Covered by the Basic Medical Insurance for the Urban Residents

6) Name: Mr. Dong

Age: 37

Education: University

Occupation: civil servant

Residence Place: Wuxi

Covered by the Basic Medical Insurance for the Urban Employees

7) Name: Mr. Xiao

Age: 32

Education: University

Occupation: working for a private enterprise

Residence Place: Wuhan

Covered by the Basic Medical Insurance for the Urban Employees

8) Name: Mr. Shi

Age: 53

Education: High School

Occupation: working for a state-owned enterprise

Residence Place: Shanghai

Covered by the Basic Medical Insurance for the Urban Employees and the Social Pooling of Medical Costs for Catastrophic Illness

9) Name: Mr. Zhou

Age: 49

Education: Primary School

Occupation: working for a cooperative privately-running enterprise

Residence Place: Suzhou

Covered by the Basic Medical Insurance for the Urban Employees

10) Name: Mr. Yiqiang

Age: 25

Education: University with a Bachelor's degree

Occupation: Working for a state-owned enterprise

Residence Place: Shenzhen

Covered by the Basic Medical Insurance for the Urban Employees and the Social Pooling of Medical Costs for Catastrophic Illness

He is suffering the Chronic Lymphocytic Leukemia (CLL)

11) Name: Mr. Qin

Age: 32

Education: University with a Master's degree

Occupation: High School teacher

Residence Place: Shanghai

Covered by the Basic Medical Insurance for the Urban Employees and the Social Pooling of Medical Costs for Catastrophic Illness

His father is at the last stage of lungs cancer Appendix B-Lists of interview questions

Appendix B- Interview Questions

Self-introduction: Hello! It is really nice that I have the chance to interview you by telephone. I hope I can introduce myself again. My name is Gao Ye and a student from Welfare Policies and Management, Sociology, Lund University. Now I am writing my master's thesis about the health care system in China. Please don't worry about your answers because I am not going to ask very difficult questions. What I am concerned with is that whether you as one of the citizens feel it is very expensive to go to the hospitals or not. And several small questions are prepared to make it easy for you to answer. If you think it is ok, shall we start?

1) Do you mind to tell me that whether your employer is the government or a private company?
And based on this, are you currently included in any social health insurances?

2) Do you have a good knowledge of the social health insurance that you have joined? About how much you can get reimbursement from the medical costs?

- 3) What do you think of the current reimbursement system? Is it convenient for you or not?
- 4) Do you remember how much it cost you when you went to the hospital last time?
- 5) Do you think the costs hospitals are expensive for you and your families? If so, what usually costs the most for you when you go to hospitals?
- 6) Can I ask you that have you had self-diagnose and buy some medicines according to your life experience or search on the internet instead of going to the hospitals because you think the hospitals are expensive?
- 7) Have you ever experienced that doctors try to promote you expensive or imported medicines instead of normal medicines which have the same effect but are much cheaper? What do you think of the bonus system of the doctors' salaries?
- 8) Are you satisfied with current health care system? If not, can you tell me the reasons?
- 9) Do you usually do some exercises to keep healthy? Does your company or enterprise or community offer you a comprehensive health check every year?
- 10) What do you think about the community hospital in or near your neighborhood? Are you willing to go there or you prefer big hospitals?
- 11) Our government is launching the new health care reform and states that by 2030, a universal and affordable health care system will be built. What is your attitude towards this? Do you think this could be realised in the next two decades?