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How does the health care reform affect citizens' access to health care in urban China?

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Abstract

This thesis is centered on the issue of how does the health care system reform change urban citizens' healthcare utilization in China. The new health care reform, against the background of building "a Harmonious Society", aims to provide a universal health care for the whole population and makes citizens' access to health care easier. Based on both quantitative and qualitative data, the study sets out to analyze strengths and flaws of the new health care system. The theoretical framework, consisting of East Asian Welfare Model and China's welfare mix, is operationalized by analyzing the impacts of government's new health policy and urban citizen's perception on the health care reform. More specifically, health financing and health service provision have been explored.

The findings show that the government has been expanding basic medic insurance coverage, improving medical institutions and increasing healthcare expenditure in order to achieve the objects of health care reform. Those efforts have brought some good effects on urban citizens' healthcare utilization; however, the still high health care cost as well as other problems which haven't been solved yet has brought negative impacts.

Key Words: China's health care reform; health policy; urban citizens; medical insurance; health care expenditure; health care utilization

List of Acronyms

CPC	Communist Party of China
LIS	Labor Insurance System
GIS	Government Insurance System
SOEs	State Owned Enterprises
BMI	Basic Medical Insurance
LMS	Labor Medical Service
FMS	Free Medical Service
UE-BMI	Urban Employees Basic Medical Insurance
UR-BMI	Urban Resident Basic Medical Insurance
SARS	Severe Acute Respiratory Syndromes
NCMS	New Rural Cooperative Medical Scheme
CHNS	China Health and Nutrition Survey
CNSB	Chinese National Statistics Bureau
WHO	World Health Organization
NHSS	National Health Services Surveys
RMB	The currency of the People's Republic of China
THE	Total Health Expenditure
PvtHE	Private Expenditure on Health
GGHE	General Government Health Expenditure

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1. Introduction

China has experienced 30 years of reform and opening up of its economy and has achieved spectacular economic achievements. In 2010, China overtook Japan ranking as the world's second largest economy. At the same time, however, the high-speed economy development leads to massive social transformation where Chinese welfare system has undergone immense changes. How is China dealing with the challenges posed by the rapid socio-economic transformation and rebuilding its welfare system? To address them, since Hu Jintao came into power in 2002, the Chinese government has re-oriented its reform direction by focusing more on the society rather than the economy. It is in this context that building a "Harmonious Society" has been put forward by the government (Zhao& Lim 2010:7; Zheng 2010:14-15).

The idea of "Harmonious Society" has first been presented in the 16th Central Committee of the Communist Party of China (CPC) in 2002.

In the first two decades of 21st century, we need to concentrate on building a well-off society of a higher standard in an all-round way to the benefit of well over one billion people, We will further develop the economy, improve democracy, advance science and education, enrich culture, foster social harmony and upgrade the texture of life for the people.¹

Thereafter, in the Fourth Plenary Session of the 16th Central Committee of CPC in 2004, the ability to construct socialist harmonious society has been put forward as one of the main tasks of the party's ruling ability². That is, building a "Harmonious Society" has been put in the priority list in the political agenda and the government is trying to transform itself from an agent of economic development to a provider of public service (Zheng 2010:15).

¹ Jiang Zemin's Report at 16th Party Congress (2002), *Build a Well-off Society in an All-Round Way and Create a New Situation in Building Socialism with Chinese Characteristics* [on line]. http://english.people.com.cn/200211/18/eng20021118_106983.shtml Nov 8, 2002

² Hu Jintao's Report (2004), *The CPC Central Committee on strengthening the party's ruling ability construction decision* [on line], <http://www.86wiki.com/view/2808339.htm> Sep19, 2004

1.1 Problem Description

Health care is closely linked to the economy and society and it is a vital component of “Harmonious Society”, relating to the 1.3 billion Chinese people's fundamental interests. As health care's significant role in “Harmonious Society”, how well this problem is solved directly affects the social harmony and stability. Therefore, the Chinese government is planning to launch a new round of health care reform to strengthen public health care service. The Sixth Plenum of the 16th Central Committee of CPC puts forward the main objectives and tasks for building a harmonious socialist society by 2020, while “building a social security system covering both urban and rural citizens is established in general”³ had first been put forward clearly.

Against this background, in 2006, the government established the Health Care Reform Leading Group, comprised of 16 ministries and chaired by then Vice Premier Li Keqiang, in order to best reform the health care sector. The overall goal of health care reform has been set into short-term objectives including:

By 2011, the basic medical security system shall have completely covered urban and rural citizens [...] the basic public health services shall have been available far and wide [...] the accessibility to the basic health care services shall have been improved markedly, citizens' burden of medical costs shall be effectively reduced, and the problem of "difficult and costly access to health care services" shall have been remarkably relieved⁴.

And long-term objectives as follow:

By 2020, the basic health care system covering urban and rural citizens shall have been established. We shall have set up, across the country, a fairly complete public health

³ Hu Jintao's Report (2006) *Resolutions of the CPC Central Committee on major issues regarding the building of a harmonious socialist society* [on line], http://english.gov.cn/2006-10/11/content_410436.htm Oct.11, 2006

⁴ Official document issued by the CPC Central Committee and the State Council (2009), *Opinions of the CPC Central Committee and the State Council on Deepening the Health Care System Reform* [on line], http://www.china.org.cn/government/scio-press-conferences/2009-04/09/content_17575378.htm 2009

service system and health care service system [...] a comparatively sound health care institution management and operational system [...] everyone shall have access to the basic health care services and the health level of the people shall be further enhanced⁵.

Chinese policymakers try to apply the Scientific Outlook on Development to guide health care reform.

The Scientific Outlook on Development is a continuation and development of the important thoughts on development advanced by the previous three generations of central collective leadership of the CPC and a concentrated expression of the Marxist world outlook and methodology with regard to development. [...] It is an important guiding principle for China's economic and social development and a major strategic thought that we must uphold and apply in developing socialism with Chinese characteristics.⁶

From these policy makers' point of view, healthcare service is a major welfare aimed at safeguarding the health and happiness of more than one billion people. According to official documents, the government has worked out effective approaches and made clear progress, and the healthcare reform has brought positive effects. And all the progress so far has helped the government to put solid foundations in place for future reform efforts.

However, disagreement among key policymakers on general framework of the new healthcare system is causing huge delay in the release of a revised health care system. For instance, some of the policymakers, most from the Ministry of Health, favor the idea of restoring the health care system adopted during the planning period (1949-1978). On contrast, other policymakers backed by the Ministry of Finance and the Ministry of Human Resources and Social Security prefer to a market-oriented solution (Gu 2010:23-24).

⁵ *ibid*

⁶ Hu, Jingtao's report (2007), *Hold High the Great Banner of Socialism with Chinese Characteristics and Strive for New Victories in Building a Moderately Prosperous Society in all* [on line], <http://www.china.org.cn/english/congress/229611.htm#3> Oct. 15, 2007

Not only policymakers, but also scholars have paid attention on health care reform. Most studies have focused on the healthcare system reform itself. For instance, what kind of healthcare system could provide better healthcare services to Chinese citizens; how to establish new mechanisms for medical and healthcare? In other words, most studies are concentrating on a macro-level. Or, most of them focus on the government's role in the healthcare reform. There are also some scholars exploring this issue from citizen's perspective instead of the government's references of such studies. Some of them discuss the access to health care services and argue for the equality of access. When they discuss this topic, most of them explore the relationship between income and health. For example, Gao et al (2001) used the data from the national household health surveys conducted in 1993 and 1998 to explore the changing utilization of healthcare among different income groups. Their findings show that there is a decline in seeking care from a health provider in each income group, and the possible reasons for this are the rapid rise of per capita expenditure on healthcare services and the decline in insurance coverage. Liu and Tsegai (2011) investigate the impact of the New Cooperative Medical Scheme (NCMS) program on health care utilization and medical expenditure for different regions and income groups in rural China, and the results reveal the NCMS program has improved medical care utilization for the poor and western regions benefitted more than others.

However, few scholars have explored the actual impact of health care reform on citizens. The government wants to obtain the goals that "By 2011, citizens' burden of medical costs shall be effectively reduced, and the problem of 'difficult and costly access to health care services' shall have been remarkably relieved"⁷ and "By 2020, the basic health care system covering urban and rural citizens shall have been fundamentally established"⁸ But, what kind of actual benefits can Chinese people get from this health care reform? Do Chinese people think the health care reform could

⁷ Official document issued by the CPC Central Committee and the State Council (2009), Opinions of the CPC Central Committee and the State Council on Deepening the Health Care System Reform [on line], http://www.china.org.cn/government/scio-press-conferences/2009-04/09/content_17575378.htm 2009

⁸ *ibid*

achieve the initial goals? These questions have not been received enough attentions whereas they are also important questions. Hence, the purpose of this thesis is to examine if and how the health care reform change healthcare utilization among residents in urban China. As there are different health care systems for urban citizens and rural citizens in China, I narrow down my study object on the urban citizens in this thesis. Based on the purpose of this study, I formulate two specific research questions as follows:

- 1) What's the impact brought by the government's new health policy in the process of the health care reform?
- 2) How does the new government's health policy affect urban citizens' access to healthcare service?

The first question focuses on what kind of new health policy has the government done so far to strengthen health care service. It is an empirical check of the impact of health care reform. The second question is centered on individual's perception about the health care reform. As the government has done its efforts to improve health care, can citizens feel positive changes in the health care utilization? As the aim of the health care reform is to provide better health care for citizens, it is important to consider government's role in the health care reform as well as individual's perception on it.

1.2 Historical Background

For those readers who are unfamiliar with its historical origins and contemporary context about Chinese welfare system, this section gives an overview about the history, social and economic background in China from 1949.

Since the establishment of People's Republic of China in 1949, the Chinese social welfare system was an integral part of socialist economy and it operated as a dual system of social policy: urban and rural welfare systems. In terms of healthcare system, rural populations were covered under cooperative medical schemes managed by agricultural communes. In urban areas, there were two systems for different groups: the *Labor Insurance System (LIS)* and the *Government Insurance System (GIS)*. The

former one was for those employees of *State-owned Enterprises (SOEs)* and collectively-owned enterprises and their dependents. The latter covered mainly employees working in government organizations and public sectors as well as university students. Both welfare systems in urban areas were based on the state enterprise economic system. The state-owned enterprises were the cornerstones of socialist economy in China. The government centrally regulated economic activities and provided social welfare through these enterprises. During this time, due to ideological orientation, political task and socialist model of economic development, the social welfare system based on a socialist program of equality and justice aimed to convince the Chinese people that the communist regime was performing better than its capitalist counterparts(Guan 2005:243; Barber & Yao2010:5-6).

However, in 1978, Deng Xiaoping launched what he called a "second revolution" that involved reforming China's moribund economic system and "opening up to outside world." ⁹ Thereafter, China has undergone a fundamental economic reform from a highly centralized communist economy into a socialist market economy. Under the socialist market economy system, China's economy has been increasing dramatically and in 2010 it overtook Japan as world's second-biggest economy. The economic reform also changed the welfare system. Before Deng's reform, "there was a 'enterprise-statist' welfare model, in which state enterprises, following governmental regulation, provided welfare benefits to employees, including pensions, health care and housing, and the government took responsibility for the enterprises' finance, including finance for their welfare provision" (Guan 2005:236). But with the market economic system set up, the government no longer took financial responsibility for enterprises; instead these enterprises had to bear their own profit and loss. Hence the old 'enterprise-statist' welfare model could no longer operate. In the late 1980s, Chinese government carried out the welfare reform which aimed to re-build the social welfare system. And this welfare reform was not a simple response to the problems caused by economic reform, but rather a long-term goal to establish a new Chinese social welfare system. When it comes to healthcare system, a new contributory

⁹ Deng Xiaoping's Economic Reforms: <http://factsanddetails.com/china.php?itemid=79>

medical insurance system named *Basic Medical Insurance (BMI)* has replaced the LIS and GIS. The government no longer takes direct financial responsibility in the new BMI, while both employers and employees have to pay for it (Guan 2005:243; Barber & Yao 2010:5-6).

By the late 1990s, the Chinese government gradually realized the social instability and unrest fuelled brought by economic growth, and the government began to shift its development strategy from initial purely economic growth towards a more sustainable and equitable approach of growth which would pay more attention to the welfare provision for people. Then in 2003, president Hu, Jintao (presidential tenure: 2003-2013) introduced the concept of a “Harmonious Society” emphasized “the need for more redistribution and equality as well as for a sustainable social agenda; aiming at the equalization of basic social services by 2020” (Sander et al, 2010:2-9).

1.2.1 Pre-reform era (from 1949 - 1978)

During the first 30 years of the PRC (from 1949 to 1978), the health care sector in urban China was an integral part of the planned economy. Almost all health care providers were owned and operated by the state, all health care professionals were state employees, and most Chinese urban citizens enjoyed free health care services (Gu & Zhang 2006:49). During this pre-reform era, with some indicators reaching the level of developed countries, China had many achievements to be proud of in the health field. For instance, “the life expectancy of the population increased from about 35 years in 1949 to 68 years in 1978; higher than that of some countries which were richer than China. The infant mortality rate declined from 250 per 1000 live births per year to less than 50 per 1000 live births per year during the same period”(Li 2011:6).

The main characteristic of the healthcare insurance system established during this period was its dual operating regime: the *Labor Medical Service (LMS)* and the *Free Medical Service (FMS)* operated in the cities benefiting urban workers (Wang 2006:259-260). The *LMS*, also known as “Laobao” in Chinese, started in 1951. The beneficiaries of this scheme are those workers working in state-owned enterprises and their direct relatives (ibid). Usually, the enterprises put aside some of their net profit as a welfare fund which amounts to 11% of salary outlay, and of which 50% is for the

Medical Service Fund. Part of the Medical Service Fund is used for the construction of the industry's own medical facilities, and the rest is used for the Labor Medical Service Fund. In terms of healthcare services provision, workplace unit operated as small-scale welfare state to deliver healthcare service instead of the state and it was regarded as one of many non-wage benefits offered to unit members (Gu & Zhang 2006:49). The covered individuals were treated in designated local hospitals, or they must visit industrial medical facilities if there are any medical problems. The industries pay the health care expense by paying the hospitals directly or by reimbursing the covered individual (Liu & Wang 1991:113). In August 1952, the government released a second healthcare insurance system which is called *Free Medical Service* or “Gongfei” in Chinese. This system applied to employees in government organizations, public organizations, veterans and university students, and other public-sector-oriented services (Wang 2006:260). According to the regulations, the covered people must visit the designated hospitals; the service fee is paid by the government, or paid first by the patients and then reimbursed by the government (Liu & Wang 1991:113).

1.2.2 Reform era (from 1978 - 2003)

After 1978, the government transformed itself from a closed centralized planned economy to a socialist market economy. This change resulted in rapid economic growth, however, leading to a decline of healthcare insurance coverage. Moreover, as the sales of medicines and services became a central part of health sectors' income, the costs for medical care increased sharply. As a consequence, accessing health care became more difficult for those who could not pay (Barber & Yao 2010:5).

In 1998, a salary-oriented social insurance plan was launched as the Urban Employee-Basic Medical Insurance (UE-BMI), which was created by the central government for urban formal sector workers. It's a mandatory program for “approximately 300 million urban employees administered at municipal level” (Barber & Yao 2010:12). By 2003, more than half of urban employees were covered by insurance.

After SARS¹⁰ outbreak in 2003, more attention was paid to healthcare reform and the government started many programs as pilots in some provinces before them could be applied nationwide. For instance, the government implemented a pilot in four provinces to revamp and expand the rural cooperative medical schemes, which renamed as the New Rural Cooperative Medical Scheme (NCMS) (Barber & Yao 2010:6).

1.2.3 The National Health Care Reform within the conception of “Harmonious Society” (from 2003)

Establishing a “Harmonious Society” aims to provide a "basically well-off" for all the citizens. Under this conception, the national health care reform emphasizes building on progress achieved with expansion of insurance coverage and benefits.

In urban areas, employed people were covered by *Urban Employees Basic Medical Insurance (UE-BMI)*; however those unemployed citizens had no insurance except for some commercial insurance. In order to provide basic medical insurance for urban citizens without a job, the *Urban Citizens Basic Medical Insurance (UR-BMI)* was piloted in 79 cities in 2007 and then has rolled out nationwide. From 2009 to 2011, the government has committed 850 billion RMB¹¹ to implement its national health system reform plan. Among this amount, 39% (331.8 billion RMB, was dedicated from the central government to provide free or nearly free universal access to health care. While about 46% (390 billion RMB) is contributed to insurance subsidies for the rural and urban citizens' programs. And the rate of national insurance coverage increased from 23% to 87% during 2003 to 2008 (Barber & Yao 2010:8). By the end of 2008, the urban basic health insurance covered 318.22 million people. Among them, people who had UE-BMI was 199.96 million, 19.76 million more than in 2007;

¹⁰ Severe Acute Respiratory Syndromes (SARS) is a viral respiratory disease of zoonotic origin. China was the major SARS-infected area.

¹¹ RMB: the currency of the People's Republic of China

the number of urban citizens who had UR-MBI was 118.26 million, gaining an increase of 75.35 million than 2007¹².

Then, in 2009, the CPC Central Committee and the State Council jointly issued two very important official documents about the health care reform: *Opinions on Deepening the Health Care System Reform* which outlined the guiding thoughts, overall objectives, basic framework, and policy measures for China's healthcare reform. The second one was *Implementation Plan for Short-Term Priorities in Health Care Reform (2009-2011)*, which identifying five key tasks in reform. The government has committed 850 billion RMB (US\$124.26 billion) over during these three years (2009-2011) to implement its national health system reform plan (Barber & Yao 2010:8). Since then, all departments and institutions concerned have engaged in a conscientious effort to implement the scheme for health care reform.

To sum up, China's pre-reform welfare system was embedded in an economic system of state planning and was dominated by the state. But the state's predominance has been weakened by economic marketization over the past three decades and as a result China's 'welfare mix' - the balance of state, market, family and third-sector provision - has changed (Duckett & Carrillo 2011:1-2).

1.3 Previous research

1.3.1 Different disciplines on health care study

Health care issue has always been concerned by scholars. Scholars from different disciplines using explore this issue from different perspectives. For instance, feminist always connect health care problems with gender equity issues; demographer may take aging perspective while economist mainly discuss the health economics. Exploring health care issues from diverse disciplines contribute to promote the development of health care study.

¹² Data from China Health Insurance Research Association:
<http://www.chira.org.cn/xinwenzhongxin/jiaodianxinwen/new321992.html>

Chen and Standing (2007) took the gender perspective to explore the equity issue in the health care reform. In the paper, they examined major trends in Chinese health care reform and its gender-differentiated health impacts during the reform process. Based on the study results, they urged the policy-makers, researchers, and activists to pay attention on the implications of China's transition and healthcare reforms for women's health needs and for gender relations impacts that may produce health inequities. The paper realized that poor, rural, older women were especially vulnerable in terms of health status and access to services. These women should receive more attention than other women. From a gender perspective, the authors paid their attention at a macro-level, focusing on policy making.

In terms of inequity, the study of Luo et al (2009) examined inequalities of access to healthcare among the urban elderly in northwestern China. The study took quantitative methodology. They collected quantitative data from three northwestern Chinese cities then used multiple and binomial regressions to estimate the effects of the factors on the use of health care services (visits to physician and hospitalizations). Their results revealed the use of inpatient care services was significantly lower among those respondents with less education, those with lower household per capita income and those without health insurance coverage. Based on the quantitative results, they concluded a significant inequality of access to health care services among urban seniors in northwestern China.

Jung and Liu (2012) explored the impact of health insurance on individual out-of-pocket (*OOP*) health expenditure in China and demonstrated that health insurance in China has increased the probability of positive *OOP* health expenditures. Their findings showed that people who are older, female, or married tend to spend more on health care and health insurance has larger effects for low and high spenders than for individuals who spend close to the median. Moreover, they pointed out that self-report health status could be a good indicator of health care spending.

These previous researches seem to indicate that there are inequalities of access to healthcare service in China. The studies from different disciplines broaden my views

to think about the direction of my study. As I am from the discipline of welfare policy, I would like to explore the health care issue from the welfare perspective.

1.3.2 Welfare mix

Although the knowledge about welfare in western countries is very mature, systematic knowledge of Chinese welfare is scarce. And it is difficult to use western welfare frameworks and theories to conceptualize and analyze welfare developments in China. Scholars indicated that China does not fit any of the classical welfare state typologies (Sander et al 2010:2). As a consequence, discussing Chinese health care reform from a “Chinese welfare system” perspective may be a new and interesting topic.

Rothgang et al. (2008) explored the changing public-private mix in OECD health-care systems within the welfare state transformations. In the study, they focused on the role of state and the market in providing health care. By discussing the health-care systems from three dimensions: financing, service provision and regulation, the results show the private health-care spending has been established as a mode of financing; the privatization of health-care sectors has increased and the regulation mechanism has moved toward more complex regulatory structures.

Gu (2010) addressed the issue of rising healthcare cost in China, which brought about by the market-oriented reforms in the health care since the economic reform in 1978. In his study, he explored a heated debate over the direction of the new health care reform: one idea is to restore the health care system adopted during the planning period, which advocated centralizing public health care services with the cost being determined by the government. That is a ‘government-directed’ approach as the guiding principle in the process of new health care system. While another idea is to adopt a market-oriented solution, supporters for which believe the health care services can become more affordable and the coverage of health care safety net can be expanded if the existing universal insurance system is improved and a third-party purchase mechanism is established. The study suggests that a regulated market-based approach should provide the middle-ground solution that can break the deadlock on both sides. These disagreements originate from different perceptions of roles for government and market in China’s health care sector. The study suggests that a

regulated market-based approach should provide the middle-ground solution that can break the deadlock on both sides.

Åke and Qian (2010) examined how the interests of patients can be protected in China's decentralized, market-based health care system. Similar to Gu, they stressed the cost of health care has grown very fast in China. With the high health care cost, many individuals and families experienced severe financial hardship when serious illness struck. Alternatively, many people did not seek medical care even when they needed it because they couldn't afford to pay for it. They argued this problem is partly caused by the reduction of government subsidies to health care providers. It forces providers to push the extra cost in their services to the patients. Their study compared two possible ways to tackle this problem: direct provider subsidies vs social health insurance, and finally suggested that the government should strengthen social insurance programs as well as provide government subsidies to health care providers.

Studies of China's social welfare system tend to pay little attention to the family's role in China's social welfare provision. Several contributions to this volume help fill this gap by examining the experiences of families and their role in supporting their children, disabled, elderly and sick. Based on a case study in rural Sichuan (southwest China), Lora-Wainwright (2011) examined two aspects: financial barriers to access and perception of efficacy, to trace the various factors influencing healthcare-seeking patterns. Her study demonstrates that the commodification of health care has established not only structural barriers to it for the poorest but also a widespread skepticism towards the medical profession, which in turn results in a general unwillingness to resort to formal medical care. In addition, family (and individual) responses to illness are shaped not only by the high cost of treatment and the lack of trust in medical practitioners, but also by historical, social and cultural factors.

These previous researches about health care from the welfare perspective seem to indicate that China's 'welfare mix' has changed. The health care reform which shapes relationship between state, market and family will continue to influence welfare provision throughout China and individuals' perceptions of health care utilization.

Based on these previous researches, I will explore the health care issue from the welfare perspective. Within the context of China's 'welfare mix', unlike most of previous researches concentrate on state and market, this study will focus on state and individual/family. Different from most scholars, for instance, Gu(2010) and Åke & Qian (2010), this study do not discuss in which ways: 'government-directed' approach or market-based health care system the government should adopt to deal with the health care problem. Instead, this study mainly focuses on an empirical check of the impacts of the governments' health policy which has been implemented so far and individuals' perception about health care utilization.

1.4 Organization of Thesis

In this chapter, I have given a description about my research problem in the beginning. Then the chapter introduces a historical background of the economic transformation in China, which explains the development of health care system since the founding of People's Republic in 1949 until the "Harmonious Society" has been put forward. Previous research also has been presented in this chapter.

Chapter 2 provides the theoretical perspective and analytical tool to the study. This chapter first presents the East Asian Welfare Model which has some commons elements with Chinese welfare system. Then focus on China's 'welfare mix', the thesis describes the China's 'welfare mix' changing from planning economy to market economy. Moreover, the state's and family's role has also been discussed in this part.

Chapter 3 concerns methodology, both qualitative and quantitative research methods are applied in this chapter. The quantitative part of the thesis is based on the secondary analysis of data¹³ from the China Health and Nutrition Survey (CHNS) and the official data from the Chinese National Statistics Bureau (CNSB) and the World

¹³ Secondary analysis of data could be collected by other researchers or by various institutions in the course of their business (Bryman 2008:295).

Health Organization (WHO). The qualitative part of the thesis uses semi-interviews to get urban citizens' attitudes, ideas and experiences related to health care.

Chapter 4 is the results chapter where I present the data results from both quantitative and qualitative research. This chapter is the basis for the analysis chapter.

Chapter 5 analyses the data results on the base of theoretical framework. The chapter starts with a discussion about health care financing issue where medical insurance coverage and health care expenditure problems will be explored specifically. After that, the chapter discusses service provision, health care utilization and perception of health care reform in turn.

Chapter 6 makes the conclusion and discussion based on previous chapters. The chapter makes a summarizing discussion about this thesis in the beginning. Then it shows the limits and weakness about this study. The thesis is ending with a section about final remarks.

2. Theoretical Framework

A theoretical framework is very important to get understand the welfare system in China. However, traditional western welfare theories cannot be applied directly to social policy development in China due to for instance the distinctive social-economic development. Nevertheless, China has showed many common elements in the development of economy and society with its neighbors from Chinese Economic Reforms; hence, the East Asian welfare model is used to understand the welfare provision in China. Then the Chinese ideas of welfare are developed in a deeper way from different perspectives to understand the health care reform. By doing this, it builds a clear theoretical framework for the analysis chapter of this thesis.

2.1 East Asian Welfare Model

Traditionally, academic research on welfare states has been strongly informed by three major approaches: socioeconomic functionalism, conflict theory and institutionalist approaches. Also a variety of scholars has tried to typologize different

welfare states (Sander et al 2010:11). The most influential and widely acknowledged typology was provided by Esping-Andersen (1990) in his *Three Worlds of Welfare Capitalism*. He distinguished three welfare state regimes among the western capitalist countries as liberal, conservative and social democratic. However, none of these classical theories can easily be applied to social policy development in China due to a totally different social, economic, political and culture structure. Whereas, East Asian countries share relatively similar situation with China-fast economic growth and increasing needs on social welfare development, hence the East Asian welfare model could be helpful to understand the welfare provision in China.

As western welfare typologies cannot explain the East Asian welfare experience, several scholars, including Esping-Andersen himself, had developed alternative typologies of welfare state regimes, or added one or more types to achieve more explanatory power.

Esping-Andersen (1997) took Japan as a deviant case and by implication possibly an East Asian 'Oriental' welfare model. He argued that "social-welfare guarantees outside the public sector are so strong and comprehensive that the state welfare need only be modest and residual" in this model (Esping-Andersen 1997:181). He also pointed out tradition: "Buddhist teachings and 'Confucian' familial and communal solidarities and obligations" should be one of the core components of this welfare model. Especially, He described 'Confucian' idea about family's role in welfare provision as "Strong familialism" which means that families have the principal responsibility for their members, as "sharing incomes or providing care to those in need" (Esping-Andersen 2001:5).

White and Goodman (1998:14-15) suggested East Asian welfare state by notion of the "Developmental Welfare State" with common elements:

At one level they reflect the broader East Asian pattern of state-sponsored development, whereby welfare arrangements have been shaped to fit the strategic priority of rapid industrialization. Rather than being 'wasted' on 'unproductive' welfare expenditures, financial resources haven been concentrated on economic development; governments have sought to keep expenditures on social assistance down and to design funded systems of

social insurance which could also provide financial resources for investment in industry and infrastructure.

There is another attempt to account for the East Asian welfare system which based on culture. Some cultural explanations have been based on notions of Confucianism which is held to be a key part of the shared heritage of East Asia as a whole (White & Goodman 1998:8). Culturalists argument about “Asian traditional values” which stress the welfare role of the family, the role of private philanthropy and the avoidance of dependence on the state. This welfare discourse draws heavily on “Confucian” rhetoric both to define and legitimate policies. (White & Goodman 1998:12)

Jones (1993) argued that societies in East Asian together “make up” their “own brand” of “welfare states” (1993:199) and “it was Confucianism being adapted after all” (ibid.: 203) The essence of this is the ideal persists, embodying “ hierarchy, duty, compliance, consensus, order, harmony, stability- and staying power” (ibid.: 202). As a consequent, she argued that it appropriated to specify an additional category which differs from western welfare states (e.g. Esping-Andersen’s three welfare capitalist typology) as “Confucian welfare state”. And the characteristics of this “Confucian welfare state” are: “Conservative corporatism without (Western-style) worker participation; subsidiarity without the Church; solidarity without equality; laissez-faire without libertarianism; an alternative expression for all this might be ‘household economy’ welfare states-run in the style of a would-be traditional, Confucian, extended family” (Jones 1993:214). It is obvious to see that the notion of state-provided welfare as a social right of citizens under this “Confucian welfare state” is weakly. Instead, non-state agencies-community, firm and family- have been expected to play a major welfare role in both financing and providing welfare services (White & Goodman 1998:14).

East Asian ‘Oriental’ welfare model or “Developmental Welfare State” or “Confucian Welfare State”, no matter which notion we adopted to describe the welfare system in East Asian countries, it’s obvious to see that there are many common elements in these countries. But, the evolution of each country’s welfare system has had its own distinctive trajectory and different consequence. In each country, the national welfare

system has developed and dynamics of social, economic and political conditions. Hence, East Asian welfare systems are not homogeneous and one over-arching “East Asian welfare model” to all these countries is misleading (White & Goodman 1998:14-20).

It is clear that the main characteristic of East Asian Welfare Model is put the economic boom in the first priority of political agenda. The resources have been concentrated on economic development, while social welfare is service for it. As the systematic knowledge about Chinese welfare is insufficient, the East Asian Welfare Model here is used to get a general idea about the welfare system in China.

2.2 China’s welfare mix

China has been following a distinctive political system path with its East Asian capitalist neighbors; however, since the Economic Reform in 1978, China has showed many common elements in economy and society with its neighbors (White 1998:175). The most notable one is, like its neighbors, China has put the economic development in the first priority, while welfare is service for its economic boom.

2.2.1 The welfare mix from plan to market.

Following the creation of the People’s Republic of China in 1949, a nationwide welfare system was gradually established in tandem with the planned economy. In urban areas, welfare was delivered by the state primarily through the work units (*danwei*). Although actual delivery was handled by workplaces, the entire system was founded on state plans which meant the state organized welfare provision. It was a period of almost full employment, when the vast majority of urban dwellers had access to state-backed welfare and high level of security. The family was a key supplementary institution for those without work. Hence, during this pre-reform period, the welfare mix was almost state and family (Duckett & Carrillo 2011:4-7).

The shift from state planning to ‘socialist market economy’ since 1978 has involved enormous changes in China’s welfare system. The redundancy in State Owned Enterprises (SOEs) eroding the full-employment system; market induced competition

also led state and SOEs to cut back on health care payment. As a consequence, the socialist health care system was unable to keep up with the challenges brought by the market reform (Gu 2010: 25). For instance, many urban citizens were uncovered by healthcare system or pay for much of their health treatment out of their own pockets (Duckett & Carrillo 2011:5-6). In this context, the public-service supply in China has resulted in a more complex pattern of provision in which state providers of health charge fees on a commercial basis and have incentives to generate revenues and new public-private partnerships are formed (Duckett & Carrillo 2011:7). One of the notable market-based reforms was health care financing (Gu 2010: 25).

2.2.2 The state's role

As the marketization has resulted in an expansion of non-state welfare provision, the state's role has changed. Local governments have taken from work units the responsibility for providing mandatory social insurance as well as financing health care services. Overall, the state is providing more programs through local governments as compared with the pre-reform era. However, it still retains a dominant role in terms of policy making, though they show policy development to be often the outcome of interactions and relationships among a range of state institutions within central and local governments (Duckett & Carrillo 2011:9).

2.2.3 Family responsibilities

As discussed in 2.1 East Asian Welfare Model, Confucianism can be identified as the fundamental cause of welfare state evolution in East Asian. With regard to China, Confucianism stresses a moral obligation to help and support family. "Social norms and rules were set according to kinship. These reflected the traditional Confucian virtues of strong family bonds, benevolent paternalism, social harmony, discipline and strong work ethics" (Sander 2010:12). China and other East Asia countries reveal a quite different, far less state-centric welfare system with an extensive family role based on savings, transfers and services. According to previous research, family is an important source of China's social welfare provision.

2.3 Analytical framework

Gough's (2008) welfare regime framework based on two basic concepts: welfare mix and welfare outcomes. By explore these basic concepts, Gough's welfare regimes framework moves forward the analysis of social policy and human welfare in development contexts. His welfare regime framework made contribute to synthesize the insights of social policy in the North with development studies in the South (Gough 2008:43). Among the welfare mix, there are five elements: state; market; community, civil society and NGOs; family and international components. Based on an empirical analysis, Gough (2008) explored the patterns of welfare mixes and welfare outcomes in the developing and transitional worlds and believed that Chinese welfare system can be regarded as "More effective informal security regimes: with relatively good outcomes achieved with below-average state spending and low international flows" (Gough 2008:43). In this thesis, since the research purpose focuses on the government and individuals, only the element (state and family /individuals) will be explored.

In respect to analyze the health care systems, Rothgang's analogy of house will be used. As showed in Figure.1, financing and service provision are 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" (Rothgang et al., 2007:133).

Different to Rothgang's study, the private dimension prefer to individual instead of the market and only the government has been considered as the service provider. Moreover, the dimension of regulation will not be discussed.

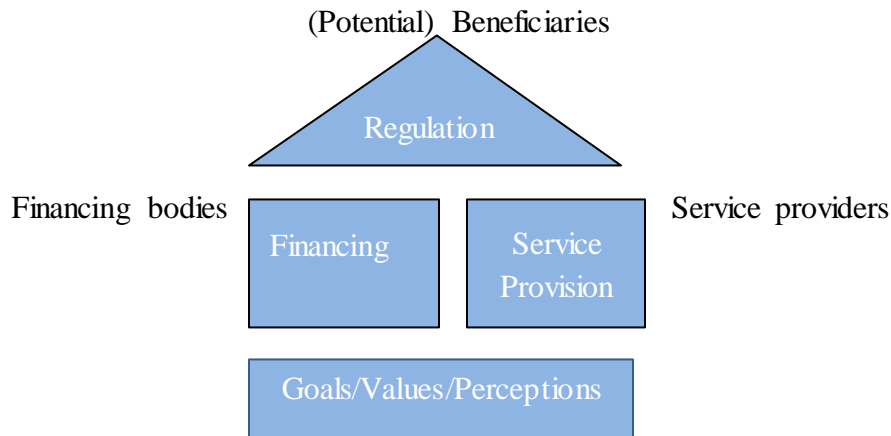


Figure 1: Dimensions of health-care systems
 Source: Rothgang et al., 2007:133

Based on China’s ‘welfare mix’ and the data results, the thesis develops the health-care systems model (Figure.1) into a suitable analytical framework to explore the health care reform in China (see Figure.3 in p.44).

3. Methodology

Almost all social research methods have specific limitations as well as particular strengths; therefore methods should be combined in order to compensate for their mutual and overlapping weaknesses when doing social research. According to Flick (2009) triangulation means combining several qualitative methods, but also means combining qualitative and quantitative methods. It is used as a strategy for improving the quality of research by extending the approach to the issue (Flick 2009:26,405). Bryman (2008) also argued that a combination of quantitative and qualitative methods could increase the possibilities to define more aspects of a phenomenon, which means that it should lead to a better result or a better understanding (Bryman 2008:602-625).

Quantitative methods can give an overview about the study issue and, whereas qualitative methods can be used to gain access to deeper knowledge of the field in order to develop theoretical concepts and explanations that cover phenomena relevant for the research domain. Hence, Quantitative and qualitative methods cannot substitute each other, but help to illuminate different aspects of sociological

phenomena and provide comprehensive explanations, for instance, “ in a sociological investigation quantitative methods can describe the actions of large numbers of different actors, whereas qualitative methods provide information about possible reasons for these actions” (Kelle 2006:309).

In this study, a mixed-methods design is starting with a quantitative study then followed by a qualitative inquiry. In this quantitative-qualitative design, the quantitative study is performed to identify research questions which have to be further investigated with the help of qualitative data and methods. The greatest benefit of quantitative methods is that you can quantify the results (Bryman 2008:22) and they are good for studying general phenomena. After quantitative study, qualitative research is used. Qualitative methods are useful for “going deeper” and finding out why people holds certain views and the reasoning behind them. Qualitative methods have both benefits and drawbacks compared to quantitative methods due, mainly, to the fact that you can’t make any generalizations from the analysis “you can’t quantify the data” (Bryman 2008:22). Qualitative methods generally have a high validity, but a low reliability; one can’t repeat the study and expect the same results or generalize (ibid: 391). To my study topic, a mixed-methods design could be a useful tool to overcome limitations of both quantitative and qualitative research. And in the quantitative research, continuous observation of the field provides a basis on which the several waves are related or from which these waves are derived and shaped in the second design (Flick 2009:25).

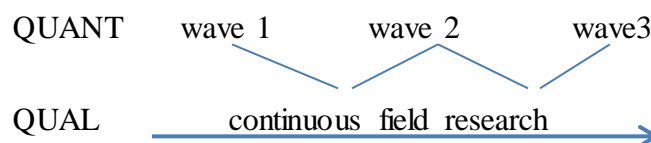


Figure 2 Research Designs (Source: Flick 2009:26)

3.1 Quantitative method

By using quantitative method, this study could get an overview about government’s healthcare input and people’s utilization of healthcare. In this quantitative part, the study will use the secondary analysis of data collected by the *China Health and*

Nutrition Survey (CHNS) as well as official statistics from the *Chinese National Statistics Bureau (CNSB)* and the *World Health Organization (WHO)*.

3.1.1 Data

First, I will use the official data from the *World Health Organization (WHO)* and *Chinese National Statistics Bureau (CNSB)* to show the change of healthcare financing and the healthcare service provision.

The main data of this study benefits from the *China Health and Nutrition Survey (CHNS)*¹⁴ data. *CHNS* is an ongoing international collaborative project of longitudinal research conducted by the Carolina Population Center at the University of North Carolina at Chapel Hill and the National Institute of Nutrition and Food Safety at the Chinese Center for Disease Control and Prevention. The study population was collected from nine provinces (Guangxi, Guizhou, Heilongjiang, Henan, Hubei, Hunan, Jiangsu, Liaoning, and Shandong). These nine provinces vary substantially in geography, economic development, public resources, and health indicators are nationally representative of the population in China. A multistage, random cluster process was used to draw the samples surveyed in each of the provinces. The survey divided into three parts: the household survey, individual survey and community survey, containing detailed information in health-related issues, such as insurance coverage, medical providers, health facilities and health status. The first round of the *CHNS* data was collected in 1989, and then subsequent rounds were conducted in 1991, 1993, 1997, 2000, 2004, 2006 and 2009. Since I want to explore the healthcare reform issue under the conception of “Harmonious Society” started in 2003, I am going to use the data of wave2000, wave 2004, wave 2006 and wave 2009. Moreover, my target groups are urban citizens, I do away with all countries and suburban villages, and I consider in the analysis urban residences.

¹⁴CHNS website: <http://www.cpc.unc.edu/projects/china>

3.1.2 Measures

1) Independent variables

Many factors have the potential to influence the use of health care services. Anderson and Newman (1973) proposed a behavioral model of health service utilization suggesting service utilization can be classified into three determinants: predisposing variables, or socio-demographic characteristics that result in a higher probability of using health care services (age, sex, educational level, etc.); enabling variables that can enable or impede the use of services (e.g. income and insurance); and need for care variables, which means a perception of one's health. (Anderson & Newman 1973:51:95-124) However, findings from previous studies have shown that service utilization is mainly associated with need for care variables. Some of the findings related to predisposing variables and enabling variables have been controversial (Lou etc. 2009:112). Hence, the independent variables in this thesis are chosen according to the model of Andersen and Newman, and I will do the "need for care variables" and enabling variables (insurance).

Enabling variables (insurance): two questions related to medical insurance will be analyzed. 1) "Do you have medical insurance? (yes, no)"; 2) "Which of the following types of medical insurance do you have? (Commercial medical insurance, Government /Free medical insurance, Urban employee basic medical insurance/UE-BMI, Urban resident basic medical insurance /UR-BMI, New rural cooperative medical scheme /NCMS, Other)"

Need for care variables: "During the past 4 weeks, have you been sick or injured? Have you suffered from a chronic or acute disease? (yes, no, unknow)" And "How severe was the illness or injury? (not sever, somewhat sever, quite severe)" were used as measures of need for healthcare services.

2) Dependent variable

Two of the most important measures of utilization of health care services were used as dependent variables: "outpatient services (physician visits)" and "inpatient services."

Using of “physician visits” was measured by asking: “Did you seek care from a formal medical provider during the past 4 weeks?” and “Was it an outpatient or inpatient visit?” was used for measuring inpatient services.

3.1.3 Reliability and validity

Reliability refers to the consistency of a measure of a concept and it is particularly at issues in connection with quantitative research (Bryman 2008:149). The quantitative research is likely to be concerned with the question of whether a measure is stable or not. Stability, however, is a prominent factor when considering whether a measure is reliable. The consideration of stability entails asking whether a measure is stable over time, so that researchers can be confident that the results relating to that measure for a sample of respondents do not vary a lot. Correlation is a measure of the strength of the relationship between two variables which can be used to test for the stability, if the correlation is high, the measure would appear to be stable, implying that respondents’ answers can be relied upon. In practice, many researchers undertake longitudinal research to capture social change and it correlates. As my research question wants to explore the development of healthcare provision, it’s necessary to obtain a trend of healthcare reform. Therefore, data from longitudinal research could be useful to my study. The reliability consideration is an important factor for me to choose four waves data form *CHNS*.

Validity is another criterion of social research. Validity is concerned with the integrity of the conclusions that are generated from a piece of research. In the quantitative part, this study focuses on the internal validity. This form of validity is concerned with the question of whether a conclusion that incorporates a causal relationship between two or more variables (Bryman 2008:32). In issue of causality, it is common to refer to the factor that has a causal impact as the independent variable and the effect as the dependent variable. In this study, the independent variable divided into two types: enabling variables and need for care variables; whereas, variable “outpatient services (physician visits)” and “inpatient services” were used as dependent variables.

Although reliability and validity are analytically distinguishable, they are related. This means that, if the measure is not reliable, it cannot be valid (Bryman 2008:153).

3.2 Qualitative method

The choice between different research methods should depend upon what you are trying to find out. Critics of quantitative research argue that official statistics and survey data may simply be inappropriate to some of the tasks of social science. For instance, they exclude the observation of behavior in everyday life. The main strength of qualitative research is its ability to study phenomena which are simply unavailable elsewhere (Silverman 2006:43). Since I am also concern with people's attitude towards healthcare reform, then qualitative methods may be favored.

Probably, the interview is the most widely employed method in qualitative research. In qualitative interviewing, there is much greater interest in the interviewee's point of view; it encourages "rambling" which gives insight into what the interviews sees as relevant and important; in the qualitative interviewing, interviews could ask new questions that follow up interviewees' replies and can vary the order of the questions. In a word, qualitative interviewing tends to be flexible, responding to the direction in which interviewees take the interview and perhaps adjusting the emphases in the research as a result of significant issues that emerge in the course of interviews (Bryman 2008:437).

Since my studying intention is urban citizens' views about healthcare reform, I chose semi-structured interviewing as the main qualitative method. In a semi-structured interview, researchers have a list of questions to be covered, which referred to as an interview guide. And the process of interview is flexible, as the interview program progressing, interviewees themselves could produce additional questions and form an integral part of study's funding (Bryman 2008: 438-439).

3.2.1 Making an interview guide

According to Bryman, the semi-structured interview needs an interview guide to cover specific topics about research question, but the interviewee has a great deal of freedom in how to reply. Moreover, questions that are not included in the interview guide may also be asked as the interviewer picks up on things said by interviewee.

(Bryman 2008:438). Hence, formulating an interview guide is essential before perform the interviews. My interview guide will cover these topics: the interviewees' background; their understanding and opinions about the medical insurances; interviewees' experience in accessing healthcare service; and their attitudes toward the up-dating healthcare reform and evaluations on current healthcare system.

More detailed questions refer to Appendix A.

3.2.2 Selecting sampling

Because my research question focuses on the urban citizens, I decided to use the purposive sampling. "Purposive sampling is essentially strategic and entails an attempt to establish a good correspondence between research questions and sampling. In other words, the researcher samples on the basis of wanting to interview people who are relevant to the research question" (Bryman 2008:458). In terms of approach to sampling, snowball sampling was used as the approach to sampling, "With this approach to sampling, the researcher makes initial contact with a small group of people who are relevant to the research topic and then uses these to establish contacts with others" (Bryman 2008:100). Snowball sampling is good to be used when there is no accessible sampling frame for the population from which the sample is to be taken and that the difficulty of creating such a sampling frame means that such an approach is the only feasible one. Since my research objectives are limited to the citizens in urban areas, I decided to interview my Aunt first, and then find other interviewees through her.

However, the 'Snowball sampling' may easy to lead the samples come from very similar socio-economic background, in order to avoid this problem; I chose vocation as my sample selecting criterion. Criteria are abstract insofar as they start from an idea of the researched object's typicality and they should be considered when doing sample selection. Usually, these criteria have been developed before data collection. (Flick 2009:115) For this study, the main criterion for sample selection is sample's vocation. Because in China, people's occupation could, in some extent, reflect their socio-economic status; hence based on vocation's difference, I could diminish the possibility of choosing interview people from very similar socio-economic

background. According to Chinese labor market and my research topic, I divided the vocation into four types: staffs in government's department and public institutions, staffs in enterprises, self-employment workers and laid-off workers. Hence, I first interviewed my Aunt who was working in a public institution, and then she helped me to get access to the interviewees with different vocations. At last, I got eight interviewees in total. The interviews were carried out by face-to-face interview and the interview times were among half an hour to one hour different by the interviewees.

Information about interviewees refers to Appendix B.

3.2.3 Reliability and validity

Researchers can follow different ways in to increase the reliability of data and interpretations. For interview data, researchers can increase reliability by interview training for the interviewers and by checking the interview guides or generative questions in test interviews or after the first interview (Flick 2009:386). After my first interview with my aunt, I checked my interview guide and made some changes. The interview guide was keeping adjusting based on the former interview.

Validity receives more attention than reliability in the discussions about grounding qualitative research. A basic problem in assessing the validity of qualitative research is how to specify the link between the relations that are studies and the version of them provided by the researcher (Flick 2009:387). 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 misinterpretation for 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 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.

3.3 Merits and demerits

3.3.1 Quantitative research

As my quantitative research mainly use the secondary analysis of data collected by the *China Health and Nutrition Survey (CHNS)*, I am going to discuss the advantages and limitations of secondary analysis.

I benefit a lot from the secondary analysis of data from *CHNS* when I was carrying out this study.

- Cost and time. Secondary analysis offers the prospect of having access to good quality data for a tiny fraction of the resources involved in carrying out a data collection exercise myself.
- High-quality data. The samples cover a wide variety of regions of China. The degree of geographical spread and the sample size of such data sets are invariably attained only in research that attracts quite substantial resources. The data sets had been generated by highly experienced researchers, the data have been gathered by social research organizations that have developed structures and control procedures to check on the quality of the emerging data.
- Opportunity for longitudinal analysis. The data are collected over time; usually certain questions are recycled each year so that trends can be identified over time.

However, there are some demerits when using secondary analysis.

- Lack of familiarity with data. When collect my own data, when the data set is generated, it is obvious that I am familiar with the structure and contours of my own data. However, using data collected by others, a period of familiarization is necessary. In this study, I have to get to grips with the range of the *CHNS* data variables, being careful with the ways in which the variables have been coded.
- Complexity of the data. The *CHNS* data sets are very large in the sense of having large numbers of both respondents and variables. Moreover, the data are collected and presented at three levels: community, household and individual. As I decide

to use the individual-level and only respondents from urban areas, I have to extract these data from the data set.

- Absence of some variables and missing data. Because secondary analysis entails the analysis of data collected by others for their own purpose, it may be that some variables related to your study may not be present. Moreover, although the data had been gathered by experienced researchers or social research organizations, the situation of missing data could happen. If the missing data is too large, it may affect the results.

3.3.2 Qualitative research

Qualitative interviews tend to be far less structured than quantitative interviews. In qualitative interview, there is much emphasis on the interviewee's point of view and "rambling" or going off at tangents is often encouraged, because it gives insight into what the interviewee sees as relevant and important. Moreover, this kind of interview tends to be flexible, responding to the direction in which interviewees take interview and perhaps adjusting the emphases in the research as a result of significant issues in the emerge in the course of interviews, which could provide researcher much rich and detailed answers (Bryman 2008:319-320). By qualitative interview, I could acquire information about how urban citizens use their medical insurance, their experience to get healthcare service, as well as their attitudes and opinions towards the current healthcare system.

However, there are some demerits for my qualitative research. First is the limitation of sample selection. The structure of the groups taken into account is defined before data collection and only "vocation" had been used as the criterion for the sample selection. Other criteria like age, education and gender had been ignored; however, these may be important factors that could affect the results. Moreover, this criterion restricts the range variation in possible comparison.

Another weakness in my qualitative research is the interpretation. Since the interviews were conducted in Chinese, there were some problems when translating into English. There were many Chinese words that hardly represented in English. Moreover,

translation is really a time-consuming job; it took me large time to transcribe the interviews into English.

4. Results

This chapter consists of the quantitative results and interview data results. I will show the quantitative results first and then present some important interview data.

4.1 Quantitative results

For quantitative results, I will show the data as following sections: results of independent variables, results of dependent variables and data for expenditure.

4.1.1 Independent variables

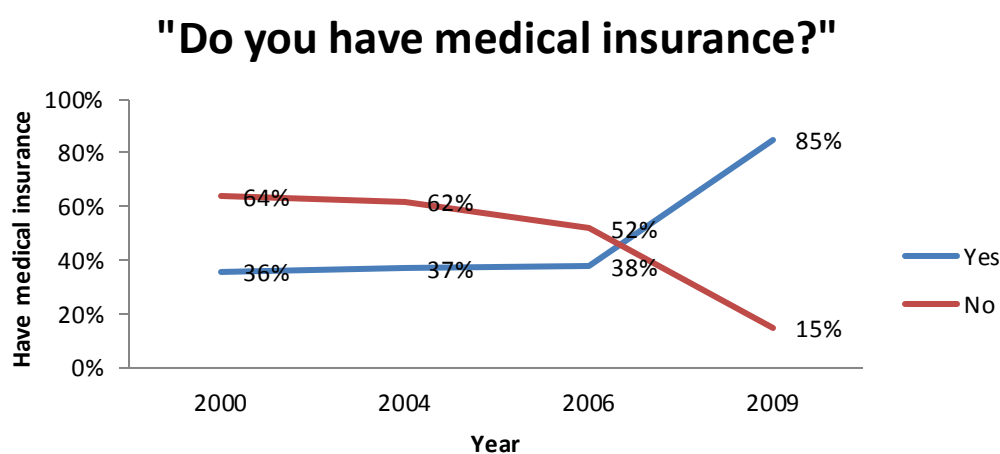
1) Enabling variables (insurance):

Basic medical insurance could benefit all Chinese individuals now and for generations to come. As a means of addressing people's demand for medical and health care, basic medical insurance has been adopted widely in the world. Most developed countries have established universal medical insurance. Some developing countries have also launched insurance programs. As a developing country, the Chinese government wants to develop a basic medical and healthcare system which is based around the universal coverage of medical insurance. The government has made some efforts to develop basic medical insurance with universal coverage in order to truly benefit its people. One of the efforts is improving medical insurance for both working and non-working citizens in urban areas¹⁵.

The data below is from the *CHNS* which shows the increasing trend of insurance coverage in urban China. Graph 1 illustrates the degree of insurance coverage among

¹⁵ Li Keqiang's Speech "Deepening the Reform of Heal Care" 2012
http://english.qstheory.cn/leaders/201204/t20120401_149156.htm

the CHNS respondents during 2000 to 2009, the number of respondents who have medical insurance increased from 36% to 85% during this period.



Graph 1

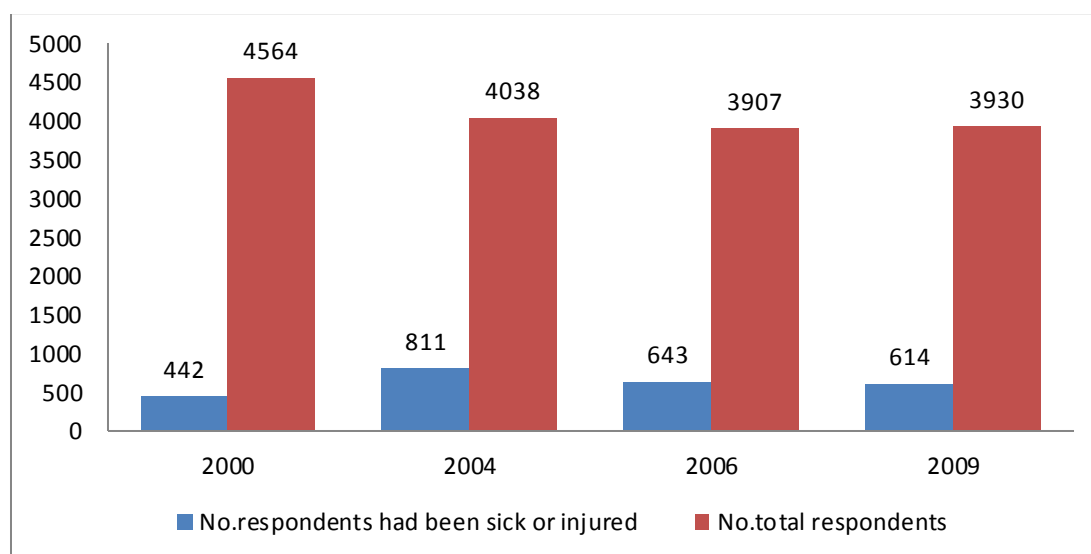
According to *2011 China Health Statistical Yearbook*, the number of urban citizens with basic medical insurance had increased a lot as well, from 223110,000 in 2007 to 432060,000 in 2010. Below, Table.1 shows the number of urban citizens with the basic medical insurance.

Year	Number of urban people with medical insurance (thousand people)		
	Total number	UR-BMI	UE-BMI
2007	223110	42910	180200
2008	318220	118260	199960
2009	401470	182100	219370
2010	432060	194720	237340

Table 1¹⁶

¹⁶ National Health Commission of China, *2011 China Health Statistical Yearbook*, Beijing: Peking Union Medical College Press, 2011:364

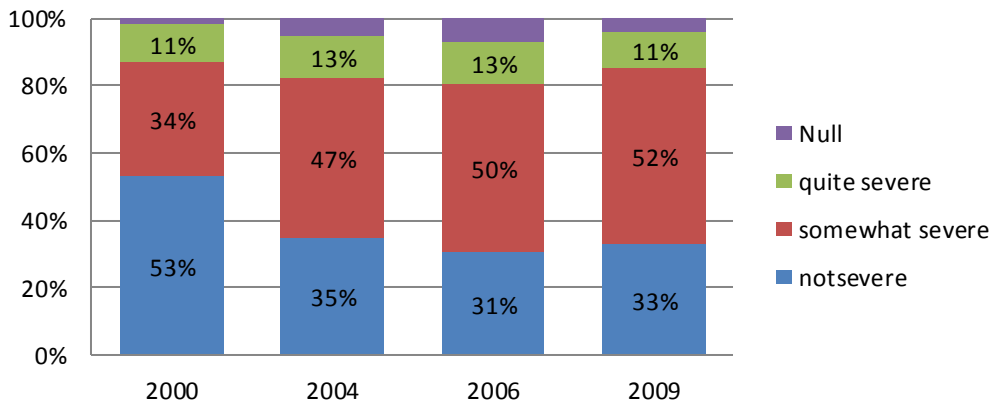
2) Need for care variables: As discussed above self-reported health status has been used to measure perceived need for healthcare. Histogram.1 presents self-reported illness during the past 4 weeks prior to the surveys. Except for 2000, it shows that there was little difference in self-reported morbidity between 2000 and 2009. In Wave2000, there were 442 (7%) respondents had been sick or injured in last 4 weeks among the total urban respondents. As for Wave 2004; Waved2006 and Wave2009 the number were 811(20%); 643(16%) and 614(16%) respectively. There was no statistically significant difference between the self-reported morbidity rates in these four years.



Histogram 1

Histogram.2 shows the answer of “How severe was the illness or injury?” among those respondents who had been sick or injured. The population of those got “not severe” illness decreased from 53% to 33% during these years. However, respondents believed that their illness were “somewhat severe” had increased from 34% in 2000 to 52% in survey of 2009.

“How severe was the illness or injury?”

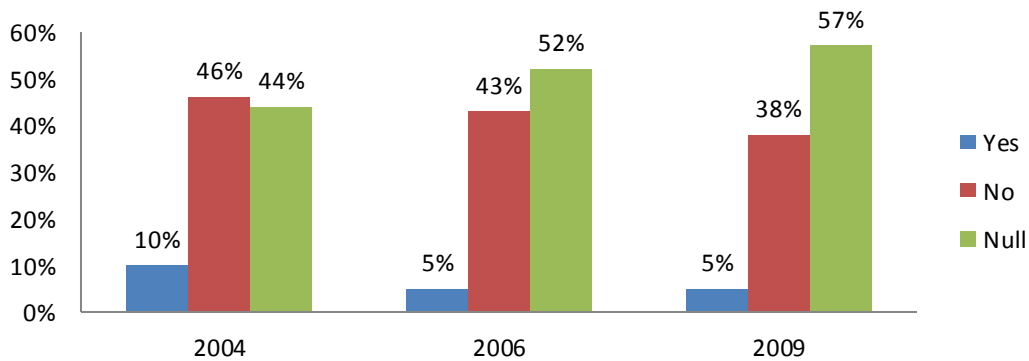


Histogram 2

4.1.2 Dependent variable

Since the question “Did you seek care from a formal medical provider during the past 4 weeks?” was not included in the survey 2000. This study only analyzes Wave 2004, Wave 2006 and Wave 2009. As shown in Histogram.3, over a half data was missing in these 3 years. One possible reason for the missing data is most of the respondents weren’t ill or injured during the past four weeks, so they skipped this question. But in terms of the valid data, only a small number of respondents sought care from a formal medical.

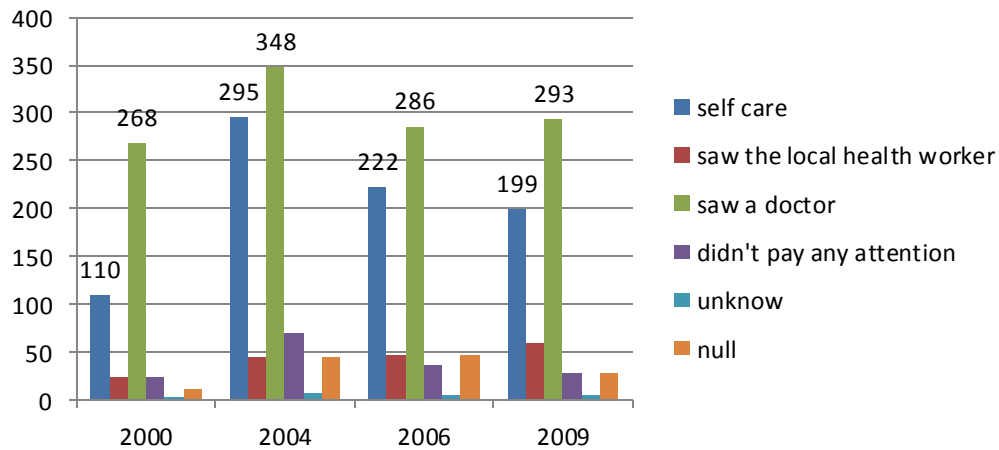
“Did you seek care from a formal medical provider during the past 4 weeks?”



Histogram 3

Below Histogram.4 shows respondents' choice when they felt ill. Although most people chose "saw a doctor", there were quite a lot people chose "self-care". Hospital care services are generally expensive in most cities and people are more likely to refuse to get health care services from formal medical institutions if they have inadequate insurance coverage or insufficient money to pay for the services (Gao et al. 2001:307).

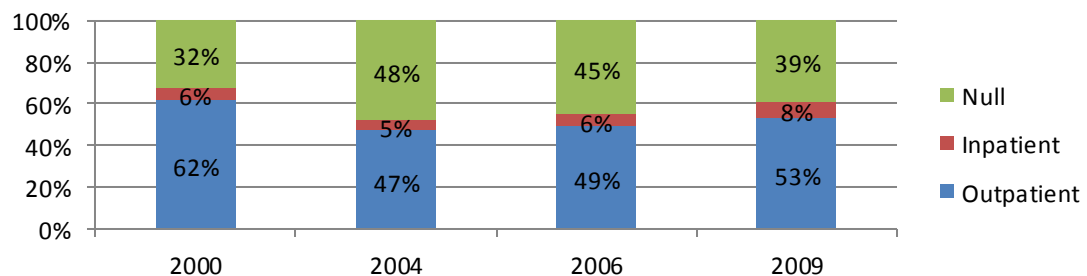
"What did you do when you felt ill?"



Histogram 4

According to Histogram.5, the percentage of outpatient among respondents had moved around 50% during 2004 to 2009. While for inpatient number, it was 32% in 2000 thereafter it had risen to over 45% from 2004 to 2006, but finally declined at 39% in 2009.

Inpatient or outpatient?



Histogram 5

Inpatient and outpatient cost/per capita (China Yuan¹⁷)

Year	Outpatient cost per capita(yuan)	Drug cost	Treatment cost	Drug cost % of Outpatient cost	Treatment cost % of Outpatient cost	Inpatient cost per capita(yuan)	Drug cost	Treatment cost	Drug cost % of inpatient cost	Treatment cost % of inpatient cost
2007	124.7	63.2	37.6	50.6	30.2	4733.5	2014.8	1175.9	42.6	24.8
2008	138.3	71.0	41.2	51.3	29.8	5234.1	2276.3	1301.7	43.5	24.9
2009	152.0	78.3	44.7	51.5	29.4	5684.0	2480.6	1428.7	43.6	25.1
2010	166.8	85.6	49.4	51.3	29.6	6193.9	2670.2	1589.8	43.1	25.7

Table 2¹⁸

Table.2 presents both inpatient and outpatient cost per capita during the period of 2007and 2010. As we can see in the table, both of the cost had accelerated during the four years.

¹⁷ U.S 1dollar=6.13 China Yuan

¹⁸ National Health Commission of China, *2011 China Health Statistical Yearbook*, Beijing: Peking Union Medical College Press, 2011:102

4.1.3 Healthcare expenditure

In this section, figures will illustrate how the health care expenditure is shared by the government and private.

Table.3 is made with figures of the *total health expenditure (THE)* as a percentage of *GDP*, *general government health expenditure (GGHE)* as a percentage of THE as well as the *GGHE* as a percentage of *GDP* during 2000 to 2011. The time (2000-2011) is considered upon two reasons: the four waves data from *China Health and Nutrition Survey (CHNS)* which is 2000, 2004, 2006 and 2009; another considered reason is the short-term objectives of health-care reform should be achieved by 2011.

Countries	Indicators	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
		Value	Value	Value	Value	Value	Value	Value	Value	Value	Value	Value	Value
China	Total health expenditure (THE) % Gross Domestic Product (GDP)	4.62	4.58	4.81	4.85	4.75	4.68	4.55	4.35	4.63	5.15	4.98	5.16
China	General government expenditure on health (GGHE) as % of THE	38.28	35.57	35.83	36.23	37.97	38.77	40.65	46.93	49.95	52.50	54.31	55.89
China	General government expenditure on health as % of GDP	1.77	1.63	1.72	1.76	1.80	1.82	1.85	2.04	2.31	2.70	2.70	2.89

Table 3¹⁹ Government's expenditure

¹⁹ Source from: the global health expenditure database (WHO) <http://apps.who.int/nha/database>

As showed in Table.3, *the total health expenditure (THE)* as a percentage of *GDP* remained around 4.5% before 2008, then from 2009 the number stayed at the level of 5%. The general *government expenditure on health (GGHE)* accounted for 38.23% of THE in 2000; however, it dropped to 35.57% in 2001. In the next five years (2001-2005), it experienced a gradual growth. From 2006, the figure increased dramatically from 40.65% to 55.89% in 2011. The GGHE made up 1.77% of *GDP* in 2000 and it slightly rises to 1.85% in 2006, followed by a gentle decrease in 2001. Since 2002, it steadily ascended every year, exceeding 2% in 2007, and reached almost 3% to by the end of 2011.

On the contrary, private expenditure on health experienced a decrease in the same time. Chart.1 shows the comparison of *GGHE* as a percentage of *THE* and the *private expenditure on health (PvtHE)* as a percentage of *THE*. It's obvious to see that *PvtHE* made up the major part of *THE* before 2008, but with the increasing of *GGHE* the gap between *GGHE* and *PvtHE* was narrowing. In 2008, the figure of *PvtHE* declined to 50% which was the same number as *GGHE*, thereafter, *PvtHE* has taken up less than half of *THE*.

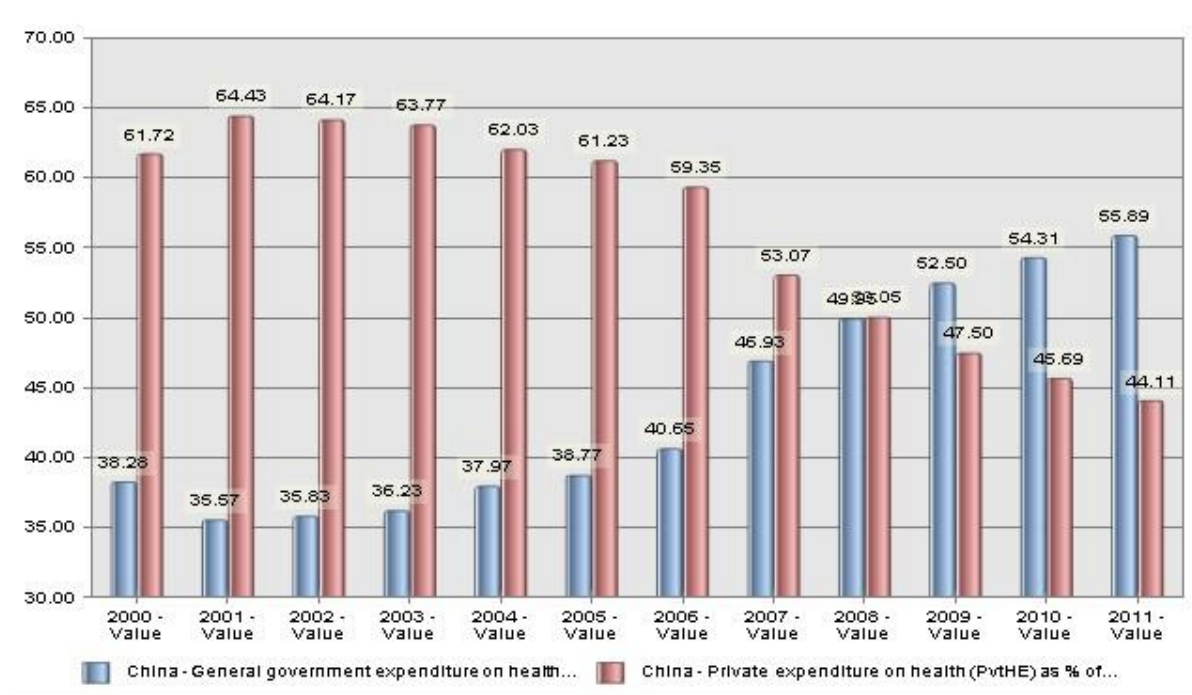
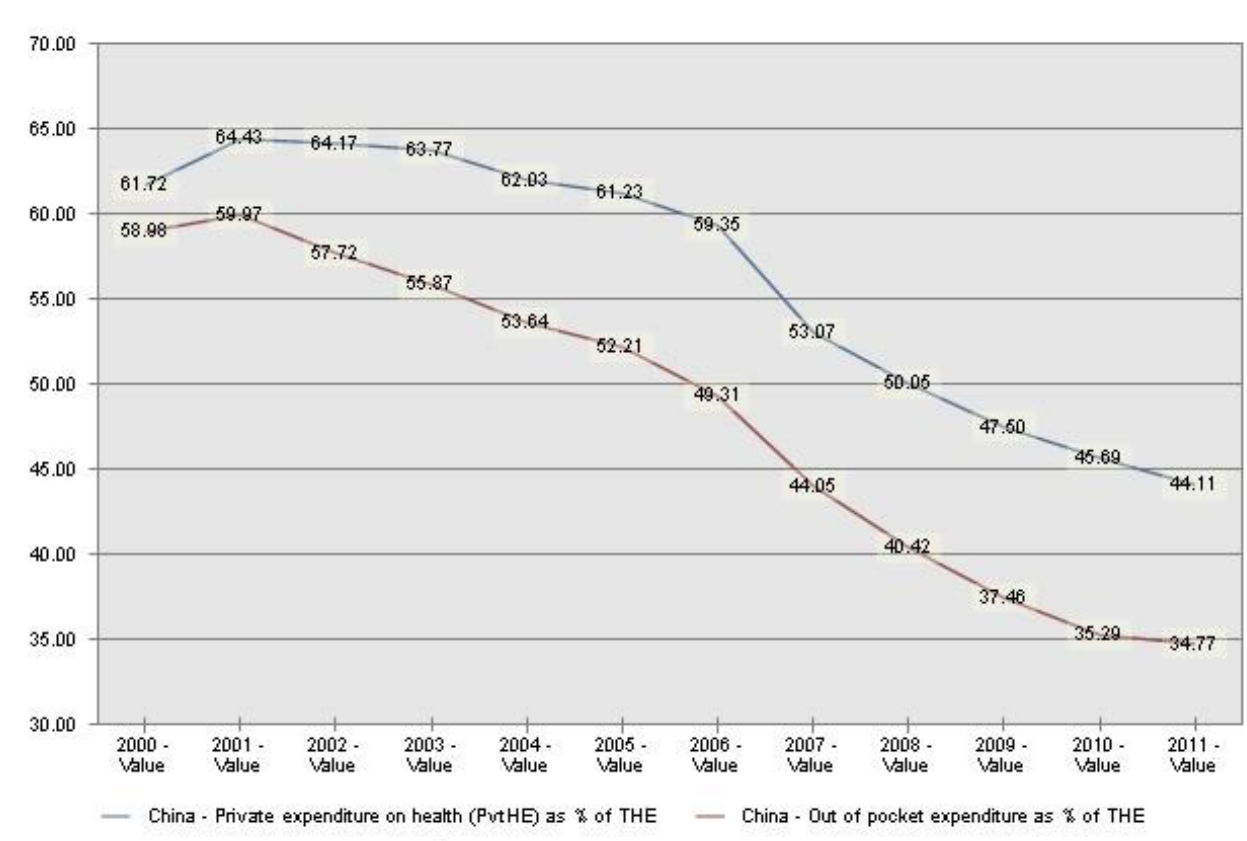


Chart 1²⁰ Comparison of GGHE and PvtHE

²⁰ Source from: the global health expenditure database (WHO) <http://apps.who.int/nha/database>

Below Graph.2 shows figures of the *private expenditure on health (PvtHE)* as a percentage of the *total health expenditure (THE)* and the out-of pocket expenditure as a percentage of THE. Specifically, *PvtHE* took up 61.72% of *THE* in 2003, and then it added to 64.43% in 2001. Thereafter, the figure had been decreasing. In 2011, the rate of *PvtHE* was only 44.11%, occupying less than a half of *THE*. In terms of out-of pocket expenditure, the decline was notable. Out-of pocket expenditure accounted for as high as 59.97% of *THE* in 2001, while the number dropped as low as 34.77% in 2011(see Graph 2).



Graph 2²¹ : Individual expenditure

²¹ Source from: the global health expenditure database (WHO) <http://apps.who.int/nha/database>

4.2 Qualitative results

In the qualitative results, I am going to show my interviews data under the following themes: medical insurance, selection of healthcare service, expenditure on healthcare and attitude towards the healthcare reform.

4.2.1 Medical insurance

For the question of “Do you have medical insurance you and what kind of medical insurance do you have?” All of my interviewees had medical insurance. Among eight of them, there were four having *UE-BMI* and three people having *UR-BMI*, while the rest one had *NCMS*.

I am in Urban Employee-Basic Medical Insurance (UE-BIM) of city level. (Mrs.Zhang’s Interview)

I used to be in the New Rural Cooperative Medical Scheme (NCMS), but now I am in Urban Citizens Basic Medical Insurance (UR-BIM). Since I bought an apartment in Fuzhou and got the City Hukou²², I have the right to join in the UR-BIM. (Mr.Li’s Interview)

I am in Urban Employee-Basic Medical Insurance (UE-BIM) of Province level...From my point of view, the difference between Province level and City level is if you have UE-BIM at the Province level then you have more choice for healthcare service than at a City level. For instance, I can go to any designated hospitals in any cities within our province, but if I have the UE-BIM at the City level, I can only go to the hospitals in Fuzhou. (Mr.Chen’s Interview)

I am in New Rural Cooperative Medical Scheme (NCMS). Although I have been working in Fuzhou this City for more than 16 years, I still don’t get the City Hukou. Since I have a rural Hukou, I can only join in the New Rural Cooperative Medical Scheme (NCMS) in my town. (Mrs.Wei’s Interview)

In terms of the question “How much do you know about the social health insurance that you have joined?” Most of my interviewees expressed that they knew little about it. Only Mr.Chen knew a little about the different levels of *UE-BIM*.

²² A Hukou is a record in the system of household registration, there are two types: Agriculture Hukou (also called City Hukou) and Non- agriculture Hukou.

4.2.2 Selection of healthcare service

There were three people in my interviews said that they preferred to go to a pharmacy to buy some medicine rather than to go to hospital when they got sick.

Generally speaking, I am very healthy. If I get a sick, I will endure it. If the illness lasts long, I may go to buy some medicine. (Mr.Li's interview)

Well, usually I will endure it if I get sick. But if the illness gets worse, I will buy medicine, but never go to a hospital. (Mrs.Fang's interview)

However, for most of my interviewees, the community medical institutions are good selections for them to get healthcare services. Data from the *2011 China Health Statistical Yearbook*²³ shows the total number of medical organizations had increased from 806,243 in 2003 to 936,927 in 2010. Among the growth, it is worth to note that the increase of community medical institutions. In 2003, there were 774,693 community medical institutions, while the number arrived in 901,709 in 2010.

My recent sought for health service was in the community hospital. Now, it seems that every community, at least each community I have known, has a community hospital or a clinic where we can use our medical insurance card to get health service. The main reason for me to choose the community hospital is because it's very close to my place, so I don't have to drive or take a bus there. It's time-saving and convenient, so that you can get treatment as soon as possible. In terms of the cost, it took me about one hundred for the flu last time. Compare with the cost in big hospital, it's cheaper... (What do you think about the community hospital?) I think the community hospital is good. At least it's very convenient for us to get medical service. My families usually go to the community hospital for some minor illness, like headache and flu. But if the illness is serious, we would choose big public hospital instead. (Mrs.Ji's interview).

Well, community hospitals are very convenient. Moreover, there are fewer patients there, so you don't have to queue. It saves time and energy to go to a community hospital. But if I have time, I prefer to go to big hospitals, because I believe that big hospitals are more reliable and they could provide better medical service. (Mr.Chen's interview).

²³ 2011 China Health Statistical Yearbook: <http://www.moh.gov.cn/htmlfiles/zwgkzt/ptjnj/year2011/index2011.html>

According to the interview data, some people chose to go to pharmacies to buy medicine to “self-care” rather than to go to hospital. They have low sense of entitlement to hospital care and their perception of medical treatment was unaffordable. Most of my interviewees would like to go to community hospitals for medical care, because they believed those community hospitals were convenient, less time-consuming and easy to get healthcare services, hence community hospitals could be a very good choice when they are in need. However, they also indicated that they would go to big hospitals if they got serious illness.

4.2.3 Health expenditure

In terms of the cost for health, all of the interviewees reflected that health care cost a lot. And it is important to note that almost all of my interviewees said the sustained increase in medicine prices was one of the important reasons which lead to the rising of their health expenditure.

It's quite expensive to go to hospital. It's expensive in every part of getting healthcare services. Taking registration fee for example, if you want to see a specialist; the registration fee is higher than see a normal doctor. The medicine price is expensive as well, especially those imported medicine. And you can't get the reimbursement by using imported medicine. (Mrs.Zhang's interview)

From my point of view, it's quite expensive to go to hospital, and the medicine is expensive as well. It can cost you about 100 Yuan for cold medicines. It seems that prices of all medicines in designated pharmacies have increased. I haven't been to hospitals for many years. (Mrs.Fang's interview)

For me, as a resident live in the city but with NCMS, it's hard for me to get healthcare service in the city. Although I have been living and working in this city for 16years, but without a City Hukou I am still a rural person. As a rural citizen living in the city without UR-BMI, the healthcare service costs more for me than other urban citizens. Since urban citizens with UR-BMI or UE-NIM could get some reimbursement after they get healthcare service, however I can't get the reimbursement form NCMS if I get medical service in the city. Go to hospital is too expensive for me, I can't afford for that. (Mrs.Wei's interview)

Most of my interviewees presented that one reason for the high cost of medicine due to some essential medicines are not included in the basic drug reimbursement list²⁴.

4.2.4 Attitude towards the health care reform

As discussed above, the “Harmonious Society” calls for universal access to healthcare and aims at building a fairly complete public health service system and health care service system by 2020. Hence, I asked some questions in relation to this theme. Although all of my interviewees expressed their support to the equalization of basic social services, however, they showed negative attitudes toward the achievement of Harmonious Society’s goals by 2020”.

If the healthcare reform can really build a universal and affordable healthcare system for all Chinese, I would like to support it. But I think it will be tough, since there are almost 0.7 billion rural population in China. I think it will cost much more time and money to build a universal and affordable healthcare system for them. (Mrs.Zhang’s interview)

I doubt about it, since we don’t have corresponding mechanisms of monitoring for healthcare sectors, so it can’t guarantee the reformation to be realized. Moreover, without an effective mechanisms of monitoring, it can’t guarantee the expenditure on healthcare can be used in really need.”(Mr.Chen’s interview)

If people from rural areas can enjoy the same healthcare service as urban citizens, I would say it is good and I will support it. But I don’t think our government can establish this universal and affordable healthcare system in the next decade, because the gap between urban and rural area is tremendous. If our government wants to build this system, from my point of view, it should try to cut down the gap of uneven economic development between urban and rural space, as well as promoting the same right in both urban and rural places (Mrs.Wei’s interview).

²⁴ China’s National Drug Reimbursement List (NRDL): There are two lists where one list consists of more basic drugs that are reimbursed according to Basic Medical Insurance Fund (BMIF) regulations while the other list of pharmaceuticals/drugs receive relatively higher prices.

5. Analysis

Based on the theoretical framework and the results from quantitative research and qualitative research, a systematic analysis is developed in this chapter. Under the conception of “Harmonious Society”, the Chinese government launched a new round of health care reforms in 2003 and aimed to fundamentally establish a the basic health care system covering urban and rural citizens by 2020. In order to achieve the goals of “Harmonious Society” for health care, a series of relevant governmental documents and polices have been presented during the health care reform. Since the research questions mainly focus on the area of government and individual, it only takes two elements state and family (individual) to explore the welfare mix in Chinese heath care system. Then, two dimensions of financing and service provision are analyzed by the results of quantitative data as well as qualitative data. Specifically, medical insurance coverage and health expenditure will be discussed in the financing part; then the growth in medical institutions will be represented in the service provision part. Lastly, the final part is to examine the outcome of the health care reforms. Based on the theoretical framework and combined with the reality of China’s health care system, I would like to develop the analytical framework to explore my research questions. Figure.3 shows the developed analytical framework:

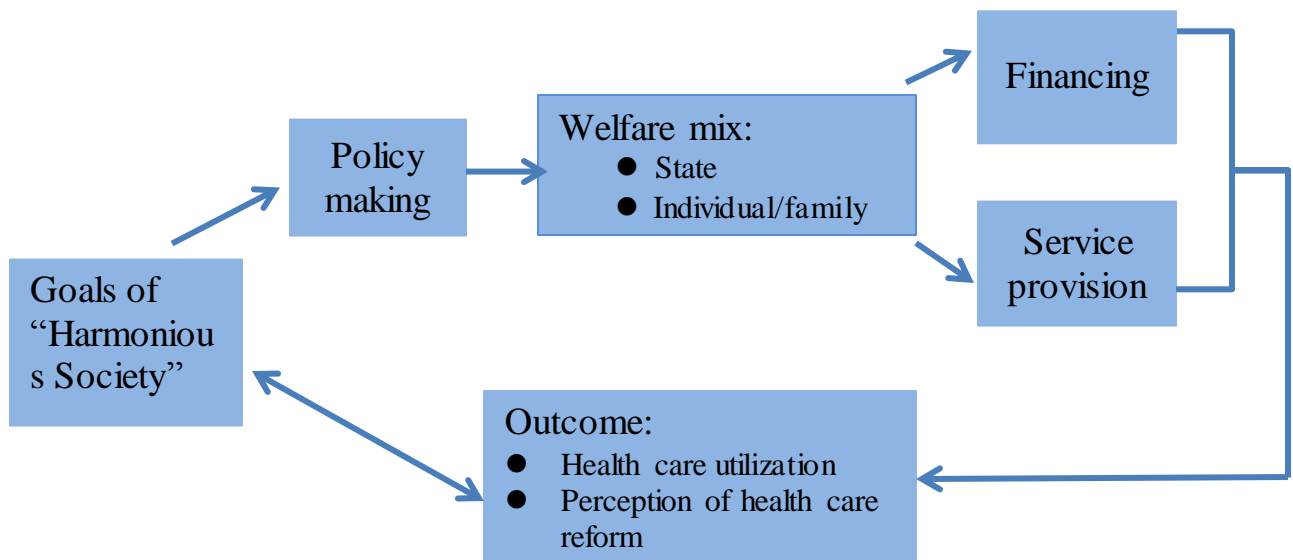


Figure 3 Analytical framework

5.1 Financing

5.1.1 Medical insurance coverage

So far, Chinese government has produced good results in the initial stage of the healthcare reform. A notable one is the coverage of basic medical insurance has been increased largely. “At present, 1.28 billion rural and urban citizens are covered by basic medical insurance, accounting for about 95% of the total population.”(Li 2012) In terms of urban citizens, the data from CHNS (see Graph.1) shows that the percentage of urban respondents with medical insurance has increased from 36% to 85% during 2000 to 2009. The statistics in Table.1 also shows the number of people with medical insurance increased from 223110,000 in 2007 to 432060,000 in 2010. Moreover, all of my interviewees have been covered by basic medical insurance. Based on these data, we could predict that the growing trend in medical coverage will continue in future and more and more Chinese people will be covered by basic medical insurance, though the basic medical insurance may be of different types.

According to Li’s report, the government had launched “a portfolio of basic public health service programs spanning 10 different categories and initiated 7 major public health service campaigns across the country” (Li 2012) to provide equitable access to basic public health services for all people. However, my interview results show that many people felt the current health care system was inequitable, especially for those urban citizens with NCMS (New Rural Cooperative Medical Scheme). Nowadays, there are a huge number of people living in urban areas without a City Hukou. Although these people have been living and working in cities for a very long time, without a City Hukou, they have neither UE-BMI (Urban Employees Basic Medical Insurance) nor UR-BMI (Urban Employees Basic Medical Insurance), hence they can’t enjoy the same health care services as other urban citizens who have a City Hukou. Most of these citizens are covered by NCMS; however, the NCMS can’t be used in urban areas. As a consequence, how to get access to healthcare service in the cities is a big problem for these urban citizens. It is noteworthy that even in the same system, the access to health care may be different. For example, in my interviews there were four interviewees covered by UE-BMI: three people at City Level of UE-BMI and one at Province Level. The one (Mr.Chen) with UE-BMI at Province Level said that having UE-BMI at Province Level means more choice for health care service than the City level. For instance,

the one with UE-BMI at Province Level can enjoy health care in any designated hospitals among the province, whereas the one with UE-BMI at City Level can only go to the hospitals in which city he lives. I noted that he was the only one working in government's department among my eight interviewees. As a civil servant, he could enjoy more healthcare benefits than other people.

5.1.2 Health care expenditure

I will describe both of the government's expenditure and private expenditure to illustrate how the health care expenditure is shared in China.

As discussed in the theoretical framework chapter, among East Asian countries, GDP growth has been put in the first place of the government's agenda. These countries have achieved great economy development, however, corresponding welfare for citizens (health care for instance) have not been enhanced. The disparity between economic growth and welfare provision is enlarged. The outbreak of SARS in 2003 exposed China's fragile public health care system, ever since from then on have the Chinese government realized the urgency of increasing health insurance coverage.

According to Li's report (2012), the government's investment in health programs has progressively increased.

From 2009 to 2011, an additional 331.8 billion Yuan in central government funds was allocated to health care reform. At the same time, all localities have also increased their expenditure in health care reform. With the significant increase of government expenditure, the proportion of health care fees borne by individuals has dropped on a constant basis. This has allowed us to ease the financial burden of the public in medical care.

The data from WHO (see Table.3) shows the government has remarkably increased the expenditure on health. In 2000, the general government's expenditure accounted for only 38.28% of total health expenditure (THE). Thenceforth, the rate has kept increasing and it exceeded 50% in 2009. During the same time, individual expenditure on health had dropped (see Graph.2). In 2000, the private expenditure on health (PvtHE) covered 61.72% of THE, while the proportion decreased to 44.11% in 2011. The out-of-pocket expenditure which affecting family and individual's accessing to health care directly showed a remarkable

decline as well. It only made up 34.77% of THE in 2011 compared to 58.98% in 2000. From the official data's perspective, the Chinese government has been increasing its expenditure in health care and individual's cost in health care has been going down in recently years.

However, my interviews data gave the opposite answers. Almost all of my interviewees reflected that their expenditure on healthcare had increased and it was more expensive to go to hospital than before. In their opinions, it was still expensive to get health care service although the health care reform aims to get the health care service cheaper and easier. Additional, they pointed that the growth of drug cost was the main reason for the increasing individual expenditure on health. As shown in Table.2, from 2007 to 2010, the outpatient cost per capita had increased from 124.7 Yuan to 166.8 Yuan, among these cost drug cost went from 63.2 Yuan in 2007 up to 85.6 Yuan in 2010. During the same time, the inpatient cost had a growth as well. Specifically, the cost increased from 4733.5 Yuan per capita to 6193.9 Yuan.

The results from quantitative data show that the government has obtained great achievement in health care reform. For the medical insurance coverage, the data from CHNS (see Graph.1) shows that the rate of medical insurance enrollment among urban respondents was 85% in 2009, over two times larger than in 2000. In terms of health care expenditure, the government has remarkably increased the expenditure on health (see Table.3), the *general government expenditure on health (GGHE)* accounted for 55.89% of *the total health expenditure (THE)* in 2011. The increasing government expenditure on health contributes to the decline of individual expenditure on health (see Chart.1). The *private expenditure on health (PvtHE)* has showed a trend of decrease since 2001, then in 2011 *PvtHE* only made up for 44.11% of *THE*. The analysis of quantitative data seems to indicate that state's responsibility in health care financing has been growing up that lead to reduce the individual's /family's health care cost burden. This results show a contrary with White and Goodman's idea of "Confucian welfare state" about East Asian Welfare Model, where they argued that the notion of state-provided welfare as a social right of citizens under this "Confucian welfare state" is weakly. Instead, non-state agencies-community, firm and family have been expected to play a major welfare role in both financing and providing welfare services.

The change seems to correspond to what Gough's (2008) point of view. Gough argued the East Asian welfare model "faced the need to move beyond Confucian familialism and were beginning cautiously to graft a social investment approach alongside a further extension of existing policies. Democratisation and nation-building are likely to generate welfare state-building in this region in the future" (Gough 2008:35).

However, results from interviews data show the health care schemes are unequal. Even in the same health care scheme there are inequalities existing and these inequalities due to the people's vocation type. When it comes to individual's health care expenditure, although the quantitative data show *PvtHE* has declined, interviewees presented that it's still expensive to get health care and the medical cost hasn't obvious decrease in their families. A factor lead to the high medical cost, they referred, is some essential medicines are not included in the basic drug reimbursement list that they have to use out-of-pocket expenditure to pay for them. While the fees and prices for certain basic health services and drugs are controlled by the state, others are not (particularly those involving new and advanced treatment techniques or import drugs). Doctors and hospitals could generate more revenue from these services and import drugs that are not subject to control, they tend to favor those treatment techniques and drugs. It contributes to the increase in individuals' medical cost (Åke & Qian 2010:41).

Based on above analysis, in order to provide universal basic health care and relieve people's burden of medical cost, the Chinese government has made efforts to increase the medical insurance coverage and health care expenditure. However, citizens still bear high health care cost and it is no easy to access to health care. One of the main reasons probably is the high-speed increase in medical costs which brought heavy pressure and burdens to the population.

5.2 Service provision

As the number of medical institutions can be seen as an important indicator for health care service, it will be discussed in this service provision section, followed by the discussion about people's health care selection.

Medical and healthcare services at the grassroots level have been improved during the health care reform. According to Li's report (2012): "More than 2,000 county-level hospitals and over 30,000 grassroots medical and health institutions have been constructed or

reconstructed.” In addition, statistics from the *2011 China Health Statistical Yearbook* shows the ascending number of medical institutions. The figure of community medical institutions was 774,693 in 2003 while it jumped to 901,709 in 2010. Most of my interviewees also reflected that the number of community medical institutions has grown in recently years. Moreover, they prefer to these institutions if their illness was not serious. From their point of view, the community medical institutions are convenient, less time-consuming and easier to access.

5.3 Health care utilization

Though the government has largely enhanced the health care services at the grassroots, some interviewees said they would endure the sickness or just go to buy some medicine instead of going to formal medical institutions to see a doctor. The data in quantitative results showed there were a lot of people hold this opinion. The information in Histogram.3 reveals that only a small number of respondents (10% in 2004; 5% in 2006 and 2009) sought care from a formal medical. As for the choice when respondents getting illness (see Histogram.4), most people chose “saw a doctor”, however, there were quite a lot people chose “self-care”. Those people who took “self-care” among my interviewees expressed that the high cost of seeing a doctor lead to the selection of “self-care”.

In the process of China’s welfare mix transform from state planned economy to market economy, the Chinese health care reform has turned to a market-based system. The activities by all types of health care providers are trying to maximize their profits from the health care marketplace. Hence, as discussed in 5.1 Financing section, during the process of medical treatment, doctors and hospitals prefer to choose new and advanced treatment techniques and import drugs which do not controlled by the state in order to generate more revenue. As a consequence, people either to pay for the high medical cost or deny formal medical treatment and turn to “self-care”.

Except for the high cost of health care, another reason for people choosing “self-care” may be the different types of medical insurance. For example, the one has NCMS but living in urban areas would prefer to choose “self-care” due to the uselessness of NCMS in cities.

5.4 Perception of health care reform

Chinese government has drawn up a grand blueprint for “Harmonious Society”. In order to achieve the goals of “Harmonious Society”, it has set up both short-term and long-term objectives for the healthcare reform. Among the short-term objectives, one is the problem of "difficult and costly access to health care services" which shall be remarkably relieved by 2011. Although the government’s expenditure on healthcare has been growing all the time, individual expenditure has kept on increasing as well. And most people still have heavy burdens of medical cost. For many people, especially those urban citizens without UE-BIM/ or UR-BIM, it is still hard to get access to healthcare service in the cities.

Based on the statistics, the basic medical security system has not yet completely covering urban and rural citizens. There are still some people do not have any basic medical insurance. Hence, from my standpoint, the short-term objectives of healthcare reform have not accomplished yet. In terms of the long-term objectives: the government shall set up a fairly complete public health service system and health care service system across the country by 2020. Although all of my interviewees expressed their support to the equalization of basic social services, however, they showed negative attitudes toward the achievement of the goals.. As my point of view, it will bring a lot benefits to the whole population if the goals could be achieved. But, as things stand now, in the process of reform there are some problems haven’t been solved yet, for example, the gap between UE-BIM/UR-BIM and NCMS. The unsolved problems will stunt the achievement of “Harmonious Society”, leading to a longer time for the government to achieve its long-term objectives.

6. Conclusion and Discussion

This chapter will first summarize the results from the analysis and holistically answer the research questions with help of the findings in previous chapters. Based on the conclusion, it will give some suggestions about the health care reform. Following, a discussion about the limits and weakness for this thesis has been presented. At the end of this thesis, final remarks will be showed.

6.1 Summarizing discussion

This thesis explores an issue in relation to Chinese healthcare reform under the conception of “Harmonious Society”: how does the health care system reform change urban citizens’ healthcare utilization in China? For this research purpose, two specific research questions round this topic have been proposed: 1) what’s the impact brought by the government’s new health policy in the process of the health care reform? 2) how does the new government’s health policy affect urban citizens’ access to healthcare service? The first question is an empirical check of the impact of health care reform, while the second question is centered on individual’s perception about the health care reform. In order to explore the research questions, the theories of East Asian Welfare Model and China’s ‘welfare mix’ have been applied to develop an analytical framework for this study. The data for this thesis has been collected by both quantitative and qualitative methods. The analysis chapter presents the results within the analytical framework.

The findings show: the government has made a lot effort on health care in both of the financing and service provision dimension during the process of health care reform, specifically expanding medical insurance coverage, increasing the number of medical institutions and adding healthcare expenditure. However, the health care outcomes have not reached the initial goals of the health care reform; a part of people haven’t been covered by any medical insurance yet; for many urban citizens, it is still not easy to get health care due to the high medical cost and different medical insurance systems. As a consequence, most people doubt that if the goals related to health care in “Harmonious Society” could really come true by 2020. As I see it, achieving the government’s overall objectives in healthcare reform will be a gradual process and it may take longer time than the initial plan.

- The Chinese government’s health care reform plan represents the main initiative towards ensuring universal access to basic healthcare, essential medicines and public health services. During the process of achieving the health care reform blueprint, basic medical insurance plays a vital role so that it should be paid enough attention. The strategy for expanding universal access largely relies on implement of insurance programs. It is recognized that there are rising demands and expectations from those urban citizens coming from rural areas without the City Hukou. Most of these people are covered by

New Rural Cooperative Medical Scheme (NCMS) which can't be used in urban areas. Hence a large part of the health care expenditure for these urban citizens is borne by individuals and their families. Solving this problem require contributions from both central and local governments. Meanwhile, the analytical results revealed that only increasing the medical institutions and expenditure on health may not translate into people's better satisfaction on healthcare service where a reasonable medicine price system are not aligned with the healthcare reform.

- Analytical results revealed that drug cost was the major cost when people seeking healthcare service. According to report form WHO "Medicines expenditures are estimated to account for just under half of individual out of pocket payments amounting to some 1.6% of GDP – which represents a much higher level of spending on medicines in comparison with other countries." (Barber& Yao 2010:23) As the high-priced drug is a major problem undermining the sound development of healthcare programs, it is necessary to establish a national price system for basic drugs. In doing so, it could effectively dispel the negative impact caused by this problem. And the key link in implement a national price system for basic drugs is to standardize the purchase of drugs. The government should set up effective operational and supervisory mechanism to carry out the policy of selling basic drugs without markups and work to ensure the quality and safety of basic drugs. This will allow us to reduce the burden of the public in the use of basic drugs. Moreover, as many essential medicines are not included in the reimbursement list, the government should make sure all essential medicines are covered by the reimbursement list as soon as possible.
- The health care reform aims to promote the primary healthcare utilization. Large-scale investments have been made to strengthen grassroots healthcare service to promote healthcare utilization at primary level. One important reflection for this is the increasing number of community medical institutions. Results from quantitative research illustrated the figure of community medical institutions has jumped up dramatically in the process of health care reform and qualitative results showed most citizens had positive attitudes towards the community medical institutions. But, there were some people think the quality of healthcare in community medical institutions was not good. From my viewpoint, promoting utilization at primary level will strengthen primary care and public health. However, some interviewees expressed that in some extent the community

medical institutions can't provide the health care which they required. Hence, in the process of health care reform, the government should not only pay attention on the growth number of institutions, but also concern on the quality of health care provided by those institutions.

6.2 Limits and weakness

According to previous research, the family plays an important role in China's social welfare provision. Theories of East Asian Welfare Model and China's 'welfare mix' have revealed an extensive family role as the resource of social welfare provision. One of the initial objects is to pursue family's role in health care provision. However, in the process of study, only health care financing issues has been discussed in the dimension of individual/family, while family's role in health care provision has been ignored. Moreover, some quantitative data results, for instance inpatient or outpatient selection, have not been included in the analysis chapter.

New questions have been raised during the process of this study. Some of the themes are within this study, while others are beyond the framework for this study. Due to the limitations of the research time and my academic background, these problems haven't been explored but could be suggested for future research. One of the noteworthy problems is the inequality between different medical insurance schemes. One of the highlight inequalities is between rural and urban areas. The group of migrant workers is a special group, these migrant workers coming from rural areas but living and working in urban areas, however, without *City Hukou* they cannot enjoy any welfare in urban areas. As for health care, even though migrant workers have enrolled in *NCMS*, they can't get any health care services in cities; this problem is related to the *Hukou* system which is another hot issue in China.

6.3 Final remarks

In recent years, health care issue has emerged as one of the main social issues in China. Chinese are finding it increasing difficult to pay for their health care expenses as well as accessing health care services. All these have triggered discontent among the Chinese population. Since Hu Jintao came into power in 2002, the Chinese government has put a great

deal of emphasis on more balanced development and re-oriented its reform direction by focusing more on the society rather than the economy. It is in this context that building a “Harmonious Society” has been put forward which aims to build a well-off society of a higher standard in an all-round way to the benefit of well over one billion people. Following the call to build a “Harmonious Society”, a new round of health care reform has been launched to deal with the existing problems in health care area since 2006.

Based on my own discipline background and previous research, I decided to use the welfare perspective to explore my research issue: how does the health care system reform change urban citizens’ healthcare utilization in China? This idea guided this study with the intention to investigate urban citizens’ healthcare utilization within the Chinese welfare system. Hence, it is important to investigate the practical side of the new health care system and examine its impacts for the citizens. The methodology consists of both quantitative and qualitative methods provide not only impacts of the new health policy at macro-level but also at micro-level. Hence, the results from quantitative and qualitative data make stronger explanation to the research topic. The findings show the new health care reform has, in some extent, brought good impacts on Chinese. However, there are some bad side effects leading to bad impacts of people’s health care utilization. As a consequence, most people doubt that if the goals related to health care in “Harmonious Society” could really come true by 2020. From my point of view, achieving the government’s overall objectives in healthcare reform will be a gradual process and it may take longer time than the initial plan.

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8. Appendix A- Interview outline:

Self-introduction: Hello! Thank you very much for your time of my interview. My name is Shufang Wei and a student from Welfare Policies and Management of Lund University. Now I am writing my master's thesis about the healthcare system in China, so your answer is very important for me. But please don't worry about it because I am not going to ask you very difficult questions. What I am concerned with is your personal ideas and experience about healthcare services. And I am not going to write your name in my thesis, so please don't worry about losing your personal information. If it is ok, shall we start?

1. Can you introduce some basic information about yourself (age, education, occupation)?
2. Are you currently included in any social health insurance? (If yes, how did you join in this insurance? If not, why don't you choose one to join in?)
3. How much do you know about the social health insurance that you have joined? And how much you can get reimbursement from the medical costs?
4. What kinds of factors affect you when you ask for health service? Do you remember where and how much it cost you when you sought for health service last time?
5. Do you think the health service costs are expensive for you and your families? If so, what usually costs the most for you?
6. What do you think about the community hospital in or near your neighborhood? Are you willing to go there or you prefer big hospitals?
7. According to your experiences, what's the problem and difficulty existed in the process of seeking for health service?
8. Are you satisfied with current reimbursement system? If not, can you tell me the reasons?
9. Do you feel any difference since April 2009; the Chinese government announced comprehensive reforms to the health system? What do you think about these differences, are they good or bad?
10. Do you think that everyone should get the equal access to have healthcare service?
11. Our government is launching a new healthcare reform and states that a universal and affordable healthcare system will be built by 2020. What is your attitude towards this? Do you think the goal can be realized in the next decade?"

9. Appendix B-Information about interviewees

Number	Name	Age	Education	Vocation	Medical Insurance
1	Mrs.Zhang	43	Middle School	Public Institution	UE-BMI
2	Mr.Chen	30	University	Government's Department	UE-BMI
3	Mrs.Fang	40	Elementary School	State Owned Enterprise	UE-BMI
4	Mrs.Wei	48	Middle School	Self-employment	NCMS
5	Mr.Zhang	42	Middle School	Public Institution	UE-BMI
6	Mrs.Ji	48	College	Laid-off	UR-BMI
7	Mr.Wang	49	Elementary School	Self-employment	UR-BMI
8	Mr.Li	41	Middle School	Private Enterprise	UR-BMI