LUND UNIVERSITY

Master's thesis WPMM42, 30 credits

Welfare Policies and Development

Department of Sociology

Supervisor:Kjell Nilsson

Spring 2021

China as a Welfare State--History, Transition and Tendency

--Based on multiple policy analysis strategy

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Abstract

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This paper regards China as a welfare state with focus of historical factors, welfare transition, institutional changes and relevant stakeholders. Theoretical analysis is divided into four parts; previous research of welfare state regime, history of welfare policies, present welfare sectors and welfare transition in China. Practical analysis centers on case study which adopts stakeholder theory. Further, health care policies and poverty policies are good examples for social welfare. Multiple analysis strategy will be helpful to identify China as a welfare state and figure out "why", "how" and "how much".

Keywords: China, Welfare State, Welfare policies, health care, poverty.

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Abbreviations

APA -- Accurate Poverty Alleviation Plan

BMI -- Basic Medical Insurance System(UEBMI+URRBMI)

CMI -- Cooperative Medical Insurance Scheme

NCMI --New Cooperative Medical Insurance Scheme

MLG -- Minimum Living-hood Guarantee Scheme

SSS -- Social Security System

SAS -- Social Assistance System

SIS -- Social Insurance System

SWS -- Social Welfare System

UEBMI -- Urban Employee Basic Medical Insurance Scheme

URBMI --Urban Resident Basic Medical Insurance Scheme

URRBMI -- Urban and Rural Resident Basic Medical Insurance Scheme

WB--World Bank

WHO--World Health Organization

Introduction

The greatest escape in humankind history is to survive from poverty and death.(Deaton 2014) In the last three decades, China has achieved an impressive economic boost which pulled 600 million population out of poverty. (World Bank 2016) At the same time, many welfare projects have been established and implemented. Yet until 2018, 942,930,000 population has joined basic pension scheme, and 1,344,520,000 population has joined basic medical insurance scheme.[1] The stereotype of reluctant/residual welfare regime seems has changed under the increasingly welfare expansion context. "Is China a welfare state or on way of it?" There is a little discussion before, because both classical welfare states and Chinese government are trying to maintain uniqueness, or welfare state seems exist in capitalist world only. But if we put ideology alongside, simply regard social welfare as a tool to secure citizens better. It is interesting to look China as a welfare state, since differences and similarities will map all formal/informal welfare regime together and inspire welfare transition.

As Esping-Andersen pointed out; (1990;3) "To study the welfare state is a means to understand a novel phenomenon in the history of capitalist societies, states vary considerably with regard to their accent on welfare, the historical characteristics of states have played a determinant role in forging the emergence of their welfare-statism." The term "welfare state" is an echo of political economy of capitalism, while China seems on a different way that authoritarian state and planed economy play very important roles in constructing welfare state regime. Besides, the securing function from family should be noted too. Such differences are rooted in culture and historical factors, similar characters could also be found in Confucian-influenced regions. (e.g. Japan, South Korea,Taiwan...) This paper will review the development of welfare regime theory in different regions (e.g. Europe, East Asia, China) at first, and then untangle the welfare transition in China under political economy context. By that means, a interaction between welfare institution and political economy will be presented, further similarities and characters under welfare regime theory could be elaborated and understood easier.

[1] Data Source:
Ministry of Human Resource and Social Security of the People's Republic of China
http://www.mohrss.gov.cn/SYrlzyhshbzb/zwgk/szrs/tjgb/201906/t20190611_320429.html
National Healthcare Security Administration
http://www.nhsa.gov.cn/art/2019/2/28/art_7_942.html

This process relates to part 1&2

Culture and history have profound influence in welfare policy making and path dependency which embodies diversity. While in reality, all the welfare states seem to encounter same challenges under globalization, for instance, aging, informal employment, flexible family, chronic disease...So the policy solution tends to be similar. For most countries are more hybrid cases than pure ideologies. Part 3 will focus on the social security system (SSS) in China, which contains five pillars(see in map 1); social insurance system (SIS) has covered largest population indicating a conservative welfare regime, followed by the social assistance system (SAS) which represents a residual style, social welfare system (SWS) is still a immature branch siting third position but it may be the key point in the future; "appropriate universal welfare system" has been put into the political schedule recent years. The rest military welfare and social charity has limited coverage and influence, will not be discussed here. In China, boundaries amid rural residents and urban residents, public/government sector employees and private sector employees reflects welfare inequality. So dual thinking of rural area and urban area, residents and employees are useful to understand welfare gap amid different groups. Besides, for most people, social welfare is an expansion of occupation welfare, family is a caring provider and people would seek for family support when they have problems. It may derive from self-reliant tradition and it also distinguish family-state model in welfare mix.

Sen (2012:24) highlighted that Chinese government has put great effort in health care and education; it improved national quality and contribute to economical boost. To some extent, health care reform is a miniature of social welfare development in China, and it is one of the most impressive parts too. So part 4 will take health care reform as an example, from 1949 to 2019, health care reform has experienced four stages. There are two basic clues thorough out the whole process; one is that government has acted as positive or passive role; the other is that medical schemes has been established and merged. Health care system embodies with universal style and conservative style, which refers to urban and rural resident basic medical insurance scheme (URRBMI) and urban employee basic medical insurance scheme (UEBMI) respectively. What's more, medical aid which is for identified vulnerable group maintains liberalism style. In the end of part 4, three blueprints of health care regime and its' challenge will be presented, it will be helpful to understand and predict

tendency of health care regime in China.

All the analysis and discussion above focused on the theoretical perspective and macro level. In part 5, I adopted a case study in my home town -Dongsheng district as an example to have a specific impression of health care system and assess the output of medical reform. Responsive evaluation highlighted by respondents from various roles; people usually speak for their own group, it will be helpful to reduce misunderstanding and strengthen relations behind each stakeholders. For example; tense relation of doctor-patient in some hospitals. In China, health care system embraced outstanding character; public sectors act as main medical service providers and main medical insurance providers. So the comparison between public sectors and private sectors has been conducted. More importantly, feedback from patients is collected via interview; for vulnerable group who has urgent medical need, which kind of help will they get from government matters. Their stories make health care equity not just an abstract concept, but a life saving straw for human beings. In part 5, many analyse based on the primary data and comparisons in different departments are highly valued.

Methodology

This paper adopted a multi-method strategy which is aiming for mixing qualitative approach and quantitative approach but focus on qualitative part more. Brannen (2005:177) divided mixing research process into “research design, fieldwork and analysis” three phases. As for analysis phase, he conceptualize it as “interpretation and contextualization”. Concerning to the welfare regime theory is from capitalist world which may not fit context in China properly, thus one more circle of contextualization is added before fieldwork in this research, which are : research design, theoretical analysis, fieldwork and mixing analysis.

Research design and questions

I divide research into three parts which derives from “three worlds”--“how”, “how much” and “Why”. In specific, the cause of welfare state relates “why”, contextual analysis including culture, politic and economy will explain the history and tendency of welfare development in China. “How” relies on qualitative analysis more which contained with; theoretical assumption from previous research, mixing analysis from present social security system and theoretical analysis of welfare transition.(i.e. medicare reform recent decades). Third part- “how much” is a case study aiming for testing theoretical conclusion-“how” in a specific context-- Dongsheng, especially the health care policy and medical aid for vulnerable group. Then we may see “how much” perception each stakeholders act and “how” the dose whole medicare system operate, “how” do people think about that...So the questions will be;

1. ***According to the welfare regime theory, which kind of welfare regime that China belongs to ? Any difference from classical typology?***

2.From the history of welfare policies in China, what builds up welfare regime (or policy preference)? Any changes or resistance?

3.Combine welfare regime theory and present social security system, how to define China as a “welfare state” ? What are the challenges and opportunities?

4.From the transition of health care system, how to define “health care regime” in China at present, in the future? What are the achievement and risk?

5.Take Dongsheng as an example, what are the stakeholders in health care system and their problem respectively ? Is health care system efficient or effective?

Theoretical analysis and framework

Welfare regime theory constructs theoretical framework mainly. From Esping-Andersen's (1990) point of view, de-comodification, social solidarity and welfare mix are three important perspectives to evaluate and classify various welfare state regimes. So relevant indicators, eligibility rules, replacement rate, entitlement range (1990;63) will be considered. And "stratification in conservative policy" will be valued more, because rather similarity than difference could be found within China and conservative welfare state regime. For example, "authoritarian paternalist conservatism has been historically important in the development of welfare-state structures....in favor of strict hierarchy, corporatism, or of familialism, the unifying theme is that traditional status relations must be retained for the sake of social integration...."(1990;79)

Until now, "top-down consensus" and "social harmony" value are still accepted and popular in China. Moreover, relative generous welfare for civil servant is a outstanding signal of welfare policies in China and conservative welfare regime as well. In terms of welfare mix, "family-state" model will be mentioned again and again. Besides that, "economy first" value from "productivist style", "family first" value from "Confucian style" and "human capital investment" value from "developmental style" will all be discussed in this paper, more or less.

Contextualization and stakeholders

Brannen (2005;176) focused on context of enquiry&justification, he argued that context matters not only for research design but also for data collection&analysis. So I divided context into macro level and medium/micro level. From macro level, SSS in China will be introduced and analyzed in general. From medium level, health care reform, which is a important branch of SIS will be emphasized. From micro level, a case study in Dong Sheng and stakeholders will tell us how much effort has been put and which kind of help people will get from SSS. Then, we may have a better view of "welfare regime","welfare transition" and "welfare evaluation" in China respectively. The reason why I divide context into three layers is because social welfare in China a broad topic, welfare policies may

depends on social status, living place and exact welfare sector.

Stakeholder theory constructs case study in the last part. As Vedung (2016:265) distinguished four waves of evaluation; the science driven wave, dialogue-oriented wave, the liberal wave and the evidence wave. Mixing strategy of dialogue model and evidence model is inspiring. “Dialogical evaluation rest upon communicative rationality and it would generate broad agreements, consensus, political accessibility...”(2016:270) “The evidence wave tends to structure the field from a social science methodology point of view, not a political , administrative or client one...”(2016:274) This combination will be helpful to generate insights from different actors but not to be subjective only.

Fieldwork and analysis

Fieldwork is based on stakeholders’ relation. Deng and Yang (2013:111) identified relation of health care system in China as “triangular square model” which involved citizens, government, medical service providers and medical insurance providers. They connect each other but speak for their own interest, their voice could be strong or weak. Baur(2010) pointed out that evaluators should empower all actors especially when asymmetric relations exist amid stakeholders. He reckoned everyone is supposed to have a chance to express themselves and evaluators should be neutral.(2010:235) From my own experience and knowledge interest, vulnerable group is valued more. Imagine that everyone stand behind veil of ignorance, no one knows what will happen, the only way is to guarantee basic benefit, then everyone will have a stable expectation and get secured, though most of people will not use it at all.

Recent years, welfare expansion(e.g. poverty policies) and economic success in China has caught world’s attention. As a Chinese, I am proud of it on the one hand, get curios how better it is on the other hand. Put abstract data alongside, welfare policies will affect everyone’s life and maybe the last hope when people get into trouble. That’s my initial motivation to write this paper, to find out welfare transition and it’s cause&tendency, and how it will change people’s (including mine) life. In an other word, my purpose is not to control the policy operation but to learn and to improve, thus stakeholder model is highly recommended.(Hansen 2005:451) I conducted several semi-structured interview for gaining mutual understanding, other indicators were collected via e-government or

fieldwork. Indeed, there is no clear boundary between fieldwork and analysis. Because collecting data and dealing with it could be conducted at the same time. I take comparison as a important approach, for example, public sector v.s. private sector, vulnerable group v.s. privileged group, hospitals v.s. clinics... Such process strongly responds to theoretical assumption but bring up new findings...

Part 1. Previous Research

Welfare state regime

"The three worlds of welfare capitalism and even more."

Welfare state may emerge as the modern industrial economy destroys traditional social institutions. (Flora&Alber 1981) As is stated by Esping-Andersen (1990;19): "Pre-industrial modes of social reproduction, such as the family, the church, noblesse oblige, and guild solidarity are destroyed by the forces attached to the modernization, such as social mobility, urbanization, individualism, and market dependency." The sum of the domestic social policies which were conducted by the nation-state are seemingly similar because of common issue but actually built up different welfare state regimes.

The classification of welfare state is a good way to make comparison among different welfare states, and reduce the complexity. Further, it may draw a path to certain typology for some "underdeveloped welfare states". The core of classification is dimension(s). As is argued by Bonili (1997: 352), the research before whether concentrated on "how much" or "how", which relates to, respectively, expenditure of social welfare and different models. (e.g. Bismarkian model & Beverigean model) But each way seems not to be comprehensive enough to reflect the treatment level of welfare state. Until Esping-Andersen (1990) brought "decomodification", "social stratification" and "welfare mix"(power structure) into the classification of welfare state. It contains "how much" and "how" at same time (Bonili 1997: 353-355), more importantly, it also paid attention to "explain why"; how policy structured society (Scruggs & Allan 2006:003) and what is the the hidden mechanism of power allocation among government, market and individual. Based on that, Esping-Andersen (1990:37) identified welfare states as liberal welfare state regime, conservative welfare state regime and social democratic welfare state regime.

Three ideal-types of welfare regimes gives a bird's eye view of broad characteristics of social or historical situation. Though the real welfare stats are hardly ever pure ideal types and are usually hybrid cases.(Arts&Gelissen 2002: 137) It not only yielded fruitful following research of welfare

comparison, but embraced some critics at the same time; a. misspecification of Mediterranean welfare states and Antipodean welfare states. b. neglect of gender-dimension.(Arts&Gelissen 2002:153) Controversy spurred expanding of welfare regimes geographically, more and more places were taken into consideration. Further, new welfare dimension (e.g. de-familization) enriched original index.

The research from Wood and Gough (2006:1696-1712) has extended the welfare regime outside the West.(e.g. Asia, Africa, Latin American). They found that informal relationship has replaced "legitimacy and governance of public goods" in some poor&transitional countries, which turns welfare "institution" to be more hierarchical and clientelist. So "de-clientelization" become a new dimension embracing a path from insecurity regime to informal security regime to formal security regime. The whole process based on the assumption that welfare states are more likely to develop the more democratic rights are extended. Esping-Andersen (1990:22) argued that welfare-state development was most retarded where democracy arrived early when it come to reality. Not surprisingly, following research is a bit disappointing. Sharkh and Gough (2009) classified 65 non-OECD countries into three meta-welfare regimes; proto-welfare state regimes, informal security regimes and insecurity regimes. Concerning to the diversified context, the dimension comprises non-state mechanism and historical&cultural factor, which makes research more sophisticated. A welfare regime map which includes developed countries and developing countries has been painted eventually. But there were few evidence of path dependency from informal security welfare regime to proto-welfare regime; the spread of political and civil rights hasn't hastened spread of social right apparently, welfare regimes across developing world were distinct and persistent.(Sharkh&Gough 2009:25-27)

Bambra(2007:1098-1102) argued that criticism of three worlds of welfare capitalism has been on three fronts; theoretical, methodological and empirical. In specific, three-typology has limited range of welfare states, gender and social service delivery has been ignored theatrically. All welfare states could only be classified into three different welfare regimes despite internal differences due to methodology. But some of them are clustered into various categories attribute to welfare transition. Furthermore, Bambra (2007: 326-338) valued female autonomy and economic independence from

family as defamilisation. So she combined maternity welfare with female labor force and created a new index for cluster analysis. The result responds to five-fold typology welfare regime; except core countries (i.e. The US, Sweden, German) keep ideal, the rest imply a broader classification. It is inspiring that research of welfare regime could focus on single welfare provision and certain population subgroup, then analyze the interaction and influence.

Scruggs and Allan (2006) embraced three ideal typology of welfare regime theory with various effect for social stratification; conservative welfare regime persevered social differentials, liberal welfare regimes sought to subordinate traditional social structure, social democratic policy prefer a equal and universal society via non-market system. The updating social stratification index exhibits similarities with "three worlds" in general but difference of welfare transition in some welfare states. Basically, three core countries experienced light welfare transformation and responds to original index. But result under socialist stratification index has challenged previous conclusion- "the socialism cluster includes the nations of Scandinavia, and the Netherlands, all countries which score low (or medium) on the two other regime-clusters."(Esping-Andersen 1990:101) In contrast, Canada and the UK scored high in socialist index and liberalism index at same time.

Recent years, people paid more attention to relation between welfare regime and family salience or social cohesion. Ganjour and Widmer (2016:201-220) consider de-familization as provision which will shape family salience in welfare states. Overall, Mediterranean regime emphasizes on family sociability and family&state support. Liberal regime embraces association and self-reliance. Corporatist regime is oriented toward the pattern of kinship or sparse contact, and seek for state support or family support. Social democratic regime is associated with association or sparse contact and state support. The result, to a large extent, responds to theoretical assumption but remains deviation. Borsenberger, Fleury and Dicks (2016:221-244) are trying to figure out if social welfare regime and social cohesion share same value; liberal regime exhibits liberty, conservative regime embraces solidarity, social democratic regime favors equality. Although the universal value hasn't matched welfare regime typology correctly, a comprehensive shift towards to a greater liberalism highlighted. It could be a new perspective to understand social changes in European; "European social models are converging under the pressure of economic European ingratiation" (Beckfifield

2013)

East Asia welfare regime

"Confucianism, hybrid case, productivist or developmental. "

Study of welfare regime in East Asia probably derive from Japan and "four little tigers".(i.e. South Korea, Hong Kong, Singapore, Taiwan). On the one hand, these countries has achieved economic miracle, on the other hand, welfare policies may lag behind. Jones (1993:184) described East Asia welfare regime under European perception as; "minimalist on welfare, minimalist on profit, the unacceptable of capitalism indeed, unfair competition." It tends to be negative and a bit arbitrary. Jones (1993: 184-200) put stereotype alongside and seek for hidden logic amid East Asia welfare state. She pointed out that all these countries have similar context; natural resource shortage but plenty of people, close to sea and insecure for future...(1993: 185) Jones embraced that Confucian culture has profound influence in social behavior and policy making. For instance, Confucianism emphasize group matters, individuals posse role and duty, ideal society ran by hierarchy, duty, consensus, order, compliance, harmony, stability.(1993:188) Thus family or community always act as main caring service provider, public policies usually made by up-down and in favor of human capital investment-education and health care...(1993:189) Jones has draw a rough painting of East Asia welfare state regime as Confucian welfare state regime which is different from "threefold typology", though it is not an accurate model, it is a good start to look East Asia welfare state as independent branch and they shared similar characteristics. Since then, many scholars, looked into these common points and give their own definition.

Goodman and Peng (1996:288-327) would rather identify that East Asia welfare regime as "Japan focused," they agreed that East Asia countries used to be affected by Confucianism and Mahayana Buddhism which makes them share same value.(1996; 292) But all of them has experienced dramatic social changes after WWII, the Western ideology has influenced local welfare system building. (1996:299) So Goodman and Peng name East Asia welfare development as "peripatetic learning" and "adaptive change."(1996; 314-316) Such process makes East Asia welfare regime hybrid cases.

Similarly, Esping-Andersen (1999: 90-94) insisted that “Japan is a hybrid welfare state regime combined liberal residualism with conservative corporatism, which was inspired by German and the US after the WWII referring to path dependency.” He simplifies Confucian as familialism and favoring Southern Europe as “fourth welfare regime” which “depends ultimately on the centrality of family”, Since then, East Asia welfare regime seems to be similar with Southern Europe, defamilization is main issue. Chau and Yu(2013: 255-367) clustered OECD countries and Asia countries into five groups by gender-based familization approach, while East Asia welfare regime or East Asia &South Europe welfare regime has not be proved statistically. Saraceno(2016:314-326) compared Italy, Spain, Japan and Korea under familialism approach; “Within a persistent familialistic orientation, Spain was moving forward to greater defamilialization, Japan and Korea is on way of greater supported defamilialization, Italy is about to defamilialization probably.

Holliday (2000:706-723) identified East Asia welfare regime as “productivist world of welfare capitalism”, where is a growth-oriented state and subordinate of all aspects of state policy. According to his definition, East Asia welfare states could be divided into three sub-types; facilitative typology, developmental-universalist typology and developmental-particularist typology. Hudson and Kuhner (2011:35-60) build up fuzzy set ideal type to find out if there is different classification among East Asia welfare regimes, and /or there is classification respond to four typology of welfare state regimes. The research adopted two approaches: protective style and productive style. After quantitative analyzing, “they find diversity within Europe, within East Asia and within South America. As for productive welfare argument, there is strong evidence that East Asia is not the exemplar of this approach.” It is relatively difficult to distinguish Asia welfare regimes statically. Choi(2012:275-294) compared welfare transition among Japan, Korea and China last decades. All of these countries have been experiencing fundamental transformations in social-economic structures, which embraced a path from productivist welfare regime to welfare state regime(or informal security regime) and may move to post-productivist regime in general. Thus East Asia welfare states regime sit in a crucial stage.

Kwon (2005:477-497) put changes and continuity of social welfare under specific context. He would recognize East Asia welfare regime as developmental welfare state rather productivist welfare state.

Kwon(2005: 479) reckoned that developmental welfare state comprise social policy and institutions which will structure and facilitate economic development.(e.g. democratization, industrialization...) Take South Korea and China Taiwan as examples, more and more selective (exclusive) welfare policies transformed into universal (inclusive) typology. Lee and Ku(2007:197-212) tested the hypothesis of the developmental welfare state, which refers to five perspectives; economic development first value, strong government, lower welfare expenditure, family act important role, selective welfare for government&public sector employees. The result clustered South Korea and China Taiwan into same group which indicates a big difference with other groups, Japan sit in the conservative group though it maintains developmental features.(2005: 206-207)

Aspalter (2006:290-301) put forward the idea that the nature of political system and dominance of conservative political parties constitute the main determinants behind the development of welfare states in East Asia.(2006: 291) Lin&Wong(2013: 270-284) agreed that East Asia welfare states share similar history, culture, economic and political conditions which will influence policy making. (2013:272) For instance, the demographic change of aging population and political pressure of democratic stirrings increase a demand for welfare expansion recent years(2013:277), and it motivates East Asia welfare regime transforming into redistributive and inclusive welfare typology. Jin(2016) regard de-familization as a main factor to analyze the welfare development of China mainland, Japan and Taiwan. The result supports Asia welfare regimes as an independent branch based on the age orientation approach. Apposite of assumption, the high level of de-familization social welfare policy in Japan has not changed the people's preference of family as caring providers. Put welfare expansion alongside, Abrahamson (2017:90-103) considers "filia piety" has shaped East Asia welfare regime in terms of caring which embracing Confucianism. And each welfare state seems on way of different direction; Japan indicates conservative typology, Korea favors liberal style, China may step into universal classification.

Welfare state regime of China

"Productive&Confucian? baseline equality & appropriate universal ?"

As an important part of East Asia, China kept Confucianism and productivist like other "tigers". As an independent state, China exhibit uniqueness for policies orientation. Xiong (2009;91-92) argued

that social welfare in China combined traditional culture.(i.e. Confucianism), past experience(i.e. communism) and current lesson (i.e.productivist). Unlike the Western world, the main challenge for government is not voters' pressure or fiscal pressure, but is to balance the economy development and social equality, maintain the social stability. Yang and Song (2012:2-16) analyzed "low-welfare growth" in China by function&capability approach, they pointed out that boosting economy improved functional welfare in general, while the residents' capability welfare lag behind which will finally erode economy development.

Zheng (2012:2-9) suggested that East Asia welfare regime rooted in history and culture, which is different from "three worlds". He highlighted the similarities amid Asia countries but differences outside of Asia; a.The idea of welfare system building is to serve for economic development, to solve the social conflicts and to supplement family security. b.The responsibility is shared by family with strong securing function, government as dominate role, and employers have unavoidable broad obligation. c.The welfare system is combined with liberalism and conservative style, "pay for welfare service" is emphasized. d. The path of development is from covering employees to all citizens. At the same time, government changed "human capital investment" policy orientation to quality life guarantee. Lin (2010:181-193) found that East Asia countries arranged social welfare categories for elderly people under the crisis of aging recent years, which is rather social expenditure than social investment, thus social policies transformed from productive style to protective style. And it strongly proved East Asia welfare regime transform into post-productive era. Lin (2015:73-78) pointed out general public is cautious to welfare expansion and in favor of "high economic growth but limited welfare". Within boosting economy slow down, government should adjust strategy to "medium economic growth and medium welfare growth". Indeed, social welfare polices tends to be positive not reluctant.

It is necessary and urgent to conduct a series welfare policies under demographic pressure and public needs. While considering fiscal limitation and cautious of welfare dependency, Chinese scholars bring up "appropriate universal welfare model" and "baseline equality model " as blueprints of welfare reform. Jing(2010:162) believed that government should guarantee all citizens' basic needs, that is so called "baseline equality". Further, He conceptualized basic needs as survival needs,

developmental needs and healthy needs. The critique is concentrated in baseline above, he embraced efficiency as basis for diversified needs. So baseline equality seems to be a hybrid style which contains universal and liberal characteristics. Wang (2009:61) fingered out that policy makers should consider the financial capacity and public needs as vital indicators to build up universal welfare system, he shelved the doubts of universal welfare system but paid more attention to policy maneuverability; Financial capability is the core restriction of social welfare and needs assessment will remedy the defect of authoritarian politic. According to the classification of policy-making from Rothstein (1998:101-104) and past experience, the procedure of public policy model in China is supposed to be a legislation-bureaucratic model, the largest flaw of mechanism is inflexibility. It is mainly reflected in two aspects;1.Social welfare and economic growth were largely decoupled during past decades.(Yang&Song 2011).2.Public participation is insufficient in social welfare governance. (Bai&Guo 2015) Unlike the classical welfare regime, welfare policy in China may embody political or economical appeal.

Will China be a welfare state? Yue (2016: 30-36) thought the key points to decide if China could be an welfare state were; 1.The government have the political intention of protecting civil right and improve the well-being. 2. The actuators should have strong will to delivery welfare service. 3. An independent social power is supposed to make sure people have institutional way to express their needs and monitor the process of public decision making. It is difficult to balance the social pressure and welfare governance under the authoritarian politics, but it is also the crux of the matter.

Summary

Welfare regime theory make welfare policy comparison simpler , it provides a new way to define welfare states qualitatively and quantitatively at same time. Meanwhile, “three worlds” explained interaction between welfare policies and social institution, thus people have a relative comprehensive understanding of “how”, “how much” and “why”. But welfare regime theory have certain scope of application and it’s neglect of family&gender breeds critiques. Following research has developed welfare regimes theory; de-familasation approach has be added into category, more and more regions has been covered. In reality, most welfare states are hybrid cases in welfare transition under the globalization so that boundaries between different welfare states became ambiguous, a perfect pure

classification example is difficult to find.

East Asia welfare model analysis originally focus on Japan and “four tigers”, the classification mainly based on qualitative result, for instance, culture, economic and political institution. It is more like theoretical concept than a realistic case. To be more specific, Asia welfare countries share same features, such as state-led economy, welfare policies in subordination, relative high investment in education and health care, family as an important “caring provider” has more functions than other no-Confucian countries. But this combination of these features have only clustered them into same group theoretically not statistically. So it should be regarded as a tool of understanding welfare regimes in Asia but not to define it as an independent ideal type parallel to three worlds typologies, because conceptualizing “Confucianism” or “productivist” is difficult. Furthermore, inter differences and transitions exist amid Asia welfare states, which indicates a relatively immature mechanism with improvement space.

Most Asia scholars are trying to find out the uniqueness of East Asia welfare regime which is independent to “three worlds” and inter difference amid East Asia welfare sates. Both two situation are responses to “three worlds” thus whole discussion has not cast off “Western gaze”. For example, de-familization seems to be a signal of advancement in Western view, which means individuals have more autonomy and freedom via welfare system, but in contrast to Confucian influenced region; general public maintains preference of family as welfare providers, especially for elderly people. And the social right; both productivist typology and developmental typology in favor of social right as core indicator of welfare improvement. East Asia states usually embodies authoritarian model, thus welfare state may highly likely to be reluctant and residual. It is understandable to think from that way but less statistic evidence could be found. Accomplished welfare system do not always relating to democratic state, ideology should not be regarded as vital valid category for welfare evaluation. A comparison between India and China could be a good example.

Mostly, social welfare is a tool for social problems or upcoming problems, so welfare expansion has closely related to aging trend, nuclear family, unemployment... And welfare expansion based on national income or fiscal capability. A responsible government (despite ideology) is always trying to

solve the problems all over the world, but exact solution is different. For instance, liberal welfare state favors market, conservative state favors work-unit, social-democratic favors public project. Such policy preference builds up diversified welfare state regime. Context factors; political economy, culture and history will actually explain why policy preference exist. “Three typology” explained “how” and “how much” in most regions, but shortcoming appears in “why” for outsiders. Compare to Western world, East Asia share internal similarity and external difference of policy preference, thus “threefold” would not be comprehensive enough to explain “the cause of East Asia welfare state regime”. This paper will combine “three typology”&“East Asia welfare regime” theory and context in China to find out the similarity and difference within “three worlds” and “East Asia welfare states.

Part 2. Context in China

--A short history of welfare policy

The beginning of modern social security system in China is from 1980s, which aims to support the reform in state-owned company, because a large number of people lost their job and their social welfare qualification.Thus social security system covered formal employees in state-monopolized industry at first, social welfare right bonds to labor contract which could be regarded as an extension of occupation welfare. Put the timeline forward, family act as an important role in securing members, government will stand out for homeless people or natural disasters only, welfare policies are rather like paternal mercy than civil right. Now days, social security function is not just an live-saving straw for most vulnerable group or occupation welfare for formal employment, but a promise of freedom&justice, more and more people have consensus that everyone, despite social status, deserve basic public goods supply(e.g. safety, education, medicare...), it is just as important as food and water. Looking into the future, universal welfare seems to be an trend. This chapter will look through welfare policies changes in agriculture society, industry society and post-industry society. To have an better understanding of current social security and future vision in China.

Agriculture era

Farming priority, stable family, education respect and hierarchical society.

China as a continental state bred magnificent agriculture civilization, Confucian is one of the perspectives. Feng(2012:27) pointed out that people live in the agriculture society are simple and easy to satisfy, thus changes are not welcomed mostly. People may live in the same place and protect their land generation by generation. Once the country is in crisis, agriculture workers are less likely to betray their monarch and move abroad due to the land dependence.(Feng:2012:18) In a classical agriculture society, family is not only a emotional belonging but a work unit as well. Confucian culture encourages people to respect authority, love people but allow differential love.(e.g. people love their family more than strangers).In that case, fathers are leaders of family & work unit naturally. Thus family is hierarchical, so the whole society dose. Jin &Liu(2011:50) thought adhesion of family and monarch built a ultrastable structure of Chinese society, the glue is Confucian culture; filial piety and loyalty. In essence, filial piety is similar to loyalty; people should treat their emperor just like

their parents, respect the authority and obey the social rules. For return, emperor should regard the people as his/her kids, be strict and loving. During this period, individuals were attached to family, most families' livelihood bonds to their land. Social risks are mainly shared by family separately, public responsibility is an substitute of family which aims to help the most vulnerable group with social aid.Welfare policies were temporary and lash-up in general, most for famine due to natural disasters. It is also a lesson from from dynasty change; people highly likely bring up revolution if they suffered a famine without any help. All these "welfare measures" were scattered and deeply marked with paternal mercy from up to down.

Basically, China maintained a prosperity despite the dynastic changes, until mid 19th ,the scale of domestic economy has kept on the top of world nearly 2000 years.(Lin 2012: 21) Lin argued (2012:52) the main reason why China fell behind western world in modern society is that Chinese people would rather to be a government employee than to be a scientist under the "Ke Ju" system (imperial examination system), thus it was in the way of technology development and industry revolution. The reason behind is that officers will have higher social status, better welfare and some privileges. It should be noticed "Ke Ju" system inspired "Chinese students" to study hard, change their social status and do some thing for their country which is a classical "Chinese dream". And it may explain why Confucian welfare regime value education a lot, it is a tradition and a practical way to transform "plenty of unskilled, impoverished people"(Jones 1993;183) into human capital.

Industrial society

Self-defending, red-green alliance, communist idea and liberal adjustment

"Industrialization makes social policy both necessary and possible."(Esping-Andersen 1990;19) Further, "the nature of class mobilization, class-political coalition structure and the historical legacy of regime internationalization should be of importance to explain welfare state cluster"(1990; 30). In China, industrialization is self-defending for semi-colonization,which full of bends and curves. Meanwhile, red-green alliance is the foundation of revolution latter. And liberal adjustment starts over modern social welfare system.

Qing government decided to learn from western world after China was invaded by industrialized

countries since 1860s. After then, national industry has a slow and light progress under internal and external pressure, thus workers has not became “the great majority”, the labor conflict was not the main social issue either. The biggest vulnerable group was agriculture workers; large gap existed between farmers and land lord. As is mentioned above, the agriculture as foundation of national economy was eroded while the industry is not strong enough to be new pillar. Affected by Marx’s ideas and Chinese context, worker-peasant alliance finally has won the broadest support in China.

According to the classical hypothesis, industrialization and urbanization will liberate many people from land, but trap them in the factory. In industry society, many agriculture workers left their homeland and move to the city. In China, the by-product of industrialization-labor conflict was controlled under the planed economy, since Marx’s ideas have profound influence in China as an socialist country, most urban residents work in the state-owned company, their social welfare right bonds to the work-unit. Rural residents will join the cooperation of agriculture production, so their welfare links to the organization. In terms of people work in the government&public sectors, they will enjoy the spacial welfare scheme. In summary, welfare policies during the planned economy was made by governors from up to down, it emphasized an universal style for both workers and farmers depending on the historical and political factors.

The modern social insurance system was founded in 1980s, as reform of economy starts, many people work in the state-owned company lost their job and their social welfare. To solve this problem, government decided to learn and rebuilt the welfare system. Take pension scheme as an example, current pension scheme is hybrid with DB(defined benefit) &DC(defined contribution), ideas have been made reference from German(DB) and Singapore(DC), the new system has concerned formal employment contract or payment as priority, thus formal employee who work in the public sector and state-owned company were covered at first. The resident social insurance were added afterwards. During this period, the mainline of social security system is to set up modern social insurance system. Social welfare system has transformed from universal (socialist) style into “quasi-conservative” style. But the limited coverage overall and strict means-test for social allowance system indicates residual character. Social welfare right relates to occupation and identity, welfare gap existing in public and private sector, urban area and rural area.

Post-industry society

Challenges and cautions

In post-industry society, universal welfare will be the key issue. Beck(2018:163) recognized post-industry society as risk society, he argued individualization will increase the dependency of system and personal vulnerability. Thus extensive anxiety of insecurity has replaced “social needs” as driving force of social development.(Beck:2018:48) Further, accompanied with flexible employment and nuclear family, a requirement of sophisticated social welfare system is increasingly urgent. The critiques of universal welfare mainly focused on individual freedom and welfare dependency.

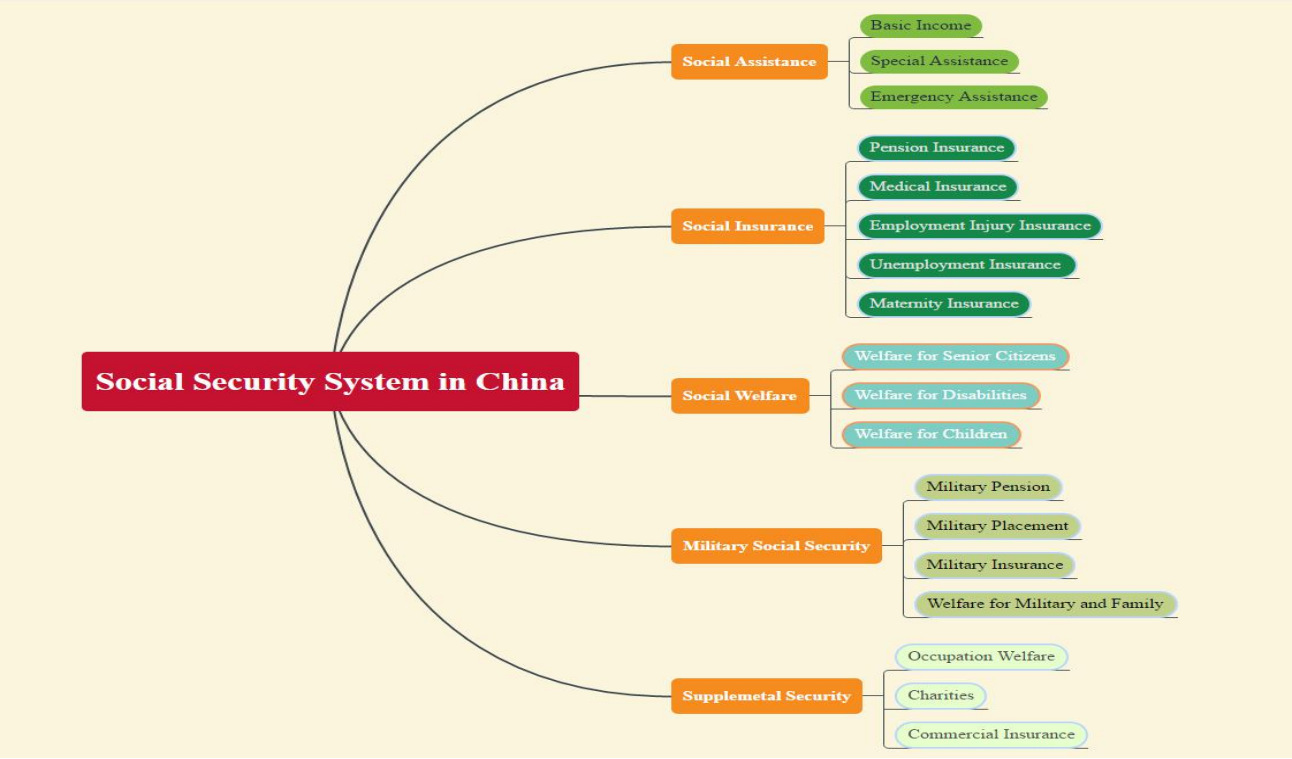
Hayek(1997:138) thought universal welfare is a threaten of freedom, and it will probably corrode the independent spiritual. Sen(2012:284) pointed out welfare shortage may leads to freedom deprivation, he would rather believe appropriate social support will increase the individual capability thus citizens have more space to realize themselves, that is freedom. As for welfare dependency, moral hazard exists in both universal welfare typology and selective typology. It is biased to affirm universal welfare typology as hotbed of welfare dependency but selective welfare policy will avoid trap. Rothstein(2017:155) argued selective welfare policies distinguish vulnerable group as “special group”, it may leads to social stigma, and affect recipients’ self-esteem. Further, the low self-esteem is hardly to be economical independent citizens. In another world, welfare dependency is not the unique characteristic of universal welfare typology, selective welfare policies could also breeds moral hazard. Even, the process of selecting recipients and treatment level may encourage corruption.(Rothstein 2017:157). When freedom deprivation and welfare dependency are not necessarily related to universal welfare policies, it is time to consider if social-democratic welfare regime is a possible solution in the post-industry society.

Most welfare regimes were hybrid cases, education and health care seem to be intensive “universal” welfare categories. For example, NHS in Britain and Nordic countries, compulsory education all over the world. Recent decade, Chinese government has put a lot of effort in education and health care like other Asia countries, some scholars identified it as characteristic of productivist welfare

regime or developmental welfare regime. There are no doubtful upcoming social issues need to be fixed under aging and modernization. Zheng (2018:47) thought SAS would not be able to provide elderly people, young people and disabled people enough public service. Unlike people live in agriculture society or industry society, the securing functions of family&land&job in post industry society is weaker than before, the requirement of accessible public basic service is on the schedule inevitably, especially, old-aged allowance and service are heated topic under the aging trend.

Part 3. The Social Security System in China

Current SSS constructed by three main pillars; liberal SAS, conservative SIS and universal SWS. The military social security sector as "special occupation security" is an important part. Commercial insurance and volunteer charity are supplements. (See in map 1). Among them, SAS has the longest history to remove the life threat for vulnerable group. SIS is the main part of social security based on the payment from employee & employer and public budget. SWS is to meet citizens certain needs and improve the national well being, the goal is to build the appropriate universal welfare system. Zheng (2011SA&SW:40) argued the policy bias of SSS has transformed from SAS to SIS and will go towards to SAS, he also described the whole process as is from mercy to justice. This part will introduce three main parts of social security system in a brief, which aims to acknowledge and classify welfare characters in China after drawing a whole picture roughly.



Map 1[2] Social Security System in China

Social assistance system

SAS is the first cornerstone of SSS and a safe net for all citizens. Generally speaking, SAS indicates

[2] The structure of social security system based on blueprint from Zheng (2011 GP: 23), And some adjustment based on the present situation made by author.

residual characters; limited coverage rate and treatment level with strict means-test. But lately transition may represent an institutional empowerment tendency. Meanwhile, SAS embodies classical Chinese political philosophy; “Min Ben”-- “people-based value”, “Zhong Nong”-- “agriculture-priority value” and “Zun Lao” -- “elderly-oriented value”. As is mentioned before, governor is responsible to take care of vulnerable group. In practical, agriculture workers and elderly citizens may enjoy higher treatment level. To have a better understanding which I mentioned above, I will take “minimum living-hood guarantee scheme (MLG)” and “accurate poverty alleviation plan (APA)” as examples.

	Population (Thousand)	Recipients (Thousand)	Coverage Rate	Disposable Income Per Ca-pita (CNY)	Minimum Living-hood Standard(CNY/Year)	Replacement Rate
Rural Resident	576610	40452	7%	13432	4300(358*12)	32%
Urban Resident	813470	12610	2%	36396	6480(541*12)	18%
Urban&Rural	139008	53062	4%	25974	5400(450*12)	21%

Table 1 Minimum Living-hood Guarantee Scheme in 2017

“MLG” is the core of SAS, which provides minimum income to absolute poverty group. In 2017 (See from table 1)[3], there were 4% population were qualified to receive minimum benefit, and the average replacement rate reached to 21%. Rural resident have relatively better treatment while the poverty situation is server in rural area. Zheng (2011:SA&SW:5) pointed out that replacement rate of MLG was from 16% to 30%, concerning to the poverty line in China is low and economic development in general, the actual secure function of MLG is limited. As Deaton(2014:150) said: “the vulnerable group below the absolute poverty line is gradually far away from the social mainstream, especially there is the life improvement in general.” Han & Guo (2012:159-163) approved that recipients of MLG have strong willingness to work if they have not lost employ-ability. So welfare dependency situation is not common. Compared to MLG, APA seems to be more generous.

[3] Data Source: National Data http://data.stats.gov.cn/easyquery.htm?cn=C01
Ministry of Civil Affairs of the People’s Republic of China http://www.mca.gov.cn/article/sj/tjgb/201808/20180800010446.shtml
Generated by author

Since 2013, Chinese government carried out APA which aims to help absolute poverty population with basic needs of food, clothing, medicare, education and safe housing in rural area. To help target population economical independently, local government cooperate with local company and local bank and establish many small business. Until 2017, the poverty headcount ratio at 2952 CNY/Year ($1.17/Day)[4] in rural area fell to 3.1%, 68.53 million population in rural area have gotten ride of absolute poverty.[5]The achievement was remarkable, it reflects a strong government policy orientation beyond reluctant typology.

APA inherit the dual thinking of rural area and urban area, the stereotype of population in rural area connect to the poorer and weaker. Concerning to the imbalance developed in China, "one size suits all" would not work in some regions, especially in southwest of China with highest urbanization rate, the gap between urban residents and rural residents is light. Yue(2019:75) thinks selective welfare may leads to "welfare overlap" for certain group and welfare shortage in general. Besides, public participation, especially for vulnerable group, is insufficient during policy making; Wan (2015:68) argued that vulnerable group has urgent needs for public aid, they would rather waiting passively than asking proactively. In contrast, people with better education and higher income tends to express their needs of welfare policies.

Social insurance system

SIS has a stable development recent years which is represented by universal coverage and increasing pooling fund, especially in pension insurance scheme and health care system. But the current insurance system divides all citizens into residents and employees, thus welfare inequity exists and run deeper via occupation status. The redistribution effect is no doubtful limited based on the dual welfare structure. The welfare treatment depending on the formal contract; SIS is essentially "occupation welfare". Further, the development of social insurance system is imbalanced regionally and systematically. For instance, labor-import province is always accompanied with larger pooling fund and less "welfare burden", locals may have better welfare treatment and social insurance system thus operated well, otherwise, the reverse. The same situation lie inside the SIS; the coverage of

[4] World Bank adopt $1.90/day as poverty line
[5] Data from National Bureau of Statistics http://www.stats.gov.cn/ztjc/ztfx/ggkf40n/201809/t20180903_1620407.html

maternity insurance, unemployment insurance and work injury insurance is constricted in the formal employees since the qualification bonds to labor contract, relative vulnerable group (e.g. migrant workers) are excluded systematically, the securing function compared to pension scheme or medicare scheme is finite.

	Pension Insurance	Medical Insurance	Unemployment Insurance	Employment Injury Insurance	Maternity Insurance
Participants (Million/People)	915.48	1176.81	187.84	227.24	193.00
Employee	402.93	303.23	187.84	227.24	193.00
Resident	512.55	873.59		78.07(Peasant workers)	
Funds Revenue (Billion/CNY)	4661.40	1793.20	111.30	85.40	64.20
Funds Expenditure	4042.40	1442.20	89.40	66.20	74.40
Cumulative Balance	5020.20	1938.60	555.20	160.70	56.40

Table 2 Social Insurance Participation and Funds Operation[6] in 2017

SIS has gradually been formalized which makes China a conservative welfare regime in general. It maintained or even strengthened current social structure. Wang, Long, Jiang etal (2016:9-11) found the redistribution effect of social insurance is limited and a bit far from the public expectation, among all these insurance scheme, pension insurance has relative high level of redistribution effect. Wang (2015:128) elaborated employees in government& public sector enjoyed high level of welfare treatment relatively, followed by employees in urban enterprise, then the rural residents and urban residents. Even, residents may not be able to join the insurance scheme since it is supposed to be payed by employers only.Take SIS participation and funds operation in 2017 as an example (see table 2), pension scheme and medical scheme has covered largest population, the rest sharing is limited. And there is balance even surplus between income and expenditure.Challenges accompanied by aging trend, flexible employment, small family... will ask for welfare transition in later years and

[6] Data Source: Ministry of Human Resource and Social Security of the People's Republic of China
http://www.mohrss.gov.cn/SYrlzyhshbzb/zwgk/szrs/tjgb/201805/t20180521_294287.html
Generated by Author

welfare equity seems to be more intensive ever. This part will elaborate each branch respectively to see the situation, problems and possible solutions. (Medical insurance scheme is not included because it will be presented in next part.)

Pension insurance scheme

As is seen from the table 2, pension insurance scheme has largest fund in the category. There was 9.l5 billion population were covered in the pension scheme and 2.62 billion[7]of them were pensioners in 2017. So far, such scale insurance funding operate well but some critiques become intensive, for example, replacement rate of pension and welfare fence among different interest groups. (e.g. residents pension scheme v.s employees pension scheme...)

There is a gap between planed replacement rate and public expectation, what's more, the gap between planed replacement rate and actual replacement rate grow larger. Mu, Shen and Fan etl(2013) found that replacement of pension scheme for rural resident has significant progress recent years and it improved replacement rate of pension scheme overall. It is a positive trend but it may not change the fact entirely. As Deng&Xian (2015:09) pointed out, the resident pension was generally very limited and it may not enough to support people's retired life. It should be noted that 5.13 billion participants were in resident pension scheme and they were relative vulnerable economically, thus their old-aged life are full of uncertainty. Li &Wang (2012:101) argued replacement rate of current employee pension scheme has fallen down year by year which is increasingly far away from target 60%. Accompanied with aging trend, the secure function of basic insurance system has been challenged.

There are welfare fences among different regions and different groups. Zheng&Sun (2012:09) argued that employee pension income in almost half of provinces (15) could not meet the expenditure. Because of the population age structure, economy situation and labor migration. Though state pension fund keeps an balance surplus in general (see in table 2), many provinces have serious financial burden based on imbalanced pooling fund of different region. As for individual, the

[7] Data Source: Ministry of Human Resource and Social Security of the People's Republic of China http://www.mohrss.gov.cn/SYrlzyhshbzb/zwgk/szrs/tjgb/201805/t20180521_294287.html

boundary of social security entitlement is also the obstacle when they chose live place or work place. Zheng (2014:25) pointed out welfare fence amid private sector and public sector damaged welfare equity. Fragmentation of pension system divides all citizens as public/government employees and private employees, urban residents and rural residents, each signal will represent different welfare right which makes people has sense of deprivation and injustice. Even more, it decreased the efficiency and effectiveness of pension system from the state level.

Based on problems above, adding one more layer pension scheme and unifying basic pension fund become basic logic. Zheng(2013:13) believed that pensioners almost put all old-age life expectation into pension scheme, due to the systematic shortage of caring insurance or other old-age security. Thus he would rather accomplish old age security system than improving replacement of pension scheme purely. Further, Dong&Sun (2011:04) suggested to integrate employee pooling and resident pooling as first pillar, which will improve the systematic equality. At the same time, income related pension will be other pillars. This idea embraced many agreement which will solve systematic inequality issue and maintain inclusive style. Besides, Zheng(2015:7) thought reform of employee pension scheme should focus on unified national pooling fund and balance the interest between central government and local government, public&government employee and private employee. In that case, old-age security system will be more equal and capable to solve the upcoming risk.

Unemployment insurance scheme

Unemployment insurance belongs to the employees' social security, insurance fee is supposed to paid by employers, and benefit eligibility is decided by payment record. It make residents excluded from the system automatically. Until 2017, there were only 187.84 million people insured. And the accumulative balance was increasingly huge.(See in table 2) Chen (2016:52) thought misplacement of unemployment population and actual participants is the main reason that unemployment insurance scheme has huge surplus but limited effect. To be more specific, most participants were from public sector or state-owned company, their unemployment risk compared to private company stuff is not sever. Moreover, Sun and Gao (2011: 122) argued current unemployment insurance system was passive labor policies. The level of treatment was relatively low which aims to maintain the basic life.

So they suggested government put more effort on career plan and work training. In that case, actions go before the result which makes whole system more sustainable.

To expand the coverage seems to be the most an urgent goal of unemployment insurance scheme. Tian(2017:22) was in favor of including flexible employment people into security system via building individual unemployment account. Unlike the pension insurance or medical insurance, the development of unemployment insurance is lagging behind, the reason could be the caution of welfare dependency or current labor surplus situation. Zheng(2014:28) worried that rapid urbanization and informationization makes more people flexible employed, it changed classic labor relations and brought new challenge to social security system. In that sense, unemployment insurance should be more active and flexible.

Employment injury insurance scheme

Employment injury insurance covered 227.24 million population and 78.07 million were off-farm workers.(See in table 2) Zheng (2008:277) identified insuring off-farm workers as an urgency, because most of them were engaged in high-risk industry. According to the report[8] from National Bureau of Statistics in 2017, there were 286.52 millions off-farm workers in total, 51.5% of them worked in the construction industry&manufacture industry. Compared to other groups, they were less educated but more vulnerable. Guo&Zhang(2013:38) pointed out that off-farm workers has relatively lower proportion of participating in social insurance among migrant workers. The bridge between workers and social insurance is a formal employment contract. Thus systematic adverse selection exists; most vulnerable group has highest possibility to be excluded of security system.

Take occupation disease as example, pneumoconiosis is the top threaten occupied 82.85% claimed samples in total.(2018)[9] As NGO-'Love Save Pneumoconiosis Fund' reported in 2014, 90% of them were off-farm workers but only 8.4% used to join the work injury insurance.[10] Although work injury insurance system is getting better and better, there is a large amount target population would not be

[8] Data source: National Bureau of Statistics http://www.stats.gov.cn/tjsj/zxfb/201804/t20180427_1596389.html
[9] Data Source: National Health Commission of the People's Republic China
http://www.nhc.gov.cn/guihuaxxs/s10748/201905/9b8d52727cf346049de8acce25ffcbd0.shtml
[10] Data Source: Love Save Pneumoconiosis Fund http://www.daaiqingchen.org

able to get compensation by various reasons. It is pondering worthy how to expand coverage especially informal employees working in the risky work place.

Maternity security scheme

Maternity security scheme is a branch of employee's social security. It has same issue of coverage, just like work injury insurance and unemployment insurance.(See table 2) Pan(2010:20) suggested to build universal maternity insurance via integration of medical insurance and maternity insurance, because it will lower down the maternity death rate significantly. He elaborated that maternity insurance in rural area is more like social aid that prevent pregnant women from life threaten. Owing to the development of medicare system, health expenditure in pregnancy has gradually covered into the medical insurance even for outsiders of maternity insurance scheme. Until 2016, the estimated maternal mortality per 1000 live birth in China has felled to 27 which is far above the average level at 91 of Asia country but much behind OECD countries at 7 still[11].(OECD 2016)

Recent years, maternity security has becoming a intensive topic attributed to implementation of new population policy-"two children" policy. Argument focused on the reproductive cost sharing; should government or employers or family undertake the responsibility. He, Yang, Wang and Xu (2014:9) specified reproductive cost as maternity allowance and medical benefit. They agreed Pan's idea that medical cost should be covered by medical insurance. As for maternity allowance which aims to maintain the living cost, employers will take charge of employees' fund and public fund should take the rest residents who do not have maternity insurance. Accompanied with the interaction of population and labor market, the maternal prevention indicates a universal trend, as is stated by Huang(2014:31), working females are less likely to have a career break if they get the maternity compensation. In summary, current maternity insurance has overlap with medical insurance that makes medical cost due to the pregnancy is not an issue for everyone. But the maternity allowance only covered employees with formal contract, thus welfare gap exists between public employers and private employers, formal employers and informal&agriculture employers.(Song&Zhou 2016:111)

[11] Data Source: OECD Statistics: Health at a Glance Asia/Pacific 2016

Social welfare system

Generally speaking, SWS has policy overlap with SAS but not an independent one yet. Gao(2011:123) argued that former one is to protect baseline security but later one is for quality life or social well being. The idea that economical development is the best social welfare used to be widely accepted in East Asia welfare state regime. In reality, some economically developed area has pioneered the trail implementation of universal welfare policies. For example, Shanghai municipal government has built noncontributory pension scheme for uninsured citizens who are over 70 years old since 2006. Similar case could also be found in Beijing, Hangzhou and Jiaxing. These attempts will provide experience for national welfare policies in next step, meanwhile it reflects an welfare gap in different region and various group. This paper will take elderly welfare policies, disability welfare policies and children welfare policies as examples, then a sketch of social welfare system will be presented roughly.

Elderly welfare policies

Recent years, the aggravating trend of aging population and declining birthrate brings impact to the elderly welfare policies, especially for old-age allowance and old-age service. He, Yang and Liu (2011:123-124) thinks old-age allowance (noncontributory pension system) should cover pension unqualified citizens and the treatment level will base on basic needs which supposed to be higher than minimum living-hood guarantee scheme (MLG). This idea embodies concerns of elderly poverty and pursue of social justice, while the financial capability and politic intention of central government and local government could be the motivation or restriction for policy implementation. Wang&Long (2018:123) argued that mismatch of supply and demand was existing in elderly service market. To be more specific, private and public resource was concentrated in middle&high income group, while low-income group people were excluded naturally. The fact revealed market failure in public goods or quasi public goods area without certain intervention and regulation.

With a view to accessibility of elderly people and family securing function, many Chinese scholars embraced community-based housing support as ideal solution, it could meet more people’s need and achieve efficiency. It is a good start that elderly welfare attracted more and more public attention and

discussion, actions will followed in the next few years.

Disability welfare policies

The development of disability welfare could be divided into “charity model” and “social right model”.(Yang 2013:11-14) He elaborated charity model as habitat model and humanitarian model, both of them were selective welfare for the vulnerable group which based on the sympathy rather than equity or social justice.(2013:14) The progress of disability is reflected as social right model that is a trend of welfare policies in China. Recent years, Chinese government put more effort in helping the disabled people via empowerment policies, which includes living allowance, medical service and labor assistance. Yang (2018:32-33) compared disability welfare policies in China and other classical welfare regimes, employment priority concept has distinguished China as unique welfare model. It is based on the self-reliance culture and consistent concerns of welfare dependency. There is no doubt that employment priority welfare policies will be helpful to avoid welfare dependency and social exclusion for people who still have the labor capability, while it may also exacerbate the social stigma for those completely incapacitated. So far, the disability welfare policies in China has a big progress in many aspects while it retained color of productivist welfare regime too, the emphasize of employment priority proved it.

Kids’ welfare policies

Kids’ welfare was selective style which aims for helping orphans at first. Current system divides kids as orphans, vulnerable kids, kids from vulnerable family and ordinary kids. Orphans and vulnerable kids are the main target population of kid’s welfare. Lately, some new changes has appeared that more and more people would regard kids’ caring as vital issue. Yue&Fan(2018:92) argued caring (i.e. take care of kids and elderly) deficit is increasingly urgent under the population aging and small family trend. Yue&Fan (2018:95) figured out that kids’ welfare could be social investment which is helpful for female employment, poverty eradication and gender equality..... Compulsory education is one of the remarkable credit in universal welfare, some scholars prefer to regard it as a independent category, while in this paper compulsory education has been counted in kids’ welfare. Education

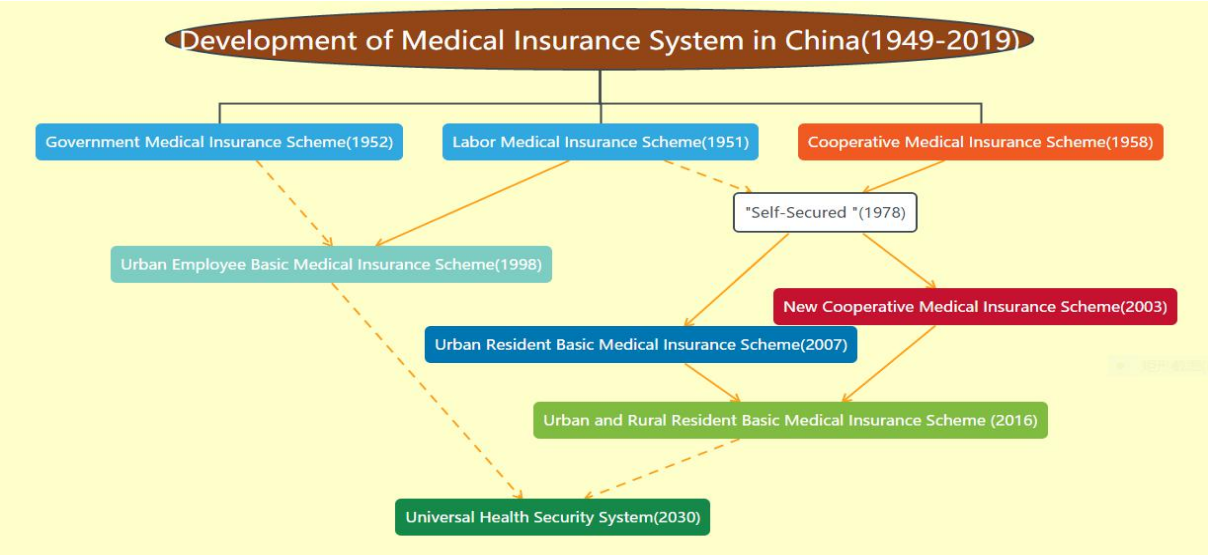
welfare is remarkable universal welfare typology that around 1.5 billion(2018[12]) students were covered in 9-year compulsory education system every year. But welfare gap exists among different regions. Wan (2012:51) took elderly welfare, disability welfare and kids' welfare as research subject, and found out that education welfare gap is obvious between eastern region (economic developed) and western region(economic under-developed).

According to the definition of "welfare" in China, social welfare project embodies "universal " typology naturally. While so far, almost all kinds of welfare projects kept residual colors which aiming for guaranteeing most vulnerable group at first. In contrast with welfare shortage in general, welfare needs becoming more urgent. Accompanied with population aging and small family trend, family as smallest unit in society may not act as "welfare provider" well as before, some "private issues" in the past, becoming an public challenge. For instance, "caring deficit" is very typical. In Confucian culture, it is doubtful that taking care of young and old should be family responsibility, but it is apparently difficult for one working couple to take care two pairs of elderly parents and their kids under the family policy. Such situation probably varies in different context, but social needs for more welfare service is experiencing a stable growth. It should be noticed that education and health care could be a good reference of public service supply during past decades, so in next part, I will take health care reform as an example, to see the policy changes and it may drew a direction of welfare development in China.

[12] Data Source: Ministry of Education of the People's Republic of China
http://www.moe.gov.cn/jyb_sjzl/sjzl_fztjgb/201907/t20190724_392041.html

Part 4. The Health Care Reform in China

Health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic of social condition.(WHO 2014) In reality, though the willingness to be healthy mentally and physically is as strong as to everyone, the capability to against risk is different from person to person. People need an equal access to necessary service via universal health coverage, and the whole system not only ask for individual responsibility, more importantly, government is supposed to dominate mechanism planing, operating and keeping. Indeed, SSS must be achieved by co-operation between the state and the individual. (Beveridge 1942: 03)



Map 2 Development of Health Care System in China

"A mature system has never been established as a result of big plans or big fights, but mostly as results of complex processes and successive steps of social and political engineering in the history"(Arts&Gelissen 2002). Since People's republic China was founded in 1949, there has been 70-year-long exploration. Until now, the coverage of health care system has already achieved to 95%, and the total expenditure maintains 6% of GDP in total. (Zheng 2018:76-83) In general, the whole process could be divided into four phases: a.Health care system in planned economy, b.Health care system in transition of economy, c.Health care reform under crisis. d. Towards an universal health coverage.(See Map 2)

Mini-welfare State:health care system in planned economy.(1949-1978)

Health policies during first three decades were essentially relative comprehensive and systematic universal health coverage.(Li 2017:56) Three kinds of medical insurance schemes covered almost whole citizens. In urban area, work-place based free health care system (Gu 2006:50) distinguished government employees and their family joined in government medical insurance scheme, state-owned company employees and their family were in labor medical insurance scheme. In rural area, cooperative medical insurance scheme(CMI) based on people's commune secured everyone. The introduction of "barefoot doctor" in rural area is an "pioneering work" in low income countries, it provides primary health care to everyone and controlled infectious diseases.(WB 2016) So a remarkable achievement has been made via whole system is that life expectancy of Chinese citizens has risen almost 20 years.

Critiques centred in efficiency and equity. Huang&Gan (2012;193-206) argued existence of serious moral hazard caused waste and low efficiency of urban medical insurance system. Zheng (2008:100) elaborated that government acted as policy maker, service provider and funding sponsor at same time, the vacancy of individual responsibility combined with excess of public responsibility leads to a heavy burden of medical insurance system. Unlike urban area, government acted like a night watchman more in CMI, because pooling fund was from "member fee" and clinic benefit. So the CMI was essentially a primary health care system manifested by compulsory individual payment and low price of medical service under the planed economy.

In summary, the health care system during the planed economy emphasize public responsibility and universal value, it secured all citizens systematically and everyone will have primary health care equally. Besides, medical resource maintains relatively low price by managed market. But the whole system was fragmented by public budgetary sectors and regions, it increased the vulnerability of each "mini-welfare state". Further, the treatment quality may depends on the social status(Yue 2018:70-72). It damaged the equity of health care system. Moreover, moral hazard increased burden of budgetary sector, and the sustainability of the whole system were challenged.

Chaos: health care system in transition of economy(1978-2003)

Alongside the development of health care system, China has experienced great and profound social changes; Chinese government implemented “Reform and Open” policy in 1978, to adjust economic structure, develop overseas trade and participate in globalization. Since then, China maintained 9.9% of GDP growth rate for 34 years long.(Lin 2011:2-5) One the one hand, people’s life quality has improved, on the other hand, the development welfare was backward compared to “economic booming”. As is argued by Wood and Gough(2006:03); “the rapid capitalist development has eroded absolute poverty, but frequently at the same time high-lightened insecurity and vulnerability”. In reality, the marketization of state-owned enterprise in urban area and privatization of land contractual operation in rural area destroyed base of classic social security and medical security system as well, unemployed workers from budgetary sectors and all agriculture workers thus encountered “self-secured” situation.

Until 1998, there were 47% residents in total without medical insurance, even 87% farmers lost social protection because collective economy collapsed in rural area.(Wang 2005). To solve this problem, State Council published “Decision to establish medical insurance system for urban stuff and workers”. Thus urban employee basic medical insurance scheme (UEBMI) which is derived from labor medical insurance scheme has been gradually built and replaced the old one. Under the policy value of “efficiency first”, new medical scheme emphasize the insurance payment shared by employer and employee, the entitlement of medical service restricted in formal labor contract. During this period, welfare policies were regarded as a supplement of economic policies; to help state-owned enterprises strip “policy burden” and maintain vigour. That was an strong character of productivist welfare regimes.

There were more critiques than agreements for health care reform. Li and Zhao(2014) elaborated the equality of new scheme was not as good as old one; the coverage shrunk, positive list limited in basic medicare and reimbursement rate fell. Moreover, individual payment has risen. Gu(2006:62) recognized whole transformation as “unmanaged marketization and reluctant privatization.” He pointed out that “dramatic institutional changes has reshaped health care financing, delivery.” For

instance, public hospitals tends to pursuit profit, thus health care workers stimulates patients over-treatment, further, social capital centered in big public hospitals, the allocation of resource is imbalanced. Li (2008:7) attributed main challenges of medical insurance system - “too expensive to see doctors, too difficult to access doctors” into medical reform.

The reform of medical insurance system transformed “work-unit” welfare into social welfare, it essentially is an conservative welfare style. Accordingly, the emphasize of individual responsibility to some extent controlled moral hazard and achieved efficiency from micro level (i.e.in hospital). But privatization or marketization of health care service increased inequality of different groups, broke the hierarchy of medicare institutions and led to low the efficiency of medical insurance system in general. The core concept of reform is so called; “decentralization”. It was an adjustment of excessive government intervention before, but health care service possess attributes of public goods, supposed to be operated by public sectors or managed competition. So the omission of government responsibility leads to serious social problems which been haunting in path of medical reform many years.

Reinventing government: health care reform under the crisis.(2003-2011)

In 2003, SARS makes fragile health care system more severe. Chinese government thus rethinks policy orientation and health expenditure to fix long-standing flaws of public health.(Zhou 2013:56) The state council published “The opinion on establishing new cooperative medical insurance scheme(NCMI) in rural area ” in 2013, and “The opinion on establishing urban residents basic medical insurance scheme(URBMI) ” in 2007. By that means, all citizens, including agriculture workers in rural are and informal/self/un employed residents (e.g. students, housewife....) are planed into basic medical insurance system. Further more, the state council published “The opinion on depending the health care system reform” and “Recent key implementation plan of reform for medical system(2009-2011)”. It should be noted that documents above is a collective of suggestions from general public(e.g. WHO, WB, Peking University...). Since then, a comprehensive health care reform which includes basic medical insurance system, primary health system, national essential drug system...was carried out. Li (2014:52-56) identified new circle of health care reform achievement as “historical changes in primary health system”; the coverage of basic medical

insurance system has reached 90%, the community clinic acted as an important role which is not profit-oriented but health-centered.

Both NCMI and URBMI are designed for serious illness reimbursement, in case participants are driven into the poverty. (Zhao 2009: 62) So it maintains liberal color and universal color at the same time; relative vulnerable group is voluntarily joined it and they will enjoy limited medical service. The payment is shared by individual and government. As evidence from WHO (2014:34), mandatory contribution mechanisms are more efficient than voluntary mechanisms, the "adverse selection" is the main issue, which will leads to a limited coverage and pooling fund. To expand coverage and break welfare fences, Shen&Peng (2009:18-23) suggested NCMI and URBMI should unified into urban and rural resident basic medical insurance scheme(URRBMI). They thought similar funding source and treatment level makes integration possible, and unified resident medical insurance scheme is helpful to break the boundary between urban area and rural area thus realize social equality.

So far, the medical insurance system were divided by working position and living place; Former one relates to UEBMI v.s. URRBMI, which indicates government employees enjoyed better medical insurance, followed by private employees, then the informal employees or residents. Later one relates to the imbalanced allocation of medical resource within economic developed region and under developed region in China, especially between rural area and urban area, people do not have equal access to the medical resource. Thus goal of health care reform has developed from "for all" to "for all with equity". Moreover, if we go beyond the medical insurance system, "high drug price" and "profit-orientated hospital" rooted in the marketization which makes reform less effective; the out of pocket money still shared 49.3% in 2006, "too expensive to see a doctor" problem has not been solved (Zheng 2011MS:4). So new circle of medical reform focus on these issues.

Healthy China:towards a universal health security system (2011-Now)

The second circle of health care reform in 2011 is the continuation of health care reform of 2009, which focus on the basic medical insurance (BMI) coverage and equal basic health care service accessibility to all citizens. In 2016, the state council published "Healthy China 2030", which put

promotion of people's health into strategic priority. Health care reform is not only for "disease management" but more like "disease prevention", NCMI and URBMI were gradually unified into URRBMI. The boundary between urban area and rural area has been broken systematically. More importantly, health care policies are not a supplement serving for economical reform anymore, but an comprehensive reform which aims to improve the health and well being for all citizens, on the way of universal health coverage. In 2018, National Health Security Administration (NHSA) was founded. Yang&Liu (2019:8) think that NHSA act as important role in health expenditure management; standard setup, price negotiation and payment regulation.

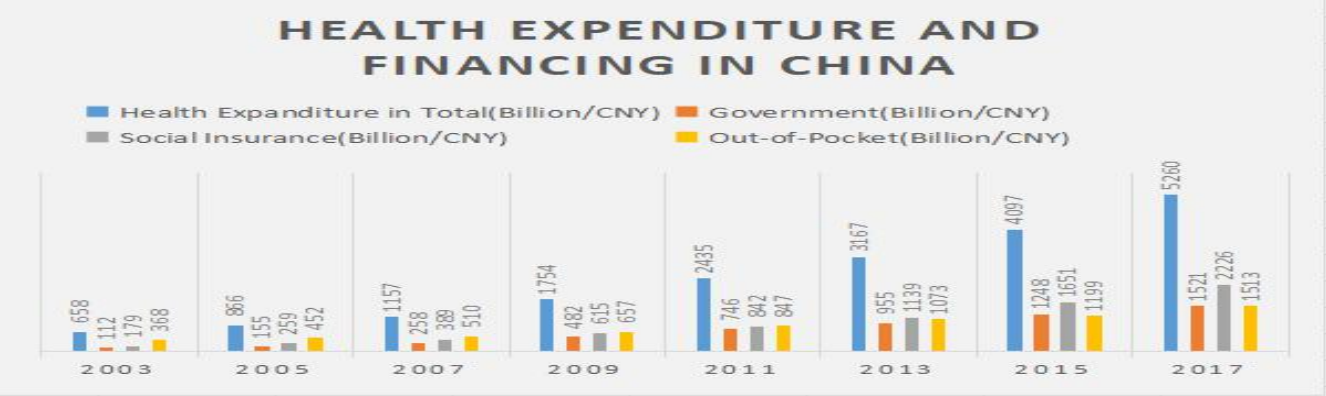


Figure 1 Health Expenditure and Financing in China[13]

Yet until 2017, almost 95% population has joined BMI and 74.23% of population has joined URRBMI (National data). Between 2003 and 2017(See figure 1), government expenditure gradually shared from 17.02% to 28.91% equally with private spending.Compared to "developed welfare sate", the proportion of health expenditure to GDP is relatively lower.(See Figure 2&3: OECD data)[14] While the excessive growth of health care expenditure may drag whole health care system in to "high cost but low value" situation.(WB 2016) Accordingly, the sharing of "out of pocket money" in total medical expenditure has fell from 55.93% in 2013 to 28.76% in 2017.(National data) Compared to EU countries (2018:EU28) as 18%, there is still some space to improve.[15] It should be noticed that 28.76% may reflect an average level, the actual burden for people who joined URRBMI is supposed to be heavier than UEBMI holders. In a short, Chinese government has made impressive

[13] National Data http://data.stats.gov.cn/easyquery.htm?cn=C01
[14] OECD Data; Health at a Glance: Asia/Pacific 2018
[15] OECD Data; Health at a Glance: Europe 2018

achievement, but there are two challenges inside the health care system; Soaring health expenditure (See in Figure 1,2,3) and health care inequality.

Soaring health expenditure to a large extent indicates a positive tendency; Li and Yu (2013:41-60) proved public expenditure in rural area released the burden of serous illness. Gan, Liu and Ma (2010:30-38) found the increase of public expenditure on health care could stimulate the domestic consumption and reduce the saving rate, further it will contribute to economy development. To some extent, it embraced problems. Chen, Fu and Li(2016:3-21) pointed out universal health coverage will promote irrational medical supply and medical needs based on the information asymmetry. Li (2014:52-56) thinks reform in large public hospitals is the main part of controlling the cost. Moral hazards combined with flawed mechanism set up many obstacles on the way efficient health care system.

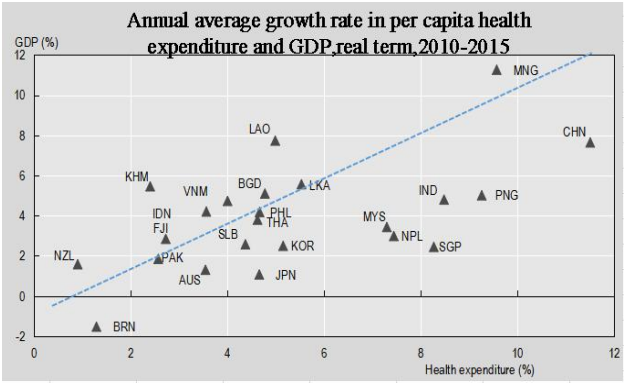


Figure 2 Growth Rate of Health Expenditure

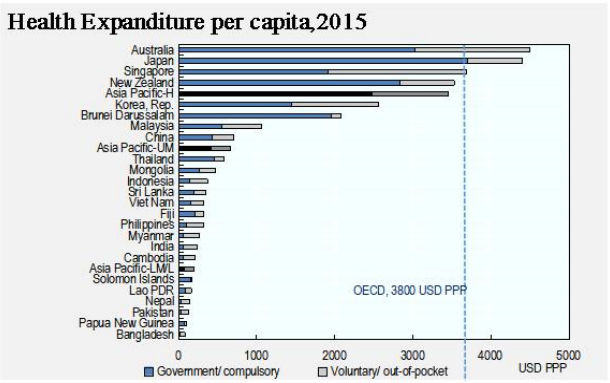


Figure 3 Health Expenditure

Health inequality gradually becoming a vital issue in China. Li, Sun and Zhang et al (2016:15-18) pointed out that utilization of medical resource was different among elderly people via medical insurance schemes; UEBMI shows a relatively high level, followed by NCMI and URBMI. Song (2017:62-67) analyzed fragmentation of medical insurance system and concluded that inequality of health care reflected in urban area and rural areal, employee and informal employee, contribution and reimbursement, same medical insurance scheme and different medical insurance schemes. Qiu&Huang (2013: 4-7) regards coordinating BMI as an effective way to achieve fair rights, fair opportunities and fair rules. So there are three kinds of blueprints for an unified and equal health care

system.

Zheng(2011:14 2018:82) was in favor of covering all people into UEBMI, which emphasized responsibility shared by individuals, employers and government. And public responsibility will be selective and centered in vulnerable group to insure them equally with other groups. Concerning to context of China, it is the mainstream idea to build health care system into “conservative regime” Gu(2017:102-109) suggested BMI should step forwards to “quasi universal health care system”, to cover everyone into URRBMI and improve the level of treatment. BMI to provide every citizens health care service equally, and non-selective public responsibility, which essentially “social democratic” style. The critiques focus on the welfare trap and sustainability of system, so the universal style has not became an intensive idea. The third idea is based on the practical experience from experimental places of medical reform.Qiu(2018:20) regarded individual affordability as vital factor, She divided integration to “same system but different level” and “same system same level”, So the URRBMI will be merged into and regard as low level of UEBMI in some underdeveloped region, the boundary will be eliminated by increasing income of resident. It maintains the current unequal situation but could be an operative way for most of regions.It paves a way to more equal health care security system which is similar to first idea of conservative style. It should be noted that all these three ideas has put into practice and operated well, referring to “Dong Guan” model (conservative), “Shen Mu” model (social democratic), “Cheng Du” model (compromising).

China rebuilt the universal health coverage within 20 years, over 1 billion populations were secured by BMI. There were exploration and adjustment on the path, finally government relocated as main role of health care, public responsibility was emphasized, especially for vulnerable group, URRBMI system is a good example. Current system contains conservative UEBMI and universal URRBMI. Finally, it may step to a stable and mature conservative health care regime. What’s more, Li (2017:61) recognized universal health care security system in China will maintain a unique feature; government will act as main insurance supporter and health care provider, which is good for balancing the efficiency and equity. Next part, more practical analysis will be around “health expenditure”, “health equity” “medical aid”... which is helpful to figure out how do health care policies affect individuals and shape society.

Part 5. A Case Study in Dongsheng District

Ordos is an energy city located in the northwest China. Coal industry and real estate used to be main pillars of local economy, brought great fortunes. Since 2008, affected by the international financial crisis and domestic police changes, real estate became over-invested industry and coal overcapacity make the situation worse. Once economy growth was not the best welfare anymore, welfare transition is incoming...

Background

Dongsheng district is the main part of Ordos. At present, there are 560 thousands people, 260 thousands residents registered in the local government.(2017) Registered population is supposed to join the SIS and also the target population in this research. Compared with Beijing and national average, target population exhibits some demographic characters below[16]:

	Working aged population(%)	Elderly population(%)	Family scale(person)	Higher Education(%)	Illiteracy Rate(%)
National Level	74.47%	8.92%	3.09	9.53%	4.88%
Beijing	66.90%	25.50%	2.45	32.83%	1.86%
Dongsheng	83.2%	3.74%	2.42	15.81%	2.74%

Table 3 Demographic Comparison Between Dongsheng and Beijing

1.The whole society enjoyed demographic dividend. Working aged population (people who are 15-64 years old) shared the largest perception of 83.2%. Sufficient labor force makes SSS less financial press but more space for welfare reform.

2. Urbanization accompanied with small families bring potential challenges for SSS. In 2017, urbanization rate has arrived to 93.43%, meanwhile, average family scale was 2.72. It weakens families' caring function, and the urban poverty become the key point of SSS.

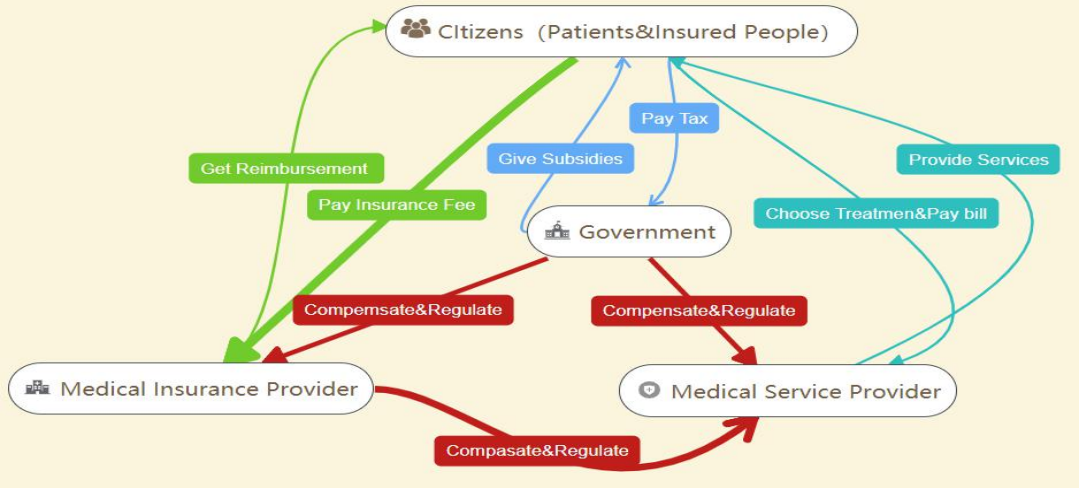
3. Population dividend had not transformed in to education dividend, some human resource may

[16] Data source; Ordos e-government http://www.ordos.gov.cn/zjordos/sqgk/
National Data http://www.stats.gov.cn/tjsj/pcsj/rkpc/6rp/indexch.htm

be wasted and may cause unemployment.(Zhong 2016). As of 2010, only 15.81% received higher education lees half than Beijing. Less educated population is more vulnerable for risk, usually they have higher level of public trust (Jing 2013). In Dongsheng, there is a classical authoritarian government providing public goods. For return, people trust public sectors more than private sectors.

Stakeholders and relations

Deng and Yang (2013:111) identified stakeholder relationships of health care system as a "triangular square"(see in map 3). Massive discussion of health care reform centering in "red triangle" is that whether government should "aid supplier" or "aid demander" to balance efficiency and equality. The "biggest colorful triangle" is a miniature of health care operation; patients were irrational consumers due to desperation and information asymmetry, thus over-treatment and trust crisis do harm to patient-doctors alliance. Medical insurance providers are responsible to regulate and monitor medical service providers, public hospital is a vital issue. UEBMI and URRBMI build up BMI but breads health inequity, out-of-pocket money is one of main perspectives. Besides that, government set up a series policy for vulnerable group, policy implementation matters. All issue above will be put into reality and analyzed in this chapter.



Map 3 Stakeholders in Health Care System

Medical service providers

Generally, medical investment and relevant facilitates are sufficient in Dongsheng. For example,

every thousand people shared 6.65 hospital beds(2017)[17], compared to national average 5.368 (2016)[18], and OECD average 4.7(2015)[19]. Specifically, public hospitals dominate medical service market, private clinics have more influence in primary health area. As of 2017, there were 103 medical institutions registered in Dongsheng district government[20], including 77 private clinics, 12 private hospitals, 17 community clinics and 9 public hospitals. Private medical organizations enjoyed an superiority from the quantitative perspective. Private clinics, especially, accounting for 74.75%. It proved that private investment centred in small&middle sized medical institutions. Because situation will revers in qualitative aspect.

Name	Hospital beds	property	Percentage
①Dongsheng People's Hospital	700	Public	54.69%
Dongsheng Maternity and Child Care Center	100	Public	7.81%
②Ordos Guangsha Hospital(tumor)	220	Private	17.19%
Ordos Urban Lady hospital	80	Private	6.25%
Ordos Ophthalmic Hospital	100	Private	7.81%
Ordos Dental Hospital	15	Private	1.17%
Ordos Maternity Hospital	65	Private	5.08%

Table 4 The Allocation of Hospital Beds in Dongsheng[21] in 2017

Still take hospital beds as an example, among 21 hospitals, 7 of them are qualified to provide hospitalization service, 2 public hospitals occupied 62.5%, the rest 37.5% hospital beds were shared by 5 specialized private hospitals separately.(See in table 4) It is an evidence proved that public hospitals have higher capability in hospitalization service despite more private medical institutions in general. Gu&Chen (2018:29) argued that private hospitals mainly served patients with characteristic service for certain illness and price is cheaper, concerning to fierce competition. Jiang, Li and Zhu

[17] From E-government of Dongsheng http://www.ds.gov.cn/

[18] From National Data http://data.stats.gov.cn/easyquery.htm?cn=C01

[19] From OECD Health Indicators
https://www.oecd-ilibrary.org/sites/health_glance-2017-62-en/index.html?itemId=/content/component/health_glance-2017-62-en

[20] There are other medical institutions registered in Ordos government, so the actual number is more than 103.

[21] Data Source: E-government www.ds.gov.cn/fw/bmdt/ylbz_103283/201701/t20170120_1880771.html
Guangsha hospital http://www.erdosgsyy.com/comcontent_detail/i=21&comContentId=21.html
Urban lady hospital website www.dsfcyy.com/

(2016 29-30) found that utilization rate of medical resource in private hospital is relatively low, talents shortage is an important reason.

Sampling

In order to make a detailed comparison, I took 'Dongsheng People's hospital ①' and "Ordos Guangsha hospital ②" as samples(See in Table 5), which represent public hospitals and private hospitals. After I asked a social worker in my community clinic, I picked "Jiao Tong community clinic③" and "Wang Yuan Clinic④" as other samples to represent public clinics and private clinics. Besides, I added a "Tong Chuan community clinic⑤" as reference sample, which is a public founded clinic and located in the rural area. From now on the comparison has been made between public medical enterprise and the private, big hospitals and small clinics, medical resource in urban area and rural area. All the data are whether from e-government or fieldwork. Public medical institutions publish their exact balance regularly, while private medical organizations do not. So almost all the private sector data was collected from doctor&nurses. For instance, working hours is a description of subjective feelings of medical staff who work in department of nephrology.

	Daily Reception	Financial Subsidy[22](CNY)	Working Hours	Staff	Hospital Beds
①	600	39,858,400(25.2%)	Longer	628	700
②	200	0	Longest	260	220
③	30	8,013,200(83%)	Normal	54	0
④	50-60	0	Long	5	0
⑤	40	2,202,500(53.4%)	Normal	14	0

Table 5 A Brief Comparison within 5 Medical Institutions

Public hospital V.S. Private hospital

Both public hospitals and private hospitals have "for-profit" mechanism, though the reason is not exactly same. ① is the second largest hospital in Dong Sheng, with comprehensive departments and

[22] Financial Subsidy=Government Subsidy/Total Income, FS is mainly used for staff wages.
Data Source: E-Government in 2017 http://www.ds.gov.cn/

professionals. Public funding only accounts for one quarter (table 4), it will encourage doctors to provide over-treatment then increase income. Xiao&Yang (2013:900) found most people have higher preference for public hospitals, it may relates to the preconceived notion. It makes money-earning easier for public hospital than private ones. ② is the largest private hospital and third largest hospital. ② used to be a tumor hospital because the founder (also the director) is an aoncologist. He used to work in the public hospital which makes him famous and appeals to many patients. Private hospitals are self-financing, even, asset-liability ratio doubled than public hospitals.(Zhou&Xu 2010:63) Financial pressure is main reason why hospitals seek for profit, "irrational patients" are gas of "profit machine".

Most patients gathers in hospitals, especially in public hospitals.(table 5) It breeds problems and even intense patient-doctor relationship. A nurse who works in ② said "It is difficult for us to ask for a leave since we do not have enough staff and working overtime is common, we have to wait until the last patient left everyday". Such situation also happens to ①, but they have strict schedule, working time is shorter. Long working time and heavy workload will decrease quality of medical service. "I have too much things to do and too many patients to talk everyday, so when I meet someone who may be less educated and ask me to repeat the same thing again and again, I lost my patience".-A physician Ms Lu who has worked in ① for 3 years shared her experience. Further, "When patients go to this hospital, many of them have serous sickness and high expectation, I understand their worries and anxiety, but there are still many problems could not be solved by technology yet, once we have not meet their expectation, they become unreasonable". When I asked how does she think about the medical expenditure, she agreed that medical cost could be very high; "Some patients came from close villages and joined URRBMI, which usually asks for advance payment. Thus living cost and medical payment increased their pressure." There is a dilemma; on the one hand, more patients may bring more "profit" to hospital, on the other hand, more patients indicates longer working hours, it makes up "unhappy doctors&nurses ", further "unsatisfied patients.

So far, it is heated issue that if government should encourage private investment in medical market. Proponents think that private hospitals are helpful to control medical cost via market competition. Ning&Gu (2018:104) found that for-profit medical hospitals have significant influence in lowering

down medical expenditure. Protectors embrace medical service is “quasi public good”, for-profit medical institutions will bring up governmental difficulties and it may leads to chaos in medical market, thus reforming public hospitals is top priority. Liu(2017:14) found that higher percentage of financial subsidy is more likely related to lower medical payment, vice versa. He concluded that increasing input in public hospitals will be helpful to control the medical expenditure and change the profit-driven medical service.

Public clinic V.S. Private clinic

Clinics sit in a bit awkward situation; people whether go to pharmacies which will save time and money, or go to hospital directly and have better medicare. Besides, people would rather chose a exact doctor via personal recommendation than a medical institution. ④ (See in Table 5) is the smallest clinic within 3 samples but accepted largest amount of patients, the doctor is retired from public hospital, he used to be a director of endocrine department. Followed by ⑤, a community clinic located in the suburban area, there is no other medical institutions, so people would go to ④ for convenience. ③ is the largest clinic with relatively comprehensive departments but accept the least patients because there are many other pharmacies and private clinics near by. ③ daily reception has reached to 30 while almost a half is going to see one doctor or get vaccines, so the medical resources has not been fully used there.

In Dongsheng, public clinics have challenge in earning trust from patients, though they enjoyed high-percentage public funding. To solve this problem, they set up health file and keep in touch with residents who has non-communicable disease regularly. It is a win-win strategy to encourage people choose community clinics as their first stop, because it will release the burden from hospitals.Then, medical staff in hospitals will have more time and patience to improve themselves and provide quality service, people will accept appropriate medical service in time despite an irrational desire “to see the best doctor”, the whole medical system will operate more organized. Just as is reported by WB (2016:19); “to provide the right service at the right place and right time”.

Medical insurance providers

Yet until 2017, there were 210,128 people joined the BMI in Dongsheng district, which accounting for 79.9% in total registered population. Amid them, 26.78% population has joined UEBMI, the 73.22% were included in URRBMI.(See in table 6) As is mentioned before, UEBMI connected with formal employment contract, it is essentially an occupation welfare relating to conservative typology. UEBMI covers clinical cost (individual account) and hospitalization cost. In terms of URRBMI, it is designed for unemployed or self-employed locals, mainly for hospitalization services, in case poverty due to catastrophic health expenditure happened. Affordable payment makes URRBMI more accessible and popular, it indicates a universal typology. This part will focus on main challenges of BMI - soaring health expenditure and health inequity, to evaluate health care policy implementation, operation and outcome in Dongsheng.

	UEBMI	URRBMI
Number	56,275(26.78%)	153,853(73.22%)
Source of Funds	Employers&Employees Payment	Public Subsidy&Individual Payment
Individual Payment(CNY/Year)	1265~5059	0~170
Nominal Insurance Ratio	90%	80%
Individual Saving Account	Yes	No
Revenue(CNY)	211,060,000	129,540,000
Expense(CNY)	134,590,000	84,220,000
Balance (CNY)	76,470,000	45,320,000
Balance in Total(CNY)	455,480,000	137,000,000
Supplemental Medical Insurance Fee(CNY/Year)	100 CNY/Person	50CNY/ Person

Table 6 Basic Medical Insurance in Dongsheng District[23]

Soaring expenditure and it's solution

Public sector is responsible for regulating hospitals and patients, more importantly, monitoring

[23] Data Source: Medical Insurance Bureau in Dongsheng in 2017
Generated by author

medical pooling operation. In Dongsheng, medical insurance bureau (MIB) adopted series policy to avoid moral hazard. Mr Ma is a office chief of MIB, he told me that they have signed contract with every hospital and set up rules for prescription&treatment. For example, hospitalization payment in ① should be around 5286 CNY/Year. For certain disease, they have made "whole package price" too. The guideline is helpful to examine and verify the appropriate medical payment. Besides, they conduct random examinations (10%) to see if patient truly stay at hospital, in case "fake hospitalization" happened. So far, BMI enjoyed a surplus every year, there is no urgent funding risk.(Table 6)

In Dongsheng, BMI still has some flaws in controlling cost; 1.Retrospective payment (Pay after medical treatment) may limit restriction in total amount controlling. 2.BMI, especially URRBMI is mainly for hospitalization, thus patients have motivation to accept over-treatment (hospitalization) and get medical reimbursement. 3.Combined with self-financing hospitals, patients and doctors both have motivation to give/accept more medical service, thus soaring medical cost is "understandable" in such context, thus "monitoring medical expenditure" become difficult.

Health equity and three dimensions

"Health can been seen as of great importance due to its' impact on people's range of opportunities -- such as their ability to work or education... "(WHO, 2014;2) What's more, "fairness of universal health care system" is conceptualized as "fair distribution, fair contribution, cost-effective".(WHO 2014) In China, thanks to the development of BMI, health equity comes to front and center. Health inequity mainly reflects on welfare gap between URRBMI and UEBMI.

1. Fair contribution

Speaking of contribution fairness of BMI, URRBMI and UEBMI operate independently. Payment of URRBMI is equal and affordable. Challenges happened to the UEBMI; adverse contribution exists and may leads to adverse distribution.

Take payment of URRBMI in 2017 as an example (See table 6), individual payment accounting for

23% (170 CNY), the rest was shared by central government 43.85% (324 CNY), Inner Mongolia government 6.06% (44.8 CNY), Ordos government 13.54% (100 CNY), Dongsheng government 13.54%(100 CNY). 170 CNY/year is affordable and accessible to everyone, public funding makes URRBMI an “universal welfare project”.

UEBMI payment base is local average wage last year which divided into two parts; 75% is payed by employers, 25% is payed by employees. For people who are self-employed, informal employed or unemployed, they have to pay 100%. Take UEBMI payment in 2017 as an example(Table 6), 5059 CNY equals to a monthly salary for a public high school teacher, and 2-month-salaery of a waitress in small canteen. Relative high payment builds up “high wall” between “residents” and “employees”. Song(2017:65) pointed out that UEBMI payment is heavier burden for relative low-income industry employees.(e,g. agriculture,construction...) Because salary shares a higher percentage in total income for relative low-income group. UEBMI closely related employment, which makes it a “conservative project”.

2. Fair distribution

BMI has limited redistribution effect. Wang (2016:10) found that Gini coefficients has changed 0.49% by BMI only. Li, Sun, Zhang and Xu...(2016:18) argued that BMI will encourage old people accept more medical treatment significantly, while compared to residents, formal employees are more willing to accept medical service. In Dongsheng, 73.22% residents has used 84,220,000 CNY, while 26.78% employees has used 1.6 times funding. It is hard to conclude that residents are healthier than formal employees, so they do not need more medicare. More likely, “ability to pay” depress their needs. To some extent, reimbursement of BMI will adjust “ability to pay” for medicare.

I asked Ma how does he think about the inequity of BMI, he would embrace the idea “treatment is decided by contribution”. “Employees have to pay 2000 CNY/Year, residents only need to pay 200 CNY/Year, the reimbursement gap between UEBMI and URRBMI is only 10%. If people pay different but enjoy the same, it is unfair for people who have payed more. For poverty population, they have multi-layers of social protection, including BMI and supplemental insurance, medical aid

and charity...”

Ma’s idea is typical. But there are some paradoxes behind. Firstly, medicare is an special need for certain group, thus supply should rather depends on needs than contribution. Secondly, employees’ payment will go back to “individual medical account”. In that sense, individual has not contributed to pooling fund. Thirdly, actual welfare gap is larger than nominal 10%, especially for imported medicine...Fourthly, only 2.8% poverty population were qualified to accept medical aid, more medical insecure group is waiting for help.

Why is “fair distribution of health care system” so important? Because it is the “tailored solution” for absolute poverty in Dongsheng. Take APA as an example, there were 31 “qualified families” in 2018. 90% of poverty is attributed to catastrophic medical expenses directly/indirectly.[24] Having serious diseases is a double shock for individual and family; On the one hand, it will decrease the household income sharply. On the other hand, it will increase medicare expenditure dramatically. But if we take ahead look in timeline, affordable and accessible medical resource will be very helpful to find out and control the illness at the early stage, then absolute poverty could managed before it happen.

3. Cost and effectiveness

From 2013 to 2017, there were 61,046 population newly joined in the BMI, accumulated balance arrived to 352,530,000 CNY which is 2.46 times current income.[25] More and more people are able to enjoy accessible and affordable medicare. BMI is sustainable and operating well. The goal of “cost-effective” has been achieved in general, but some risks should be noticed;

First of all, BMI is not flexible enough to respond to changing reality and social needs. The huge surplus indicates a risk of funding depreciation and improvement space. Unlike pension scheme which is supposed to consider aging trend, BMI should focus on current balance and make pooling fully used. Such situation may derive from relative high insurance payment. BMI, especially UEBMI payment experienced a stable increase year by year despite a economic fluctuation in reality.

24 Data from Poverty Alleviation Office in Dongsheng

25 Data Source: Medical Insurance Bureau in Dongsheng in 2017

Second of all, adverse selection exists in medical insurance market, it will negatively affects BMI operation. Many commercial insurance companies sell health insurance at same price of UEBMI, consumers are promised to get capital back after several years if there is no medical affairs. And poor-health people are not allowed to join in such schemes. “Worthy” commercial insurance makes BMI less attractive, more importantly, “adverse selection” will leave more problems to BMI operation in the long run.

Third of all, irrational patients combined with “for profit” medical institutions lead to a “high price but low value” situation. Besides, supplemental insurance and medical aid are operated by private companies bring inspirations and problems at the same time. It is interesting to analyze public private participation (PPP) under authoritarian politics.

Commercial insurance

Private insurance companies embrace different roles for MIB; competitors and cooperators. This part will focus on supplemental insurance of BMI. (See in table 6) Supplemental insurance schemes are designed for critical disease to release economical burden every year. People’s insurance company (PICC) used to be main cooperator of BMI within past 5 years. Until 2018, BMI dose not allow same company bid UEBMI and URRBMI together, PICC bid for supplemental insurance of URRBMI. Hua insurance company took over the UEBMI part.

Mr Zheng is an experienced employee of PICC, who takes charge of PPP affairs. He told me “Recent years, our insurance loss ratio has arrived to 130%~140%, and amount of loss is 25,490,000 CNY in total (2018)”. When I asked why would they still bid for this unprofitable project, he answered: “I understand your point but you have not considered two factors; market share and social reputation, we PICC is a state-owed company, only us will be capable to take the social responsibility even bear deficit ...” Hua seems to be a contrary example, unlike PICC did before, supplemental service of UEBMI suffered a obvious drop comparing to URRBMI. Even employees has paid higher (100 CNY/Year) than residents (50CNY/Year) “They will have funding left this year unlike us suffered

deficit during past years". Mr Zheng said so.

It is hard to blame Hua insurance company has not maintained treatment since they are trying to keep the balance of income and expenditure. Like other private sectors, public responsibility is not their obligation in law. PICC is an exception but state ownership may explain why. It is easy for private sector to achieve "cost-efficiency", but difficult to realize "cost-effectiveness", especially in public goods area, because life or opportunity is difficult to calculate as cost or outcome. No one knows how much dose an opportunity actually cost for a specific person, people whether underestimate or overestimate his/her potential mostly. In a short, "value of money" principle makes private sectors more competitive in the market but inherent defected for public goods.

Government

Government will step forward for vulnerable groups. In 2017, 5134 people were qualified to accepted medical aid which accounting for 1.93% in total registered population and 2.44% in total insured people in Dongsheng. Amid them, 641 people has received over 90% medical insurance reimbursement. And the rest will get 70% medical payment reimbursement after BMI.[26] Medical aid entitlement bonds to household income which is part of social assistance plan -- MLG, APA,TN&FG. ("three non-personnel"&"five guaranteed people") (See in table 7)

MLG is designed for low-income family in both urban area and rural area, their annual per ca-pita income should less than 8700 CNY. Insured people will enjoy 1.4% more medical reimbursement. APA is designed for absolute poverty family in rural area, target families' net income per ca-pita should less than 2952 CNY/Year, people will enjoy 90% medical reimbursement rate and their out-of-pocket money is supposed lower than 3000 CNY/Year. TN&FG is mainly for people who have no income, no capability to work, no supporter from family, which are always elderly widows&widowers or orphans, their medical payment is 100% covered by public medical funding. All the medical aid plan were PPP projects, operated by PICC, payed by government. (See in table 7)

[26] Data from PICC in Dongsheng,Civil Affairs Bureau,Poverty Alleviation Office
E-government http://ds.gov.cn/qq/gk/shsy_103240/201703/t20170317_1909649.html

Medical aid plans embraced public responsibility and some critiques; a. Limited coverage is a symbolic of residual SAS under authoritarian model, it leads to a systematical exclusion of target population. b.unnecessary deferential treatment with absolute poverty population increased fragmentation of BMI, which will increase the management cost and enhance inequity further. c. PPP model makes policies implantation more complex, it may improve the efficiency of policy at the sacrifice of effectiveness.

	MLG	APA	TN&FG
Population	4493	80	561
Medical Insurance Payment	230 CNY/Year	480 CNY/Year	230 CNY/Year
Reimbursement Rate	1.5%~2% increase	Over 90%	100%

Table 7 Medical Aid for Different Vulnerable Group in Dongsheng in 2017

Individual

Individual is the smallest unit in society, act as different roles in various situation, they could be kids, parents, employees or patients. They have similar or different experience, everyone have their own up and down. From my point of view, social welfare is an important tool to smooth ups and downs; people will save or share the energy when they are up, more importantly, people will accept energy in case falling off the cliff when they are down. There are many challenges all the mankind have to confront, poverty, sickness, pollution...As for health care system, rapidly aging society and non-communicable diseases becoming crucial.(WB 2017:28) This part based on the experience from five non-communicable patients to see how social welfare system affect their life, if their needs get satisfied well. Most interviews took place in hospital, interviewees are from snowball sampling despite one case is from APA office. Similarly, in order to make comparison, they joined different medical insurance scheme and social assistance scheme, then we will see interaction between welfare policy and individual specifically.

“The thing I expect most is to see my grand kids during weekend”-- Mrs. Ji

Ji is 53 years old and get retired 3 years ago, she has diagnosed as kidney failure since 1995. So far, she has dialysis every other day. It will cost 15 000 CNY/Month in total, she need to pay 3000 CNY/Month since she joined UEBMI. Concerning to 2000 CNY/Month pension, it is a problem. Family support is a crucial for her; besides her husband income, her two kids--a son and a daughter, both have stable job and get married, it makes her economic situation better. She likes square dance and feeding cat in daily time. Weekend is a big day, her grandson and granddaughter will visit her. When it comes to unsatisfied part now, she said “Many sick friends had left me now, I kinda miss we chat a lot when we have dialysis. Doctors won’t take my suggestion seriously when I insist to use imported medicine”

“Please help me.”--Mr Dong

Dong’s parents got divorced when he was young, his father seldom take care of him and his mother remarried. Dong is 27 years old, he was diagnosed as uremia and dropped out from school at 17. He joined URRBMI and MLG and has to rely on 634 CNY/ Month covering all. His mother dose not have formal job either. They sometimes have to borrow some money from friends or relatives. Compared to other patients, Mr Dong has better health since he is still young , while economical plight stressed him a lot. Until now, Mr Dong has posted his situation on we-chat crowd funding project. “I do not have courage to borrow more from relatives and friends since I am worried about I may not be able to pay debt. I would not expect a kidney transplantation since it is too expensive, all I wish is to maintain the current situation, please help me.” He likes to play video game and watch series. When he saved some money, he was happy to eat hot pot for once. He is like other same-aged peers, but he spent most time in hospital which makes his life very different.

“I am satisfied with my life but not sure if policy will change.”-- Mr. Wang

Wang is a 40-year-old single man with 12 years dialysis history. He used to work in a company but lost his job after he was ill. Wang used to join the UEBMI then transformed into URRBMI with MLG due to the relatively high payment of UEBMI. In 2018, he was identified into TN&FG

program, his medical payment will be covered 100%. So far, he has dialysis three times a week and live in a low-rent housing, which only costs 45 CNY/Month. Besides, he receives 1000 CNY/ Month, it will cover his living cost just enough. He said he was very satisfied current life. “I moved to an independent apartment from hospital, my life has changed much better, I have a quality sleep and more freedom.” He watches TV and walks around in the community when he get free. His best wish is to transplant kidney while it is too expensive to afford it. The only thing he worried is that, it is first year for him not to pay any medical payment, he dose not know if policy will change later.

“The diseases has changed my life a lot”--Mr. Zhong

Zhong is 35 years old, he was diagnosed as uremia a year ago. He kept dialysis twice a week and it costs 1200 CNY/Month. He told me that he has master degree and worked in a state-owned company before, his salary arrived to 10,000 CNY/Month before, so he has joined the UEBMI. Though his manager asked him to stay, he has to resign because cannot work like a healthy person. He has get married and his son was only 5 years old. Economic pressure is affordable so far, but will be a trouble in the long run. According to the MLG policy in Dongsheng, Zhong is not qualified. It will at least take 18 years to get a master degree in China. Uremia changed his life entirely; his income decreased from 10,000 CNY/Month to -1200 CNY/Month, he has to give up familiar social circle, he will be affected by uremia in the rest life.

A case from poverty alleviation office--Mr Zhang

Zhang has gastric cancer, diabetes and hypertension and his wife got diabetes and hypertension too. Though both of them have received pension every month, catastrophic medical payment has dragged family into dilemma. Government officers has covered them into MLG and APA project after means-test. Besides social allowance and medical aid, government has funded them with livestock breeding. Concerning to they may not be able to take good care of cattle, community officers has contacted local agriculture cooperative organization to keep Zhang’s pigs. Combined with social allowance, pension and farm income, the household expected annual net income will reach to 38,784 CNY.

Some ideas

1. Family-government cooperation

In china, family has undertaken caring responsibility for young&old&ill family members. Mostly, government will stand out when people lost the ability to work and family protection. Mrs. Ji and Mr Zhong would not be able to break even but family support makes their life more tolerable. That is also the reason why they are not qualified to accept medical aid. Take MLG in Donghsheng as example, there are many strict standard for applicators and their family; applicators annual per ca-pita income should less than 8700 CNY (2017 in Dongsheng), their spouse is not supposed to be formal employee in government/public sectors or state owned company... To regard people as family member is understandable in the Confucian culture. But recent years, families tend to be smaller and more flexible under the family plan and increasingly divorce rate, the actual welfare function from family is not as stable as before. So, regarding vulnerable group as individual rather than family member is a reasonable way to confront new challenges.

2. Welfare gap and medical insecure group

Current social allowance system divide people into different vulnerable group, it is unnecessary to do so; although their actual ability to pay has light difference, they are already absolute poverty group. Government provides relatively generous social aid for people who lost capability to work and family support. Amid these examples, Mr Wang has covered in TN and Mr Zhang has joined APA enjoyed high level of social assistance and medical aid, Mr Dong received MLG package but expenditure exceeds income. Take MLG and APA as example, APA has obvious generous social benefit for target population, which is aims for citizens who live in the rural area. But people who live in rural area only account for 8.69% (2017)[27] in Dongsheng, the boundary is ambiguous under urbanization.

Mrs Ji and Mr Zhong will be able to afford the medical payment with family support so far. They are medical insecure group but not economic insecure group. Unlike poverty policies, medical aid is

[27] Data from E-government http://www.ds.gov.cn/zw/tjxx_103535/tjnj/201806/t20180605_2173733.html

supposed to provide to certain group not every one. To secure poverty population with medical aid seems to secure the vulnerable group, it may exclude some people they do need medical aid but are unqualified poverty population. Such economic classification will increase the management cost and leads to welfare shortage to medical insecure group.

3.Marginalization and worries

Marginalization seems to be a unavoidable issue for people who has serious non-communicable diseases, they will not be able to work or study like healthy people, so their family is emotional belonging mainly. From interviews I have found that patients' life simple and quiet. They are gradually staying away from social circle and get used to that. Subjective well-being or metal health is important but seems to be a relatively private issue. Many patients have to deal with negative feeling every day. Empowerment policy could be the possible trial; take Mr. Dong as example, he would not be able to live with benefit of MLG only, it is difficult for him to find a stable job outside, but it may be possible to get loan from bank or work flexible in the community just like Mr Zhang who has covered in APA.

Though for most people, such situation will not happen to their life, uncertainty could also affect people's life; A retired female Mrs Wang has bought a commercial insurance which accounts for 20% annual pension, she told me that she is worried about her URRBMI is not good enough once she has serious illness. "I do not want to make my children's life tough, I'd rather save money for insurance payment, it is better than crowed funding which asks for sympathy from friends, relatives, even strangers on internet". Mrs Wang's idea is not a single case, residents have awareness of welfare gap between URRBMI and UEBMI, thus willing to pay more and get medical secured. Irrational consumption exists in medical service market and medical insurance market. In that sense, to integrate URRBMI and UEBMI into same system is efficient and effective choice, everyone enjoy equal medical service and insurance treatment which is provided by public sector, such uncertainty will become certainty.

Conclusion

Q1

Unlike other East Asia welfare sate, most welfare research in China focus on institutional changes in terms of welfare polices last three decades. Scholars accept the definition of “productivist welfare state” or “developmental welfare state regime”, but drew two different kinds of welfare state regime blueprints for China- “baseline equality welfare style” and “appropriate universal welfare style.” Compared to classical welfare state typology, China embraced conservative character and liberal character, and a universal trend. The original motivation of welfare reform is to coordinate economic reform and keep social stability from up to down, government and public sector have acted as vital roles through whole process. Meanwhile, family is the main “caring provider” and also the welfare preference for general public. The cooperation of government-family style is the most outstanding signal, while this model will be affected a lot under the demographic changes; which will create prevalence social needs for a universal welfare system.

Q2

Welfare transformation is a microcosm of social changes. China is affected by Confucian Culture, Marx’s idea and experience from welfare states (e.g. German, Singapore). This combination makes China as unique hybrid welfare regime. Confucian culture emphasize self-reliant spiritual, family bonds and authority-respect. It drew a picture of family-state cooperation and indicates a liberalism character to some extent. Marx’s ides ask for an universal and equal welfare regime. Worker-peasant union makes social welfare covered most citizens during planed economy, it embrace social democratic character. In China, such idea has practical experience in planned economy system while now has limited influence. Experience from other welfare states has built up present welfare system in China under the globalization, SIS is the main part of whole. Welfare qualification bonds to the employment contract and payment which responds to conservative character.

Government dominates welfare policy changes, and family provide caring. Social welfare for most people is an extension of occupation welfare. To understand welfare changes and it’s logic in China,

the responsibility allocation between public sector and family is vital. Besides, Some policy preference should be noticed; government will consider rural residents and agriculture workers more in policy-making, because rural area residents are still the vulnerable majority and agriculture is the foundation of national economy. Elderly people will have better social welfare under the aging trend and elderly-respect is a tradition. Privileged welfare for rewarding loyalty leads to welfare gap and structures society.

Q3

SSS indicates China is rather on way of welfare state than a mature welfare state. Because the actual treatment is still limited. For SAS, government has put a lot effort to solve absolute poverty which embodies a strong public responsibility, but limited coverage and treatment indicates residual style. For SIS, it covered largest population which achieved a equal access for citizens, but internal inequality exists, residents may only have health care and pension security, the treatment level is much lower than employees'. For SWS, most welfare policies are designed for vulnerable group which is overlap with SAS and far away from "appropriate universal welfare ", although different regions have experiment pilot, there is no unified and sophisticated welfare system.

Last decades, the development of SSS could be regarded as from SAS to SIS and will go towards to SWS. In summary, welfare system in China is a hybrid case with liberalism SAS, conservative SIS and universal SWS. SIS is the main part which covered most population, but universal SWS is an direction which is based on aging trend, flexible employment and unstable family. The welfare responsibility which used to be shared by families, formal labor contract even informal employment, will be a public issue. It asks for an institutional welfare plan to reduce prevalent vulnerability, it could also be the opportunity to create more space for citizens to realize themself and is for social justice and freedom.

Q4

As is mentioned above, BMI embodies conservative UEBMI and universal URRBMI, which covers employees and residents respectively. Recent decades, Chinese government has adjusted policy orientation and conduct reforms; from universal socialist style to liberalism&conservative style and

finally cooperative&universal style. The health care reform used to serve to economy development and keep social harmony, now become an independent social policy for improving social well being. The achievement is remarkable, over 1 billion population has covered into BMI, everyone have equal access with affordable payment. And the systematic boundary between urban area and rural area has vanished. More importantly, actual welfare gap (e.g. reimbursement rate, medical resource...) has decreased via public funding. While the risk has followed under the prosperity; soaring medical expenditure and health care inequity may drag health care system into “high cost but low quality ” trap. These two issues will also be the crux of health care reform.

To manage the challenge, deepening health care reform in public hospitals and integrating medical insurance system matters. The ultimate goal of health care reform is on way of more equal quality universal health care system, which may indicates a conservative typology. Besides, public sector act as main medical service providers and main medical insurance providers at the same time, which makes it easier to conduct health care reform and achieve health equity systematically.

Q5

There are 4 types of stakeholders involved; medical service providers, medical insurance providers, government and individuals, medical insurance&service providers could also be divided into public sectors and private sectors, it should be noticed that public sectors always act as main role in health care system.

Different kinds of medical institutions have various challenges. Public hospitals have absolute advantage from every aspects and rule the medical service market, but too many patients bring up too much work pressure. Public clinics are less competitive than some private clinics, thus seeking for patients is their challenge. For private medical institutions, personal capability is the key issue for their development, almost all the leaders in private medical institutions have rich working experience in big public hospital which helps them accumulated a very good reputation. Compared to public medical institutions, they are self-financing and their salary and working-time is more flexible, it encourages medical workers to treat patients with more patience but it may also leads to a longer working time than public hospitals. Some people embraced that competition among public hospitals

and private hospitals will be helpful to control the medical cost but it may drag medical staff into a tougher situation or transform into “arms race”.

Medical insurance providers aim to support insured people economically that people can work through illness predicament. The biggest challenge for public sector is to balance the equality and efficiency in medical insurance scheme. Though universal coverage health care system removed life threaten, welfare gap exist in different medical insurance scheme. Compared to commercial medical insurance scheme, public medical insurance scheme is less competitive in payment and treatment, because commercial insurance companies are more sensitive and flexible to market and they exclude risky population via big data. It is worth thinking that how to regulate commercial insurance company in health care insurance area, in case people’s vulnerability is taken advantage for profit. Even, “adverse selection” will press public medical insurance scheme in the long run.

Government dominates health care reform and regulates each stakeholder, this paper focuses on vulnerable and their satisfaction. People have medical reimbursement bonus after means-test, while medical-insecure population and economical-insecure has large overlap but not exactly the same. So government should distinguish medical insecure population and support them with appropriate help. Besides, medical aid is supposed to be more comprehensive which is not just economical benefit but caring as well under aging and family plan context. What’s more, government should make sure citizens have formal path express their needs and respond via policy making under the authoritarian model.

For individuals, their challenge is to cultivate risk awareness and protect themselves and their family from serious illness and catastrophic health expenditure. Concerning to the medical service/insurance matters to life, most people tend to over-consumption. Moreover, information asymmetry make their situation tougher. It is difficult to be rational after chronic disease or cancer happens to, since sickness is accompanied with employment deprivation and economical deprivation even social deprivation... It is easier to have a healthy life style or join different medical insurance schemes beforehand. For people who are suffering from illness, their challenge is to keep positive attitude towards life and their family needs to take the caring responsibility. More importantly, people needs

to express their needs actively rather wait passively and seek for help from government when they encountered problems.

In Dongsheng district, soaring health expenditure and health care inequality also exist. And there are some new characters; medical resource is sufficient but utilization of public clinic is a bit low, it disorders health care system and weakens efficiency in general. The difference between rural residents and urban residents is light, so current medical assistance system divides vulnerable group according to live place is unnecessary but increase systematic fragmentation. PPP makes medical aid more efficient but less effective. Individual account is unnecessary even strengthen health inequity between URRBMI and UEBMI. The welfare funding enjoys a big surplus due to the population age structure and policy payment&treatment in general, it creates the risk of capital depreciation and space for welfare reform.

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