

CHINA'S DOUBLE MOVEMENT IN HEALTH CARE

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The concept of a 'double movement' is adopted from Karl Polanyi, in his seminal 1944 book, *The Great Transformation*. In Polanyi's view, 'the idea of a self-adjusting market implied a stark utopia. Such an institution could not exist for any length of time without annihilating the human and natural substance of society; it would have physically destroyed man and transformed his surroundings into a wilderness'.¹ The extension of the 'self-regulating' market, he thought, was bound to provoke a countermovement aiming at protecting society against 'the ravages of this satanic mill'.² Polanyi's thesis is helpful in understanding the great transformation in health care in China over the last sixty years.

HEALTHCARE UNDER MAO

Prior to the foundation of the People's Republic in 1949, most Chinese had no access to healthcare services. As the vast majority of people earned barely enough to subsist and survive, malnutrition presented a grave threat to their health, and endemic diseases were prevalent. The country's infant mortality rate was as high as 250 per thousand³ and average life expectancy barely 35 years, roughly on a par with the US level in the 1780s.⁴

Soon after the People's Republic was established, the central government held the First National Health Work Conference, which laid down the 'workers, peasants and soldiers' oriented healthcare guidelines. The first and foremost objective of healthcare then was to turn a countryside 'without doctors and drugs' into a countryside 'with doctors and drugs'.⁵ Even during the Korean War, the new government made rapid progress in developing rural medical organizations. The number of county-level health institutions rose from 1,400 in 1949 to 2,123, by the end of 1952, covering over 90 per cent of the nation's regions.⁶ Throughout Mao's era, China placed great emphasis on egalitarian principles. The government made enormous efforts to establish a healthcare system that could provide all citizens with access to basic health services at an affordable price.

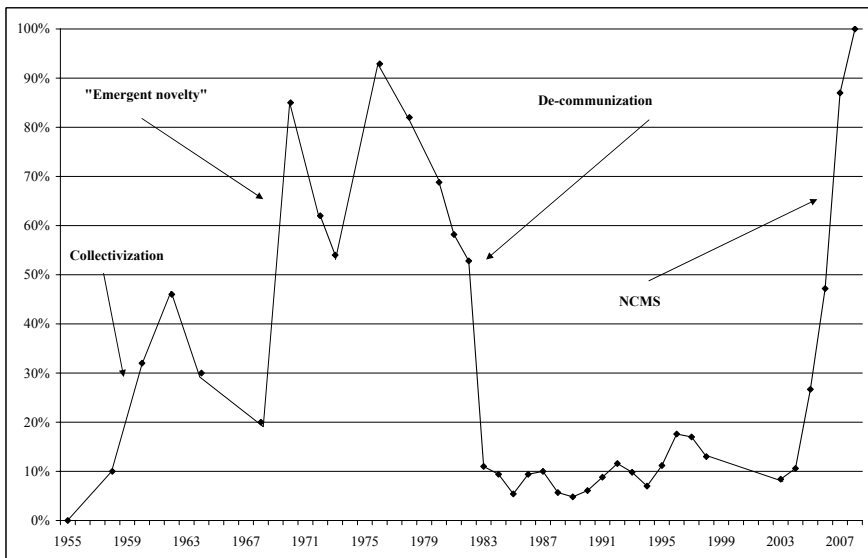
In urban areas the healthcare financing system consisted of two schemes: (1) the Government Insurance Scheme (GIS) for all government employees (including retirees), disabled veterans, college teachers and students, and employees of non-profit organizations; and (2) the Labour Insurance Scheme (LIS) for employees (including retirees) of all state-owned enterprises (SOE) and some collective enterprises. The beneficiaries of the GIS received largely free outpatient and inpatient health services, except for a small number of items, such as a registration fee, tonic medicines and plastic surgery. Moreover, there were avenues through which coverage could be extended to members' dependants. The LIS provided its members with benefits similar to those provided by the GIS, and reimbursed half of all medical expenditures for their immediate dependants.⁷

The GIS was financed and administered by governments at various levels, while the LIS was financed by enterprises' welfare funds and administered by each individual enterprise.⁸ Thus, despite the name 'insurance', the GIS was actually a self-insurance scheme with no risk-pooling across localities, and the LIS a self-insurance scheme with no risk-pooling across work units. In other words, GIS members' medical benefits theoretically depended on the tax revenues available in their particular administrative region, and LIS members' benefits were tied to the profitability of their particular enterprise. This implied that medical benefits might vary vastly from region to region and from enterprise to enterprise. In reality, however, no such differences existed prior to the economic reform because, thanks to the 'soft budget constraints' that existed under the planned economy, the central government served as the payer of last resort for all outstanding health bills and the whole system functioned as if there were a nationwide pool.

As for service provision, for several decades urban China maintained a three-tiered structure of healthcare delivery. Medium-sized enterprises normally ran their own clinics to provide their employees with free outpatient services; enterprises with more than 1,000 employees tended to operate their own hospitals; while city hospitals provided inpatient services for medium-sized enterprises, and all health services for small enterprises and the uninsured. All health institutions were publicly-owned. Government budgets directly or indirectly subsidised most of their recurrent costs (e.g., salaries of health personnel and equipment), their remaining revenue coming from fee-for-service activities. Regulated by the government, prices for medical services as well as drugs were universally set below cost so that even the poor and uninsured could afford them. Whenever health institutions ran deficits they could ask for more subsidies from the government. On top of that, the government was also responsible for their capital investments.

In rural areas China developed a quite distinctive medical system that had two key components: the Cooperative Medical Scheme (CMS) for health financing, and 'barefoot doctors' for service provision. The CMS was financed from three sources: 'healthcare fees' (RMB 0.5 to 2 per year) paid by villagers, the village's collective welfare fund, and medical proceeds (mainly charges for medicines).⁹ Rural residents who participated in the CMS were entitled to receive such benefits as free visits at the village clinic, free drugs, or copayment for drugs, at the village clinic, and copayment for referred hospital visits and for hospitalization.¹⁰ By the end of Mao's era, the CMS had been adopted by 92.8 per cent of production brigades nationwide, covering 85 per cent of the rural population (Figure 1).¹¹

Figure 1: The Proportion of Villages Adopting the CMS (1955-2008)¹²



'Barefoot doctors' were farmers who received a brief period (from a few months to more than a year) of basic medical and paramedical training and worked in villages to promote hygiene, preventive health care and family planning, and to treat common illnesses. They referred seriously ill people to township and county hospitals. They were able to keep medical costs to an affordable level for three reasons. First, government provided funding to defray their training costs and for them to acquire essential medical equipment. Second, barefoot doctors worked both as farmers and as doctors, often spending as much as 50 per cent of their time in the field;

and their income was only slightly higher than that of other villagers. Third, they were actively engaged in gathering, growing, harvesting and making Chinese herbal medicines and in applying acupuncture (herbal medicines and acupuncture were normally provided free of charge).

Both the CMS and the barefoot doctors reflected an approach to health care that was egalitarian, grassroots-based, decentralised, de-professionalised, 'low-tech', economically feasible, and culturally appropriate. Together, the two components ensured that the people's basic health needs were met.

Thus, on the eve of the economic reform, China's healthcare system provided inexpensive and equally accessible medical care for virtually all urban residents and most rural residents, although the quality of medical services was not then very high.¹³ In the mid-1970s, China was not an affluent country but universal healthcare coverage helped to make it possible for the country to achieve significant improvements in people's health. Average life expectancy surged from 35 years before the Liberation to 68 years in 1980, while the infant mortality rate fell from approximately 250 per thousand before the Liberation to less than 34 in 1980.¹⁴ China's medical services then were internationally recognised for fairness and accessibility and became a model for the entire developing world.¹⁵ The Nobel laureate economist Amartya Sen is by no means an uncritical admirer of Mao. However, he acknowledged that Mao's China enjoyed 'a large and decisive lead over India' in terms of the health status of its people.¹⁶

THE MOVEMENT TOWARD THE MARKET

In 1979 China embarked on market-oriented reforms. Since then its economy has grown on average by 9.9 per cent a year and the living standard of its people has improved markedly. The rapid growth of the economy has no doubt increased the total resources available to pursue better health for all citizens. When we examine China's health performance, however, the picture does not appear to be as thrilling as the growth in GDP and even in spending on health. Though life expectancy continued to grow and the child mortality rate continued to drop, progress slowed down considerably. Some may think that once life expectancy approaches seventy years, further gains are bound to come more slowly. Yet trends in other parts of the Asia-Pacific region indicate otherwise. From 1980 to 1998, for instance, China's average life expectancy rose by merely two years, but Australia, Hong Kong, Japan, New Zealand and Singapore, which had started from higher bases, increased their average life expectancy by four to six years. Sri Lanka, whose base had been similar to China's in 1980, increased average life expectancy by five years. Similar disparities can be seen in changes in infant mortality rates.¹⁷

Even the Development Research Centre (DRC), a leading policy think tank directly under the State Council (China's Cabinet), openly admitted that the country's health reform up to the turn of the century was 'not successful', or even an outright 'failure'.¹⁸

Why, with higher disposable income per capita, better nourishment, and a bigger proportion of its national income devoted to health and health care, has China's health performance been so disappointing during the reform era? Determinants of health outcomes are of course multifarious, encompassing social, cultural, economic, and other factors. A possible culprit is mounting socioeconomic inequality. Over the last 25 years, a series of empirical studies, across both a wide range of countries and within industrialized nations alone, have related socioeconomic inequality to morbidity, mortality, and life expectancy. They all come to a consistent finding that the less equitable a country is, the less favourable its health outcome is.¹⁹ The key message seems to be unequivocal: inequality is bad for national health, whatever a country's absolute material standard of living.

China used to be an egalitarian society, with income inequality well below the world average. However, the reforms of the 1980s through the 1990s drastically widened the gaps between regions, between urban and rural populations, and between rich and poor households in both urban and rural China. These inequalities are overlapping and interrelated. By the beginning of the new century the growing inter-regional, inter-personal, and rural-urban income differentials together made China's overall income distribution much more unequal than ever before in the history of the People's Republic. Such a steep rise in inequality in such a short period may have been gravely harmful to the nation's health, whatever the mechanisms underlying this relation may have been (e.g. the psychological effects of relative deprivation, the breakdown of social cohesion, and the like).

A more direct determinant of sluggish health improvement perhaps has to do with the government's reluctance and/or inability to spend on health. The pre-reform healthcare system was affordable and equitable primarily because it was based upon social norms that favoured equity. Underlying the reforms was a paradigm shift in ideology. Rather than equity and security, Chinese policy-makers now gave top priority to rapid aggregate economic growth. Their obsession with the fastest possible GDP growth rates made them ready to tolerate a certain degree of inequity and to sacrifice some basic human needs, including health care. Behind all the measures of healthcare reform introduced in the 1980s and 1990s lay an unstated premise: the market was more efficient than the state in allocating health resources. Faith in market forces gave the state an excuse to retreat from its roles as the funder and

provider of healthcare. Indeed, in those two decades the state tried hard to give up its responsibility for healthcare financing and provision and expected societal actors to pick it up.²⁰ At that time, the Chinese leadership appeared to have intentionally or otherwise embraced the ‘trickling down’ hypothesis advocated by neoliberal economists: as long as the economic boom continued all citizens, rich or poor, would eventually be able to afford their health care out of their own pockets.

Among the first casualties of the ideological shift was rural health care system. As early as the second half of 1978, cracks had emerged in the CMS. *Document 37* issued by the Chinese Communist Party Central Committee on June 23 barred commune and brigade from ‘allocating and transferring human, financial and material resources to conduct non-productive construction’ and requested them to ‘cut non-productive expenditures’.²¹ Subsequently, some localities began to treat cooperative health care as a system of ‘the poor eating the rich’ and ‘adding to the farmers’ burdens’. As a result, ‘the rural cooperative medical services drastically declined in some Northeastern provinces and were blown away by a gust of wind even in many brigades that had solid economic basis ... As cooperative medical services were shut down, barefoot doctors were dismissed as non-productive personnel or brigade clinics were contracted to barefoot doctors who assumed sole responsibility for profits or losses; in many brigades, the peasants found it difficult and expensive to see a doctor’.²² Other provinces reported similar problems.²³ In 1980, for instance, ‘the cooperative medical services of many brigades were halted or ground to a standstill’ across Henan Province so that some people issued a strong appeal for urgent action to salvage the CMS.²⁴ Nationally, the proportion of brigades covered by the CMS fell from 92.8 per cent in 1976 to 52.8 per cent in 1982, a 40 per cent drop in six years.

As a result of the official abolition of the People’s Communes in 1983, the rural CMS collapsed like an avalanche and its coverage plunged to 11 per cent (Figure 1). By 1985, the number of villages that were still practising the CMS had decreased to 5 per cent. In the mid- to late-1980s, cooperative medical services still existed in the areas of suburban Shanghai and southern Jiangsu, where the collective economy was still strong.²⁵ Elsewhere, however, such services were retained in only a few localities, such as Macheng County of Hubei and Zhaoyuan County of Shandong.²⁶ As the CMS broke down, the vast majority of village clinics became privatised and the user-pay medical system became dominant again.

Why did the once world-renowned rural CMS decline so swiftly after reform? The most important reason was the change in the economic basis on which the CMS operated. Only under the institutional environment of

a collective economy could the funds for cooperative medical services be drawn and retained directly from the collective economy so as to ensure a smooth financial path. After the household responsibility system was put in place, the collective economy became very weak or even non-existent in most villages, except in a few regions where collective township and village enterprises (TVEs) flourished. It was therefore no longer feasible in most localities to support cooperative medical services by collecting and retaining collective public welfare funds. The importance of a collective economy can be seen in the 40 per cent decrease in CMS coverage in 1983, when the People's Commune system was abolished. In the 1980s, while national cooperative medical services shrank, the rural cooperative medical coverage of southern Jiangsu was still kept at a level of more than 85 per cent, but this could hardly be sustained in the 1990s when the collectively owned TVEs there were restructured through 'privatization'. The experience of southern Jiangsu confirms that a collective economy was the backbone of the traditional CMS.

In addition, as a result of the breakdown of the collective economy, most villages could no longer afford to pay barefoot doctors reasonable salaries and had no alternative but to sell or contract out village clinics to individual doctors, offering them the motivation to seek profits. Meanwhile, it was no longer possible to collectively grow, gather, and make Chinese herbal medicines after the land had been allocated to individual households. Eventually, in early 1985, Health Minister Chen Minzhang announced the official abolition of the name 'barefoot doctor'.²⁷

Another reason was that in much of the 1980s China's top leaders decided to let the rural CMS take its own course. Some health officials even openly advocated dissolving the CMS and contracting out village clinics to barefoot doctors. They asserted that this was an 'inevitable trend' of development.²⁸ When the CMS collapsed, they took pleasure in such misfortunes, saying, 'This is a great progress'. They believed that 'the user-pay medical system is here to stay for some considerable time in China'.²⁹

For the urban healthcare system the turning point came in the mid-1980s when the market-oriented reforms accelerated. As reform deepened, market ideology steadily infiltrated the urban health sector, becoming the effective guiding principle of healthcare reform. Official documents dealing with health reform were imbued with such buzzwords as 'private initiative', 'market incentive', 'competition', 'choice', and 'individual responsibility'. Behind all these trendy catchphrases lay an unstated premise: the market would increase the efficiency of resource allocation, including health resources.

The economic reform steadily ruined the base of the GIS-LIS financing

system. As mentioned before, the GIS and LIS were locality- and unit-based self-insurance schemes that could only function under the condition of 'soft budget constraint'. Decentralisation and marketisation, while giving local governments and state-owned enterprises (SOEs) greater operational autonomy, imposed stern fiscal discipline on them. The shift from 'soft budget constraints' to 'hard budget constraints' effectively dismantled the de facto nationwide risk pool and made it much more difficult for individual SOEs and local governments to finance employees' health care.

Starting in the early 1990s workers' medical benefits became increasingly tied to the profitability of the firms responsible for their health coverage. Facing mounting competitive pressures prompted by the economic reform, non-profitable SOEs could often not continue paying the fixed percentage of wages needed to preserve sufficient medical insurance funds, thus jeopardising workers' access to health care. Moreover, due to the downsizing and bankruptcy of SOEs, millions of workers lost their jobs. As a result, they effectively lost health insurance cover. Even profitable firms might favour lower social insurance burdens in order to stay competitive. The problem was compounded by the rapid rise of the non-state sector. Not required to provide their employees with medical benefits, the upsurge of private and foreign invested firms further threatened access to healthcare coverage for workers and their dependants.

The economic reform also gradually crumpled the financial base of the GIS financing system. Fiscal decentralisation shifted an increasing share of social expenditures to sub-national governments and thus created pressures on them to meet such costs from locally-generated revenues. Increased fiscal autonomy was beneficial for governments in relatively advanced regions, and particularly good for governments in regions along the east coast that formerly had to remit revenues to the central government. In contrast, the weakened fiscal transfer capability of the central government hurt underdeveloped regions. Handicapped by their poor natural endowment and thin tax bases, governments in inland areas could often not afford to provide adequate health services for their employees. Combined with growing regional economic disparities,³⁰ the unequal distribution of fiscal resources across local authorities gave rise to huge gaps in the provision of health care. Although the GIS was nationally mandated, from the early 1990s onwards medical benefits began to vary vastly between different administrative jurisdictions, depending on the funds available to their respective governments.

In order to extend health insurance to the non-state sector, and to pool large health risks beyond individual firms and individual localities, the government began in the 1990s to experiment with a range of new health

insurance schemes. Eventually, in 1999, a new Basic Medical Insurance System for Urban Employees emerged to replace the two old urban healthcare schemes.

Unlike the GIS and LIS, which had been solely financed by employers (SOEs or the government), financing for the new system was based on joint contributions from employers and employees. The new system extended its scope along two dimensions. First, it required all employees (including retirees) to participate, no matter who they worked for – government agencies, SOEs, collective-owned enterprises, private firms, or otherwise. Second, risk-pooling was no longer limited to individual work units. Rather, a citywide health insurance for catastrophic diseases was built up to cover all units within the jurisdiction. Together, the broad coverage and city-wide pooling were expected to minimize adverse selection (that is, the danger that only people with higher health risks might participate) and to establish a reliable mechanism that could share the health risks of retirees, and of the employees of loss-making firms, among all the firms in the area.

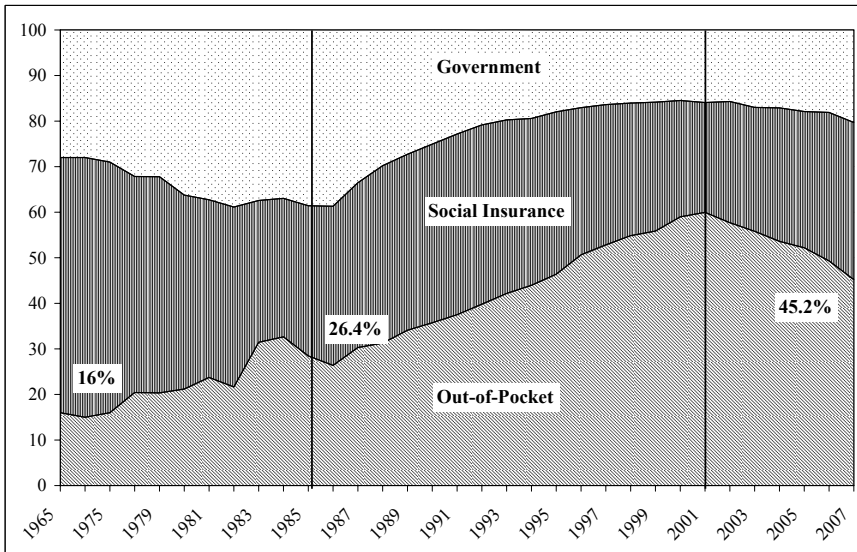
However, employees' dependants were no longer covered. Also excluded were the self-employed, workers in informal sectors, and migrant workers. Whereas the coverage of health insurance was nearly universal for the urban population at the onset of economic reforms, by the end of 2003 only roughly half of urban residents were insured. Were migrants to be counted in, the rate of coverage would be even lower.

Ideological shift aside, the economic reform also critically enfeebled the government's ability to deliver social welfare even if it was so desired. At the core of Deng Xiaoping's reform programme was decentralisation. The massive fiscal decentralisation implemented between 1978 and 1993 might have been instrumental in generating high economic growth in those years, but it also significantly weakened the government's extractive capacity. In the 18 years between 1978 and 1995, the ratio of total government revenue to GDP fell from 31.2 per cent to around 10.7 per cent (Figure 4). Moreover, the central government's share in overall government revenues declined. Even compared to low-income countries, the extractive capacity of the Chinese government in general, and of the central government in particular, was rather weak.³¹ With so little at its disposal, the central government simply could no longer afford to serve as the payer of last resort in health care.

The government's unwillingness and inability to shoulder the responsibility of primary health care for all is evident in Figure 2. Before the economic reform, the government's fiscal allocation and social insurance accounted for more than 80 per cent of the country's total health expenses. In the course of the economic reform, however, both the fiscal allocation and the social

spending dropped dramatically, reaching a nadir at the beginning of the new century. By 2001, the share of the government's allocation in total health spending had decreased to 15.93 per cent, and the share of social insurance to 24.1 per cent. Their combined share was barely 40 per cent. The shrinkage of the governmental allocation and social insurance caused a skyrocketing of peoples' out-of-pocket payments. In 1975, Chinese people's out-of-pocket payments had only accounted for 16 per cent, but by 2000-2001 it had increased to nearly 60 per cent. In other words, China's healthcare system effectively became a system funded mainly by private sources, while public sources only filled up the blanks here and there. This transformation fundamentally shifted the responsibility for health care from government and society to individuals. By the beginning of the new century, China's reliance on out-of-pocket payments exceeded that of most countries in the world. Even compared only to developing countries, China was still an outlier, which meant that China's healthcare system became one of the most commercialised in the world.³²

Figure 2: Structure of Total Health Expenditure



Whether health costs are borne by individual or by public sources is certainly not just a question of whether money comes out of the left pocket or the right. When medical costs are primarily borne by public sources, even poor people may enjoy a minimum level of health care. When health costs are primarily borne by individuals, however, the distribution of income and wealth largely determines who has access to necessary health care, because

the market only serves the consumers who are capable of paying the bill. Relying on the free market to finance and provide health care would inevitably lead to reduced access to health services for the poor and the vulnerable. This was precisely what happened in China. The marketisation of health care was particularly detrimental to the wellbeing of the poor. While the rich could enjoy first-class medical care by international standards, the poor were often forced to endure minor health problems and put off dealing with major health conditions.

Based on data from four national health services surveys conducted by China's Ministry of Health from 1993 through 2008, Table 1 shows rates of foregone medical care (outpatient and inpatient). Evidently, the marketisation of health care created access barriers for many people.

**Table 1: Rate of Foregone Medical Care
Due to Cost Concerns from 1993 to 2008**

	Foregone Outpatient Care Due to Cost			Foregone Inpatient Care Due to Cost		
	Total	Urban	Rural	Total	Urban	Rural
1993	5.2	1.8	6.7	20.1	10.7	24.6
1998	13.8	16.1	12	21	17.7	25.1
2003	18.7	20.7	17.7	20.7	15.6	22.8
2008	5.69			14.7		

There was a marked rise in the percentage of people not seeking care for economic reasons. In 1993, only a tiny fraction of urban residents (1.8 per cent) who reported feeling sick during the two weeks prior to the interview did not seek outpatient treatment due to cost concerns. The ratio quickly climbed to 16.1 per cent in 1998 and 20.7 per cent in 2003.³³ The proportion of rural residents who were sick but did not seek outpatient care due to cost concerns also increased continuously from 6.7 per cent in 1993 to 17.7 per cent in 2003.

The proportion of urban and rural residents who reported having refused to be hospitalised against professional advice in the year before the interview also rose between 1993 and 1998. The most important reason for not seeking inpatient care was, again, fear of being unable to pay hospital fees. Inability to pay was the reason given by 10.7 per cent of urban patients who refused to be hospitalised when they should have been in 1993; the ratio soared to 17.7 per cent in 1998, before falling to 15.6 per cent in 2003. Marketisation of medical services started in rural areas in the 1980s and only

became pervasive in the cities during the mid-1990s. Therefore, as early as 1993, about a quarter of rural residents who refused inpatient care did so due to cost concerns. Thereafter the ratio remained around this level.

Table 1 shows that the growing financial burden engendered by market-oriented health reform prevented a large segment of the population from accessing the existing healthcare services. Furthermore, a comparison of the survey results for 1993, 1998 and 2003 demonstrates how quickly income became a critical factor in deciding who received healthcare services and who did not. In 1993, income level did not seem to have played a significant role in determining whether or not one sought outpatient care. In fact, the proportion of urban residents who reported feeling sick but not seeking care was higher in the middle three income quintiles than in the lowest quintile, and the difference between the lowest and highest quintile was almost negligible. After 1998, however, low income became a factor that severely limited urban residents' health seeking behaviour. By 2003, nearly two-third of the lowest quintile did not seek outpatient care while only 45.2 per cent of the highest quintile did the same. With regard to inpatient care, a gradient by income quintile was already visible in 1993. By 2003, the gradient had become much steeper (Table 2). Among rural patients, income had already been decisive in 1993, but the income-related inequality in foregone health care grew stronger in 1998 and 2003.³⁴

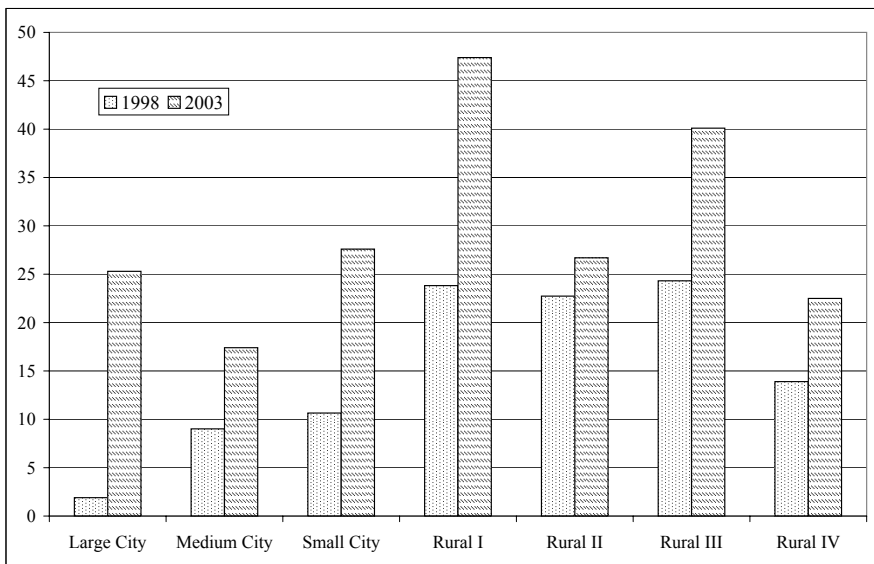
Table 2: Proportion of Urban Residents 'Not Seeking Care' by Income Quintile

Income Quintile	Lowest	II	III	IV	Highest
Year	Not seeking outpatient care in the last two weeks%				
1993	37.50	42.70	40.20	39.40	35.90
1998	49.10	46.10	44.10	45.50	39.90
2003	60.20	57.70	54.20	51.20	45.20
Year	Not seeking inpatient care in the last year%				
1993	31.67	23.84	22.42	21.04	16.87
1998	46.80	42.60	33.00	29.00	27.40
2003	41.58	32.30	22.73	28.23	17.18

When the poor were forced to endure minor diseases and delay treatment of major ones, minor health problems could become major ones, and major health problems could lead to the loss of the ability to work. The vicious cycle of 'illness due to poverty' and 'poverty due to illness' became a prominent social problem in urban China around the turn of the century. Massive medical bills or the loss of the ability to work brought many people's standard

of living below the poverty line. When the Ministry of Health conducted its 'Second National Health Services Survey' in 1998, disease and injury had not yet become a major cause of poverty in large cities: less than 2 per cent of people living below the poverty line attributed their misfortune to 'illness or disability'. But in medium- to small-sized cities, about 10 per cent of poor people were poor because of illnesses or disability. By 2003 the percentage of illness-caused poverty reached a quarter of the total urban poor (Table 3). Evidently, at that time one case of major illness could sink a once well-off family into dire straits and make a poor family absolutely impoverished.

Figure 3: Illness and Disability as Causes of Poverty per cent³⁵



The same national health services surveys found that the role of illness in aggravating poverty was more pronounced in rural China. The 'Second National Health Services Survey' in 1998 had already found that disease and disability were a major cause of rural poverty. By the time China conducted its third survey in 2003, a third (33.4 per cent) of rural poor families had at least one member with a chronic disease or disability. By that time illness had become the single most important cause of rural poverty.³⁶ The heart-rending saying of rural people – 'we don't fear being poor, just getting sick' – stemmed precisely from the serious threat that illness poses not just to poor people's health but to their very livelihoods.

The data shown above indicate that behind China's macro-level economic prosperity there was a relatively large segment of poor households that could not access existing health care. When they were sick, they did not dare see

a doctor; when they were seriously ill, they did not dare enter hospital; and when they were hospitalised they rushed out before they were well, afraid of being crushed by the heavy financial burden.

THE COUNTER-MOVEMENT

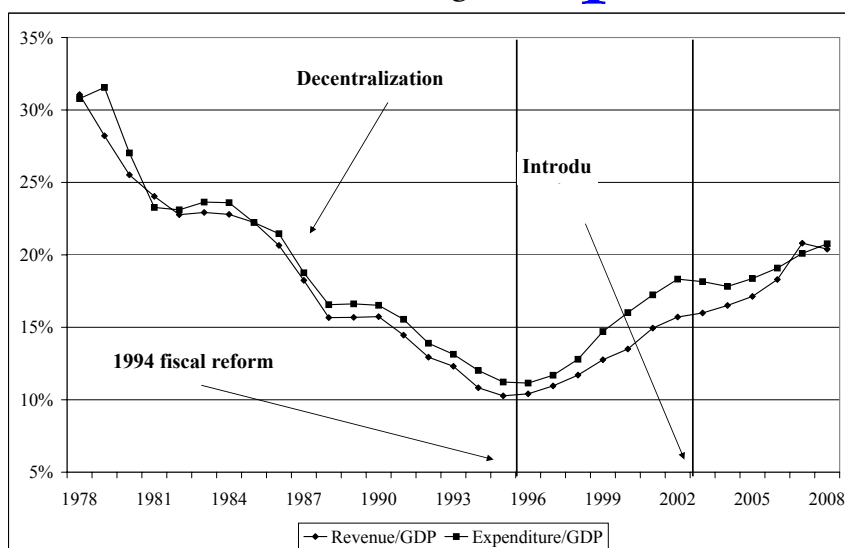
Karl Polanyi is absolutely right when he argues that a fully self-regulating market is a brute force, because creating a self-regulating market economy requires that human beings and the natural environment be turned into pure commodities, which assures the destruction of both society and the natural environment. Although China experienced perhaps the highest economic growth in the world in the 1980s and 1990s, the blind pursuit of high GDP growth rates gave rise to a host of serious problems. Such problems were perhaps not pronounced at the initial stage of reform, but as time went by they became increasingly evident and by the late 1990s some problems became critical. Around that time people's livelihoods became almost completely dependent on markets. Since markets only served people who had money, or who could show that they were capable of repaying their debts, ordinary workers and farmers had much less security than before. In their view, the burdens imposed on them by market forces were too heavy, even unbearable.

In this context the golden banner of market reform became tattered and the consensus on it was broken. The classes of people whose interests were hurt, or who were insufficiently enriched in the previous round of reform, no longer lent unreserved support to new market-oriented reform initiatives; on the contrary, they fretted about every move labelled with the terms 'market' and 'reform' for fear of getting hurt again. These people generally believed that China's reform had gone astray and that it was time to stress economic and social development in a coordinated way. Prompted by this uproar there arose a protective countermovement aiming at enabling people to maintain 'a livelihood without reliance on the market'.³⁷ The government began to move gradually away from the reform strategy that had been based on 'the Washington Consensus' and to adopt what Stiglitz calls the 'second generation reform', concerned as much with human security and distributive justice as with economic growth.³⁸ Since 2002 the government has put more and more money into safety-net building in general, and health care in particular (Figure 2). The share of individual out-of-pocket payment in China's total health expenditure plunged, from 60 per cent in 2001 to about 45 per cent in 2007, the latest year for which data is available. It is expected the ratio will further decline to around 30 per cent in few years.

The counter-movement in the area of healthcare surfaced first in rural

China in 2002. As early as the late 1980s, the Chinese government had already pledged to the World Health Organization that China would fully improve primary health care in rural areas by 2000.³⁹ To this end, the government set itself the mission of 'restoring and rebuilding' the rural CMS. During the entire 1990s, however, the government still wanted to avoid responsibility for financing the system because at that point it was experiencing the most horrendous financial crisis: the government's fiscal revenue as a percentage of GDP barely exceeded 10 per cent and the proportion of the central government's fiscal revenue in GDP was merely 5 per cent (Figure 4). At that time, even if the government did not shirk responsibility for the farmers' health security, it was financially incapable of funding the cooperative medical scheme.

Figure 4: Chinese Government's Fiscal Revenue/Expenditure as a Percentage of GDP



For this reason, throughout the 1990s, the government still insisted that the rural CMS should 'raise funds primarily from individual contributions, supplemented by collectively pooled subsidies and supported by government policies'. As a result, after a decade-long endeavour, the rural CMS was not restored as anticipated and its coverage remained below 10 per cent. Worse yet, even such a poor coverage base risked being eroded, thereby falling prey to a vicious circle of 'start-retreat-collapse-restart', 'getting started in the spring, going bust in the fall'.⁴⁰

The tax-sharing reform initiated in 1994 swiftly reversed the perilous

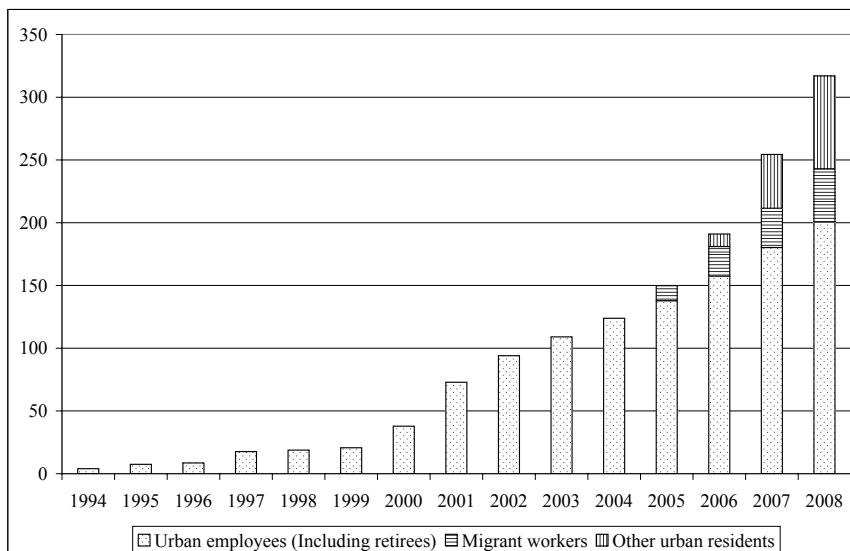
declining trend of the government's extractive capacity. As shown in Figure 4, by 2002 the Chinese government's fiscal revenue as a percentage of GDP rose to 16 per cent, while the central government's fiscal revenue as a proportion of GDP rose to 9 per cent. Only by that time did the government gain the fiscal capability to fund the rural cooperative medical scheme. Thus a drastic change in the government's rural healthcare policy at that time came as no surprise.

In October 2002, the government adopted a new approach towards the rural CMS. In a jointly promulgated *The Decision on Further Boosting Rural Healthcare Endeavor*, the Central Committee of the Chinese Communist Party and the State Council declared that the country would gradually set up a 'New Cooperative Medical System' (NCMS) and ultimately expand it to cover all rural residents by 2010.⁴¹ The main difference between the NCMS and the traditional CMS lies in public financial involvement: in addition to an annual contribution from participating rural residents (RMB 10 per head in 2003, RMB 20 per head in 2008), the central and local treasury offer a specific amount of annual subsidy for each NCMS participant (RMB 20 per head in 2003, RMB 40 in 2005, and RMB 80 in 2008).⁴² In addition, the *Decision* pledged to provide medical assistance for poor rural residents who could not afford to pay.⁴³

The injection of public funds has vigorously pushed forward the rapid development of the NCMS, in stark contrast with past practice (as shown in Figure 1, above, on the trends from 1955 to 2008). In 2003, when the Ministry of Health conducted its Third National Healthcare Service Survey, the rural CMS only covered 9.5 per cent of the rural population. Five years later, by the end of 2008, the NCMS had covered nearly all administrative villages in the whole country, with 815 million participants, accounting for 91.5 per cent of China's rural population.⁴⁴ Thus, after nearly sixty years of development through several twists and turns, the cooperative healthcare system finally reached an all-time high.

In urban China, various medical insurance schemes have also developed very fast since 2002 (Figure 5). The number of active employees who joined the Basic Medical Insurance System for Urban Employees, for instance, multiplied from 45.4 million in 1998 to 200.5 million in 2008. It should be noted that this basic medical insurance scheme also covers retirees, so that the people who tend to have the most fragile health benefit from it. During the same period, the number of retirees covered increased from 5.6 million to about 50 million, accounting for more than 80 per cent of retirees, proportionally much higher than the coverage of younger, active employees.

Figure 5: The Coverage of Basic Medical Insurance Schemes for Urban Residents (Million)



Starting around 2005 some cities began experimentally to provide medical care to other non-working urban residents. Approximately 10 million more people joined such medical care insurance schemes by the end of 2006. Finally, to achieve ‘seamless’ coverage for all urban residents, the State Council decided at its executive meeting in April 2007 to pilot a Basic Medical Insurance for Urban Residents in 88 cities. This new system aimed at covering all those who were not eligible for the Basic Medical Insurance for Urban Employees, such as children, students, the elderly, and other non-employed urban residents. Then, in February 2008, the central government decided to expand the experiment to a half of all Chinese cities. By the end of 2008, an additional 74.01 million urban residents had joined the scheme. This medical insurance scheme is expected to become fully established in all cities in China by 2010.⁴⁵

Medical insurance for migrant workers is more complicated because they tend to be unwilling to participate in insurance due to their young age and high mobility, and because their employers are reluctant to pay for their insurance. In the late 2002 and early 2003, Shanghai and Chengdu began to pilot a system designed to provide migrant workers with comprehensive insurance. In 2003 and 2004 the Ministry of Labour and Social Security stepped in, requiring local governments to cover all migrant workers who had formed stable working relationships with their employers.

A turning-point came in March 2006, when the State Council issued

Opinions on Solving Migrant Worker Problems, stressing ‘the top urgency of solving medical care problems for migrant workers on serious diseases’ and placing migrant worker medical insurance issues in a prominent position on the agenda. The Ministry of Labour and Social Security subsequently set an objective of ‘striving to increase the number of migrant worker participating in medical insurance to 20 million by the end of 2006 ... striving to cover all migrant workers (who have entered into long-term working relationship with urban employers) with medical insurance by the end of 2008’. This signals entry of migrant worker medical care into a new ‘push’ stage. Each locality responded swiftly with ‘opinions’, ‘regulations’ and ‘measures’ to solve migrant workers’ medical care problems.⁴⁶ The number of migrant workers participating in medical insurance reached 23.67 million by the end of 2006, and rose to 42.49 million by the end of 2008 (Figure 5).⁴⁷

Finally, on April 6, 2009, after three years of preparation, including months of public consultation, China announced the outlines of a comprehensive reform of its healthcare system that pledged to extend some form of basic health insurance to 90 per cent of the population by the end of 2011, and to provide ‘safe, effective, convenient and affordable’ basic health services to all citizens by 2020. With five medical care schemes (that is, Basic Medical Insurance for Urban Employees, Basic Medical Insurance for Urban Residents, Basic Medical Insurance for Migrant Workers, New Rural Cooperative Medical Scheme, and Medical Assistance to Rural and Urban Residents) already in place, and covering 41.65 billion of the country’s 1.32 billion people by the end of 2008, China should have little difficulty in achieving these goals.

Good health is both intrinsic to human wellbeing and instrumental to a whole range of human functioning.⁴⁸ The absence of good health can deprive people of their right to exercise choices, pursue social opportunities and plan for their future. Moreover, cross-national comparisons have established that a healthy population can help alleviate poverty, reduce wider social inequality, and enhance economic growth.⁴⁹ For both ethical and practical reasons, therefore, ensuring the health of every citizen must be an important goal for policymakers of any country, but particularly China, a country that still professes to uphold the socialist principle of equity. In Mao’s era the health of the population was one of the country’s proudest boasts. But the market-oriented reforms of the 1980s and 1990s gradually shattered the country’s social safety nets, including its once famous healthcare system, making it difficult for many rural and urban residents to afford treatment. In reaction to this, a burgeoning protective counter-movement emerged in recent years. A growing number of people, including government decision-

makers, have come to realize not only that relying primarily on the free market to finance and provide health care would inevitably lead to reduced access to health services for the poor and the vulnerable, but that since health is so important to everyone's wellbeing, it should never be allowed to flounder at the mercy of the market. The Chinese government has now committed itself to restoring an affordable and equitable healthcare system. With both political will and fiscal capacity on the part of the government in place, China should be able to universalize access to basic healthcare again, as it did thirty years ago.

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