

Chinese healthcare policy: the occidental European influence on the restructuring after 1978¹

Política de saúde na China: a influência ocidental europeia em suas reformas a partir de 1978

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Abstract

This paper intends to study the health policy in China. It starts from the hypothesis that the changes brought by the political and opening-up reform after 1978 are not configured by an “Americanization” process (implementation of the neoliberal project), but by an European occidentalization process based on the social services of the Welfare State of the “thirty glorious years”. This process has a contributory character, through the introduction of social insurance in the constitution of China’s social security system and, consequently, in its health systems. This results in a throwback in the health policy’s collective and universal character, with problems to face regarding access and the financing of the health systems existing today, if we compare the Maoist period with the period after the political and opening-up reform launched by Deng Xiaoping. This situation brings to China the big challenge of creating strategies and reforms to ensure coverage of access to health services and equipment to its large population.

Keywords: Chinese Healthcare Policy; Economic Planning; State Reforms.

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Resumo

Pretendeu-se estudar a política de saúde na China sob a hipótese de que as mudanças sofridas pela reforma política e de abertura a partir de 1978 não se configuram por um processo de “americanização” (implantação do projeto neoliberal), mas por um processo de ocidentalização europeia, sob o pilar dos serviços sociais do bem-estar social dos “trinta anos gloriosos”, de caráter contributivo, através da introdução dos seguros sociais na constituição de seu sistema de segurança social e, por conseguinte, nos seus regimes de saúde. Comparada com o período maoísta, a reforma política e o processo de abertura iniciado por Deng Xiaoping resultou em um retrocesso ao caráter coletivo e universalista do sistema de saúde chinês, com o enfrentamento de problemas de acesso e financiamento da saúde, nos dias atuais. Isso ocasiona à China o grande desafio de criar estratégias e promover reformas para garantir a cobertura do acesso aos serviços e equipamentos de saúde a sua numerosa população.

Palavras-chave: Política de Saúde Chinesa, Planejamento Econômico, Reformas Estatais.

Introduction

This article presents the results of a study about the social healthcare policy in China and its particularities concerning the following dimensions: nature, access and coverage (universal and/or segmented); financing sources (taxes, social contributions, private and/or public insurance, direct payment); integration between financing agencies and health service providers (identification and quantification of financing agencies/providers in national or local systems and the presence of governmental agencies - Ministry of Health, Departments, etc.); and nature of the ownership of equipment and services (public, private or philanthropic).

This study was carried out in light of China's experience of economic growth in the 20th and 21st centuries, with the historical delimitation of the establishment of the People's Republic of China in 1949, and with the advent of the Socialist Revolution, under the command of Mao Zedong. Mao was the first representative of generations of leaders of the Communist Party of China (CPC), followed by Deng Xiaoping (second generation), Jiang Zemin (third generation), Hu Jintao (fourth generation) and Xi Jinping (fifth generation and the current president of the People's Republic of China).

This effort to understand the Chinese social healthcare policy is justified by the scarce academic debate on this theme. In this study, we consider the reality and peculiarities of a country that, according to the official discourses, is in the long road to socialism, even with the fall of real socialism in the USRR, which ceased to exist in 1991. Many studies on the principles of social policy refer to works that focus on this theme in the context of capitalist nations, not in China. In the case of European countries, according to Mishra (1995), Rosanvallón (1998) and Castel (1999), the implementation of the neoliberal project and the dissolution of the Welfare State have caused the end of the perspective of full employment and universal social services, structural unemployment, poverty and the need to implement minimum survival standards. These minimum standards are justified by a public financing “crisis” whose adhesion criteria are grounded on solidarity or meritocracy principles. Another

approach, according to Coimbra (1987), Romero (1998) and Pereira (2007), is the theoretical study of social policies in order to present the different lines: liberal, social-democratic and Marxist, based on models and typologies grounded on Weber's ideal type, without considering these policies within their conjuncture and historical context nor their internal and external particularities. In this perspective, in Latin America, particularly in Brazil, authors like Behring (2002, 2003, 2008, 2010), Danani (2010), Carvalho (2003) and Salvador (2010) deal with the condition of public social security in a logic of loss and restriction of social rights, of a financing "crisis" and fiscal adjustment.

In this perspective, we studied the healthcare policy in China, which underwent changes brought by the implementation of the economic and political reforms at the end of the 1970s and beginning of the 1980s. According to our hypothesis, these changes are not configured as an "Americanization" process (implementation of the neoliberal project), but as a process influenced by the European occidentalization, based on the universal social services of the Welfare State of the "thirty glorious years"². This process has a contributory character, through the introduction of social insurance in the constitution of China's social security/protection system and, consequently, in its healthcare systems. However, there was a throwback in some aspects of these policies in comparison with the Maoist period, during which these policies were characterized by their collective and universal nature.

Our defense is motivated by a broader debate between two perspectives that analyze the social direction given to the reforms implemented by Deng Xiaoping at the end of the 1970s and in the 1980s. In the first perspective, some authors argue that the general direction of the reforms has a capitalist and "neoliberal" character³, targeted at reducing the government's role in the provision of social assistance and at increasing the individual's responsibility for

social security/protection and welfare, including health. However, it has been observed that the Chinese government does not intend to create a social welfare system that is entirely privatized.

The second perspective defends that the present and future of health reforms were and must be analyzed in light of two primordial objectives of the governmental policy: economic development together with the maintenance of social/political stability aiming at socialism. In this sense, some authors, like Xiping Guan (2000), characterize the social policy in the Mao Zedong era as "traditional", to distinguish it from the proposals of the reforms that have been implemented from 1978 onwards. We will also use the term "traditional" to refer to the organization and financing of the healthcare policy in the Maoist era. We believe that there is no rupture of its nature between the governments of the first and of the other generations of Chinese leaders (that is, from Mao to the current days) concerning the society project in the long road of transition to socialism.

Thus, we agree with Samir Amin (2013) when he says that China has taken a peculiar path from 1980 onwards, but since the 1950s, it has undergone diverse stages and presented very distinct aspects in favor of a coherent project that is able to meet the needs of the Chinese population. The project of construction of a "socialism with Chinese characteristics" is not characterized as capitalism because the land is not treated as a commodity and China remains linked to a private logic of contemporary financial globalization.⁴ Nevertheless, using the words of the author himself:

The fact that the Chinese project is not capitalist does not mean that it "is" socialist, only that it makes it possible to advance on the long road to socialism. Nevertheless, it is also still threatened with a drift that moves it off that road and ends up with a return, pure and simple, to capitalism. (Amin, 2013, p. 7).

² It refers to the so-called "Golden Age" of capitalism, the boom in economic growth between the end of the Second World War and the beginning of the 1970s. This meant improvements in the Europeans' living conditions established by pacts signed between capital and work through the adoption of Keynesian policies, aiming at full employment and the Welfare State institutions (Harvey, 2005; Rosanvallon, 1998; Castel, 1999).

³ See Harvey, 2005; Nabuco, 2009, 2011.

⁴ See Amin (2013).

The traditional healthcare policy: the Mao Zedong era (1949-1976)

The seizure of power by Mao Tse-Tung in 1949 occurred in the midst of social chaos: the country was devastated by the war against the Japanese occupation and also by the civil war it had faced against the nationalists. The economic scenario was far from stable: agriculture had been ruined and the existent (rudimentary) industry had been destroyed (...). It is in this context that the consensus about the need of an extensive and efficient agrarian reform emerges. We can describe the Chinese economy at that moment as dual, composed of a vast agricultural territory with few “industrial” cities surrounding it. The economy was largely dependent on agriculture, with 80% of the population in the rural area and more than 70% of the GDP coming from the primary sector (Milaré; Diegues, 2012, p. 4).

Despite all the Chinese difficulties in the context of Mao’s era, authors like Guan (2000) and Ramesh and Wu (2009) agree that there was a high level of social healthcare provisions targeted at the low-income population. Some authors state that, in comparison with the proportion of expenses of the European countries, social welfare was tackled in a low-income country (Liu; Zhang, 1989; Guan, 1995), especially considering the Chinese urban state sector.

According to Xinping Guan (2000), this was possible due to the basic conditions of the traditional healthcare policy, based on a socialist economic system and presenting three fundamental characteristics: the public ownership of the means of production, a centrally planned economy system and an egalitarian ideology.

In the case of the first characteristic, for example, it is known that, in the agrarian reform movement of the 1950s, the ownership of almost all the means of production became public, in two forms: state-owned and collective, and rural and urban. The collectivization of ownership and production was the essential basis to the central government’s intervention in social affairs, at different levels. This was a fundamental step to the constitution of a centrally planned economy system, in which the government controlled the most important resources and procedures related to the economic activity. The government, in turn, provided resources to develop diverse social welfare experiences, including the organization of the healthcare system. Although the healthcare services were distinct, they should guarantee access in an egalitarian way, and the government (at the local, provincial or central level⁵) played an active role in all of them.

Thus, Mao’s governmental program for the healthcare policy in urban and rural areas can be summarized according to the table below:

Table 1 – Characteristics of the healthcare systems in the Mao Zedong era, China, after 1978

| Urban areas | Rural areas |
|--|--|
| <ol style="list-style-type: none"> 1. Preventive health action organized and financed by the government and state-owned enterprises. 2. Public hospital system financed by the government and state-owned enterprises, resulting in low prices for medical care. 3. Free medical assistance for State employees and government personnel. | <ol style="list-style-type: none"> 1. Preventive health action organized and financed by collective organizations and subsidized by the government. 2. Rural cooperative medical system based on the rural collective economy. |

Source: Guan, 2000, p. 116.

⁵ “Fairbank and Goldman (2007, p. 326-328) state that, from 1958 onwards, seven ‘production groups’ at the village level (each of the five million groups with approximately 150 people) started to form a ‘brigade’ and fifteen brigades, a popular commune of approximately 15,000 people. Above 70,000 communes, 2,000 counties and almost 30 provincial regions, the PRC central government outlined the general lines of the agricultural production and distributed part of it” (Silva; Vargas; Venturini, 2013, p. 3).

According to Ramesh and Wu (2009, p. 2257), this program refers to the three social security schemes: Government Insurance Scheme (GIS), for the government's employees; Labor Insurance Scheme (LIS), for the urban population; and the Cooperative Medical System (CMS), for the rural population. The GIS was financed by the government's budget and covered all the government's employees at the time: retired and disabled, teachers and university students. The LIS was financed by state-owned enterprises beyond their social security fund (11%-14% of the salary); its employees received health services free of charge, while their dependents could request a reimburse of up to 50% of the medical expenses. The CMS, in turn, was operated at the village level and was financed through rural social security funds and participants' contributions.

It is important to highlight that the majority of the population was covered by one of these three schemes and the Chinese population's health status improved significantly: between 1952 and 1982, the infant mortality rate decreased from 200 to 34 per one thousand live births, while life expectancy increased from 35 to 68 years.⁶ These achievements also reflected the amplification of infrastructure⁷ and of the health network: in 1949, there were 2,600 hospitals, and this figure had increased 24 times by 1975: 62,425 hospitals. The expansion of maternity hospitals and children healthcare centers was even more significant: in 1949, there were only 9 units and in 1975, there were 2,025 (SBB, 1996).

In short,

The Chinese health care system until the early 1980s was typical of the type found in centrally planned economies whereby health care was a part of comprehensive social welfare provided by the state (Bloom & Gu, 1997; W.C.L. Hsiao, 1995). The

population had almost universal access to decent primary and hospital care as well as pharmaceuticals. Government agencies and large state-owned enterprises usually operated their own clinics which provided free primary care to their employees. Hospitals and other health facilities were owned by the government and prices were usually set below cost (Yip & Hsiao, 2001). Preventive care was financed by the government and provided free of charge (Ramesh; Wu, 2009, p. 2257).

In an attempt to characterize the specificity of this policy among the others of the Chinese social security⁸, Ricardo Montoro Romero (1998, p. 45) states that it is a "total model", or a "total planning" model, as it intends to guarantee access without eligibility, selectivity and focalization criteria. The reason is that access to health services by means of the communes (rural and urban) and state-owned enterprises is recognized as a socially legitimate need in a public and social intervention program. The author adds that the result of this policy is intrinsically related to the socialist transformation processes applied to production.⁹

However, despite the significant results, the communes and state-owned enterprises faced limits concerning productivity and increases in the national economic surplus (Shu, 2004; Bramall, 2006). This became visible after the adverse results of the "Great Leap Forward" (1958-1962), in addition to climate problems and famine (Duckett, 2011). We can add to this the poor performance of the collective healthcare system in the period of the Cultural Revolution (1966-1976), as the structure in the countryside was considered the main national health policy initiative. Thus, "Facing the crossroads of deciding to maintain the pillars of its socialist model and the healthcare system corresponding to it, or altering them to promote

6 More remarkably, these achievements were reached at a relatively low cost: total health expenditures totaled only 3% of the GDP at the beginning of 1980 (Ramesh; Wu, 2009).

7 "The healthcare system is composed, in this period, of hospitals, asylums, maternity hospitals and children healthcare centers, laboratories for drug and chemical reagent testing (high complexity health services/tertiary care), specialized centers (medium complexity/secondary care), clinics, disease control and sanitation units, medical science institutions (low complexity/primary care) and other institutions (low, medium and high complexity)" (Silva; Vargas; Venturini, 2013, p. 6).

8 The following aspects constitute the Chinese social security in the Maoist era: social insurance, education, health services, employment, housing and social services (orphans, older adults and those who did not have family support) (Guan, 2000).

9 See also Pagoto (2006).

the development of the country's productive forces, the PRC under Deng decided to promote the economic reform" (Silva; Vargas; Venturini, 2013, p. 8).

Healthcare policy in China after the reforms initiated by Deng Xiaoping

In 1978, Deng Xiaoping started to direct China towards an economic restructuring process by means of implementing reform programs and opening the country to foreign trade, aiming to develop the productive forces. These programs were called the "Four Modernizations" (agriculture, industry, national defense and science and technology).

With this purpose, he stimulated the de-collectivization of land through a system of family responsibility¹⁰ and, in July 1979, through the creation of Special Economic Zones (SEZ), with the introduction of direct investments from foreign capital sources. These investors, in turn, would introduce modern technologies and administration methods in China. According to Deng, it was a "market socialism", which, with the modernization program, would integrate the experience of the foreign models into Marxism and the country's reality, in order to build a "[...] socialism with Chinese characteristics" (Marti, 2007, p. 10). In this context,

There was an improvement in the economic conditions of the Chinese population, with a remarkable increase in the *per capita* income (from CNY 133.60 in 1978 to CNY 686.30 in 1990). And it was for the families living in the countryside that this income increase was most significant, even though the absolute values are lower than those of the city, as the urban families increased their *per capita* income by more than CNY 1,000.00 in these twelve years. To the population as a whole and in this same period, the annual *per capita*

consumption increased by 436% and savings per worker rose from CNY 21.88 to CNY 615.24 (Silva; Vargas; Venturini, 2013, p. 9).

However, there is no doubt that the economic reforms that were implemented affected the traditional healthcare policy and changed its basic sustaining conditions (collective ownership, centralized planning and egalitarian ideology) (Guan, 2000). According to Hanhua Liu, Richard Emsley and Graham Dunn (2013), a series of health reforms initiated in the 1980s gradually altered the Maoist universal and collective healthcare system. The central element of the health reform (in the 1980s and 1990s) was the introduction of the market mechanism in public hospitals with the intention of making the healthcare users "cooperate" with the government regarding the financial burden. In this sense, the government gradually reduced its budget for public hospitals. In return, these hospitals were granted an almost unlimited freedom to raise funds. A common practice of the Chinese hospitals was to "maximize" the patients' medical expenditures through, for example, the prescription of more drugs and diagnostic tests.

Ducket (2011) argues that the Cooperative Medical System (CMS), targeted at the rural population, was the one that suffered the greatest impact, as it was gradually abandoned by the Ministry of Health between 1979 and 1981. This contributed to: 1) a reduction in the community funds; 2) an increase in the reimbursement percentage related to drugs; and 3) the integral charge from the health service by cooperatives in which the fund was temporarily low for reimbursement because the local government had failed to pay the financing. "Nevertheless, the official permission for charging fees only authorized what was already happening in many places" (Silva; Vargas; Venturini, 2013, p. 11).

In this conjuncture, the communes were reduced to a minimum. The provision of health services at the workplace was also reduced, and the marketi-

¹⁰ "[...] With the launch of the reforms in 1978, land de-collectivization was promoted by means of the family responsibility system (*bao-chan daohu*), through which the land was distributed among the families in smaller proportions. This resulted, in the medium term, in surplus manpower, which moved to the non-agricultural sector; in addition, there was a progressive increase in labor-intensive productive activities, which resulted in the current process of industrialization and, therefore, in a greater absorption of workers in the cities. Therefore, although China is still predominantly rural, it is clear that the proportion of people in the cities has been increasing over the years (Fernández-Stembridge, 2005, p. 356-357).

zation of the sector occurred. The management of the financing operated at the village level was extinguished. The dissolution of collective farms during the 1980s led to the disappearance of the CMS, and the great majority of the rural population was left without any form of healthcare coverage. At the end of the 1970s, 90% of the rural population had access to care of a reasonable quality and some protection against catastrophic expenditures, but after one decade, this proportion had decreased to 5% (Ramesh; Wu 2009).

In the 1980s, the Government Insurance Scheme (GIS) was also extinguished. It insured state employees (9% of the urban population) and was financed by the central government (Dong, 2009). As for the Labor Insurance Scheme (LIS), it was restructured at the beginning of the 1990s in a gradual way. According to Pomar (2003, p. 122-123),

[...] by winning autonomy, participating in the market and adopting new management methods, the state-owned enterprises increased their efficacy and their profits, and reduced their operating, administrative and directive personnel. At the same time, they were obliged to create re-employment projects and to establish the social security system to maintain the dismissed workers' life standard. The number of its employees decreased from 74 million in 1978 to approximately 25 million in 1995, a figure that has remained the same since then.

But the fact is that this new arrangement negatively affected the capacity of many state-owned enterprises for financing their employees' healthcare. The active and retired employees, as well as their families, were covered by any form of social insurance (except for the urban population - only 45% was insured in some way in 1998). Concerning those who obtained coverage, many times the benefits were reduced in the form of a requirement of higher copayment. Many enterprises with financial problems also started to neglect their commitment to reimburse their employees' medical expenditures (Ramesh; Wu, 2009).

In view of the limits of GIS and LIS, in 1998 the central government launched the Basic Health Insurance Scheme (BHIS), targeted at the urban employees, in order to guarantee the participation

of social risks (in the case of health) among them. BHIS is financed by the contributions of employees (2% of the salary) and employers (6%). Although participation was mandatory to all the governmental agencies and state-owned enterprises, in practice adherence was low. In addition, this system insured neither workers in the informal sector nor migrants, and it did not cover the employees' dependents. As a result, only 28% of all urban inhabitants were covered by the scheme in 2006 (Ramesh; Wu, 2009; Dong, 2009).

Samir Amin (2013) and Xiping Guan (2000) agree that, in the 1990s, the reforms in the healthcare policy were made because of the immediate priority for accelerating the Chinese economic growth and its efficacy. However, they involved not only the health field, but also the entire social welfare system.

The government and most of the researchers believed that it was necessary to reform the welfare system for two basic reasons. First, there were intrinsic features of the traditional system which seemed to run counter to economic efficiency. The welfare system was widely seen as a main source of reduced economic efficiency, because it absorbed too many financial resources which might otherwise be used to accelerate economic growth. Furthermore, the welfare system encouraged dependency and laziness in the workplace, especially in the state enterprises. As a result, the government came to believe that reforming the system was a necessary component of the Reform movement. Meanwhile, second, and more importantly, the welfare system had to be reformed in any case, owing to the changes in socio-economic circumstances brought about by two other profound and lasting developments: market reform and the Open Door policy (Guan, 2000, p. 118).

It is important to highlight that, in 2002, the government tried to implement a rural insurance by means of the Rural Cooperative Medical Scheme (RCMS), in a pilot basis financed by a governmental subsidy of approximately US\$ 2.50 per year and by the associates' annual contribution of US\$ 1.25. This system ensures hospitalization only (high complexity and outpatient clinic assistance), under

a high franchise rate. Adhesion to it is voluntary. It is subsidized by the local and central governments (*per capita* contribution per rural resident/year). Nevertheless, this contribution represents less than one third of the *per capita* health expenditures in the rural areas (Ramesh; Wu, 2009). Generally speaking, RCMS:

Was instituted aiming to combat the problems generated by excessive expenditures on critical diseases, monitored by WHO indicators. The local governments' significant autonomy to manage these insurances and their reimbursement policy grants an extreme diversity to them due to the profile of the local governments: whether they are from richer regions, whether they are more involved in the health issue, whether they are less involved in corruption problems in the use of resources. According to Dong (2009, p. 593), at the end of 2007, 85.6% of the counties had already implemented the system and 86.2% of the peasants were insured (Silva; Vargas; Venturini, 2013, p. 17).

It is possible to notice that these market-oriented health reforms created a problem of access to care for the Chinese, mainly because of the government's exoneration from health expenses. The Ministry of Health revealed this by saying, in 2000, that these costs had increased to a very high level, even to middle-income families, without any form of subsidy. More than 63% of the urban patients did not look for hospital assistance when necessary, and the main reason for this was that the doctor was expensive (Liu; Emsley; Dunn, 2013). According to Blumenthal and Hsiao (2005), this was caused by the modification in the system of doctors' salaries, in which variable bonuses were included, deriving from sales of drugs and from expensive services that the doctor performed to the hospital.

Consequently, there was a boom in the global health expenses, and drug expenditures reached half of the expenses in 2002.¹¹ In the subsequent years, health expenses continued to increase sharply, as it was observed in 2009: China's private health expenses was 49.9% of total expenses, while in the United Kingdom, in the same year, it was 16.4%. In fact, health problems not only caused difficulties to the Chinese population, but they also represented political risks to the government:

The rising inequality in access to health care severely undermines the government's professed commitment to "harmonious society". Realizing the problems, the Sixth Plenary Session of the Communist Party's Central Committee in 2006 specifically identified health care reform as a national priority, and the government has committed to achieve universal health coverage by 2020. Despite the urgency of the problems and high-level political commitment, reforms have been slow due to sharp divisions among experts and government departments over reform directions (Ramesh; Wu, 2009, p. 2258).

One of the initiatives of China's central government when it realized the gravity of the problem, in 2007, was to entrust to nine organizations - the World Bank, the World Health Organization, Peking University and the McKinsey Institute among them - the recommendations to the healthcare system reform. Subsequently, in March 2008, the prime minister Wen Jiabo announced, in a speech, a 25% increase in the government's health expenses. Along this line, two reform proposals should be highlighted: the first dealt with a substantial increase in the budget for public hospitals and other state-owned health facilities, so that they could provide primary care free of charge or charging very reduced prices.¹² The

¹¹ "Thus, as a consequence of a new guiding logic, radically grounded on pecuniary gain, PRC's healthcare system, despite maintaining its state character, was reoriented towards the remunerated provision of services and drugs of higher technological complexity. At the same time, it made the equipment used in primary care recede, as well as essential assistance or drugs, whose price was controlled by the central government. This caused the expansion of Specialized Centers and Medical Science Institutions targeted at the most profitable areas of the system" (Silva; Vargas; Venturini, 2013, p. 13).

¹² Its defenders argue that the massive increase in total health expenses in the past was stimulated by the reduction in budget allocation to public hospitals, which obliged them to increase their revenues by prescribing expensive drugs and unnecessary treatments (Ramesh; Wu, 2009).

second proposal established the expansion of the health insurance subsidized by the government to approximately 80% of the population that was not covered by any form of insurance¹³ (Ramesh; Wu, 2009). According to these authors, there are clear signs that the two proposals have guided the reforms conducted by the Chinese government in current times.

One characteristic that is common to both reform proposals is that they concentrated on increasing public health expenses as a solution to the problems that the country was facing in this area. Ramesh and Wu (2009) argue that spending more money could seem to be easy in the context of the increasing revenues of the Chinese government, but increasing the public health expenses would not necessarily lead to better results. The planned expansion of health insurance could undoubtedly improve access to healthcare, but critical issues of efficiency, quality of the services and their financial sustainability remained unsolved.

One alternative emerged in February 2008, when the government announced an insurance premium subsidy of at least 40 Yuan to each urban dweller without insurance (Ramesh, Wu, 2009; Dong, 2009). However, Liu, Emsley and Dunn (2013) argue that it was in April 2009 that the Chinese government launched its large-scale health reform, with the aim of reestablishing the universal system that would provide primary care accessible to all. To meet this goal, the government would amplify the health financing by means of central and local budgets. The central government promised to spend 850 billion Yuan in the initial stage of the implementation plan, from 2009 to 2011. Two strategies were conceived and proposed to reach this objective: the first was to establish a public health insurance system so that all the Chinese were covered by an adequate health insurance scheme; the second was the reform of public hospitals, which would once again play the key role they had had in the Maoist regime.

According to Yip and Hsiao (2009), the purposes of this initiative were: 1) to expand health insurance coverage aiming at its universality by 2011,

stimulating adhesion to the voluntary insurance of the Rural Cooperative Medical Scheme (RCMS) and of the Basic Health Insurance Scheme (BHIS); 2) to increase the government's public health expenses, mainly in low-income regions, in order to homogenize expenditures in different regions; 3) to establish healthcare centers for primary care; 4) to implement reforms in the pharmaceutical market; and 5) to carry out pilot projects in public hospitals.

According to Liu, Emsley and Dunn (2013) and to Keyong Dong (2009), public health insurances were re-implemented by the April 2009 reform, encompassing four schemes and their respective target audiences. The first one was the Government Insurance Scheme (GIS). As it was mentioned above, it was established for the first time at the beginning of 1950, and now it would cover again the institutional population, including government employees (civil servants), public workers (military personnel) and the academic population (teachers and students). The second was the Labor Insurance Scheme (LIS). Also established at the beginning of 1950, LIS would cover the population in formal employment, both in state-owned and private enterprises. The third was the Urban Social Insurance Scheme (USIS). Created in 2000, USIS would cover the population that lived in urban areas or cities not covered by GIS and LIS – for example, autonomous workers, unemployed individuals and retired workers. Its main aim:

[...] is to reduce the impacts that medical expenditures in the case of chronic diseases cause in terms of impoverishment of individuals and families, focusing on hospitalization and outpatient services related to chronic and fatal diseases, such as diabetes, heart diseases, etc. The insurance premium is higher than the New Cooperative Medical Insurance, but lower than the Basic Medical Insurance for Urban Employees. The government's participation is variable (although it cannot be lower than 40 Yuan), depending on the region's economic level and on the individual's economic situation. The basis for individual premium in the other cases is the average income of the city's inhabitants, who

¹³ Its defenders argue that the expansion of health plans subsidized by the government not only promotes access to healthcare, but also enables the government to lever its position as a massive buyer of health services to promote competition among suppliers (Ramesh; Wu, 2009).

have the urban *hukou*, receiving more the higher complexity assistances (Silva; Vargas; Venturini, 2013, p.19).

The fourth was the Rural Cooperative Medical Scheme (RCMS), which would cover the rural population. The local administrative authority that was responsible for the public health insurance schemes was the Labor and Social Security Department, and the central authority was assigned to the Ministry of Labor and Social Security. The four schemes are formed by tripartite contributions - the individual, the employer (or the local government for USIS) and the central government.

Regarding access to health services, the public health insurance system divided the care into *Men Zhen* (includes primary care and any treatment that does not involve hospitalization) and *Zhu Yuan* (hospital care). In the first one, the scheme deposits a certain amount of money on an annual basis and issues an integrated care card (IC) to each insured individual. The insured individual can use this card to cover pharmaceutical products (drugs) and the costs of his/her non-hospitalized care. If the costs of drugs exceed the deposit in the IC card before its annual renewal, the insured individual must pay the exceeding amount out of his/her own pocket. In addition, any remaining deposit in the IC card at the time of its annual renewal can be transported to the following year. Patients with chronic diseases, such as diabetes and thyroid disorders, can request an extra subsidy in their card to cover expenditures on drugs of daily use. The method of payment through the IC card was accepted only by health professionals regularly instituted in public and local hospitals (Liu; Emsley; Dunn, 2013).

In the *Zhu Yuan*, the health insurance system made an arrangement with the healthcare providers (designated local public hospitals) in such a way that the payment of the bill must be made directly to the hospitals, according to the fixed percentage of payment to be made by the health insurance system. However, some authors highlight that there were problems associated with this policy:

Our study revealed the inconvenience of the rigid policy set by the public health insurance system to only cover health care accessed at designated local

public hospitals. It also revealed that coverage of the health insurance schemes varied between different schemes and in different places. For example, interviews with our two rural families informed that non-hospitalised care was not covered by their RCMS, whilst two of our participants covered by GIS said they could get up to 90% of their non-hospitalised and hospitalised care costs covered. Deductible and cap policies were adopted to control costs. In practice, these policies were set locally. For example, in Guangshan County of Henan Province, patients covered by the public health insurance system had to pay the full amount of the first 200 yuan (£18.80) of their hospitalised care bill out of their own pocket in 2011 and the expenditure cap on hospitalised care bill for 2011 was 100,000 yuan (£9,400). In a large city in Guangdong Province, patients covered by the public system had to pay the full amount of the first 700 yuan (£65.80) of their hospitalised care bill out of their own pocket whilst for 2011 the expenditure cap on hospitalised care bill was 200,000 yuan (£18,800) (Liu; Emsley; Dunn, 2013, p. 64).

The results of the study mentioned above indicate that the April 2009 health reform aimed to offer primary care at accessible prices to the country's general population. However, it presents a limit of access, as it is intrinsic to the policy of public, typically local hospitals, which prevents the inclusion of insured individuals in hospitals that do not belong to the network (non-local and non-public hospitals):

We understand that such policies might have been intended as mechanisms to controlling payment made out of the insurance system, but given the present economics structure, this is simply impractical, especially for the working population of the country. Presently, people in China are changing jobs and/or migrating more frequently than during the Maoist years. So policy makers and reformers should have considered the practicality of this designated, local public hospitals policy, hence at least minimise (if not eliminate) the inconvenience it brings to ordinary healthcare users (Liu; Emsley; Dunn, 2013, p. 65).

Therefore, there is evidence of the existence of

inequalities in access to health care and in the results of the health services in the Chinese system. Nevertheless, aiming to minimize them, authors like Hipgrave et al. (2012) highlight that, in July 2011, the State Council of the People's Republic of China demanded the standardization of primary care, the implementation of public health programs, community education, participation in health financing systems, and the maintenance of individual medical records as new functions to be incorporated by medical institutions at the local level. This new system contributed to the accessibility of the Chinese population, even of users/participants from the country's poorer regions. Given the geographical and population dimension of China, this fact is characterized as a great achievement (Liu; Emsley; Dunn, 2013, p. 65).

Another initiative of the council was to allocate 22 billion yuan to the construction of a health information management system to be implemented between 2011 and 2015. This system, which contains data of health providers and facilities up to the village level (with the proposal of real-time feed) will provide information that will subsidize decision-makers and health managers, aiming to expand the coverage of health insurances by 2020 (Liu; Emsley; Dunn, 2013).

These experiences and intentions of the central government in relation to the healthcare system (universal), especially from the 2009 reforms onwards, show the commitment to provide healthcare for the population in general. China's biggest challenges are: 1) to maintain these achievements; 2) to guarantee the sustainability of the recently established system in the long run; 3) to combat health inequalities, considering the huge debts of the public sector; and 4) to meet the increasing demand for healthcare due to demographic and technological changes (Liu; Emsley; Dunn, 2013).

In search of solutions for the challenges imposed to the healthcare policy, we observe that there is an open debate in the government itself concerning the methods to implement it and the health schemes. The "left" defends, today, the French distribution system based on the principle of solidarity among workers and different generations - which are getting prepared for the long road to socialism -, while

the "right" prefers the system of the USA, which divides workers and transfers the risk from capital to work. However, what we have observed up to the moment in relation to the healthcare policy and its schemes is the French influence (before the crisis of the Welfare State, that is, up to the 1970s):

The French system is universal and unified, maintained by diverse types of organizations (National Trust of Employees' Health Insurance; National Trust of Urban Informal Workers; Agricultural Social Mutuality; etc.) that reimburse their associates' expenditures. The reimbursement covers 75% of doctors' fees, from 35 to 65% of expenditures on drugs, 90% of hospital expenditures and 100% for diseases that disable the insured. Some trusts reimburse in lower proportions. Employees from state-owned enterprises have their own health insurance. Despite the diversity, there are three basic systems that cover the mass of the population and diverse special systems for limited categories. Assistance subject to reimbursement is performed by private clinics (organized for profit or not). Through these mechanisms, a great freedom of choice is ensured. In addition to the system, paid by the user and reimbursable, there are public hospitals that are directly supported by the State whose assistance is not charged. Prevention (vaccination, maternal, infant or school prevention) is not charged, too (Rosanvallon, 1998, p. 14-15).

In spite of its different structuring perspectives, the Chinese and the French healthcare policies have common characteristics: State intervention on market regulation and public health facilities. Thus, it is distinct from the North American policy, which emphasizes healthcare approached as an individual problem, and its needs should be satisfied by the private market or the family. Only the poor and those incapable of competing in the market receive some form of intervention (for a limited period) in health institutions subsidized by the government (Romero, 1998; Conill, 2008).

Furthermore, it is important to highlight that the Chinese healthcare policy is not only influenced by the European culture (in this case, France), but it can also influence some reforms in the National Health Service (NHS) of the United Kingdom, according

to Liu, Emsley and Dunn (2013). The health reform experiences that have been promoted in China since the 1980s are a valuable source of political learning and a lesson to the British coalition government. The highlight in the Chinese experience is the public hospital's almost unlimited freedom to raise funds in its programs of market-oriented reforms through an efficient and powerful regulation system. Such implications would contribute to make the United Kingdom abolish the arbitrary income coverage of the private patient in the NHS Foundation Trusts (PPI Cap), so as to struggle against health inequalities and guarantee the good behavior of health service providers.

In an attempt to provide a general analysis, we can say that the reforms have shown innovations and the central government's commitment to healthcare targeted at the Chinese population. The reforms were distinct, historically speaking, in relation to coverage, financing sources and, consequently, to the extent of the integration between financing agencies and providers that own the services. We believe that they are not characterized by the implementation of a counter-reform project against China's sovereign project ("socialism with Chinese characteristics"), as its policies have not been dismantled based on neoliberal guidelines. However, it is true that the reforms were influenced by an occidental European perspective, especially the French healthcare system (before the "crisis" of its Welfare State).

However, we observed that, in Mao's era, the healthcare policy was characterized by a high level of health services provision for a low-income population. All the equipment and infrastructure of the health providers had a public character, of collective or state ownership, grounded on parameters established by central planning, under the responsibility of the local, provincial and central governments (Ministry of Health). The health financing source were contributions in a decentralized structure (government, state-owned enterprises, collective organizations - communes and cooperatives). The management and administration model was organized in three social security systems: Government Insurance Scheme (GIS) for the government's employees; Labor Insurance Scheme (LIS) for the urban population; and the Cooperative Medical

System (CMS) for the rural population. The majority of the Chinese was covered by one of these schemes and the population's health improved significantly.

After the reforms of the Deng Xiaoping era, which triggered the end of the communes and the restructuring of the state-owned enterprises, a series of health reforms gradually altered the Maoist universal and collective healthcare system, negatively affecting the collective character of the contributions with the aim of making the users "cooperate" with the government in the financing of health. Another initiative refers to the nature of the access to equipment and infrastructures, as the government strived to introduce the market mechanism in public hospitals. As a result: 1) the government reduced its financing; 2) the public hospitals were granted an almost unlimited freedom to raise funds, charging the patients for medical fees; 3) the healthcare schemes instituted in the Maoist era were abandoned or gradually restructured up to the 1980s; and 4) the population's access to healthcare was reduced because it did not present any type of coverage.

This context changed with the reforms in 1998 and in the 2000s, when the central government instituted and introduced, according to new patterns, the healthcare schemes of the Maoist age: Government Insurance Scheme (GIS); Labor Insurance Scheme (LIS); Urban Social Insurance Scheme (USIS); and Rural Cooperative Medical Scheme (RCMS). These initiatives aim to expand the health insurance coverage towards universality, to increase the government's public health financing, mainly in low-income regions, in order to homogenize the expenses in different regions, to constitute healthcare centers for primary care, to establish reforms in the pharmaceutical market, and to carry out pilot projects at public hospitals, so that they play the role they used to have in the Maoist regime. As for financing, it was characterized by a tripartite contribution - the individual, the employer and the government - local and/or central). Administration and management were decentralized, but in another arrangement, as the Labor and Social Security Department became responsible for the local administration, while the central authority was assigned to the Ministry of Labor and Social Security.

In spite of changes in the direction taken by the healthcare policy registered between 1970 and

1980, these reforms are different from the Maoist era (egalitarian ideology) because their pillars are grounded on two essential proposals: 1) the increase in the budget for public hospitals and other publicly owned health facilities, aiming at the provision of primary care free of charge or at very reduced prices; and 2) the planned expansion of health insurance subsidized by the government to approximately 80% of the population that was not covered by any form of health insurance. These proposals represent an advance in the population's access to healthcare, but they also present challenges in the long run, mainly regarding financial sustainability.

Finally, despite all the restructuring suffered by the Chinese healthcare policy, it is not configured as an "Americanization" process. However, there is no doubt that there was a throwback in comparison with Mao's period. This throwback consists of an occidental and European influence in the constitution of its social security system, and, consequently, in the healthcare schemes.

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