Moving towards universal health coverage : challenges for the present and future in China

Luk, Sabrina Ching Yuen

2018

Luk, S. C. Y. (2018). Moving towards universal health coverage : challenges for the present and future in China. In Fong, B., Ng, A., & Yuen, P. (Eds.), Sustainable health and long-term care solutions for an aging population (pp. 19-45). doi:10.4018/978-1-5225-2633-9.ch002

<https://hdl.handle.net/10356/142911>

<https://doi.org/10.4018/978-1-5225-2633-9.ch002>

© 2018 IGI Global. All rights reserved. This book is made available with permission of IGI Global.

Downloaded on 26 Apr 2023 20:37:33 SGT

Chapter 2

Moving Towards Universal Health Coverage: Challenges for the Present and Future in China

Ching Yuen Luk

Nanyang Technological University, Singapore

ABSTRACT

This study uses a refined version of historical institutionalism to critically examine the complex interplay of forces that shape the health insurance reform trajectory in China since the mid-1980s and identifies problems that impede the government from achieving universal health coverage (UHC). It shows that China's multi-layered social health insurance system has covered more than 95 percent of its population, but failed to provide insured people with access to a range of essential services and make health care affordable. To achieve UHC, the government has to overcome significant hurdles, which include the inherently discriminatory design of the social health insurance system, disorder in the drug distribution system, deficits in the funding of health insurance, and insufficient medical protection for the old people.

INTRODUCTION

Since the mid-1980s, the problem of rising medical costs and the combining forces of population ageing and the burden of non-communicable diseases (NCDs) have driven the Chinese government to establish a multi-layered social health insurance system with an aim of providing affordable and sustainable health care for its population. At present, the social health insurance system has covered more than 95 percent of population (Asia Insurance Review, 2015). However, many insured people still have difficulties in accessing a range of essential services and face high out-of-pocket medical expenses. Meanwhile, the uninsured people lack access to basic and affordable health care. The government still has a long way to go to achieve universal health coverage (UHC), which refers to all people having access to needed health services without suffering financial hardship (World Health Organization, 2013, p. xi).

DOI: 10.4018/978-1-5225-2633-9.ch002

Health insurance reform in China has been explored and examined in many Western and Chinese studies. But the processes of health insurance reform and forces that shape the reform trajectory have not been completely understood. The relationship between UHC and health insurance reform has not been explored clearly. In order to fill the existing research gaps, this study uses a refined version of historical institutionalism to examine the forces that have shaped the trajectory of health insurance reforms in China since the mid-1980s, the problems that have impeded the government from achieving UHC and solutions adopted by the government to solve such problems.

BACKGROUND

Rapidly ageing population (Hsu et al., 2015), rising medical costs (Augustovski et al., 2011) and the burden of NCDs (Bristol, 2014, p.1) have driven governments worldwide to find ways to achieve UHC. According to the World Health Organization (WHO), there are three dimensions of UHC: (i) the breadth of coverage; (ii) the depth of coverage; and (iii) the height of coverage (World Health Organization, 2008, pp. 25-6). The breadth of coverage refers to ‘the proportion of the population that enjoys social health protection’ (World Health Organization, 2008, p. 25). The depth of coverage refers to the provision of the range of essential services that can effectively address people’s health needs (World Health Organization, 2008, p. 26) while the height of coverage refers to the portion of healthcare costs covered by pooled funding and pre-payment mechanisms (World Health Organization, 2008, p. 26). In recent years, UHC has become a key global health objective advocated by WHO and the World Bank (Cheng, 2015, p.1) and has been adopted by many countries as a national aspiration (Reich et al., 2016, p. 811). It is believed that UHC can improve the health and well-being of people (World Health Organization, 2013, p. xi), and “is necessary for economic growth and development” (Cheng, 2015, p. 2).

However, there is neither a single model nor a single correct path to achieve UHC. Due to resource constraints and differences in political, economic, social and historical contexts, the timetable, the pace, the process and the approach to achieve UHC vary among developed and developing countries. International evidence shows that UHC is achieved gradually and over many decades (Carrin et al., 2008; Savedoff & Smith, 2011). The study of Savedoff and Smith (2011, p. 45) found that Chile and Malaysia achieved UHC at least 20 years later than Sweden and Japan, but they reached comparable levels of population health by spending smaller shares of their income on health services. The study of Reich et al. (2016) categorized 11 countries into four groups based on their pace of attaining UHC. Bangladesh and Ethiopia belonged to Group 1 countries because they were still in the agenda-setting stage of attaining UHC (Reich et al., 2016, p. 812). Indonesia, Vietnam, Ghana and Peru belonged to Group 2 countries, which had initial programmes in place but “coverage gaps remained in access to services and financial protection” (Reich et al., 2016, p. 812). Thailand, Brazil and Turkey belonged to Group 3 countries, which had achieved many UHC policy goals but faced the challenges in sustaining coverage (Reich et al., 2016, pp. 811-2). Japan and France belonged to Group 4 countries, which had achieved UHC but continuously adjusted their national policies to meet changing circumstances and solve the problem of rising costs (Reich et al., 2016, pp. 811-2). The above studies show that achieving UHC is a long term process and an ongoing task with different development stages.

Like its country counterparts, China puts UHC high on its reform agenda. Its effort to reform the health care financing system began in the mid-1980s when the central government encouraged local government to explore different payment methods to reduce skyrocketing medical costs. In 1994, the pilot medical insurance model implemented in the cities of Zhenjiang in Jiangsu province and Jiujiang in Jiangxi province paved the way for the establishment of the multi-layered basic medical insurance system. The multi-layered basic medical insurance system consists of four schemes: (i) a mandatory Urban Employee Basic Medical Insurance (UEBMI) Scheme; (ii) a voluntary New Rural Cooperative Medical System (NRCMS); (iii) a voluntary Urban Resident Basic Medical Insurance (URBMI) Scheme; and (iv) the Critical Illness Insurance Scheme (CIIS). By the end of 2014, China's coverage rate of basic medical insurance exceeded 95 percent (Asia Insurance Review, 2015). However, China still lags behind in terms of the depth and the height of coverage.

MAIN FOCUS OF THE CHAPTER

Issues, Controversies, Problems

In China, rising medical costs, a rapidly ageing population and the burden of NCDs are the three main reasons for the government to implement health care financing reform. Since the 1980s, the implementation of pro-market economic reforms drastically raised medical costs. Fiscal decentralization emphasized self-sufficiency, “with very few resources transferred from higher levels of government to facilities at the lower levels to support recurrent costs” (Shen et al., 2014, p. 142). Government subsidies to hospitals were reduced to “basic salaries and minimal administrative costs” (Pang, 2003, p. 67), which “accounted for only about 10 percent of average public hospital revenues” (The World Bank, 2010, p. ix). Hospitals became profit-driven and cost recovery institutions (Feng, 2016, p.102). They recovered their operation costs through sales of services and drugs (Langenbrunner & Somanathan, 2011, p. 214). The bonus system for hospital doctors was also introduced, which linked the performance of doctors to “the revenue generated by doctors through provision of services and drugs over a revenue target” (Liu & Mills, 2005, p.11). This provided a strong incentive for hospital doctors to “induce patient demand for both services and drugs” (Liu & Mills, 2005, p. 11). Overprescribing and overcharging became a widespread practice in hospitals (Langenbrunner & Somanathan, 2011, p. 214). It drove up medical costs. Meanwhile, the free health care enjoyed by urban population through Labor Insurance Scheme (LIS) and Government Funded Health Care Scheme (GHS) encouraged waste and abuse in the health care system (Huang, 2013, p. 63). From 1986 to 1992, the spending of LIS and GHS “together grew at an annual average of 25 percent” (Duckett, 2001, p. 293). The combined medical care expenditure from LIS and GHS drastically increased from Reminbi (RMB) 3.16 billion in 1978 to RMB 56 billion in 1994 (Huang, 2013, p. 63). Rising medical costs drove the government to reform the urban health care financing system. In rural areas, the Cooperative Medical System (CMS), which provided peasants with basic medical care through their contribution to a commune-based medical fund, collapsed in the 1990s because the transition from agricultural collectives to the household responsibility system under the economic reforms weakened the financial base of the CMS (Liu, 2004, p. 159). The collapse of the CMS led to almost 80 percent of the rural population having no medical coverage (Li et al., 2015, p. 1079). “Since then, medical expenses

[in rural areas] sky-rocketed along with high-rate economic growth, which outstripped the growth of personal income” (Li et al., 2015, p. 1079). Health care in rural areas became unaffordable and peasants suffered from medical impoverishment (Li et al., 2015, p. 1079).

In China, population ageing “has emerged too early and too rapidly, under circumstances of relative socio-economic under-development” (Permanent Mission of the People’s Republic of China to the United Nations, 2008). In 1985, China had the largest number of elderly in their population. They accounted for 20 percent of the world elderly population (Wu, 1991, p. 18). In 1999, China officially became an ‘ageing society’ when its population aged 60 and over reached 10 percent of its total population (Zhu, 2011, p. 431). In 2015, the number of elderly population aged 60 and over passed 220 million, which accounted for 16 per cent of the total population in China (finance.china.com.cn, 2016 March 8). Population aging in China did not go hand-in-hand with economic growth. Per capita Gross Domestic Product (GDP) of China was only US\$806 in 1999 (Zhang, 2013, p. 344). It was very much lower than per capita GDP of developed countries. Developed countries had already attained high socio-economic development when becoming an ‘ageing society’, with per capita GDP ranging between US\$5000 and US\$10,000 (Kaufman et al., 2013, p. 45). In this sense, China has the characteristics of ‘getting old before getting rich’, which refers to the situation of achieving a high aging degree on a lower income level (Cai, 2015, p. 128) while developed countries get rich first before getting old (Haber, 2013, p. 376). Consequently, China’s phenomenon of ‘getting old before getting rich’ brings pressures and burden to economy and society because the country lacks money and resources to provide medical services for the elderly. According to Ministry of Health (MOH), chronic disease incidence and physical disability rate of old people aged over 60 years was respectively 3.2 times and 3.6 times that of the total population in the nation (Li 2006 September 29). MOH reported that health resource depletion by old people aged over 60 years was 1.9 times the national average (Li, 2006 September 29). Per capita health care expenditure for the elderly in China was three to five times higher than that of young adults and average annual per capita health care expenditure for the elderly was 2.56 times the national average (Qiu, 2015, p. 96). Under this circumstance, the health care system will be increasingly under pressure to cope with the increasing demand by ageing population.

The burden of NCDs is another reason why the government wants to implement health insurance reform and achieve UHC. When the People’s Republic of China (PRC) was founded in October 1949, China carried a heavy burden for communicable diseases, such as tuberculosis, dysentery and smallpox (The China Health Care Study Group, 1974), due to decades of war, polluted water supplies and poor sanitary conditions (Banister, 1987, p. 50). By the mid-1970s, many communicable diseases had been eliminated or greatly decreased in incidence through vaccination, environmental sanitation and hygiene, patriotic public health campaigns, health education, disease screening and the provision of community-level health care (Hipgrave, 2011, pp. 225-9). Since the late 1970s, China has experienced rapid economic growth due to modernization and its transformation to a market economy. Its population enjoyed better living standards and had higher disposable income. They shifted away from the traditional consumption of grain products toward high-fat, low-carbohydrate and low-fiber diets (Zhang et al., 2015, p. 4661). Their physical activity levels decreased due to improvement in public transport system, workers’ transitions from heavy industry to service industry jobs (Zang & Ng, 2016), “higher community urbanicity, vehicle ownership, [television] TV and computer ownership” (Zang & Ng, 2016, p. 40). Physical inactivity and unhealthy diet led to more Chinese people suffering from and dying of chronic NCDs. Data from Global Burden of Disease showed that 65 percent of the worldwide mortality in 2010 was caused by NCDs (Min et al., 2015, p. 840); whereas in China, 85 percent of the mortality in 2010 was

caused by NCDs, with cardiovascular diseases (38 percent of deaths), malignant neoplasms (26 percent of deaths), and cerebrovascular disease (21 percent of deaths) being the leading causes of death (Min et al., 2015, p. 840). Consequently, NCDs lead to serious financial loss of the Chinese economy (Sun et al., 2009). In 2003, the estimated economic burden of chronic diseases in China accounted for 7.3 percent of Gross Domestic Product (GDP) and 71.5 percent of the total economic burden of all diseases (Sun et al., 2009, p. 42). NCDs also lead to “indirect economic loss due to lost employment, disability, or premature deaths” (Tang et al., 2013, p. 7). Besides, NCDs “impose a substantial financial burden on many households” (Kankeu et al., 2013, p. 31). For example, about 11.6 percent of households in Central and Western China were pushed under the US\$ 1.08 poverty line due to outpatient expenses incurred by chronic diseases (Kankeu et al., 2013, p. 31). In sum, the problems of ageing population, rising medical costs and the burden of NCDs have driven the Chinese government to attain UHC.

The Chinese government strives to provide equitable and affordable health care services for its people through a multi-layered basic medical insurance system. A review of literature shows that many studies examined the effects of individual medical insurance scheme in China. Most of these studies analyzed the UEBMI, the URBMI and the NRCMS in specific places in China. For the UEBMI, there were studies examining the impact of the pilot experiment of urban health insurance scheme on equity in health care access (Liu et al., 2002), the impact of the UEBMI on equity in health care financing (Yi et al., 2005), hospital expenditure containment (Meng et al., 2004), cost containment and access to care (Dong, 2008). Studies on the URBMI are relatively scant, which included those examining the impact of the URBMI on health care utilization and expenditure (Liu & Zhao, 2014), health services access (Chen et al., 2014), health status, relieving financial burden and satisfaction rate of participants (Lin et al., 2009). For the NRCMS, there were studies examining the impact of the NRCMS on primary health care (Babiarz et al., 2010), health service utilization and out-of-pocket spending (Wagstaff et al., 2009), accessibility and affordability of health care services (Wang et al., 2014) and satisfaction of participants (Chen et al., 2015). There were also studies examining inpatient reimbursement from the NRCMS (Wang et al., 2012) and the achievement of policy goals of the NRCMS (Li et al., 2015). Meanwhile, some studies used a comparative perspective to examine the impact of UEBMI and URBMI on the hospitalization services utilization (Feng et al., 2013), inpatient and outpatient health service utilization (Zhou et al., 2014), or the impact of the UEBMI, the URBMI, the NRCMS on health outcomes among the elderly in 20 provinces (Liu et al., 2016). Literature review shows that most of these studies are quantitative studies that use multi-year data and economic models to examine health insurance schemes in China. The strengths of these studies lie in providing numeric estimates and deriving important trends from research data. However, the weakness of these studies is that most of the correlations produced by such studies only examine the closeness of the variables, but ignore underlying causes. Moving towards UHC is a long process, fraught with challenges and requiring patience. A review of literature review shows that previous studies examined specific health insurance scheme(s) in a specific place and in a specific period. Besides, they used different methodologies to collect data and different perspectives to analyze health insurance scheme. As a result, they fail to provide a clear picture about the way China moves towards UHC and forces that shape the developmental trajectory towards UHC. In order to fill the existing research gaps, this study uses a refined version of historical institutionalism as a unifying logic to analyze the process of health insurance reforms in China since the mid-1980s and critically examines forces that shape the reform trajectory over time. It examines the problems that impede the government from achieving UHC and the government’s solutions to solve such problems.

THEORETICAL FRAMEWORK: THE REFINED VERSION OF HISTORICAL INSTITUTIONALISM

The traditional version of historical institutionalism is characterized by its emphasis on the roles of institutions and path dependency in shaping the goals, preferences, strategies and behavior of political actors and generating distinctive policy trajectory of a nation (Hall & Taylor, 1996; Lecours, 2000; Pierson & Skocpol, 2002). Institutions are defined by historical institutionalists as “the formal and informal procedures, routines, norms and conventions embedded in the organizational structure of the polity” (Hall & Taylor, 1996, p. 938). Emphasis is put on asymmetric power relations (Hall & Taylor, 1996, p. 940; Saurugger, 2014, p. 91) that some groups win while others lose (Hall & Taylor, 1996, p. 941). Path dependence refers to the dynamics of self-reinforcing processes in a political system (Pierson, 2000a, p. 74) that “[d]ecisions made and structures introduced in the past generate irreversibilities” (Kirchner, 2013, p. 45). “[A]ctors have strong incentives to focus on a single alternative and to continue down a specific path once initial steps are taken in that direction” (Pierson, 2000b, p. 254).

Understandably, historical institutionalism is a useful approach to explain policy continuity (James, 2015, p. 218). Nevertheless, it is “less equipped to explain policy changes” (Weir, 2006, p. 172) or path-breaking reforms (James, 2015, p. 218). In many historical institutionalist accounts, the concept of critical junctures is used to explain rapid policy changes (Moore, 1966; Collier & Collier, 1991; Thelen, 1999; Mahoney, 2001). Critical junctures refer to change points where big, exogenous shocks (such as cleavages or crises) disrupt the existing institutional equilibrium and consequently set institutions onto a new path or new equilibrium state that will be reproduced through increasing return processes. Junctures are ‘critical’ because “once an option is selected, it becomes progressively more difficult to return to the initial point when multiple alternatives were still available” (Mahoney, 2001, p. 7). Nevertheless, using the concept of critical junctures to explain policy change contains three conceptual shortcomings. Firstly, it ignores the possibility that change can be endogenously generated (Streeck & Thelen, 2005, p. 19). Secondly, transformative policy change often results from “an accumulation of gradual and incremental change” (Streeck & Thelen, 2005, p. 19). Thirdly, institutional or policy change becomes purely a product of fate (Steinmo, 2008, p. 129) because critical junctures are often unpredictable and unforeseeable based on prior events (Flynn, 2015, p. 10).

Recognizing the fact that the traditional version of historical institutionalism has limitation to explain policy or institutional change, this study adopts the refined version of historical institutionalism, which was developed by the author in her book entitled *Health Insurance Reforms in Asia* (2014), to examine China’s transformation to a multi-layered health insurance system. The refined version of historical institutionalism identifies three sources of change -- environmental triggers, institutional entrepreneurs and ideas – and examines how these three sources of change interact with institutions and path dependency over time to produce a particular policy trajectory and lead to policy change. As an open system, institutions interact with their external environments in a back-and-forth manner (Burke, 2011, p. 71). They must respond to or adapt to changes in external environments for the purposes of survival and prosperity, “which can result in changing the mission and shifting priorities and goals” (Lussier, 2009, p. 53). Political, economic, social and technological are four macro forces that frequently affect institutions and the changes that institutions pursue (Auster et al., 2005, p. 21). In order to examine the interaction between institutions and the shifting contextual conditions, the refined version of historical institutionalism brings in the concept of environmental triggers, which was developed by Cortell and Peterson (1999).

Environmental triggers refer to unexpected international or domestic events, crises or gradual pressures, alone or in combination, that produce pressure for institutional or policy changes (Cortell & Peterson, 1999, pp. 183-4). International triggers include geopolitical conflict, war, changing balance of power, macroeconomic change, technological change, shocks, and international treaties (Cortell & Peterson, 1999, p. 185). Domestic triggers include election, change of government, coup d'état, revolution, civil war, social movement, social conflict, economic change and demographic change (Cortell & Peterson, 1999, p. 185). External environments only “act as stimulant or trigger for [institutional] change” (Bratton, 2015, p. 504). It still requires institutional entrepreneurs to exploit windows of opportunities opened by external environment in order to enact change (Luk, 2014, p. 13). Institutional entrepreneurs are the agents of change (DiMaggio, 1988). They are agents of legitimacy who “support the creation of new institutions and reform existing institutions in ways that they deem to be appropriate and aligned with their interests” (Haunschild & Chandler, 2008, p. 633). To bring about institutional change depends on institutional entrepreneurs’ willingness and ability to act (Battilana & Leca, 2009, p. 263). While willingness to act is dependent on the interests of institutional entrepreneurs, ability to act is mostly determined by tangible resources (e.g. employees, material and financial assets) and intangible resources (e.g. reputation, knowledge, social capital) institutional entrepreneurs possess or to which they have access (Battilana & Leca, 2009, p. 263). Institutional entrepreneurs must alter “deeply embedded norms, values and practices” (Hardy & Maguire, 2008, p. 209) and then legitimate and establish the new rules or practices as the expected, important and valued ones for the institutional field (Hinings et al., 2004, p. 309). To do so, they need to use new ideas as catalyst for change. Ideas are causal beliefs that “posit connections between things and between people in the world” (Béland & Cox, 2011, p. 3). They are important because “they are simultaneously the media through which agents understand the world and the material that constitutes it” (Blyth, 2011, p. 84). They “shape the content of policy proposals and the perception of interests at the heart of political struggles” (Béland, 2007, p. 23). They provide interpretive frameworks (Béland & Cox, 2011, p. 3) for policy actors to prioritize certain concerns of policy over others and strategically craft frames to make policies politically feasible and acceptable (Luk, 2014, p. 14). New ideas can take hold when old ideas are discredited and push aside. It happens when old ideas become unfit for the changing environment or less responsive to policy problems, and “are perceived to fail for some reasons” (Campbell, 2002, p. 33). This opens a window of opportunity for institutional entrepreneurs to introduce new ideas. Institutional entrepreneurs who are in a strong position to campaign for new ideas can generate support for such ideas and new practice.

To sum up, the refined version of historical institutionalism brings in environmental triggers, institutional entrepreneurs and ideas to explain how their interaction with institutions and path dependency can lead to institutional change. Meanwhile, the refined version of historical institutionalism has a core assumption that institutions remain key influences on policy outcomes because political institutions can either reinforce or upset the effects of environmental pressures, enable or constrain the behavior of institutional entrepreneurs, and filter ideas (Luk, 2014, pp. 16-7).

HEALTH CARE FINANCING SYSTEM IN THE PRE-REFORM ERA

On 1 October 1949, the PRC was founded by the Chinese Communist Party (CCP) under the leadership of Mao Zedong. In the context of the Cold War, the world was divided into two hostile camps: the capi-

talist camp led by the United States and the socialist camp led by the Soviet Union (Chen, 2001, p. 50). Mao chose to lean to the side of the Soviet Union. Against this background, China adopted the Soviet-style political system that emphasized “absolute single-party rule by a disciplined and hierarchical party organization” (Walder, 2015, p. 83) and “an economic model that mandated complete state ownership and control over the economy” (Walder, 2015, p. 83). A healthy workforce was crucial to developing the economy and society. But the lack of health resources and the Soviet model of economic development that strongly emphasized heavy industry led to an urban bias in health care financing system in China. Two types of free health care programs were implemented in urban areas: the LIS in 1951 and the GHS in 1952. The LIS was part of the wider labor insurance system that was modeled after the Soviet Union. Following the Soviet model, the LIS did not require employees’ contributions; it put the trade unions in charge of its administration; and it copied many details concerning eligibility and benefits (Hu, 2016, pp. 96-7). Although the term ‘insurance’ was used to describe the scheme, the LIS did not contain any insurance elements (Luk, 2014). It had no premium contribution. Instead, it required state and collective enterprises to initially contribute 3 percent, and then 4.5 to 5.5 percent in 1957 of the payroll to the labor insurance fund (Li, 2009, pp. 34-5). The LIS provided medical coverage for employees and their direct dependents. For eligible employees, the LIS covered all their charges for diagnosis, treatment, generic drugs and hospitalization (Li, 2009, p. 35). As to their direct dependent, they could consult doctors free of charge at designated hospitals, with the LIS covering one-half of their fees for generic drugs and surgery (Li, 2009, p. 35). In the midst of the Cultural Revolution (1966-1976), the LIS was no longer administered by the trade unions but was handed over to enterprises (Duckett, 2001, p. 292). The LIS was then funded by the enterprises’ employee welfare funds (Duckett, 2001; Li, 2009). As regards the GHS, it was funded by the state budget to provide medical coverage for government employees and retirees, personnel employed by institutions engaged in cultural, educational, health, and economic-construction activities, cadres, disabled military personnel, university and college students (Li, 2009; Wong et al., 2006). It covered both outpatient and inpatient expenses of eligible persons (Li, 2009, p. 36). For urban population who were not covered by the LIS or GHS, they had to pay on their own when seeking medical care. Nevertheless, hospitals were nationalized and prices for medical services and drugs were set below actual costs in order to “allow the average uninsured or poor Chinese to access basic health services” (Yip & Eggleston, 2004, p. 269). “The revenue shortfall was subsidized by government budgets, which made up more than 60 percent of total hospital operating revenue” (Yip & Eggleston, 2004, p. 269). Health care during Mao’s era aimed to achieve Mao’s objective of providing accessible and affordable health care services.

Due to urban bias in health care financing, most of the rural population had to pay on their own when seeking medical care before 1955 (Liu & Cao, 1992, p. 503). In the mid-1950s, the development of collective economy in rural areas provided the basis for the development of CMS. The CMS was a pre-payment health plan which collected funding from three sources: individual contribution, collective welfare fund and government subsidy (Liu et al., 1995, p. 1086). CMS participants enjoyed free visits and certain drugs free of charge at the village clinic, enjoyed 70 to 90 percent discount rate for buying certain drugs, copayment for referred hospital visits at township or higher-level and copayment for referred hospitalization (Liu & Cao, 1992, pp. 502-3). The CMS was promoted after the Sino-Soviet Split in 1960 and developed rapidly during the Cultural Revolution. The participation rate drastically increased to 80 percent in the late 1960s and reached the peak of 90 percent in 1979 (Liu & Cao, 1992, p. 504).

HEALTH CARE FINANCING REFORM SINCE THE MID-1980S

Due to rapid increase in health care costs, local governments in the mid-1980s were encouraged to carry out experiments on demand-side and supply-side cost containment. According to the study of Zheng (2009), there were three types of demand-side cost containment measures: copayment policy, financial contracting with the GHS participants, and the social pooling of the LIS. Under the copayment policy, the LIS participants were required by their working units to bear 15 percent of their medical expenses (Zheng, 2009, p. 263). As to the GHS participants, they were required to bear 5 to 20 percent of their outpatient and inpatient medical expenses (Zheng, 2009, p. 262). The copayment policy was intended to make the LIS and GHS participants more cost conscious. As regards financial contracting with the GHS participants, certain amount of health care funds was appropriated by local governments to cover participants' outpatient medical expenses only or all of their medical expenses (Zheng, 2009, p. 262). The implementation of the social pooling account of the LIS required employers' and employees' financial contribution to pay for medical expenses of certain types of critical illnesses (Zheng, 2009, p. 263). As to the pre-payment scheme in hospitals, a lump sum was given by work units to hospitals to pay for the medical expenses of their employees (Dong, 2001; Gu, 2001). Hospitals were "allowed to retain their residual revenues when the costs of health care were less than the specified amount" (Dong, 2001, p. 7). But they had to bear the financial burden if there was cost overrun. Health care financing reform at this stage remained limited by its narrow scope (Dong, 2001; Gu, 2001) and failed to tackle the fundamental weaknesses that were rooted in financing, payment and management of the LIS and GHS (Dong, 2001, p. 8).

In November 1994, the government selected Zhenjiang in Jiangsu Province and Jiujiang in Jiangxi Province as pilot reform cites to implement a health insurance model that was later known as the two-*jiang* model. The two-*jiang* model was characterized by combining an individual Medical Savings Account (MSA) and a social pooling fund (SPF). It required both the employers and employees to have mandatory contribution, with the former contributing 10 percent of their total annual payroll and the latter contributing 1 percent of their annual salary to the health insurance fund (Zheng, 2009, p. 266). Premium contributions were then split into the MSA and the SPF to pay for medical expenses of insured employees. Medical expenses were funded through three tiers (Cheung, 2001, p. 69; Liu et al., 2004, p. 48; Zheng, 2009, p. 266). The first tier was the MSA. The second tier was out-of-pocket payment for medical expenses that exceeded the amount in the MSA. The third tier was the SPF with copayment schedules (Liu et al., 2004, p. 48) when the out-of-pocket payment exceeded 5 percent of an employee's annual salary (Zheng, 2009, p. 266). The merits of the two-*jiang* model were that it was able to increase individual cost consciousness by introducing cost-sharing components and strengthen risk pooling. In 1996, the pilot reform on the basis of the two-*jiang* model was extended to 57 cities in the nation.

On the basis of experience from the pilot reform, the government in December 1998 introduced a nationwide health care financing reform through the implementation of the UEBMI Scheme. The UEBMI Scheme, which was designed on the basis of the two-*jiang* model, consisted of an individual MSA and a SPF. It required the mandatory contribution from employers and employees in both the public and private sectors. But retired employees could participate in the UEBMI Scheme without any premium contribution. Employers were required to contribute 6 percent of their total wage bills while employees were required to contribute 2 percent of their total wage bills to the Basic Medical Insurance (BMI) Fund

(The State Council, 1998). Premium contributions were then split into the MSA and the SPF. The MSA covered the general outpatient medical expenses and drug fees at designated medical institutions (Li, 2009, p. 46). The SPF covered inpatient medical expenses that were above the threshold or below the ceiling, with the rest being paid out-of-pocket by the insured employees (Li, 2009, p. 46). The threshold was about 10 percent of the average local wages while the ceiling was about four times the average annual local wages (The State Council, 1998). Health insurance cards were issued to the UEBMI participants to seek medical care at designated medical institutions. *The Drug Formulary for National Basic Medical Insurance* was also issued by the government to specify essential medicines that could be reimbursed by the UEBMI Scheme (Luk, 2014, p. 49). Local governments could adjust premium contribute rate, threshold and ceiling of the SPF according to the economic condition and the principle of balancing revenue and expenditure (The State Council, 1998). On the other hand, retired cadres, old Red Army and disabled military personnel could still enjoy free health care (The State Council, 1998), with their medical expenses paid by the SPF of the UEBMI Scheme (Luk, 2014).

In 2003, the government implemented the NRCMS to reduce rural population's financial burden caused by illnesses and improve their health (General Office of the State Council, 2003). Based on the spirit of mutual aid, the NRCMS was a voluntary scheme that provided rural households with medical protection against catastrophic illnesses. It was financed through three sources: individual contribution, local government subsidies, and central government subsidies (General Office of the State Council, 2003). An individual annually contributed RMB 10, with local and central government each providing subsidies of RMB 10 per enrolled individual (General Office of the State Council, 2003). The NRCMS was administered in county level that "county administrators [were] encouraged to define benefits packages on the basis of local needs and resources" (Babiarz et al., 2010, p. c5617). In July 2003, the NRCMS was implemented in 310 of China's more than 2,800 rural counties (Bai & Wu, 2014, p. 452). The coverage was further extended to 1,451 counties in 2006 and 2,729 counties in 2008 (Li, 2009, p. 65). The participation rate reached 91.5 percent in 2008 and 98.7 percent in 2013 (National Bureau of Statistics of China, 2014).

In July 2007, the government implemented the URBMI Scheme to provide non-working urban residents with medical protection against catastrophic illnesses treated at outpatient and inpatient settings (The State Council, 2007). Non-working urban residents referred to young children, primary and secondary school students, unemployed urban residents, the severely disabled and the elderly from low-income families (The State Council, 2007). The URBMI Scheme "adopts voluntary enrolment, a decision that was made after weighing the high administrative costs and the risk of adverse selection" (Chen et al., 2014, p. 278). It was funded by individual contributions and government subsidies. According to the State Council (2007), the government would provide subsidies of not less than RMB 40 per enrolled individual.

In August 2012, the government implemented the CIIS, which provided the NRCMS and URBMI participants with an extra layer of medical protection against catastrophic illnesses (National Development and Reform Commission et al., 2012). The CIIS was bought from a qualified commercial insurer by using the surplus of the NRCMS and the URBMI or increasing the funds collected from the NRCMS and the URBMI (National Development and Reform Commission et al., 2012). Those insured by the CIIS would be compensated for at least half of their out-of-pocket medical expenses that exceeded the average annual per capita disposable income, on top of their basic medical insurance reimbursement (National Development and Reform Commission et al., 2012).

FORCES THAT SHAPED THE HEALTH CARE FINANCING REFORM TRAJECTORY

The establishment of the multi-layered health insurance system demonstrates the government's ongoing effort to provide affordable and accessible health care for its population. This study reveals that there is a complex interplay of forces shaping the health care financing reform trajectory in China, which included (i) a highly centralized political institution, (ii) domestic environmental triggers, (iii) the introduction of new ideas by institutional entrepreneurs, and (iv) the lock-in effects of health insurance model.

China is run by a party-state system. The CCP, which has been the ruling party in China, is a highly centralized political institution that emphasizes "concentration of power in the hands of its top leaders" (Larus, 2012, p. 108). It "enforced strict discipline and had tentacles that reached into the state governing apparatus and the military" (Larus, 2012, p. 107). It "entrusts implementation of its policies and day-to-day administration of the country to the institution of the State, headed by the State Council" (Lawrence & Martin, 2013, p. 4). "The top State officials at every level of administration usually concurrently hold senior Party posts, to ensure Party control" (Lawrence & Martin, 2013, p. 4). The highly centralized political structure enables the top leaders to enjoy the monopoly on implementing health care financing reforms without having any political opposition.

Windows of opportunity for implementing health care financing reforms are mainly created by domestic environmental triggers. When Deng Xiaoping succeeded Mao to become the new political leader in 1978, he transformed China from a centrally planned economy to a market-oriented one. The market-oriented economy reduced the government's role in hospital financing while giving hospitals greater financial autonomy to charge medical fees. Hospitals became profit-driven. They regarded patients as consumers and medicine as a commodity (Pang, 2003, p. 42). Their profit-seeking behavior led to the collapse of the LIS and GHS systems because the government and the employers were unable to pay the drastically increased medical expenses of their employees. The changing economic context caused by change in political leadership triggered the experimental reform in containing medical costs in demand-side and supply-side in the mid-1980s. Economic reforms were continuously pursued by Jiang Zemin, who was the successor to Deng. This further drove up medical costs and compelled the government to introduce a two-*jiang* model in the pilot health insurance reform in 1994 and eventually implement a nationwide health insurance reform that led to the UEBMI Scheme replacing the old LIS and GHS schemes. Meanwhile, the changing social context due to the combining forces of rapidly aging population and the burden of NCD also created windows of opportunity for institutional entrepreneurs to implement health care financing reforms.

The opening of policy windows provides the opportunities for institutional entrepreneurs to introduce new ideas into the policy environment and transform such ideas into the two-*jiang* model. New ideas became politically prominent because the old ideas were seen as failing and new ideas were more responsive to the problem of rising medical costs. The old ideas of free health care and egalitarianism endorsed by Mao were discredited during Deng's era because they failed to fit into the market-oriented economic environment. In particular, the idea of free health care encouraged overuse of medical services and both demand-side and supply-side moral hazard, which led to drastic increase in medical costs and the collapse of the LIS and GHS systems. This provided an opportune time for political leaders to advocate a replacement set of ideas: individual responsibility, social solidarity, cost sharing and risk pooling. These new ideas were then transformed into the two-*jiang* model. The successful experience of the two-*jiang* model in reducing medical costs created a lock-in effect, which led to the path of subsequent

health insurance reforms following the same direction of promoting the ideas of individual responsibility, social solidarity, cost sharing and risk pooling, and introducing health insurance schemes for different segments of population. The lock-in effect created a transformative effect on the health care financing system that a multi-layered health insurance system was established to replace the LIS-GHS system.

The use of refined version of historical institutionalism shows that health insurance reform in China is shaped by a complex interplay of forces. Among these forces, window of opportunity alone is not enough to bring changes if institutional entrepreneurs who are the agents of change do not exploit windows of opportunities. Meanwhile, institutional entrepreneurs who have political will to implement health insurance reform also need to have a highly centralized political system that put them in an advantageous position to promote new ideas and reforms. Political institutions remain the most dominant force in shaping health insurance reforms because political institutions can reinforce or upset the effects of environmental triggers, filter ideas, enable or constrain the behaviour of institutional entrepreneurs.

PROBLEMS IN THE CURRENT HEALTH INSURANCE SYSTEM

Based on the principle of ‘basic medical protection, wide population coverage’ (*bao ji ben, guang fu gai*), the government since 1998 has gradually established a multi-layered medical insurance system to provide medical coverage for different segments of population. However, the medical insurance system contains several problems: (i) the inherently discriminatory design of the social health insurance system; (ii) disorder in the drug distribution system; (iii) deficits in the medical insurance fund and (iv) the fragmented design of the social health insurance system.

Firstly, the inherently discriminatory design of the multi-layered medical insurance system creates deep structural inequality between different population groups. It is similar to a feudal hierarchy in ancient China (Luk, 2014, p. 74), which divides people into different classes, with different rights. The retired cadres, old Red Army and disabled military personnel are the privileged few enjoying free health care, with their medical expenses paid by the SPF of the UEBMI. Free health care is a way for the Chinese government to repay for the continuing loyalty of these special groups of people who served the country and fought for the country (Luk, 2014, p. 74). The UEBMI Scheme is the most comprehensive scheme in the multi-layered medical insurance system because it covers both outpatient and inpatient medical expenses while the NRCMS and the URBMI Scheme only cover medical expenses for catastrophic illnesses. The NRCMS and the URBMI Scheme are unable to alleviate participants’ financial burden of health care expenditure that many participants have to pay medical expenses on their own. According to Mr. Hong Huang, Vice-President of China Insurance Regulatory Commission, insured peasants still had to bear rather high out-of-pocket medical expenses because the NCRMS only reimbursed half of their medical expenses (Lu, 2015 February 10). In 2012, there were more than 1 million URBMI patients whose inpatient fees exceeded catastrophic household expenditure for health care (China Social Insurance Net, 2015). Catastrophic household expenditure for health care was defined as out-of-pocket payments for health care that exceeded 40 percent of annual household non-food expenditure (Su et al., 2006; Gotsadze et al., 2009). The average catastrophic household expenditure for health care in China was RMB 9,826 in 2012 (China Social Insurance Net, 2015). On the other hand, inequality between the retired and incumbent employees is found within the UEBMI system. It is because retired employees do not have to pay any insurance premium, with their medical expenses paid by the SPF of the UEBMI Scheme. Besides, they enjoy higher reimbursement rate but lower self-payment rate than incumbent

employees. At present, migrant workers are still excluded from joining the basic medical insurance system because their rural *hukou* do not grant them any rights or access to participate in the UEBMI. Since they are engaged in low-wage, low-skill jobs, most of them can only afford to go to ‘black clinics’ that are unlicensed clinics with poor hygiene to seek medical care (Xinhua Net, 2013 March 28).

Secondly, money in the individual MSA and the SPF was inappropriately depleted due to high drug prices and physician-induced demand. In China, “on average 40-50 per cent of hospital revenues come from drug prescriptions” (Brombal, 2014, p. 107) while “medicines account for less than 15 percent of total healthcare expenditure across Europe” (European Federation of Pharmaceutical Industries and Association, 2014, p. 20). It shows that drug prices are unreasonably high in China and impose heavy financial burden on insured and uninsured people. Drug prices have risen quickly since the mid-1980s when the government let market forces determine drug prices. Drug prices have been marked up for many times after going through the complex pharmaceutical distribution system that contains six to nine manufacturer-wholesaler-retailer layers (Li, 2013, p. 19). For example, the retailing price of a cancer drug was seven times higher than the wholesaling price and 14 times higher than the manufacturing price, generating a profit of 1,300 percent (Kong et al., 2011, p. 1069). High drug prices were also caused by the practice of drug manufacturers and wholesalers offering kickbacks to hospitals and doctors to ensure the sale of certain types of expensive drugs (Li, 2013, p. 18). Since 1998, the government has imposed price caps on drugs for more than 30 times (Beijing Business Today, 2014a December 9). But the result was that price-cut drugs quickly disappeared from the market because their profit margin was too small in the eyes of drug manufacturers and health care providers (Henan Business Daily, 2013 December 31). In 2010, a survey found that 342 of more than 500 types of essential medicines were in severe shortage in 40 major hospitals in China (Wang & Chen, 2015 October 12). Doctors ended up prescribing the more expensive drugs that accelerated the depletion of medical insurance fund. Besides, the practice of physician-induced demand through doctor ordering unnecessary tests, performing unnecessary surgeries, asking patient to have inpatient treatment, and prescribing unnecessary drugs (e.g. antibiotics and imported drugs) also led to the inappropriate depletion of basic medical insurance funds and unnecessary waste of medical resources (Lei & Wu, 2014, p. 10).

Thirdly, medical insurance fund deficit has been reported in many places that people may face the risk of being ‘underinsured’ or ‘uninsured’. According to Mr. Wei-gang Jin, Head of the Social Security Institute, the Ministry of Human Resources and Social Security, some regions had already experienced a deficit in the medical insurance fund due to the growth rate in expenditure exceeding the growth rate in revenue of different medical insurance funds (Beijing Business Today, 2014b December 9). According to Mr. Jin, a total of 225 districts in China in 2013 experienced a deficit in the UEBMI funds and a total of 108 districts experienced a deficit in the URBMI funds (Beijing Business Today, 2014b December 9). Meanwhile, places such as Beijing experienced a deficit in the NRCMS fund in 2012 (Li, 2015 February 13). *Green Book of Health Reform and Development 2014* estimated that there would be deficit in all the NRCMS funds in 2017 (Nanfang Metropolis Daily, 2015 February 10). Paying the rising medical expenses of retired employees, over-prescription and paying expensive examination fees of hospitals and health insurance fraud were regarded as three main reasons for putting increasing pressure on the country’s health insurance fund (China Business News, 2015 November 30).

Fourthly, the fragmented design of the social health insurance system fails to provide sufficient medical protection for the old people. At present, China does not have a health insurance scheme tailored for the elderly. According to *the 2013 Analysis Report of National Health Services Survey in China*, 45.1 percent of 61,057 old people surveyed participated in NRCMS, 32.4 percent participated in the

UEBMI Scheme, and 10.8 per cent participated in the URBMI Scheme in 2013 (Center for Health Statistics and Information, 2015, p. 95). But the medical services and drugs covered by these health insurance schemes are not specific for treating common diseases in old age. Unlike young people, old people usually have greater medical need and suffer from NCDs that have higher prevalence rate, a longer period in treatment and higher medical expenses. The two-week prevalence, “an index of health service need and one of the morbidity indicators used to investigate inequalities in health status” (Zhu et al., 2015, e008441) drastically increased from 25 percent in 1993 to 56.9 percent in 2013 (Center for Health Statistics and Information, 2015, p. 98). In 2013, high blood pressure and diabetes were top two diseases for the two-week prevalence (Center for Health Statistics and Information, 2015, p. 100). In the same year, NCDs, including cerebrovascular disease, high blood pressure, ischemic heart disease, chronic obstructive pulmonary disease (COPD) and diabetes, were top five diseases that required urban and rural old people aged 60 or above to receive inpatient treatment (Center for Health Statistics and Information, 2015, p. 111). In 2013, the average number of inpatient days for the old people was 12.8 days (Center for Health Statistics and Information, 2015, p. 111) and the average inpatient cost for old people was RMB 9,506 (Center for Health Statistics and Information, 2015, p. 113). Since the current fragmented health insurance system only provides basic medical coverage for the participants, many old people have to pay their medical expenses on their own. Out-of-pocket medical expenditures impose a heavy financial burden on old people (Ma & Sun, 2014, p.29). Due to the problem of ‘getting old before getting rich’, many old people do not have enough money to pay for their medical expenses. The lack of financial means becomes a barrier for old people to seek medical treatment. For example, having financial difficulty was the main reason for old people who needed inpatient treatment ended up not receiving any inpatient treatment in 2013 (Center for Health Statistics and Information, 2015, p. 113). But for old people who really seek medical treatment, they may possibly fall into poverty or fall back into poverty due to illnesses (Wu & Li, 2006, p.121).

SOLUTIONS AND RECOMMENDATIONS

At present, many insured participants, in particular the URBMI and NRCMS ones, still find it difficult and expensive to seek medical care due to having partial medical coverage, bearing high out-of-pocket expenses and facing a continuous increase in medical costs. To alleviate the financial burden of these groups of people and reduce health inequality, the State Council in January 2016 issued *Opinions on Integrating the Basic Medical Insurance Systems for Urban and Rural Residents* (hereafter the 2016 Opinions), which aimed at gradually establishing a unified basic medical insurance system through the integration of the URBMI Scheme and the NRCMS (The State Council, 2016). According to *the 2016 Opinions*, the URBMI and NRCMS participants will have the same payment standards and enjoy the same medical insurance coverage. The new system will be mainly financed by individual contribution and government subsidies and cover medical expenses of outpatient and inpatient services, with a reimbursement rate of up to 75 percent for inpatient stay (The State Council, 2016). A unified drug formulary and medical service item catalogue will be issued for insurance reimbursement (The State Council, 2016). It is expected that the unified medical insurance system can break the urban-rural dichotomy, strengthen the efficiency of risk pooling, provide better financial protection and achieve equal medical treatments.

Migrant workers finding it difficult and expensive to seek medical treatment is still a pressing issue at this stage. In February 2016, Premier Li Keqiang said that 100 million migrant workers would be granted

urban residence permits in an orderly way by 2020 (Xinhua Net, 2016 February 1) and might have full right and access to urban social services in future. Over the past few years, some local governments have carried out different measures to reduce the medical inequality of migrant workers. For example, county government in Sichuan starting in 2015 provided free medical checkup for migrant workers (Xinhua Net, 2016 January 15). Starting in 2012, the Zhengzhou government established Migrant Worker Basic Medical Insurance System, which provided inpatient medical coverage for about 100,000 migrant workers (Xinhua Net, 2016 January 15). Starting on January 1 2014, the Shenzhen government expanded Local Supplementary Medical Insurance Scheme to cover migrant workers' treatment costs for catastrophic illnesses at outpatient clinics (Shenzhen News, 2013 October 18). However, there is yet to establish a unified medical protection system for migrant workers.

The medical expenses of retired employees would deplete medical insurance fund quickly and affect the financial sustainability of medical insurance fund in the long run. In face of a rapidly ageing population, the government were examining the feasibility of retired employees paying premium contribution for health care (Guo, 2016 January 4). At present, it is too early to tell whether the base premium should be determined by the pension fund received by retired employees per month or the average monthly salary before retirement; and how insurance premium should be paid or what the level of medical coverage should be (Guangzhou Daily, 2016 January 5). But one thing is for sure, retiree contribution for health care requires amending *The Social Insurance Law of the People's Republic of China*, which states that retired employees do not need to pay any premium contribution for health care (Guo, 2016 January 4; Guangzhou Daily, 2016 January 5).

The ineffective mechanism to reduce health providers' moral hazard is one of the reasons for a considerable unnecessary drain on medical insurance fund and the inefficient and unnecessary use of medical resources. Restraining health providers' moral hazard does not mean that health care providers should be prohibited from earning profits. After all, health care providers receive inadequate subsidies from the government and need to generate enough revenues to keep up their operations. Nevertheless, a line should be drawn between earning profits and protecting the interests of patients. To ensure that money accumulated in the individual MSA and the SPF are appropriately used, the government has carried out several measures to reduce hospitals' reliance on drug sales as the main source of revenue and the practice of physician-induced demand. Since 2012, the government has introduced a pilot program of the zero-markup policy for essential drugs in primary health care institutions, county hospitals and urban public hospitals, "with the aim of delinking the financial relationship between medical services and medicine delivery" (Mao & Chen, 2015, p. 10). Under the zero-markup policy, public hospitals abolish the 15 percent mark-up they charge on drug sales but are compensated by receiving government subsidies and increasing charges for consultation, hospital beds, surgery and medical tests. The zero-markup policy for drugs has brought mixed results for patients and hospitals. The policy helps patients greatly reduce their financial burden if their medical treatment simply relies on taking medicines (Zhou, 2016 February 1). For patients who require surgical treatment and hospitalization, however, they may face higher medical expenses. On the other hand, some hospitals in Zhejiang had deficit due to the financial incapability of local government to compensate the hospitals with enough subsidies (Time-weekly, 2014 April 10). Some hospitals in Guangzhou had deficit of over RMB 6 to 7 million because government subsidies were not enough to compensate their loss of drug revenues (Zhou, 2016 February 1).

In order to restrain the profit-seeking behavior of health care provider, the Ministry of Human Resources and Social Security in August 2014 imposed penalties on health care providers that breached the terms of agreement or committed fraudulent activities. They included the government refusing to pay

the bills for services provided in medical institutions, temporarily suspending settlement of health insurance claims and ordering rectification within a prescribed time period or terminating service agreement (Ministry of Human Resources and Social Security, 2014). Another measure is that, starting from June 1, 2015, the government lifted price controls for most of the drugs and let the market determine drug retail price (National Development and Reform Commission et al., 2015). Maximum ex-works prices and maximum retail prices of narcotics drugs and Class I psychotropic drugs would still be subject to the government's price control while ex-work price or retail price of other drugs would be determined by the market (National Development and Reform Commission et al., 2015). The government would strengthen its role in monitoring drug prices and conduct investigations when necessary if there are frequent or significant drug price fluctuations (National Development and Reform Commission et al., 2015).

The problem of ageing population has become more serious. In response to this problem, the government can consider establishing a health insurance scheme tailored for the old people, especially for the needy and disabled ones. In Singapore, the government introduces two health care financing schemes for the old people. One of the schemes is called Medifund Silver, which provides financial assistance for needy elderly patients aged 65 or above that have problems paying their medical bills (Ministry of Health, 2008). Another scheme is called ElderShield, which is a voluntary and affordable severe disability insurance scheme that provides basic financial protection to those who need long-term care, especially during old age (Ministry of Health, 2016). "All Singapore Citizens and Permanent Residents with Medisave accounts are automatically enrolled in ElderShield at the age of 40" (Ministry of Health, 2016) and can receive a monthly cash payout in the event of a severe disability (Ministry of Health, 2016). The Chinese government can learn from the Singaporean government in order to reduce the financial burden of old people. Meanwhile, the Chinese government has proposed the idea of integrating medical and nursing care for the elderly, which aims to achieve the important goal of 'healthy aging' through the provision of all-round care for the elderly (The National Committee of the Chinese People's Political Consultative Conference, 2014). By integrating medical and nursing care for the elderly, the government wants to allow senior care facilities to provide medical service legally and emphasizes prevention of diseases, maintaining good physical and mental health, rehabilitation services and sense of security. Emphasis on the prevention of disease can reduce the old people's financial burden caused by medical treatment. This can also reduce their demand for medical services in public hospitals.

FUTURE RESEARCH DIRECTIONS

It is undeniable that the Chinese government has made great efforts to reduce rising medical costs and finance health care through a multi-layered health insurance system. But the government's effort to achieve UHC still has a long way to go. To achieve the real sense of UHC, the ongoing health insurance reform should be accompanied by reforms on drug prices and hospital management. Besides, these reforms need regular review and assessment in order to see if they can meet the original policy goals. At the time of this study, the data for assessing the CIIS is still unavailable and specific plans for integrating the URBMI Scheme and the NRCMS have not been formulated. Future studies can examine the impact of the CIIS or the unified health insurance system on reducing medical expenses. Future studies can also examine the financial sustainability of social insurance system in China or compare the financial sustainability of China's social insurance system with that of social insurance system in other Asian or Western countries.

CONCLUSION

To conclude, China's health insurance reform is an ongoing process responding to changing political and socio-economic circumstances. Three decades of health insurance reforms show that China's transformation to a multi-layered social health insurance system was due to the complex interaction between political institutions and three sources of institutional change: environmental triggers, institutional entrepreneurs and ideas. China is moving towards UHC and is moving towards the right direction. Nevertheless, the government has to overcome significant hurdles, in particular the inherently discriminatory design of the social health insurance system, disorder in the drug distribution system, deficit in the funding of health insurance, and insufficient medical protection for the old people in order to achieve a real sense of UHC.

REFERENCES

- Asia Insurance Review. (2015). *China: 1 bln+ people to have state-run critical illness cover*. Retrieved June 12, 2016, from <http://www.asiainsurancereview.com/News/View-NewsLetterArticle?id=33334&Type=edaily>
- Augustovski, F., Martí, S. G., Riviere, A. P., & Rubinstein, A. (2011). Universal coverage with rising healthcare costs; health outcomes research value in decision making in Latin America. *Expert Review of Pharmacoeconomics & Outcomes Research*, 11(6), 657–659. doi:10.1586/erp.11.83 PMID:22098279
- Auster, E. R., Wylie, K. K., & Valente, M. S. (2005). *Strategic organizational change: building change capabilities in your organization*. Basingstoke, UK: Palgrave Macmillan. doi:10.1057/9780230508064
- Babiarz, K. S., Miller, G., Yi, H., Zhang, L., & Rozelle, S. (2010). New evidence on the impact of China's New Rural Cooperative Medical Scheme and its implications for rural primary healthcare: Multivariate difference-in-difference analysis. *BMJ (Clinical Research Ed.)*, 341(2), c5617. doi:10.1136/bmj.c5617 PMID:20966008
- Bai, C., & Wu, B. (2014). Health insurance and consumption: Evidence from China's New Cooperative Medical Scheme. *Journal of Comparative Economics*, 42(2), 450–469. doi:10.1016/j.jce.2013.07.005
- Banister, J. (1987). *China's changing population*. Stanford, CA: Stanford University Press.
- Battilana, J., & Leca, B. (2009). The role of resources in institutional entrepreneurship: insights for an approach to strategic management that combines agency and institutions. In L. A. Costanzo & R. B. MacKay (Eds.), *Handbook of research on strategy and foresight* (pp. 260–274). Cheltenham, UK: Edward Elgar. doi:10.4337/9781848447271.00022
- Beijing Business Today. (2014a, December 9). *Price caps on drugs has little effectiveness*, Chinese version. Retrieved July 15, 2016, from <http://finance.sina.com.cn/chanjing/cyxw/20141209/012021026167.shtml>
- Beijing Business Today. (2014b, December 9). *Some regions experience a deficit in the medical insurance fund*, Chinese version. Retrieved July 15, 2016, from <http://www.cn-healthcare.com/article/20141209/content-465355.html>

- Béland, D. (2007). Ideas and institutional change in social security: Conversion, layering, and policy drift. *Social Science Quarterly*, 88(1), 20–38. doi:10.1111/j.1540-6237.2007.00444.x
- Béland, D., & Cox, R. H. (2011). Introduction: ideas and politics. In D. Béland & R. H. Cox (Eds.), *Ideas and Politics in Social Science Research* (pp. 3–20). New York: Oxford University Press.
- Blyth, M. (2011). Ideas, uncertainty, and evolution. In D. Béland & R. H. Cox (Eds.), *Ideas and Politics in Social Science Research* (pp. 83–104). New York: Oxford University Press.
- Bratton, J. (2015). *Introduction to work and organizational behaviour* (3rd ed.). New York: Palgrave Macmillan. doi:10.1007/978-1-137-43206-3
- Bristol, N. (2014). *Global action toward universal health coverage*. Retrieved June 1, 2016, from <https://www.ciaonet.org/attachments/24280/uploads>
- Brombal, D. (2014). Health sector reforms in contemporary China: a political perspective. In K. E. Brodsgaard (Ed.), *Globalization and Public Sector Reform in China* (pp. 100–124). Abingdon, UK: Routledge.
- Burke, D. D. (2011). *Organization change: theory and practice* (3rd ed.). Thousand Oaks, CA: SAGE Publications.
- Cai, F. (2015). *Demystifying China's Economy Development*. Berlin: Springer Berlin Heidelberg. doi:10.1007/978-3-662-46103-7
- Campbell, J. L. (2002). Ideas, politics, and public policy. *Annual Review of Sociology*, 28(1), 21–38. doi:10.1146/annurev.soc.28.110601.141111
- Carrin, G., Mathauer, I., Xua, K., & Evans, D. B. (2008). Universal coverage of health services: Tailoring its implementation. *Bulletin of the World Health Organization*, 86(11), 857–863. doi:10.2471/BLT.07.049387 PMID:19030691
- Center for Health Statistics and Information. (2015). *The 2013 Analysis Report of National Health Services Survey in China, Chinese version*. Retrieved February 26, 2017, from <http://www.nhfpc.gov.cn/mohwsbwstjxxzx/s8211/201610/9f109ff40e9346fca76dd82cecf419ce.shtml>
- Chen, D., Tang, K. K., Zhao, L., & Zhang, Y. (2015). Will China's Cooperative Medical System fail again? Insight from farmer satisfaction survey. *Health Promotion International*, 30(2), 251–261. doi:10.1093/heapro/dat032 PMID:23669160
- Chen, G., Liu, G. G., & Xu, F. (2014). The Impact of the urban resident basic medical insurance on health services utilisation in China. *PharmacoEconomics*, 32(3), 277–292. doi:10.1007/s40273-013-0097-7 PMID:24178373
- Chen, J. (2001). *Mao's China and the Cold War*. Chapel Hill, NC: University of North Carolina Press.
- Cheng, T. (2015). Universal health coverage: An overview and lessons from Asia. *Harvard Public Health Review*, 4, 1–12.
- Cheung, A. B. L. (2001). Health policy reform. In L. Wong & N. Flynn (Eds.), *The market in Chinese social policy* (pp. 63–87). Houndmills, UK: Palgrave. doi:10.1057/9781403919939_4

China Business News. (2015 November 30). *Expenditures of medical insurance funds exceeded revenues of medical insurance funds in many regions in China*, Chinese version. Retrieved July 14, 2016, from <http://finance.sina.com.cn/china/20151130/005723882229.shtml>

China Social Insurance Net. (2015). *Analysis on personal financial burden among inpatients who were covered by the Urban Resident Basic Medical Insurance Scheme*, Chinese version. Retrieved July 14, 2016, from <http://www.spicezee.com/zhishi/yiliao/108433.html>

Collier, R. B., & Collier, D. (1991). *Shaping the political arena: critical junctures, the labor movement, and regime dynamics in Latin America*. Princeton, NJ: Princeton University Press.

Cortell, A. P., & Peterson, S. (1999). Altered states: Explaining domestic institutional change. *British Journal of Political Science*, 29(1), 177–203. doi:10.1017/S0007123499000083

DiMaggio, P. (1988). Interest and agency in institutional theory. In L. G. Zucker (Ed.), *Institutional patterns and organizations: culture and environment* (pp. 3–21). Cambridge, MA: Ballinger Pub. Co.

Dong, W. (2001). *Health care reform in urban China*. Retrieved July 7, 2016, from http://munkschool.utoronto.ca/cphs/wp-content/uploads/2012/03/Weizhen_Dong-2001-02.pdf

Dong, W. (2008). Cost containment and access to care: The Shanghai health care financing model. *The Singapore Economic Review*, 53(1), 27–41. doi:10.1142/S0217590808002823

Duckett, J. (2001). Political interests and the implementation of China's urban health insurance reform. *Social Policy and Administration*, 35(3), 290–306. doi:10.1111/1467-9515.00234

European Federation of Pharmaceutical Industries and Association. (2014). *Health & Growth: Working Together for a Healthy Europe*. Retrieved July 17, 2016, from www.efpai.eu

Feng, Y., Xiong, X., Xue, Q., Yao, L., Luo, F., & Xiang, L. (2013). The impact of medical insurance policies on the hospitalization services utilization of people with schizophrenia: A case study in Changsha, China. *Pakistan Journal of Medical Sciences*, 29(3), 793–798. doi:10.12669/pjms.293.3273 PMID:24353630

Feng, Z. (2016). Marginalisation and health provision in transitional China. In H. X. Zhang, B. Wu, & R. Sanders (Eds.), *Marginalisation in China: perspectives on transition and globalization* (pp. 97–116). Aldershot, UK: Ashgate.

finance.china.com.cn. (2016 March 8). *Li Bin: China's elderly population aged 60 and over passed 220 million in 2015*, Chinese version. Retrieved June 18, 2016, from <http://finance.huanqiu.com/roll/2016-03/8672801.html>

Flynn, M. B. (2015). *Pharmaceutical autonomy and public health in Latin America: state, society, and industry in Brazil's AIDS program*. New York, NY: Routledge.

General Office of the State Council. (2003). *Opinions on Establishing the New Rural Cooperative Medical System*, Chinese version. Retrieved July 12, 2016, from http://www.law-lib.com/law/law_view.asp?id=43058

Gotsadze, G., Zoidze, A., & Rukhadze, N. (2009). Household catastrophic health expenditure: Evidence from Georgia and its policy implications. *BMC Health Services Research*, 9(1), 69. doi:10.1186/1472-6963-9-69 PMID:19400939

Gu, E. (2001). Market transition and the transformation of the health care system in urban China. *Policy Studies*, 22(3/4), 197–215. doi:10.1080/01442870120112692

Guangzhou Daily. (2016 January 5). *Do retired employees need to pay premium contribution for health care?* Chinese version. Retrieved July 16, 2016, from <http://jiankang.163.com/16/0105/08/BCI6N50N0038002S.html>

Guo, J. (2016 January 4). *How long does it last for 720 million retired employees not paying premium contribution for medical care?* Chinese version. Retrieved July 16, 2016, from <http://www.yicai.com/news/4733894.html>

Haber, D. (2013). *Health promotion and aging: practical applications for health professionals* (6th ed.). New York, NY: Springer Publishing Company, LLC.

Hall, P. A., & Taylor, R. C. R. (1996). Political science and the three new institutionalisms. *Political Studies*, 44(5), 936–957. doi:10.1111/j.1467-9248.1996.tb00343.x

Hardy, C., & Maguire, S. (2008). Institutional entrepreneurship. In R. Greenwood, C. Oliver, K. Sahlin, & R. Suddaby (Eds.), *The SAGE handbook of organizational institutionalism* (pp. 198–217). Los Angeles, CA: SAGE. doi:10.4135/9781849200387.n8

Haunschild, P., & Chandler, D. (2008). Institutional-level learning: learning as a source of institutional change. In R. Greenwood, C. Oliver, K. Sahlin, & R. Suddaby (Eds.), *The SAGE handbook of organizational institutionalism* (pp. 624–649). Los Angeles, CA: SAGE. doi:10.4135/9781849200387.n27

Henan Business Daily. (2013, December 31). *The reasons for cheap essential drugs disappearing from the market in China*, Chinese version. Retrieved July 15, 2016, from http://www.cb.com.cn/investigation/2013_1231/1031072.html

Hinings, C. R., Greenwood, R., Reay, T., & Suddaby, R. (2004). Dynamics of change in organizational fields. In M. S. Poole & A. H. Van de Ven (Eds.), *Handbook of organizational change and innovation* (pp. 304–323). New York: Oxford University Press.

Hipgrave, D. (2011). Communicable disease control in China: From Mao to now. *Journal of Global Health*, 1(2), 224–238. PMID:23198121

Hsu, M., Huang, X., & Yupho, S. (2015). The development of universal health insurance coverage in Thailand: Challenges of population aging and informal economy. *Social Science & Medicine*, 145, 227–236. doi:10.1016/j.socscimed.2015.09.036 PMID:26452699

Hu, A. (2016). *China's social insurance in the twentieth century: a global historical perspective*. Leiden, Germany: Brill.

Huang, Y. (2013). *Governing Health in Contemporary China*. Milton Park. Abingdon, UK: Routledge.

- James, K. (2015). *The rise of the value-added tax*. New York, NY: Cambridge University Press. doi:10.1017/CBO9781107358522
- Kankeu, H. T., Saksena, P., Xu, K., & Evans, D. B. (2013). The financial burden from non-communicable diseases in low- and middle-income countries: A literature review. *Health Research Policy and Systems*, 11(1), 31. doi:10.1186/1478-4505-11-31 PMID:23947294
- Kaufman, S. R., Livingston, J., Zhang, H., & Lock, M. (2013). Transforming concepts of ageing: three case studies from anthropology. In T. Denning & A. Thomas (Eds.), *Oxford Textbook of Old Age Psychiatry* (2nd ed.; pp. 39–56). Oxford University Press. doi:10.1093/med/9780199644957.003.0004
- Kirchner, S. (2013). How organizations become enduring: disentangling the organizational identity paradox. In J. Sydow & G. Schreyögg (Eds.), *Self-reinforcing processes in and among organizations* (pp. 33–54). Houndmills, UK: Palgrave Macmillan. doi:10.1057/9780230392830_3
- Kong, X., Li, Z., & Kong, Y. (2011). The formation basis of high drug prices, Chinese version. *China Pharmacy*, 22(12), 1069–1071.
- Langenbrunner, J. C., & Somanathan, A. (2011). *Financing health care in East Asia and the Pacific: best practices and remaining challenges*. Washington, DC: World Bank.
- Larus, E. F. (2012). *Politics and society in contemporary China*. Boulder, CO: Lynne Rienner Publishers.
- Lawrence, S. V., & Martin, M. F. (2013). *Understanding China's Political System*. Retrieved July 18, 2016, from <https://www.fas.org/sgp/crs/row/R41007.pdf>
- Lecours, A. (2000). Theorizing cultural identities: Historical institutionalism as a challenge to the culturalists. *Canadian Journal of Political Science*, 33(3), 499–522. doi:10.1017/S0008423900000172
- Lei, P., & Wu, Z. (2014). Analysis on over-medication in hospitals in China, Chinese version. *Chinese Health Economics*, 33(5), 9–11.
- Li, C., Hou, Y., Sun, M., Lu, J., Wang, Y., Li, X., & Hao, M. et al. (2015). An evaluation of China's new rural cooperative medical system: Achievements and inadequacies from policy goals. *BMC Public Health*, 15(1), 1079. doi:10.1186/s12889-015-2410-1 PMID:26494015
- Li, Q. (2009). The study on realizing the path to universal health insurance in China, Chinese version. Beijing: People's Publishing House.
- Li, S. (2006, September 29). *Population aging brings three types of pressure to China*, Chinese version. Retrieved June 24, 2016, from <http://www.huaxia.com/xw/zh/2006/00516600.html>
- Li, T. (2015, February 13). *Individual premium contribution of the New Rural Cooperative Medical System (NRCMS) will increase to Renminbi 120, but some regions still have the problem of expenditure exceeding revenue of the NRCMS fund*, Chinese version. Retrieved July 14, 2016, from http://news.xinhuanet.com/politics/2015-02/13/c_127491063.htm
- Li, Y. (2013). Analysis on high drug prices, the practice of drug kickbacks, and the centralized bidding and procurement for drugs, Chinese version. *Contemporary Economics*, 23, 17–19.

- Lin, W., Liu, G. G., & Chen, G. (2009). The urban resident basic medical insurance: A landmark reform towards universal coverage in China. *Health Economics*, 18(S2), S83–S96. doi:10.1002/hec.1500 PMID:19551750
- Liu, G. G., Yuen, P., Hu, T., Li, L., & Liu, X. (2004). Urban health insurance reform: what can we learn from the pilot experiment? In A. Chen, G.G. Liu, & K.H. Zhang (Eds.), *Urbanization and social welfare in China* (pp. 38-62). Aldershot, UK: Ashgate.
- Liu, G. G., Zhao, Z., Cai, R., Yamada, T., & Yamada, T. (2002). Equity in health care access to: Assessing the urban health insurance reform in China. *Social Science & Medicine*, 55(10), 1779–1794. doi:10.1016/S0277-9536(01)00306-9 PMID:12383462
- Liu, H., & Zhao, Z. (2014). Does health insurance matter? Evidence from China's urban resident basic medical insurance. *Journal of Comparative Economics*, 42(4), 1007–1020. doi:10.1016/j.jce.2014.02.003
- Liu, X., & Cao, H. (1992). China's cooperative medical systems: Its historical transformation and the trend of development. *Journal of Public Health Policy*, 13(4), 501–511. doi:10.2307/3342538 PMID:1287043
- Liu, X., & Mills, A. (2005). The effect of performance-related pay of hospital doctors on hospital behaviour: A case study from Shandong, China. *Human Resources for Health*, 3(1), 11. doi:10.1186/1478-4491-3-11 PMID:16253137
- Liu, X., Wong, H., & Liu, K. (2016). Outcome-based health equity across different social health insurance schemes for the elderly in China. *BMC Health Services Research*, 16(1), 9. doi:10.1186/s12913-016-1261-5 PMID:26762146
- Liu, Y. (2004). Development of the rural health insurance system in China. *Health Policy and Planning*, 19(3), 159–165. doi:10.1093/heapol/czh019 PMID:15070864
- Liu, Y., Hsiao, W. C. L., Li, Q., Liu, X., & Ren, M. (1995). Transformation of China's rural health care financing. *Social Science & Medicine*, 41(8), 1085–1093. doi:10.1016/0277-9536(95)00428-A PMID:8578331
- Lu, X. P. (2015, February 10). *Government official from China Insurance Regulatory Commission: Individuals currently still have to bear a relatively high medical expenses*, Chinese version. Retrieved July 14, 2016, from <http://finance.sina.com.cn/stock/t/20150210/111321518553.shtml>
- Luk, S. (2014). *Health Insurance Reforms in Asia*. London: Routledge.
- Lussier, R. N. (2009). *Management fundamentals: concepts, applications, skill development* (4th ed.). South Western College.
- Ma, Y., & Sun, S. (2014). Analysis on the medical insurance system for the elderly, Chinese version. *China Social Security*, 9, 28–29.
- Mahoney, J. (2001). *The legacies of liberalism: path dependence and political regimes in Central America*. Baltimore, MD: Johns Hopkins University Press.

Moving Towards Universal Health Coverage

- Mao, W., & Chen, W. (2015). *China: The zero mark-up policy for essential medicines at primary level facilities*. Retrieved July 17, 2016, from http://www.who.int/health_financing/documents/Efficiency_health_systems_China/en/
- Meng, Q., Rehnberg, C., Zhuang, N., Bian, Y., Tomson, G., & Tang, S. (2004). The impact of urban health insurance reform on hospital charges: A case study from two cities in China. *Health Policy (Amsterdam)*, 68(2), 197–209. doi:10.1016/j.healthpol.2003.09.010 PMID:15063019
- Min, Y., Jiang, L., Yan, L. L., Wang, L., Basu, S., Wu, Y., & Stafford, R. S. (2015). Tackling China's noncommunicable diseases: Shared origins, costly consequences and the need for action. *Chinese Medical Journal*, 128(6), 839–843. doi:10.4103/0366-6999.152690 PMID:25758283
- Ministry of Health. (2008). *Medifund Silver*. Retrieved February 26, 2017, from https://www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2008/medifund_silver.html
- Ministry of Health. (2016). *ElderShield Fast Facts*. Retrieved February 26, 2017, from https://www.moh.gov.sg/content/dam/moh_web/Publications/Educational%20Resources/2016/ElderShield%20Fast%20Facts%20Brochure.pdf
- Ministry of Human Resources and Social Security. (2014). *Opinions on Further Strengthening the Supervision and Management of Medical Services for the Basic Medical Insurance*, Chinese version. Retrieved July 17, 2016, from http://www.law-lib.com/law/law_view.asp?id=460883
- Moore, B. (1966). *Social origins of dictatorship and democracy: lord and peasant in the making of the modern world*. Boston: Beacon Press.
- Nanfang Metropolis Daily. (2015 February 10). *Green Book of Health Reform and Development 2014 said that medical insurance funds are faced with risks and will have a deficit in 2017*, Chinese version. Retrieved July 12, 2016, from <http://www.nandu.com/html/201502/10/1050767.html>
- National Bureau of Statistics of China. (2014). *China Statistical Yearbook 2014*. Retrieved July 12, 2016, from <http://www.stats.gov.cn/tjsj/ndsj/2014/indexch.htm>
- National Development and Reform Commission, Ministry of Health, Ministry of Finance, Ministry of Human Resources and Social Security, Ministry of Civil Affairs, and China Insurance Regulatory Commission. (2012). *The Guiding Opinions on the Launch of the Work on Critical Illness Insurance for Urban and Rural Residents*, Chinese version. Retrieved July 12, 2016, from http://www.gov.cn/gzdt/2012-08/31/content_2214223.htm
- National Development and Reform Commission, National Health and Family Planning Commission, Ministry of Human Resources and Social Security, Ministry of Industry and Information Technology, Ministry of Finance, Ministry of Commerce, and China Food and Drug Administration. (2015). *Opinions on Proceeding with the Reform on Drug Pricing*, Chinese version. Retrieved July 17, 2016, from <http://www.sdpc.gov.cn/zcfb/zcfbtz/201505/W020150505398057890638.pdf>
- Pang, S. M. (2003). *Nursing ethics in modern China: conflicting values and competing role requirements*. Amsterdam: Rodopi.

- Permanent Mission of the People's Republic of China to the United Nations. (2008). *Preventing neglect and abuse in a rapidly ageing society*. Retrieved June 18, 2016, from http://www.china-un.org/eng/chinaandun/socialhr/aging_disabilities/t531015.htm
- Pierson, P. (2000a). Not just what, but when: Timing and sequence in political processes. *Studies in American Political Development*, 14(1), 72–92. doi:10.1017/S0898588X00003011
- Pierson, P. (2000b). Increasing returns, path dependence, and the study of politics. *The American Political Science Review*, 94(2), 251–267. doi:10.2307/2586011
- Pierson, P., & Skocpol, T. (2002). Historical institutionalism in contemporary political science. In I. Katznelson, & H. V. Milner (Eds.), *Political science: The state of the discipline* (pp.693-721). New York: American Political Science Association.
- Qiu, Y. (2015). The impact of aging population on health care expenditures in China, Chinese version. *Journal of Nanjing College for Population Programme Management*, 31(2), 95–102.
- Reich, M. R., Harris, J., Ikegami, N., Maeda, A., Cashin, C., Araujo, E. C., & Evans, T. G. et al. (2016). Moving towards universal health coverage: Lessons from 11 country studies. *Lancet*, 387(10020), 811–816. doi:10.1016/S0140-6736(15)60002-2 PMID:26299185
- Saurugger, S. (2014). *Theoretical approaches to European integration*. Basingstoke, UK: Palgrave Macmillan.
- Savedoff, W. D., & Smith, A. L. (2011). *Achieving universal health coverage: learning from Chile, Japan, Malaysia and Sweden*. Retrieved June 5, 2016, from <http://www.resultsfordevelopment.org/knowledge-center/achieving-universal-health-coverage-learning-chile-japan-malaysia-and-sweden>
- Shen, C., Zhao, X., & Zou, H. (2014). Fiscal decentralization and public services provision in China. *Annals of Economics and Finance*, 15(1), 135–160.
- Shenzhen News. (2013, October 18). *Shenzhen will implement new medical insurance measure starting on January 1 next year; Local Supplementary Medical Insurance Scheme will cover migrant workers*, Chinese version. Retrieved July 16, 2016, from http://www.sznews.com/news/content/2013-10/18/content_8641375.htm
- Steinmo, S. (2008). Historical institutionalism. In D. D. Porta & M. Keating (Eds.), *Approaches and methodologies in the social sciences: a pluralist perspective* (pp. 118–138). Cambridge, UK: Cambridge University Press. doi:10.1017/CBO9780511801938.008
- Streeck, W., & Thelen, K. (2005). Introduction: institutional change in advanced political economies. In W. Streeck & K. Thelen (Eds.), *Beyond continuity: institutional change in advanced political economies* (pp. 3–39). Oxford, UK: Oxford University Press.
- Su, T. T., Kouyaté, B., & Flessa, S. (2006). Catastrophic household expenditure for health care in low-income society: A study from Nouna District, Burkina Faso. *Bulletin of the World Health Organization*, 84(1), 21–27. doi:10.2471/BLT.05.023739 PMID:16501711

Sun, Q., Liu, X., Meng, Q., Tang, S., Yu, B., & Tolhurst, R. (2009). Evaluating the financial protection of patients with chronic disease by health insurance in rural China. *International Journal for Equity in Health*, 8(1), 42. doi:10.1186/1475-9276-8-42 PMID:20003188

Tang, S., Ehiri, J., & Long, Q. (2013). Chinas biggest, most neglected health challenge: Non-communicable diseases. *Infectious Diseases of Poverty*, 2(1), 7. doi:10.1186/2049-9957-2-7 PMID:23849054

The China Health Care Study Group. (1974). *Health Care in China, an introduction: The report of a study group in Hong Kong*. Geneva: Christian Medical Commission.

The National Committee of the Chinese People's Political Consultative Conference. (2014). *Integrating medical and nursing care for the elderly*, Chinese version. Retrieved February 26, 2017 from <http://www.cppcc.gov.cn/zxww/2014/12/30/ARTI1419900481141424.shtml>

The State Council. (1998). *The Decision of the State Council Concerning the Establishment of the Urban Employee Basic Medical Insurance*, Chinese version. Retrieved July 8, 2016, from http://www.gov.cn/banshi/2005-08/04/content_20256.htm

The State Council. (2007). *The Guiding Opinions on Piloting Urban Resident Basic Medical Insurance*, Chinese version. Retrieved July 13, 2016, from http://www.gov.cn/zwgk/2007-07/24/content_695118.htm

The State Council. (2016). *Opinions on Integrating the Basic Medical Insurance Systems for Urban and Rural Residents*, Chinese version. Retrieved July 16, 2016, from http://www.gov.cn/zhengce/content/2016-01/12/content_10582.htm

The World Bank. (2010). *Fixing the public hospital system in China*. Retrieved June 26, 2016, from <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1285186535266/FixingthePublicHospitalSystem.pdf>

Thelen, K. (1999). Historical institutionalism in comparative politics. *Annual Review of Political Science*, 2(1), 369–404. doi:10.1146/annurev.polisci.2.1.369

Time-weekly. (2014). *The Zero-mark-up Policy for Drugs in Public Hospitals in Zhejiang*, Chinese version. Retrieved July 17, 2016, from <http://money.163.com/14/0410/07/9PF0NPUI00252G50.html>

Wagstaff, A., Lindelow, M., Gao, J., Xu, L., & Qian, J. (2009). Extending health insurance to the rural population: An impact evaluation of Chinas new cooperative medical scheme. *Journal of Health Economics*, 1(1), 1–19. doi:10.1016/j.jhealeco.2008.10.007 PMID:19058865

Walder, A. G. (2015). *China under Mao: a revolution derailed*. Cambridge, MA: Harvard University Press. doi:10.4159/9780674286689

Wang, J., & Chen, G. (2015 October 12). *Cheap essential drugs disappear from the market: 342 of more than 500 drugs are in severe shortage*, Chinese version. Retrieved July 15, 2016, from <http://news.sciencenet.cn/htmlnews/2015/10/328428.shtm>

Wang, J., Zhou, H., Lei, Y., & Wang, X. (2012). Financial protection under the New Rural Cooperative Medical Schemes in China. *Medical Care*, 50(8), 700–704. doi:10.1097/MLR.0b013e318249d8bf PMID:22354207

- Wang, X., He, X., Zheng, A., & Ji, X. (2014). The effects of Chinas New Cooperative Medical Scheme on accessibility and affordability of healthcare services: An empirical research in Liaoning Province. *BMC Health Services Research*, 14(1), 388. doi:10.1186/1472-6963-14-388 PMID:25217224
- Weir, M. (2006). When does politics create policy? The organizational politics of change. In I. Shapiro, S. Skowronek, & D. Galvin (Eds.), *Rethinking political institutions: the art of the state* (pp. 171–186). New York: New York University Press.
- Wong, C., Lo, V. I., & Tang, K. (2006). *China's urban health care reform: from state protection to individual responsibility*. Lanham, MD: Lexington Books.
- World Health Organization. (2008). *Primary health care: now more than ever*. Retrieved February 19, 2016, from http://www.who.int/whr/2008/whr08_en.pdf
- World Health Organization. (2013). *The world health report 2013: research for universal health coverage*. Retrieved June 1, 2016, from http://apps.who.int/iris/bitstream/10665/85761/2/9789240690837_eng.pdf?ua=1
- Wu, C. (1991). *The aging of population in China*. Retrieved June 21, 2016, from <http://www.cicred.org/Eng/Publications/pdf/c-d16.pdf>
- Wu, G., & Li, W. (2006). *New Health Revolution*, Chinese version. Beijing: Tsinghua University Press.
- Xinhua Net. (2013, March 28). *Mass media in the West said that the presence of structural defects in China's health insurance system had pushed migrant workers to visit black clinics*, Chinese version. Retrieved July 14, 2016, from <http://news.qq.com/a/20130328/000824.htm>
- Xinhua Net. (2016, January 15). *The Chinese Communist Party's newspaper reported that migrant workers find it difficult to see a doctor*, Chinese version. Retrieved July 16, 2016, from <http://finance.sina.com.cn/china/2016-01-15/doc-ifxnrahr8315304.shtml>
- Xinhua Net. (2016, February 1). *China to orderly urbanize migrant workers: Premier Li*. Retrieved July 16, 2016, from http://news.xinhuanet.com/english/2016-02/01/c_135065434.htm
- Yi, Y., Maynard, A., Liu, G., Xiong, X., & Lin, F. (2005). Equity in health care financing: Evaluation of the current urban employee health insurance reform in China. *Journal of the Asia Pacific Economy*, 10(4), 506–527. doi:10.1080/13547860500291745
- Yip, W., & Eggleston, K. (2004). Addressing government and market failures with payment incentives: Hospital reimbursement reform in Hainan, China. *Social Science & Medicine*, 58(2), 267–277. doi:10.1016/S0277-9536(03)00010-8 PMID:14604613
- Zang, J., & Ng, S. W. (2016). Age, period and cohort effects on adult physical activity levels from 1991 to 2011 in China. *The International Journal of Behavioral Nutrition and Physical Activity*, 13(1), 40. doi:10.1186/s12966-016-0364-z PMID:27094983
- Zhang, R., Wang, Z., Fei, Y., Zhou, B., Zheng, S., Wang, L., & Yu, Y. et al. (2015). The difference in nutrient intakes between Chinese and Mediterranean, Japanese and American diets. *Nutrients*, 7(6), 4661–4688. doi:10.3390/nu7064661 PMID:26066014

- Zhang, Y. (2013). Meeting the ageing challenge: China's social care policy for the elderly. In G. Wang, & Y. Zheng (Eds.), *China: Development and governance* (pp. 343-350). Singapore: World Scientific Pub. Co.
- Zheng, G. C. (2009). *The development of social security system with Chinese characteristics*. Beijing: China Labour & Social Security Publishing House.
- Zhou, Q. (2016, February 1). *The zero mark-up policy leads to hospitals having difficulty in earning revenues*, Chinese version. Retrieved July 17, 2016 from http://news.youth.cn/sh/201602/t20160201_7591716.htm
- Zhou, Z., Zhu, L., Zhou, Z., Li, Z., Gao, J., & Chen, G. (2014). The effects of China's urban basic medical insurance schemes on the equity of health service utilization: Evidence from Shaanxi Province. *International Journal for Equity in Health*, 13(1), 23. doi:10.1186/1475-9276-13-23 PMID:24606592
- Zhu, C., Sun, X., Geng, Q. F. R., Yang, H., & Jiang, W. (2015). Self-rated chronic conditions and 2-week prevalence in adults in Zhongshan, China: An epidemiological survey. *BMJ Open*, 5(11), e008441. doi:10.1136/bmjopen-2015-008441 PMID:26560055
- Zhu, Z. (2011). Whither China in the 21st century? In Z. Zhu (Ed.), *The People's Republic of China Today: Internal and External Exchanges* (pp. 429-440). Hackensack, NJ: World Scientific.

KEY TERMS AND DEFINITIONS

Ageing Population: A population with an increasing proportion of people over 65 years old.

Basic Medical Insurance: A form of public insurance that covers medical costs of the Chinese population. But its reimbursement for medical care is quite limited that participants still have to pay high out-of-pocket medical expenses.

Drug Formulary: A list of approved prescription drugs that are selected for coverage by a medical insurance plan based on their reported medical efficacy, safety and cost effectiveness.

Historical Institutionalism: An approach that centers on political institutions and past events to explain political or policy outcomes.

Non-Communicable Disease: A disease that is not contagious among people.

Physician-Induced Demand: A phenomenon whereby a doctor provides excess medical treatment for a patient in order to earn more revenues.

Universal Health Coverage: A form of medical insurance that is provided to all citizens of a country.